A STUDY ON INTERNAL/EXTERNAL HOMOPHOBIA AND THE IMPACT ON LONG-TERM HEALTH OUTCOMES: THE EFFECT ON GAY, LESBIAN, BISEXUAL, AND TRANSGENDER EDLERS IN HEALTH CARE AND THEIR DECISION TO DISCLOSE THEIR SEXUAL ORIENTATION TO HEALTHCARE PROVIDERS

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ABSTRACT

A Study on Internal/External Homophobia and the Impact on Long-Term Health Outcomes: The Effect on Gay, Lesbian, Bisexual, and Transgender Elders in Health Care and Their Decision to Disclose Their Sexual Orientation to Healthcare Providers

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An ever increasing body of literature finds a connection between strong social support and the optimum physical and mental health of the aging population. Largely unexamined, however, are the impact and the meaning of the aging process on gay and lesbian elders. This midlife cohort of "Baby Boomers" stands to be the first group of homosexuals who have lived a politically open life. This group's lifelong impact on social, political, and economic strides, however, comes into conflict within the heterocentric framework of American culture and specifically on aging research.

Historically, this group remained hidden without adequate social or material support. The exclusion of GLBT elders from gerontological theory has rendered them invisible and has silenced their unique experiences.

The purpose of this dissertation is to examine the concerns and fears of the aging gay, lesbian, bisexual, and transgender (GLBT) population. Specifically, it focuses on anti-GLBT attitudes among healthcare providers—just at the time of life when the GLBT patient's healthcare needs are growing. This research will examine if and how these fears

have the potential to drive GLBT individuals who have been "out" most of their lives back into the closet, thereby depriving them of the benefits necessary for optimal physical and mental health later in life.

In addition, the research will investigate healthcare provider attitudes in order to determine whether homophobia and fears of anti-GLBT bias has an effect on GLBT elders seeking health care services. A working hypothesis is that whether or not the research finds anti-GLBT bias among healthcare providers, the fear of that bias nonetheless affects the aging GLBT population's sense of well-being and may limit their full access to appropriate healthcare or social services.

The very process of ageing is exponentially detrimental when the individual withholds or withdraws from the physician/patient relationship. This returning to the closet and the social changes in aging may profoundly affect their willingness to access appropriate care. This impact could grievously impact an individual's quality of life thereby affecting their health outcome. Additionally, their sense of well-being could be undermined and exacerbated by heterocentric institutions.

Dedication

To Clark

You see the potential of what I can be when I am blind to it, you encourage me when I cannot lift myself up, and you are my north, south, east and west.

Because Time is precious, I will love you forever.

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Glossary of Acronyms

The following abbreviations have been used throughout this report:

AARP	Association of Retired Persons
ACA	Affordable Care Act
AIDS	Acquired Immune Deficiency Syndrome
AAPHR	American Association of Physicians for Human Rights
AMA	American Medical Association
AOA	Administration on Aging
CFR	Code of Federal regulations
DHHS	Department of Health and Human Services
DSM	Diagnostic Skills Manual
GLBT	Gay, Lesbian, Bisexual, and Transgender
GLBT-MEA	GLBT Medical Education Assessment
GLTF	Gay and Lesbian Task Force
GRID	Gay Related Infectious Disease
ICPSR	Interuniversity Consortium for Political and Social Research
IP	Internet Protocol Address
NBI	New Beginning Initiative
QOL	Quality of Life
SAGE	Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders
SAGE	Senior and Gay Equality

Chapter 1

Introduction

> *Homosexuality is assuredly no advantage, but it is nothing to be ashamed of, no vice, no degradation, it cannot be classified as an illness; we consider it to be a variation of the sexual function produced by a certain arrest of sexual development. Many highly respectable individuals of ancient and modern times have been homosexuals, several of the greatest men among them (Plato, Michelangelo, Leonardo da Vinci, etc.). It is a great injustice to persecute homosexuality as a crime, and cruelty too....*
>
> — Freud, 1935[1]

This dissertation is concerned with the issues of aging gay, lesbian, bisexual and transgender (GLBT) population, specifically, the impact that aging has had on a generation of gay baby boomers. My interest in this research is a postulation that barriers both institutional and/or internal may hinder or prevent or cause a negative impact on the delivery and health care of GLBT elders.

These circumstances may align in such a way that the health care professionals may not be aware of an individuals' sexual orientation, unique risks, or potential medical conditions that impact the GLBT community. Transversely the GLBT individual may inadvertently create complications in the health care process by not disclosing their sexual orientation and thereby contribute to the conditions that would negatively affect their long-term health outcomes.

[1] Reprinted in Jones, 1957, pp. 208-209, *The American Journal of Psychiatry*, 1951, *107*, 786

The reasoning for not being open and frank with regards to sexual orientation, medical history, medical risks, or lifestyle choices may be in part due to the social stigma attached to GLBT patient. Contributing to this is the individuals' own history and experiences of coming out. It is my contention that as the GLBT population ages, they may find themselves back in the "closet" due to a determinate of lack of social support, heterocentric norms with the medical establishment, and prejudice/homophobia experienced.

The perceived necessity of remaining silent or closeted may be in reaction to several factors, one of which includes my contention that both sides of the equation—GLBT elders and the healthcare profession—contribute and equally share the responsibility of a patient's health.

The medical establishment through historic precedence, which includes institutional heterocentric perspectives, homophobia/ discrimination, and inadequate education/training/research, continues the myopic exclusion of the GLBT cohort elder. I further believe that both the GLBT baby boomers and the medical profession may be explicitly, overtly, and institutionally hindering the health care seeking behavior of GLBT patients. Additionally, the intersections of discrimination and homophobia, and the impact within medicine requires further investigation to define the attitudes of both sides of the stakeholders; the healthcare providers and the GLBT community.

The two factors interacting together are the GLBT individuals and the process of aging – combined. In American society we no longer view old age as a reward for a life well lived, no longer do we respect and appreciate the elders in our midst. This change

has left a society that glorifies the young and leaves the experience of aging as a place we attempt to circumvent. This commodification of youth is a staple in the mass media. Advertisements fill magazine and television commercials, targeting the silver haired; regaling the public with elixirs and medications that can get it up, if it is down; turn it brown if it is gray; and lift you up if you are down. We have come to believe that aging is not for the timid to paraphrase Mae West.

We are a society that fears a natural progression of aging and the implication of what that may mean. We are a society that presently staves off aging through the use of medication and nutraceuticals to magically restore our youth through chemical/natural compounds. Society in general is ill-prepared to face the prospect and eventually of the rapidly aging population. Our culture of youth is so pervasive in the mass media, film, and psyche of the American public that the idea of growing old is dismissed or shoved to the back of the geriatric closet.

The many needs of seniors go far beyond just the social context of the aging experience in America. The social services and medical care of the population at large (read heterosexual) and the growing number of individuals (baby boomers) joining retirement age has been continuously researched over the past several years in the gerontology field.[2]

[2] Predictors of Healthy Aging: Prospective Evidence from the Alameda County Study. A longitudinal study that researched a cohort of subjects from 1965-1984 (Guralnik and Kaplan 1989).

An increasing body of medical and academic literature finds a connection between strong social support and the optimal physical and mental health in the aging population. Dr. Donna Shalala, Secretary of Department of Health and Human Services (DHHS) stated in her opening remarks at the *Partnerships for Health in the New Millennium: Launching Healthy People 2010* conference, "We are going to double the number of elderly in the next decade…we must promote a healthy community that will promote healthy lifestyles."[3] Geriatric research has identified areas like financial stability, access to safe and appropriate housing, quality health care, and supportive services as just a few of the universal needs of seniors.

The current body of research strongly suggests that the ability of an aging population to age where they live and have access to both community support and social services is an imperative for aging well (Vaillant, 2002). An ever increasing body of medical and academic literature finds a connection between strong social support and optimal physical and mental health in the aging population (Uchino, Cacioppo, & Kiecolt-Glaser, 1969). As previously stated - the many needs of seniors go far beyond just the social context of the aging experience.

[3] The conference was sponsored by DHHS in conjunction with the Healthy People Consortium and Partnerships for Network Consumer Health Information. A full transcript of the conference can be accessed through the DHHS web-link: http://www.healthypeople.gov/2020/default.aspx

A Survey of Needs

Much research over the years has added a great depth and knowledge to the study of gerontology, utilizing many different constructs in order to better understand the experiences; however, within this broad area, little beyond the predominant race, ethnicity, or gender has been focused on. Sub-group populations are particularly overlooked.

One such sub-population that remains under researched and somewhat cloaked in hidden numbers or invisibility is the gay, lesbian, bisexual, and transgender (GLBT) population. This group represents a *class* where little specific research has been put forth in comparison to the general heterosexual population. This shortcoming has been identified in the geriatric field, GLBT community, and academic/government research centers. There have been however, recent strides to address and initiate the current body of research and literature in this area. This is where the intersection of my research will attempt to augment and fill some of the voids by studying and identify the research issues in the field of aging GLBT populations.

Recent initiatives include the commissioned consensus study by the Institute of Medicine of the National Academies (IOM) specifically on GLBT health issues, research gaps, and opportunities. This study is to assist in the National Institute of Health efforts to increase the research efforts in studying these groups. (IOM 2011). The study and research into GLBT elder experiences present a ripe and unique opportunity to expand the current knowledge, adding to an otherwise thin research dossier.

In an "American Journal of Public Health" article published in 2002, researchers conducted a literature survey on studies that included lesbian, gay, bisexual, and transgender populations published in the past 20 years on the subject of public health research.[4] Their findings concluded that "historically, public health researchers have not recognized GLBT persons as a population with distinct health issues outside of a framework of sexual deviance or sexually transmitted diseases" (Boehmer, 2002).

I previously used the term "class" to differentiate from the larger general population that is a heterocentric construct. The heteronormative culture is not a single monolith. The experience of race, economics, geography, education and health all play a large role in defining who one is in society, as does sexual orientation. How one copes with and addresses the changing role of their lives within the aspects and subject of aging in society cannot be generalized by the default heterocentric model.

This heterocentric model, whether explicitly or implicitly applied, nevertheless affects the GLBT elder. As for the aging gay population specifically, the impact of society on a generation of openly gay baby boomers who, as they age, may find themselves a stranger in a foreign land, navigating and accessing social support systems that may, explicitly or implicitly, push them back into the closet. My focus will

[4] This study approached the literature review by searching the National Library of Medicine and MEDLINE for any articles published between 1980-1999 that included the term GLBT or individually named. A total of 3, 822, 822 citations were assessed from the National Library of Medicine and 3,777 from, Medline. The conclusion of the study determined that only 0.1 percent of the Medline articles focused on GLBT individuals.

specifically review how the gay and lesbian senior experience intersects with their health care needs.

What I attempt to present and what this study is focused on is the institutional approach to the exclusion or minimization of the experiences of GLBT elders, and specifically to study the effects of sexual orientation disclosure on the individual as well as the healthcare provider. To categorically define homophobia as an institutional construct minimizes the important concept that internal homophobia can have the same detrimental effect on the long-term health outcomes of GLBT elders.

When internal/ external homophobia prevents or inhibits communications with healthcare providers, the cause and effect of poor medical histories, sexual conduct discussion, risk of undiagnosed mental disorders, alcohol/drug use, etc., can create conditions that will adversely impact the medical treatment plan. Without an open communication between the patient and provider a void within the communication and understanding that should take place between a patient and their health provider cannot happen.

My working hypothesis explores whether disclosure or lack of disclosure creates cause and effect differences that impact the long-term health outcome for this aging GLBT population. One other aspect of the disclosure question is centered squarely in the discussion of (internal as well as institutional) homophobia by both individuals and healthcare professionals.

> Many GLBT people encounter stigma from an early age, and this experience shapes how they perceive and interact with all aspects of society including health-related institutions. Likewise, heterosexual people (including many health care

> professions) have been socialized in a society that stigmatizes sexual and gender minorities and this context inevitably affect their knowledge and perceptions of GLBT people. (IOM 2011)

When any obstacle prevents an exchange of information, sharing of communications, or creates an environment that is not supportive of freedom from condemnation, blame/guilt, or dehumanization, the place for medical humanities exists.

When attitudes or perspectives toward patients create this obstacle, the withholding of pertinent information that could more fully explore an individual's medical history or life experiences deters and perhaps prevents the goal of appropriate medical treatment and negatively impacts that individual's health outcome. These obstacles can include cultural, financial, or due to a lack of education or resources. As I propose in my findings, the obstacles of prejudice and bias can also impact the larger health care system, individual stakeholders, healthcare professionals and, most importantly, the patient.

How can society assess and define the needs of the gay and lesbian community without examining the uniqueness of their experience compared to their heterosexual contemporaries? While many studies have researched the aging process, there has been little attention paid to "the voices that emanate from the bodies themselves" (Nettleton and Watson 1998).

Terry Kaelber at the "Make Room for All" summit meeting in Washington, DC[5] made this summation of the aging process: "If we're to have a society where age is

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[5] White House Committee on Aging (WHCoA) Conference 2005. *Make Room for All: A National Summit and Hearing on the Recommended Priorities for the WHCoA:*

valued, differences must be acknowledged…aging is not one size fits all" (O'Brian, 2006). The "one size fits all" generalization is clearly not successful when applied to a once hidden sector of the population.

Gerontologists and clinicians working with older adults are aware that the aging experience differs between the majority population's (heterosexual) experience and the GLBT population's experience. There is increasing research and recognition of social and cross-cultural differences, and how these experiences shape the diversity of the aging experience, but aging in a non-heterosexual context remains under studied.

Has this "profound cultural silence" (Twigg 1996) continued the health care system's traditional heterocentric viewpoint and not recognized or denied another? Lesbian and gay elders are among the most invisible of all Americans. These elders suffer from a double stigma in society, a hidden sexual population as well as an aging population with no true representation.

In 2000, there were an estimated 35 million people age 65 or older in the United States (Bureau, 2001). In 2010, the post-World War II baby boom generation will begin to turn 65, so that by 2030 there will be approximately 70 million older persons—more than twice of those in 2000 (DHHS, 2001). It is widely believed that approximately 10%

Diversity, Cultural Competency and Discrimination in an Aging America. Sponsored by the National Gay and Lesbian Task Force, the event highlighted the growing diversity of the country's aging population, as well as the challenges that diversity presents to policymakers and service providers. *Make Room for All* was backed by the American Society on Aging and its constituency groups, the Lesbian and Gay Aging Issues Network and the Network on Multicultural Aging; National Association on HIV Over Fifty; SAGE; Older Women's League; and Griot Circle, among others. Summit keynote speaker Dr. Norma B. Thomas, director of the Philadelphia-based Center on Ethnic and Minority Aging, said, "We are not ready for the increased diversity."

of the population is homosexual, give or take a two percent error margin. It is possible that by 2030 the gay and lesbian population could amount to as many as seven million individuals.

Table 1.

Estimates of the Base Rate of Homosexuality and Bisexuality

Estimates of Percentages of population that is Homosexual	Definition of Homosexuality (sample description)	Research Study
37.0	Men admitting to at least some overt homosexual experience between adolescence and old age (5300 white males in the United States).	Kinsey, Pomeroy and Martin (1948)
20.3	Adult males having had a homosexual experience to orgasm (data from National Opinion Research Center survey of 1450 males in the United States).	Fay, Turner, Klasser, and Gagnon (1989)
18.6	Males reporting same-sex attraction to or sexual behavior since age 15 (3381 participants in the United States, France and the United Kingdom).	Sell, Wells, and Wypij (1995)
18.6	Females reporting same-sex attraction to or sexual behavior since age 15 (1874 participants in the United States, France and the United Kingdom).	Sell, Wells, and Wypij (1995)

Table 1 *continued*

Estimates of Percentages of population that is Homosexual	Definition of Homosexuality (sample description)	Research Study
17.0	High estimate of predominant same sex orientation (review of Kinsey, Pomeroy and Martin (1948) and Laumann, Gagnon, Michael and Michales (1994) studies adjusting for possible risks involved in self-disclosure).	Gonsiorek, Sell, and Weinrich (1995)
15.3	Males reporting being homosexual to some degree (stratified random sample of 750 males in Calgary).	Bagley and Tremblay (1997a)
13.0	Women admitting to at least some overt homosexual experience between adolescence and old age (5940 white females in the United States).	Kinsey, Pomeroy, and Martin (1948)
10.0	Men who were more or less exclusively homosexual for at least three years (5300 white males in the United States).	Kinsey, Pomeroy, and Martin (1948)
9.2	High estimate from a male twin study (161 males in the United States).	Bailey and Pillard (1991)
9.0	Men reporting having had frequent or ongoing homosexual experiences (cross sectional nationwide survey of American adults aged 18 and over).	Janus and Janus (1993)

Table 1 *continued*

Estimates of Percentages of population that is Homosexual	Definition of Homosexuality (sample description)	Research Study
7.5	Males reporting same-sex sexual partner in last five years (3685 participants in the United States, France and the United Kingdom).	Sell, Wells, and Wypij (1995)
7.0	High estimate of males having experienced some same sex sexual contact in adulthood (review of five probability surveys from 1970 to 1990 in the United States involving 8,857 participants).	Rogers and Turner (1991)
7.0	Males having a homosexual experience during more than three years of their lives (volunteer survey of 2036 people).	Hunt (1974)
7.0	Preferential, experimental and situational homosexuals (review of 12 large surveys)	Hewitt (1998)
6.9	High estimate of females reporting homosexual behavior (review of studies conducted in Japan, Thailand, Denmark, France, Palau, Great Britain, and Australia from 1948 to 1991).	Diamond (1993)

Table 1 *continued*

Estimates of Percentages of population that is Homosexual	Definition of Homosexuality (sample description)	Research Study
6.0	High estimate of individuals reporting to be homosexual or bisexual since age 18 (probability sample of approximately 1500 people; nationally representative in the US).	Smith (1991)
5.5	Males reporting homosexual behaviour (review of studies on homosexual behaviour from 1948 to 1991).	Diamond (1993)
5.3	Men reporting sexual activity with a same sex partner since age 18 (national probability surveys with 3941 respondents in the United States between 1989 and 1994).	Binson, Michaels, Stall, Coates, Gagnon, and Catania (1995)

Source: (Banks 2003)

The following statistical results garnered from a government publication from a Center on Elder Abuse research project represents significant findings and presents a picture that reflects an overall negative outcome for the GLBT elder population.

- In a survey of 416 LGB elders, aged 60 or older, *65% of respondents reported experiencing victimization due to sexual orientation* (e.g., verbal abuse, threat of violence, physical assault, sexual assault, threat of orientation disclosure, and discrimination), and *29% had been physically attacked*. Men were physically attacked nearly three times more often. Those who had been physically attacked reported poorer current mental health. Many in the study were still closeted from others. Serious family or personal problems can result

from disclosure of an older adult's LGB identity. (D'Augelli & Grossman, 2001)

- Caregivers may not be accepting of GLBT elders. In a survey of 3,500 GLBT elders, 55 and older, *8.3% of the elders reported being abused or neglected by a caretaker because of homophobia, and 8.9% experienced blackmail or financial exploitation*. (Frazer, 2009)

- Prejudice and hostility encountered by GLBT elder persons in institutional care facilities create difficult environments. Staff may deny an GLBT elder's visitors, refuse to allow same-sex couples to share rooms, refuse to place a transgender elder in a ward that matches their gender identity, or keep partners from participation in medical decision making. (Map, Sage, & Cap, 2010).

- Transphobia, or social prejudice against transgendered persons, may be more intense than that of homophobia with a *very high rate of violent victimization* (Cook-Daniels, 1998).

- Cross study investigation reveals that transgender people, in general, are at high risk of abuse and violence. Initial data reported by MAP state that an average of *42% of transgender people have experienced some form of physical violence or abuse*. Further, on average *80% of transgender people have experienced verbal abuse or harassment* (MAP, 2009). Therefore, it is a reasonable assumption that transgender elders may have experienced some form of abuse. (Aging N. C.-A., 2013)

Historically, the gay and lesbian community has been excluded from gerontological theory with the exception of the studies of deviant or abnormal behavior research studies. The hidden population of gay and lesbian elders and the lack of adequate research of their needs were acknowledged by the US Office on Aging in 2001 as well as peer reviewed journal articles (Orel, 2004; Haber, 2009). In a report from the Office of Aging, it was recognized that gay and lesbian elders are underserved by the federally funded programs that receive support through the Older American's Act.

My research explores how the gay and lesbian elder often does not access adequate or appropriate health care or social services they may need due to perceived

homophobia or institutionalized historic heterosexism. One such example is that little research has been presented from government or academic researchers in the field of aging that include questions about sexual orientation or gender identity.

My supposition is that discrimination influences health outcomes; discrimination is best described as active/passive, overt/covert, or implicit/explicit. The stakeholders include the aging patient, the physician, and institutions of health care, government, and academic bodies. To quote one researcher "older gay men and lesbians, out of fear of discrimination are five times less likely to access health care and social services (King 2010).

As the population ages it will obviously increase the services required and impact the availability of these services to patients. Services and access will be affected, and will also expand or contract depending on economic factors. The area that I am interested in not only defines the needs of the elders, but asks, what are the barriers or hurdles that prevent full access to health care services? My research includes addressing the barrier to full disclosure and defining the factors that lead many GLBT elders to the decision to remain hidden.

Promoting a universal "successful aging strategy" for any senior would encompass a variety of quality of life (QOL) issues regardless of their sexual orientation. These issues or needs include maintaining physical and emotional well-being, self-determination or autonomy/independence, and aging in their own community or home with respect, safety, and support. Yet, the process of aging and its related experiences are generalized. These are life experiences that are both similar and unique to both groups.

Department of Health and Human Services (DHHS) Secretary, Kathleen Sebelius in an announcement of a major DHHS grant to the Services and Advocacy for Gay, Lesbian, Bisexual, and Transgender Elders (SAGE) stated, "Agencies that provide services to older individuals may be unfamiliar or uncomfortable with the needs of this underserved population…we now recognize that GLBT older adults also represent a community with unique needs that must be addressed" (Sebelius 2010).

The Administration on Aging (AOA) recognizes that there has been a gap in the aging systems and services developed within and for the GLBT community. AOA has set several goals to redress these issues by: "educat[ing] mainstream aging service organizations about the existence and special needs of GLBT elders, [and sensitizing] GLBT organizations about the existence and special needs of older adults" (Aging, 2003).

It is difficult to quantify how many GLBT older adults are accessing or refusing to access mainstream services when agencies do not ask relevant demographic or social questions. In the past, there has been little to no federally-funded research or data collection on GLBT older adults, which effectively obscures the many unmet needs and vulnerabilities of this group and prevents an academic review of the very size of the GLBT population at large or the study of this group's unique experiences and needs.

The research field, however, partly due to changing social and cultural dynamics, has begun to take a serious look beyond the study of GLBT populations as sexual deviants or in the context of sexually transmitted diseases, and has begun to conduct serious research in both quantitative and qualitative studies of this group. Many

partnerships have been started that include academia, government, state agencies, and private institutions that are seeking to answer the questions that affect the various experiences of this population. Groups such as the National Gay and Lesbian Task Force have commissioned work to be done in the area that has contributed to the discourse (Cahill, South, & Spade, 2000).

Serious research into the concept of viewing the GLBT elder population as a class or socially identifiable group has enabled a more thorough study of the issues surrounding this cohort. Early research by queer studies theorist, Evelyn Hooker's study *Homosexuality*, approached the study of gay and lesbians as a distinct culture; a culture simply defined includes shared language, customs, and identity. Society historically, marginalized the gay and lesbian experience, branding those members as deviant, sinful, or criminal, any research was centered on that academic construct.

It is not surprising that GLBT elders would be wary of disclosing their orientation. Much of the ill-treatment of gay and lesbians historically has been either at the hands of or caused by the medical establishment, perhaps the fear of the medical establishment remains today (Aging, 2013).

There has been an increase in research and investigations into examining bias and negative attitudes toward GLBT elders by healthcare providers and the impact that this issue has on the long-term impact on health outcomes (Claes & Moore, 2000). Many of these studies, surveys, are ongoing and have yet to be published; however, an initial

review of journal articles and conferences highlight the role of homophobia and bias in the attitudes of healthcare providers.[6]

Having established the scarcity of contemporaneous research in this field, I have determined that in order to fully pursue this area of study, the research conducted for this paper would require a more direct approach and various truncated searches.

The prerequisite literature review includes published reports pertaining to health care, homophobia, health care attitudes, gerontology, and standard foundations for examining a field of study. These strategies have a valuable place at the table, but also represent only a snap-shot in time, of a given moment, or a particular theory/understanding.

Given that we live in the age of the internet and ease in which to capture and collect large amounts of data, easy access to target groups through social media, and the tools of modern computing, the ease in research is aided by these modern utilities.

Hooker in the past relied on volunteers met through intimate/chance meetings to derive her study and research. She reached out to the place that people gathered to ask for volunteers. In this research project the spirit of Dr. Hooker was channeled and an appeal was made to an anonymous social media website whose members generally were gay and bisexual men. The survey tool Graying of the Pink was completed by study

[6] Stanford University: The study was conducted by members of the Lesbian, Gay, Bisexual and Transgender Medical Education Research Group, which was founded at Stanford's School of Medicine in 2007. http://med.stanford.edu/ism/2011/september/GLBT.html

volunteer subjects and included questionnaires and free text narratives of their experiences.

In addition, volunteer participants were self-selected, self-identified through the social media survey and inclusion criteria of age verified through the social media's profile. The information and experience collected during this process, allowed me to focus my attention on the identified gaps that appear in the intersections of published papers and research studies.

A Brief History

It is important to survey the broader context of the GLBT history over the past 50 years, or post World War II period. For the changes in the now known GLBT movement in America and the politicalization of an outcast group labeled as criminal, deviant, mentally ill, and morally repugnant was not immediate or easily won.

The decriminalization of the state and federal laws associated with homosexual behavior, known collectively as the sodomy laws, and the coming of age of the gay liberation movement in the late 1960s, provide a backdrop to the events and experiences that this targeted GLBT elder population experienced. It shaped and affected their lives on a personal as well as global scale, and radically changed the perspective of homosexuality for society, including the medical profession.

It was during this time that the first serious study of human behavior in relationship to homosexual behavior was undertaken. The age of Kinsey[7] (Kinsey, 1948/1998), and Hooker[8] research brought about dramatic changes that shaped the medical treatment of homosexuality as an illness to its removal from the Diagnostic Skills Manual (DSM) in 1973.[9]

The social changes that have resulted from the horrific modern day plague known as Acquired Immune Deficiency Syndrome (AIDS) shaped this GLBT group of elders. Historic realities clearly show that the gay and lesbian community cut their teeth and honed their political skills organizing grass root responses, applied financial dollars to political campaigns, but most importantly, they became cognizant that it takes the whole community to construct change. The GLBT elders were spectators and participants of this this age; these events galvanized a politicalness that could be compared to the civil

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[7] Alfred Kinsey: *One of the most influential* Americans of the 20th century, Alfred Charles Kinsey conducted landmark studies of male and female sexual behavior that helped usher in the "sexual revolution" of the 1960s and 1970s. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1447862/

[8] For more on Evelyn Hooker see: http://www.psychologicalscience.org/ index.php/publications/observer/ 2011/october-11/psychology-yesterday-and-today-evelyn-hooker.html

[9] In 1973, the weight of empirical data, coupled with changing social norms and the development of a politically active gay community in the United States, led the Board of Directors of the American Psychiatric Association to remove *homosexuality* from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Some psychiatrists who fiercely opposed their action subsequently circulated a petition calling for a vote on the issue by the Association's membership. That vote was held in 1974, and the Board's decision was ratified. http://psychology.ucdavis.edu/faculty_sites/rainbow/html/ facts_mental_health.html

rights experiences. Events that shaped and defined this collective group of individuals, defined not necessarily by social class, education, economics, or religious affiliations, but through the shared experience of being GLBT.

The single voice could be joined with hundreds and thousands of other like voices to scream out their anger and rage, mobilizing the engine of change.[10] Those once youthful voices have matured over the years, and like myself have survived one crisis (AIDS) to find ourselves facing another more natural crisis of sorts—aging and the intersection of medicine.

Turning of age in the late 1970s and early 1980s, many contemporaries believed that this generation was standing in the footsteps of a "*Brave New World.*" This was absolutely true. What hope, enthusiasm, and optimism that was collectively shared as gay and lesbians was quickly replaced with the emergence of Gay Related Infectious Disease (GRID)[11] —the gay plague—later called AIDS.

The political ramification of our government's silence or lack of involvement early on in the AIDS epidemic highlighted a reality. That reality was simply this, the voices of gay and lesbians were irrelevant and considered to be part of the fringe; the disenfranchised, the morally objectionable. 'Those queers, faggots, dykes' who spoke

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[10] AIDS Coalition to Unleash Power's (ACT UP) non-violent direct action, often using vocal demonstrations and dramatic acts of civil disobedience, focuses attention on the crucial issues of the AIDS crisis. http://www.actupny.org/documents/capsule-home.html

[11] http://www.nytimes.com/1982/05/11/science/new-homosexual-disorder-worries-health-officials.html

out or attended demonstrations were viewed with suspicion and faulted as morally responsible due to their "choice" and "lifestyle."[12] Main stream media highlighted the sympathetic side of illness, death, was balanced with the prevailing notion that homosexuals brought their illnesses upon themselves through their sexual perversity and promiscuity. Religious leaders and conservative politicians alluded to the illness as a faulted event, meaning that the fault of the sickness and death lay at the feet of the individuals and the GLBT community.

The gay community collectively experienced these seminal events. Many survivors were left with few remaining friends. The social network of extended families was decimated. What few community supports were available were applied to those suffering from the terrible effects of the AIDS outbreak. Many contemporaries withdrew out of self-protection, burn out, or to lessen their grief. This grief, survivor guilt, took hold within the community.

Writing about AIDS, Levine (1989) noted that disasters can destroy a community's social-cultural order. This event can cause a form of survivor guilt—a trauma that refers to the loss of community; the network of relationships and shared

[12] The grass roots movement and response within the Gay community to the AIDS crisis established a moral and political voice. This epidemic dramatically shifted most gay men and women's acceptance of their place in society and challenged the idea that their lifestyle marginalized their lives and experiences. The group ACT UP became the rallying cry, political voice, and urban guerilla demonstration organizers in direct opposition to the government's silence. The many slogans or banner cries included "Silence = Death." The demonstrations included events at St Patrick's Cathedral in NYC, The International AIDS Conferences in Europe, "die ins" in NYC, LA, SF, as well as direct action against Pfizer, the maker of AZT. Eventually these types of demonstrations lead to collations between government, pharmaceutical companies, and the gay community.

meanings that provide a sense of self, social support, and cultural community. This idea is further presented in a later section as a comparison to the natural aging experience.

Those that experienced life before the age of AIDS lost valuable social connections and support systems; a community was created between positive and negative people. The loss included acquaintances, whole networks of friends, life partners, and extended families. The difference between the AIDS epidemic and the natural progression of aging is that with the AIDS epidemic, the cultural group was younger; in their prime. Many of those affected were at the beginning of their professional and adult lives. Randy Shilts (1987) wrote about the generation, the lives of men, rejected by their biological relatives, cared for by same-sex partners and extended gay families—a community of choice; a whole "generation" of young men, killed by rare and exotic diseases.

Perhaps, it is akin to war, able-bodied young men struck down in their prime. Earnest Hemingway and Gertrude Stein referred to the dead soldiers after World War I as the "Lost Generation," a way of summing up the idea of the complete loss of talent, youth, and hope for a better future. I feel that Hemingway and Stein were also addressing the mourning of the lost generation's collective accomplishments that would never come to pass.

These are the events that shaped this group of GLBT elders; their experiences vastly different from the heterocentric majority population. Their experience was a cultural revelation, one that is arguably a defining snapshot of a cultural community akin to other cultural communities be they ethnic, religious, or national. This comparison is

relevant to later discussions on cultural competencies and specific to healthcare providers working with GLBT elders.

The history of the GLBT elder is important, for the lessons learned from these past experiences can be applied to the looming issue of aging in the gay and lesbian community. Like AIDS, very little research money has previously been available or earmarked to study this specific population, little research or information has been published on the subject of aging in the gay and lesbian community, and the number of individuals affected by the "aging process" is rapidly swelling.

As with the AIDs epidemic frustrated by the slow pace of research, GLBT activists and grass-root community-based organizations are partnering with healthcare workers to organize community-based research studies and models to address these needs. Many of these studies are targeting large urban cities like New York, Chicago, Boston, and Los Angeles; however, the study on the impact of homophobia and long-term health outcomes has been missing from the discussion.

Accepting that research is growing in this field and understanding the difficulties associated with studying a population as diverse as the GLBT elders, any contributing research is in and of itself valuable to the field. [If gerontologists and clinical understanding is that the aging experience is unique and different in particular sub-groups from the general population, how then are the professional communities ignorant of the manner that GLBT elders experience transitional or specific phases of their lives.]

The elder lesbian, bisexual, gay and transgender population in the United States is estimated at three million. If that is accurate, "it is as large as the elder U.S. population

of African ancestry, and three times the size of the U.S. elder Asian population" (Thompson, 2008). Yet, as a culturally defined sub-population, the GLBT elder remains under represented in the numerous government, academic, and medical research programs within the gerontology field domain.

Methods

One of the stakeholders that I reached out to in this research was the gay community. Utilizing a social networking site, a request went out asking volunteers to complete a 25 question survey. The survey group consisted of a bi-coastal geographic location that included the cities of New York and San Francisco. Over 460 self-identified gay men indicated interest and possible study participation. After the initial screening, a total of 236 men met the inclusion criteria of "baby boomer age" (48-72 years; born between 1945-1964) parameters (N=460 with 236 meeting inclusion/exclusion criteria a 51% rate). This survey was administered through an anonymous third-party hosted, web-based survey vendor. (N=236 with 61 completing, or a 26% completion rate).

The survey included questions concerning basic demographics; age, race, marital status/partnered/single, religious affiliation, income, and questions on psychological and social profiling. Additionally, five open-ended questions were presented so the respondents could have an active voice in discussing their own experiences, expectations, and points of view on their own aging process.

This survey was initially slated to be statistically analyzed for relevance and general outcome; however, this process was not successful, not in the outcome, but in the

logistics of getting it reviewed and categorized for statistical analysis. This is one of the areas that can be pursued in the future and included in future investigations with a larger number of survey participants, involving lesbian, bisexual, and transgender elders.

Augmenting the survey, a review of the literature contained in journals, newspapers, academic/peer reviewed papers, Internet searches, and including government research, programs, and projections was conducted throughout the course of this project. The body of lesbian and gay elder literature is expanding and academic interest is growing, however, many of the references currently being cited such as *Midlife and Aging in Gay America* were published prior to 2003 and are now somewhat dated.

The data from these works are indicative of a snap shot in time, meaning that the relevance is limited to a historic context and dated in light of cultural shifts in political and public arenas. Prior to 2005, marriage equality and the associated rights of the other half were not included in the discussion of aging and health care.

The key to any successful research project is to access contemporaneous research and publications in this field. With my research subject focused on the GLBT elder and health care tied to the health care outcome, I determined that a review of healthcare provider's attitudes on GBLT elders would be relevant.

Stanford School of Medicine's GLBT Medical Education Assessment (GLBT-MEA) has been conducting a research project for several years on this topic. This national survey is a longitudinal study that continues to be administered to medical students throughout North America, what data has been published has provided much information on many lines of inquiry on healthcare providers and the GLBT community.

A dialogue with the abovementioned GLBT research group at Stanford University was initiated to request access to survey data that was published in 2012. The results of the published findings play a role in determining and gauging the current viewpoint held by medical students toward GLBT patients.

Further research with the American Medical Association shows that the GLBT Physician Forum pursued an inquiry into the changing attitudes within the medical profession and the impact those changes have had on the GLBT community. Though the direction of focus for this research was on the GLBT patient, a secondary outcome to this review provided insight into the homophobia bias and discrimination experienced by the GLBT healthcare providers, including physicians, nurses, physician assistants, and medical/students; for to truly comprehend the impact of homophobia on the patient; we must also question the possible impact of homophobia and discrimination on those that provide the health care. A more detailed account of this line of discovery will be presented later in this research.

Chapter 2

Literature Review

In the review of the literature sources, including documents, manuscripts, and letters, texts and monographs as well as journals, newspapers, government reports, and public documents yielded a surprising large body of general information. A summary of the medical literature through computerized searches from January 2010 to Nov 2013 included MEDLINE, GOOGLESCHOLAR, and HEALTHSTAR is included in this paper. The search strategies included health care of gays and lesbians and clinician-patient communication, homophobia, heteronormative, and barriers to healthcare in elders. Additional searches were conducted in subject areas such as gerontology, medical education, cultural competency, and cultural diversity. The results from the searches identified a number of prevalence, trends, and disparities.

This trove of material, however, spans the vast category of subjects covering the GLBT subject matter. When one drills down to view material more germane to GLBT elders, internal/external homophobia in health care, and combine this search with long-term health outcomes, the sheer size of the material pool dwindles to a trickle.

A Medline database review of literature published during 1980-1999 brought to light the fact that only 0.1% of the articles had focused on GLBT issues. This percentage was based on the contents of the entire Medline database of 3,777 articles. Much of the literature citations and abstracts found focused on HIV/AIDS, substance abuse, and mental health (Committee on Lesbian Populations & Medicine, 2011).

Within this body of results further search parameters were entered to expand and collapse the research variables. An example of the funnel approach to the research is found in Literature Internet Search Parameters, Figure 1. The results fell into two areas, a demarcation defined by a large body of work that represents a pre-2000 data set (a conservative status quo on social attitude concerning GLBT individuals) and a much smaller pool of information that represents post-2000 (progressive social contexts concerning GLBT populations).

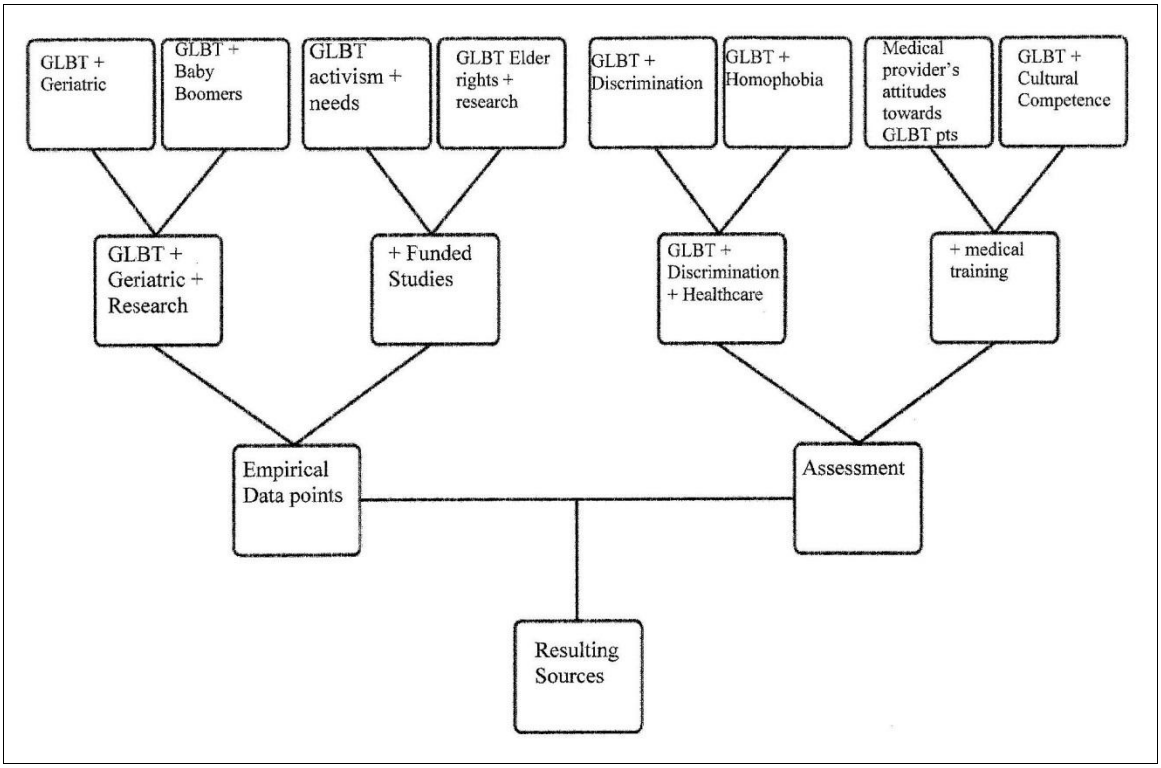

Figure 1. Literature Internet Search Parameters.

The conclusion that can be immediately drawn from the survey of the past and current literature of the GLBT elder experiences is that there is a scarcity of research conducted in GLBT elders. There is currently little public health infrastructure for funding and supporting research on the health of gay and lesbian elder populations (Shippy, 2001).

Recently, however, the latest mined data and research reports have began to be more fortuitous in material published in scientific periodicals and peer reviewed articles. The *Sexuality Research and Social Policy Journal* and the *Journal of Gay, Lesbian, and Bisexual Identity* contained a number of contemporaneous articles addressing the growing aspects of aging from a GLBT perspective. These articles would appear to substantiate the notion that research in queer and gerontology theories is expanding.

Along with an increase in recent articles and published reports, federal government agencies are becoming increasingly active in research and more inclusive in their study parameters. Many of the government reports have become available through the government clearinghouses and on-line servers. The variety of subject matter has expanded during the three years this study has been conducted.

The National Healthcare Disparities Report of 2011,[13] have included information specifically addressing the inequality faced by the transgender community. On the local level, state agencies, including those that have been historically identified as the least

[13] http://www.ahrq.gov/qual/nhdr11/chap10a.htm

supportive of GLBT rights, are producing detailed datasets that expand the current thinking and knowledge.

An example of this is GLBT Health Disparities in Missouri, a factsheet that reports: "In Missouri, lesbian, gay, bisexual, and transgender individuals experience poorer access to care and worse health outcomes than heterosexuals" (Winter, 2012).

Grass root actions to examine and address aging GLBT people have helped to start the discussion on identifying the unique needs of this aging population through direct action, partnering with academic researchers, and outreach education found in published reports like The San Diego County GLBT Senior Health Care Needs Assessment, articles by the Chicago Task Force on GLBT Aging, and Boston's Health outreach programs.

Resource references previously cited *Midlife and Aging in Gay America,* published prior to 2003 which offers a snap shot in time, but are now dated (Kelly, 1977). More contemporaneous and ongoing research papers, particular to the unique and specific aspects of the GLBT population can be found in periodicals, peer review papers, and academic journals. However, a search in these journals has found that little empirical work has been done specific to the unique experiences and needs of GLBT elders.

The San Diego County GLBT Senior Health Care Needs Assessment report noted that "research on GLBT seniors is limited and very little information is available about GLBT seniors in our society" (Zians, 2004). According to Laura Dean's publication "Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns" (2000), the experience of aging is ripe for investigation, but definitive studies on the relative risk of

individuals for specific health problems such as cancer, long-term use of hormone replacement in transgendered individuals, contraception studies in the lesbian population, or other diseases are quite rare.

In the last decade, much of the research and attention on the GLBT community has been in the HIV/AIDS field and in particular the study of the effect of HIV/AIDS. This focus though necessary has obscured or possibly sidelined an important field of study; to investigate and determine the specific needs of GLBT elders. In recent publications, there is a slowly growing body of literature that has begun to research and study the life experiences of older lesbian women and gay men, but much of the existing scholarly body of lesbian and gay elder literature is somewhat dated.

As previously stated, historically, the gay and lesbian community has been excluded from gerontological research and theory. This lack of research has rendered the group hidden within the general population, without social acknowledgement or critical research data supporting their unique experiences or strategies. Perhaps one of the extenuating circumstances for such small scholarly interest is a legacy impact; an impediment to research in this area due to the fact that during much of the twentieth century consensual same-sex sexual behavior was illegal and homosexuality was considered a form of mental illness or deviance. This societal viewpoint has shaped and influenced many contemporary institutions that contributed to the discussion in this field.

John Hopkins Center for Health Disparities Solutions identified in their webinar series: *Understanding the health needs of LGBT People: an introduction*, that barriers to care include lack or minimal healthcare provider training. Statistics included that in a

2009-2010 survey of 133 medical school deans noted that the median time for LGBT content in curriculum was 5 hours. Most of this instruction was focused on HIV/AIDS training, treatment, and diagnosis.

If research studies are designed to describe population characteristics, explore unanswered questions, test hypotheses in order to validate findings, or investigate areas that are as yet unexplored, why has research failed thus far to explore the full lives of GLBT elders? In essence, where is the research and investigation into and including the missing voice of the elders?

It is difficult to ascertain or definitively categorize why there is only dated and/or insufficient data research available on the GLBT elder. Research that is objectively exploring the questions and pursuing the field work without bias or prejudice has been limited. Much of the literature historically has been concerned with negative stereotypes (Berger, 1996).

Academic centers across the nation are beginning to wade into this research field. The Center for Population Research in GLBT Health's[14] mission statement reads "…supports and stimulates research to fill critical knowledge gaps related to the health of sexual and gender minorities, strengthening the foundation for culturally competent treatment and behavior change models."[15] What is interesting here is that the vision of

[14] ICPSR-InterUniversity Consortium for Political and Social Research

[15] http://www.lib.vt.edu/find/databases/C/center-for-population-research-in-GLBT-health-from-icpsr.html

the institution is to create a framework that will support the interdisciplinary fields of GLBT health and population work.

One question that a researcher should ask is: what are the aspects of GLBT elders that are intrinsically outliers to the heteronormative society at large? The major themes that impact the health of individuals include, but are not limited to, social gradient, stress, social inclusion, and social support (Steinbock, Arras and London 2009). In defining the areas of research to be studied, one can start with defining the "determinates of health"[16] in the GLBT population. These issues would include those that are shared and generalized to a heteronormative population, but also include divergent areas of concern unique to the GLBT elder that currently remain particularly obscured.

In "Aging in a Non-heterosexual Context," the authors note that "aging in a non-heterosexual context remains remarkably under-studied" (Heaphy, Yip, & Thompson, 2004). This published research presents a study detailing the "…contexts in which non-heterosexuals negotiate personal aging. This not only provides insights into the specific challenges that aging presents for non-heterosexuals, but also offers insights into the changes faced by aging non-heteronormative, and heterosexuals in 'de-traditional' settings" (Heaphy et al., 2004).

Relevant scholarship appears to support the current thought that aging in a heterocentric society is detrimental to a non-heteronormative population, supporting further the conclusion that the effects of heterosexism or heterocentric tradition do indeed

[16] World Health Organization definition of " determinates of health" can be found at: http://www.who.int/hia/evidence/doh/en/

play a defining role in the experiences of the GLBT elder (Burn, Kadlec and Rexer 2005).

The heterocentric approach as an interlocking aspect of the life course perspective for GLBT populations has rarely been sufficiently studied in longitudinal aspects. A fuller examination of the role that heteronormative standards contribute to the factors that shape the personal lives of GLBT elders is required to adequately address their needs. (This is a subject area that could be further expanded in future research projects.)

Evelyn Hooker directly tested the assumptions of the underlying medical establishment by questioning the long-held belief that homosexuality was inherently linked with psychopathology. This primary conclusion was important, however, the secondary outcome was that her methodologies broke the previously held practices in conducting research. Her research cohorts were not the institutionalized, jailed, or medically identified study subjects that previous study populations had focused on.

Hooker's research investigated a study population through the culture of the gay underground—educated, single, young, and socially adjusted. Her guide was a University of California at Los Angeles (UCLA) graduate researcher who introduced her to other gay men who volunteered to speak with her about their lives and experiences. Her methods and conclusion received extensive support in subsequent empirical research (Gonsiorek, 1991).

Research into the unknown. With the advent of the Internet and social media, access to sub-populations and virtual chat rooms, allows the researcher a completely new

set of tools with which to conduct research. Being able to identify the opportunities and seek out the group to be studied, one is able to move beyond conventional methodologies.

"People are not aware of the real aging crisis in our community, due to the fact that the old are so invisible" (Quittner, 2002). "Little is known about GLBT elders because of the widespread failure of government and academic researchers to include questions about sexual orientation and gender identity in their studies of the aged" (National Gay and Lesbian Task Force).

We live in a society that is both ageist and homophobic. When these two areas are combined within a study it opens up a unique area for investigation and research. Without a concerted effort in addressing the inadequate research currently available the unique needs of the gay and lesbian population may not be properly identified and appropriately studied. The overall reason as to why such paltry data is available may be due to cultural bias, fear and/or homophobia, but I believe that in large part it is also due to the invisibility of the very study group itself.

In September 2009, the Obama administration directed the Department of Health and Human Services (DHHS) to form a committee that would address issues relating to the aging of the gay and lesbian population. This was achieved in response to a growing political voice from the GLBT community (the Senior and Gay Equality (SAGE) organization) associations like the Association of Retired Persons (AARP), and the federal agency of Administration on Aging (AOA); all stakeholders in the attempt to study and understand the uniqueness that an aging GLBT population experiences.

The AOA's mission statement is inclusive: "The mission of the Administration on Aging (AOA) is to ensure that older Americans have the opportunity to age with dignity, have choices in managing their own lives, and remain active and productive members of their families and communities" (n.d.). Without sufficient and appropriate study and research this population remains hidden.

The resulting work of the committee culminated in a publication that framed the discussion historically, mapped both past and present research theory/studies, and attempted to remediate a field of study that has been largely ignored outside of academic circles. The Committee on Lesbian Populations and Medicine's (2011) book, *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding,* acknowledges that "studies of aging among GLBT elders will generate new knowledge about aging in general as questions are framed and concepts considered which fall outside of traditional 'heteronormative' perspectives".

The National Coalition for GLBT health, a member the New Beginning Initiative (NBI) coordinated by the Gay and Lesbian Task Force, has a number of recommendations presented in the *Health Care and Public Health Research: Filing Knowledge Gaps in GLBT Health*. The first recommendation is that the Secretary of Health and Human Services should encourage the development of GLBT-related research projects consistent with the new and expanded research opportunities available under the Affordable Care Act (ACA) by proactively engaging researchers working the field of GLBT health, through the formal application process and via demonstrated interest from DHHS in support of GLBT health research. The second recommendation is in

establishing an ACA-related research funding agenda; the Secretary should prioritize projects that address the health needs and outcomes of disparity populations such as the GLBT community. These recommendations come to address what the National Task Force sees as "GLBT people face significant health disparities and often lack access to quality health care, there is a lack of federal funded research on GLBT-related health service issues, quality of care, community-based prevention and health outcomes" (New Beginnings Initative 2012).

In conjunction with the documentation proving that minority individuals bear an increased burden of exposure to negative health outcomes and risk factors when compared to the dominant group, I postulate that this could equally be applied and validated with the GLBT population, specifically the elder cohort. Citing Dr. Payton's work in identity and mental health, "research demonstrates that one's environment plays a key role in human development, self-construct, resiliency, and overall mental health…internalized cultural messages about salient reference groups such as race, gender, or sexual orientation—may result in identity conflicts and deleterious mental health outcomes" (Payton, 2008).

As indicated in numerous studies, minority stressors become social determinants of health (Wilkinson & Marmot, 2003). Minority stressors in this case relate to the concept that society's negative attitudes toward GLBT individuals create the expectation of rejection/discrimination. The concept of minority stressors relates to how a heteronormative individual internalizes homophobia versus how a non-heteronormative individual's internalizes his own experiences of discrimination/homophobia and the

stigma that is attached to the GLBT experience (Meyer, 1995). Simply put, this concept is based on gay people in a heterosexist society who are subjected to chronic stress relating to their stigmatization.

When one approaches the discussion of bias or prejudice, a researcher must consider the justice, health, and those aspects contributing to the overall social meaning of discrimination, or in this case homophobia. The social meaning as it relates to health care is hampered by several factors when a predominant group (heterocentric) negates actively researching the size of a sub-population (GLBT), and holds a cultural indifference to the 'other' i.e., minority groups experience, presenting a heteronormative world view while disregarding the rich diversity of any other group outside of its own.

J. Michael Cruz's *Sociological Analysis of Aging: The Gay Male Perspective* (2003) highlights and demonstrates a difference in the aging experiences of a cohort of gay men. Dr. Cruz's research study group is in itself a sub-study group, geographically situated in four Texas cities, comprised of men older than 55 years of age who "own their own homes outside a gay ghetto and report little interest in gay congregated housing. Most of the men report they are in good health although a number of them report somewhat lowered morale" (Cruz, 2003).

The *Journal of Gerontology Social Work* published an interesting perspective titled: "*Who's Afraid of Growing Old? Gay and Lesbian Perceptions of Aging*" (Schope, 2005), whose findings indicate that gay men have more negative views of aging compared to lesbians, and gay men exhibited a greater propensity toward ageist attitudes.

With little investigation into examining bias or negative attitudes toward GLBT, the casual effect of attitudes cannot be fully examined on any relevant subject of study. Implementation of remediation through specific policies or social reforms can only be achieved after sufficient research and study has been conducted. My research paper views the experience of the GLBT elder as it intersects with the healthcare providers and medical community. Kimmel, Rose and David (2006) posited the idea of using empirical research as a vehicle for social change in the newly developed field of GLBT aging.

In *Heterosexism in Health and Social Care* (2006), Julie Fish addressed one of the tenets of this dissertation by asking, "What is heterosexism?" She asked and defined the concept, laying out the impact of heterosexism on the lesbian experience.

Unfortunately, a large number of older gay and lesbian elders are hesitant to identify themselves, having come of age at a time of acute homophobia at every level of society, including academia, social services, and the medical profession. It is not difficult to imagine that perhaps there is a reluctance or concern that by participating in research or accessing health care or other specialty services, gay and lesbian elders may be inviting judgment or condemnation.

Many older gay and lesbian people have responded to pressures of discrimination by concealing their sexuality in settings where being "out of the closet" might hinder their access to quality care or even endanger their well-being. For many older gay and lesbian elders in their 70s and 80s, implicitly or explicitly, passing as heterosexual has been a lifelong survival strategy.

And yet, the intellectual prerogative mandates that researchers studying sensitive topics must address the reluctance of some participants in pursuing the goal of obtaining a data sample that sheds new light on an unexplored research project.

Chapter 3

Methodology

Geriatric studies and research have been expanding during the past 25 years, social scientists and governments are recognizing the importance of this growing population and its impact on the social structures of society, "as baby boomers morph into a seniors' boom, the quality of life is going to become a central challenge to our health [care] system" (Marwick, 2000).

With the number of aged increasing and statistical models projecting a rapid growth as reflected in this statement from the Veterans Administration Geriatric Research, Education & Clinical Center office, "by 2030, the number of older Americans will have more than doubled to 71.5 million, or one in every five Americans. By 2050, that number will grow to 80 million Americans over 65, with 18 million over 85 years of age." (Howe, et al. 2013). It is imperative that a more full understanding of the aging experience is researched.

It is generally understood that varying percentages of the population identify as heterosexual versus homosexual, and that heterosexuality is the predominant group and majority within society. For research purposes and arguments sake it would be appropriate to establish a percentage size of homosexuals (including lesbians). Generally the numbers are bantered around of approximately ten percent of the population give or take a two percent error margin. In sheer numbers, by 2030 the gay and lesbian population could amount to seven million individuals. One British government study in

2012 reported that approximately six percent of the citizens identified as GLBT for that government study (Govan, 2005).

The issues that confront the aging community in general can be daunting but for the GLBT elder this experience can be more complex. Within the broad range of aging issues, many are similar by with a GBLT population there are some that are of unique emphasis and with particular importance.

This study was exploratory in nature and includes both quantitative and qualitative dimensions. It was guided by the use of research questions, a methodology employed in sociological research (Berg, 2001). The survey questions were designed to collect data to explore the under researched aspects of the GLBT experience and pose the unasked questions.

Data collection and analysis was consistent to develop a common and divergent theme(s). Each survey was analyzed section by section, question by question, although several issues arose from the survey questionnaire, the one theme that emerged repeatedly and most frequently was the profound marginalization experience by older gay men in respects to aspects of social life.

Prior to the start of this research project a Drew University Institutional Review Board (IRB) submission was presented for review. This submission included the study project proposal, completion of the required study questionnaire, submission of the announcement/enrollment flyer, and a brief description concerning safeguarding the confidentiality of subject information. IRB approval was granted on April 8, 2010 (see Appendix A).

The survey included quantitative questions concerning basic demographics: age, race, marital status/partnered/single, religious affiliation, income, as well as questions on psychological and social profiling. Additionally, five qualitative open-ended questions were presented so the respondents could contribute an active voice in discussing their experiences, expectations, and viewpoints.

The data for this research was derived from the completed surveys. Of the 236 invited to participate, only 61 completed the survey, resulting in a 26% completion rate (N = 61). Quantitative and demographic data was drawn from the survey along with the qualitative data primarily being derived from the five open-ended discussion questions. The survey was coded by default sequentially from the date of completion and onward. Identification data corresponding to specific urban regions was not captured.

The criteria used for selection for this study (Graying of the Pink survey) was based on self-identification and self-nominating members between the ages of 46-75 who responded through a male homosexual social web site.

The geographical region selected for study was the New York City Metropolitan area and the San Francisco Bay area. It is believed that the data will be skewed since the two geographical areas are considered to have a higher percentage population of GLBT elders/populations. This skewing however is taken under advisement for three specific reasons as variables – firstly, the higher concentration of GLBT population would provide a reliable foundation starting point in collecting a data set. Secondly, the urban versus rural variable may correlate to degree of outness or closetedness overall, and finally, with the use of the New York and San Francisco survey cohort data would

represent a more creditable set of data points – for areas including outness, medical decision making, incomes, age, social support structures.

An announcement was made and invitation posted requesting study volunteer subjects for this project (see Appendix C). Additionally, the Adam4Adam.com[1] web site membership profiles[2] were initially screened to ensure that the age reported by the potential individual participants adhered to the age criteria of the protocol. The posting was directed to and posted for the 'baby boomer age'; those males born between 1945 and 1964.

Over 436 individuals self-identified as interested in participating, however, only 236 met the age and geographical location inclusion criteria. Only those individuals who met the study protocol requirements were forwarded the information detailing the study specifics and instructions to access the on-line anonymous survey and web site (SurveyMonkey.com) login password. The tracking of individuals who requested information was not maintained and on-line history of any discussion beyond the introduction and supplying of SurveyMonkey's login information was deleted from the profile history of the researcher.

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[1] The Adam4Adam web site is a social networking hub utilized by men who are seeking other men. It is generally considered to be a site for men who are seeking male partners for sex. www.adam4adam.com

[2] Profiles are typically a unique name/handle that a person creates for himself. Personal information, identity, etc. is missing from the profile. Information that is entered and shared such as age can be viewed or blocked depending on the wishes of the site member. Only individuals who met the age criteria and expressed interest in the project were invited to complete the questionnaire on the SurveyMonkey.com web page.

The initial login of each participant blocked redundant logins, disallowing duplicate subjects and duplicate data sets. Internal software parameters that were established with the server host site allowed for IPO address tracking to be disabled, maintaining the anonymity of each individual. No identifiable personal information was collected or associated with the individual survey results. Initial introductions through the Adam4Adam website did identify individual data that included age, location, and a profile name. When an individual did meet the initial inclusion criteria and "volunteered" to participate that individual was sent the information to access the SurveyMonkey's portal page.

This resulting survey data set is to be entered into SPSS, a statistical software package for statistical survey analysis, for the compilation of descriptive statistics. Statistical analysis has not been completed, a further presentation of the data will be completed for future research publications. Because of the sample, this study does not aim to test hypotheses, or measures of association, or test of significance are not appropriate for these data. Cross-tabulation of some items was generated in order to look at possible associations and possible areas to expand or contract research focus projects.

Survey Questionnaire

The questionnaire consisted of 25 questions in four sections:

- The first section contained questions about demographic data regarding the participant: age, race, religion, income, and relationship status.

- The second section contained questions regarding disclosure of sexual orientation to family, healthcare professional and sexual history.
- The third section contained the information defining the patient/doctor relationship, how often health care is sought, information on healthcare directives/decisions, and end of life decisions.
- The fourth section addresses the concerns of aging, ageism, sexual age discrimination, and defining social structures.
- Finally, the last section is a free text option that consisted of five directed open-ended questions requesting the surveyor complete with suggestions/ recommendations or comments.

This survey was developed by the author. The sections are detailed below.

Demographic statistics.

Age: Participants were requested to record their age (in years).

Race: Individuals were requested to self-identify their race: Caucasian, Black, Asian, and Hispanic/Latino. Where more than a single race was identified the first race listed was determined to be the predominant race self-identity and for study purposes was used as the demographic determinate.

Disclosure of relationship status: Two choices were offered to the survey takers: single or partnered. This question was followed-up with a question to determine whether the subject lived alone or with someone else.

Religion: Individuals were requested to self-identify their religious affiliation.

Income: To record their income, participants could select the appropriate income range from a range bracket of five choices.

1) $0 - $50,000

2) $50,000 - $75,000

3) $75,000 - $100,000

4) $100,000-150,000

5) 150,000+

Sexual orientation.

Participants were requested to free text the age they came out. They were asked whether the subject was out to their family and their medical/healthcare provider. They were asked to describe their relationship with their biological family and their relationship with their medical care provider, and how often they see their physician. The participant also was asked whether he was currently sexually active.

Group study

The third section of the questionnaire contained questions concerning their perspective on ageism within the gay community, what middle age is to them, whether they felt their age was a deterrent in attracting sexual partners, and whether they felt they were the subject of hurtful rejection based on their age. Follow-up questions were used to identify and determine the social structure and socialization of the participants with

questions concerning their social network, age of their social circle, and the number within their social circle.

Open-ended questions

The final section of the Graying of the Pink questionnaire was developed to allow for a free text and possible storytelling narrative to develop. Questions were posed that directed the individuals to ponder their greatest concerns about growing old and being gay. It also included questions concerning what their own strategies were in the event that they could not take care of themselves. Finally, the last question was posed to elicit their response concerning their suggestions/recommendations on the issue of ageism in the gay community.

Each of the sections contained a majority of multiple choice questions, requiring the participant to tick the most appropriate box to record their answers. The five open-ended questions were included to allow participants to record more detailed answers to certain questions.

Procedure

A small scale pilot study was conducted in order to determine whether the questions were clear and understandable, and to determine whether the answer categories were sufficient to capture the full range of possible responses. The survey was administered to three volunteer participants who are homosexual individuals known by

the researcher. The results from the initial beta pilot were excluded from the study data set.

Following the pilot, adjustments were made to the questionnaire in order to separate and clarify questions. In addition, multiple choice response options were adjusted to cover a greater range of possible responses. These changes included additions of "no response" to each of the multiple choice questions. No other adjustments were made.

The Drew University Human Research Ethics Committee approved the initial survey project. The questionnaire was anonymous, and participants were not at any time required to record identifying information. No inducements were offered for participation in the study. Participants' consent was assumed by the completion of the survey on SurveyMonkey.com where access was granted through a closed system of e-mail instructions to the IP address and login code access number. Approximately 236 individuals responded to my post on the social network site, affirming their interest in participating to the study with 61 completing the on-line survey resulting in a 26.0% response rate.

Recruitment Strategies

A single method was utilized to recruit participants for this project. An announcement of the study was posted on a gay men's social networking site, inviting individuals to contact the researcher through the on-line social profile if they were interested in participating in this study.

Upon the initial contact with the subject, an introduction summary was provided to each of the potential subjects, informing them of the study intent (see Appendix D). If the potential subject electronically agreed to participate in the study, a second e-mail with the URL of the SurveyMonkey web address and a randomized log-in code was sent.

A final e-mail thanking them for their participation was sent to the subject, upon their notifying the researcher that they had completed the survey. The identity of each of the study participants remained confidential, through the application of 21 CFR Part 11 rules.

The social network IP addresses of each of the participants was initially configured to prevent the capture of addresses, tracking cookies, or other methods of cross-referencing identification. Participants completed the questionnaire at their convenience within the open survey time period of 90 days between April 9, 2010 and July 9, 2010.

The database was locked on July 10, 2010, and the review of the data sets initiated on July 20, 2010. While an exact record of each of the questionnaires was kept, the information was further stripped and entered into a spreadsheet to enhance the participants' confidentiality.

In an attempt to recruit specific geographic regional participants, an introduction of the study was posted on New York and San Francisco community boards, however, due to the inadequacy of the study program software it was impossible to delineate the respondents by specific geographic location. This shortfall could have the potential to skew the data set in unexpected particular ways as it pertains to income, race, or religion

for example, based on a geographical variability. However, it is felt that given this potential skewing, the overall success rate of completions allowed a statistically significant number to provide data to correlate and draw a valid conclusion. The data from this study could be expanded and, with further research cross-correlation, analysis could provide future opportunities for research.

Participants

Gay males were targeted to participate in the study through the on-line social network site of Adam4Adam. Basic age parameters were pre-determined and set to prevent age outliers from viewing the posting. The use of a social networking web site was set primarily due to the ease in accessing a readily self-identified cohort group; a site used for men who engage in sex with men.

This particular social networking site was selected in that it is and by default would be inclusive in targeting both the age and sexual orientation (homosexual and bisexual men) of the study cohort group. The choice of the Adam4Adam web site was primarily one of default due to the web site's large clientele base.

A total of 263 participants out of a potential volunteer group of 436 (n = 436, 60.32% study participants) fitting the study protocol criteria were identified. The mean age of participants was 55.85 years, with age ranging from 47 to 68 years.

General Categories

All participants lived in the regional cities of New York and San Francisco. These two cities were chosen in an attempt to allow a greater racial diversity population spread potential. The outcome represented a significant percentage of the responders in the following racial groups: Caucasian, Black, Asian, and Hispanic/Latino. Religious group affiliations included self-identifying as Christian, Catholic, Protestant, Jewish, Wicca, Atheist or none.

Graying of the Pink—Survey Participants Demographics

The completed survey demographic characteristics of the men who took part in this study are presented in detail below with graph charts presented for answer categories. The findings of this dissertation are presented and organized around these following research questions.

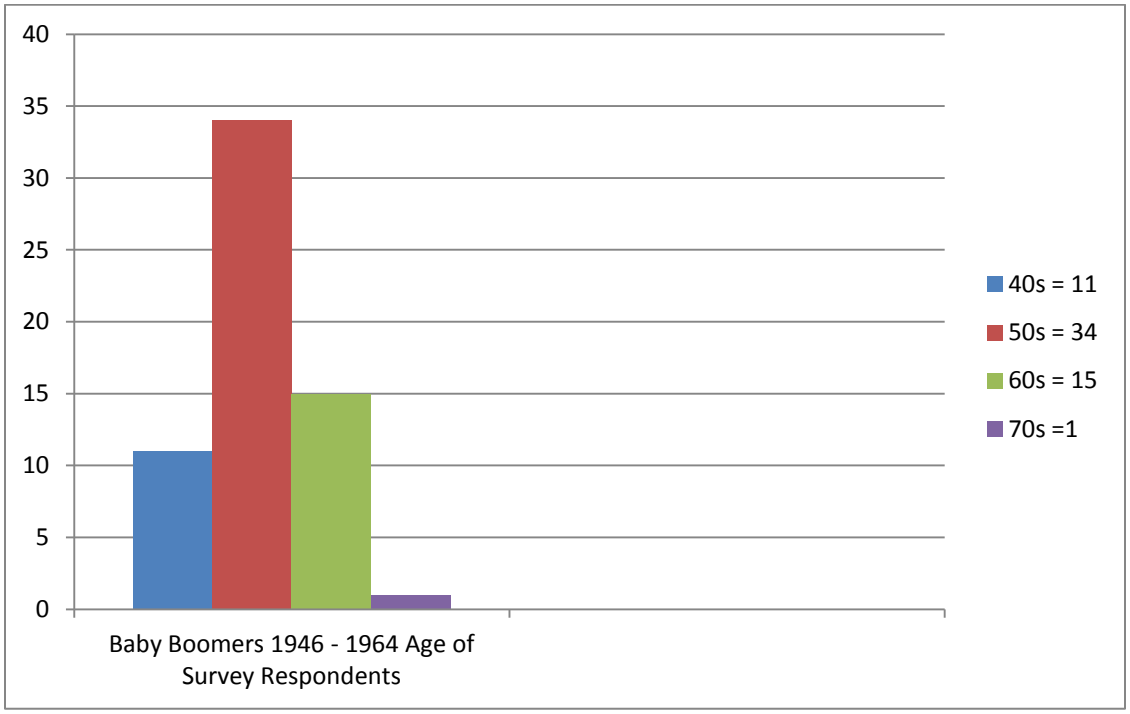

Figure 2. Survey Question 1: What is your age? Response Count = 61; *answered question,* 61; *skipped question,* 0.

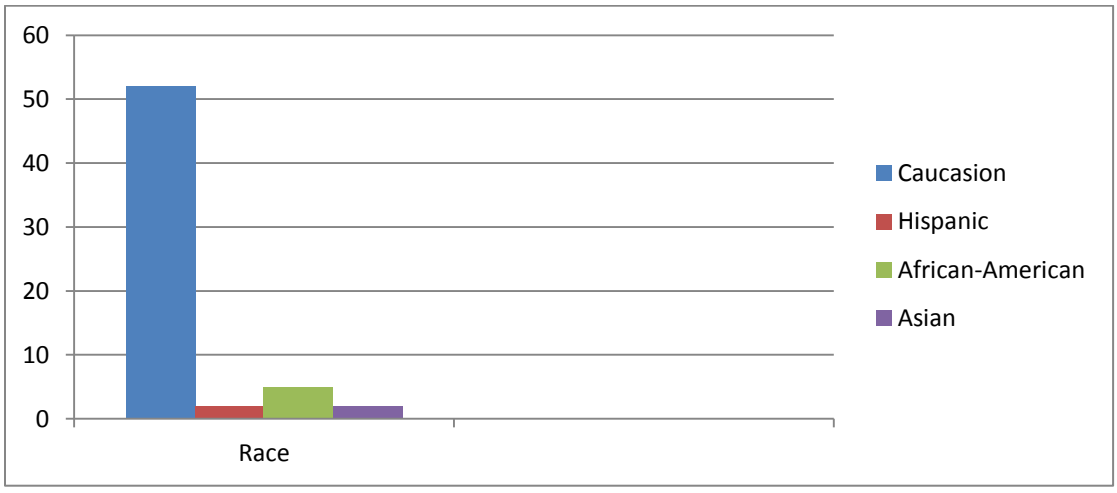

Figure 3. Survey Question 2: How do you define your race? Response Count = 61; *answered question,* 61; *skipped question,* 0

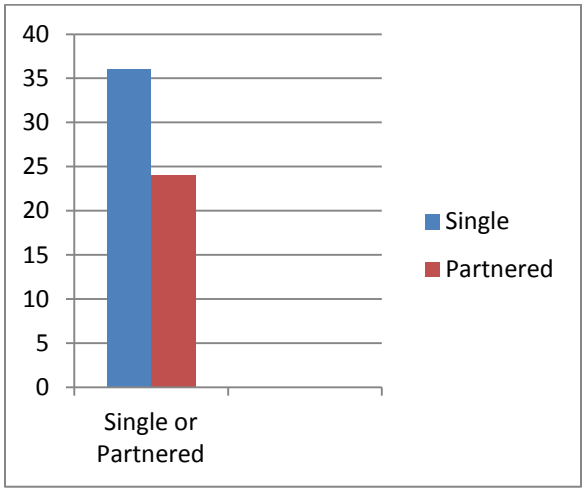

Figure 4. Survey Question 3: Are you single or partnered? Response Count = 61; *answered question,* 61; *skipped question,* 0.

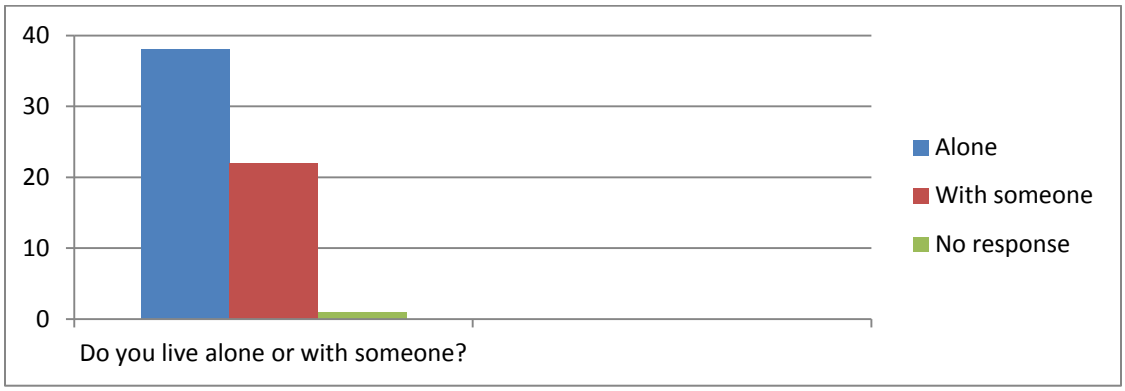

Figure 5. Survey Question 4: Do you live alone or with someone? Response Count = 60; *answered question,* 60; *skipped question,* 1.

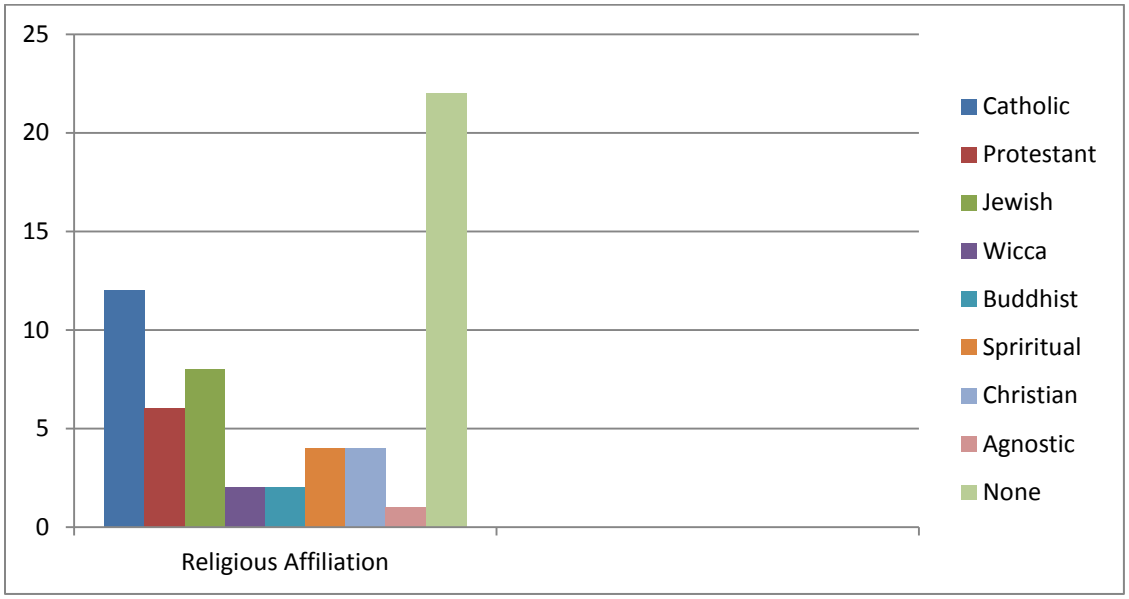

Figure 6. Survey Question 5: Do you have a religious affiliation? Would you please identify affiliation. Response Count = 61; *answered question*, 61; *skipped question*, 0.

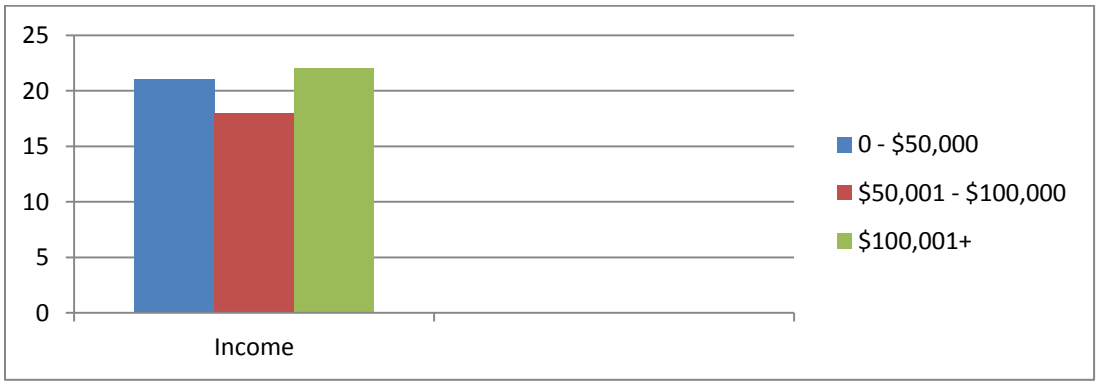

Figure 7. Survey Question 6: Would you please pick the appropriate income bracket? Response Count = 61; *answered question*, 61; *skipped question*, 0.

Table 2.

Response to Financial Breakdown with Respective Percentages and Counts of Survey Question 6.

Financial Breakdown	Response Percentage	Response Count
$0-$50,000	34.4	21
$50,001-$100,000	29.5	18
$100,000+	36.1	22

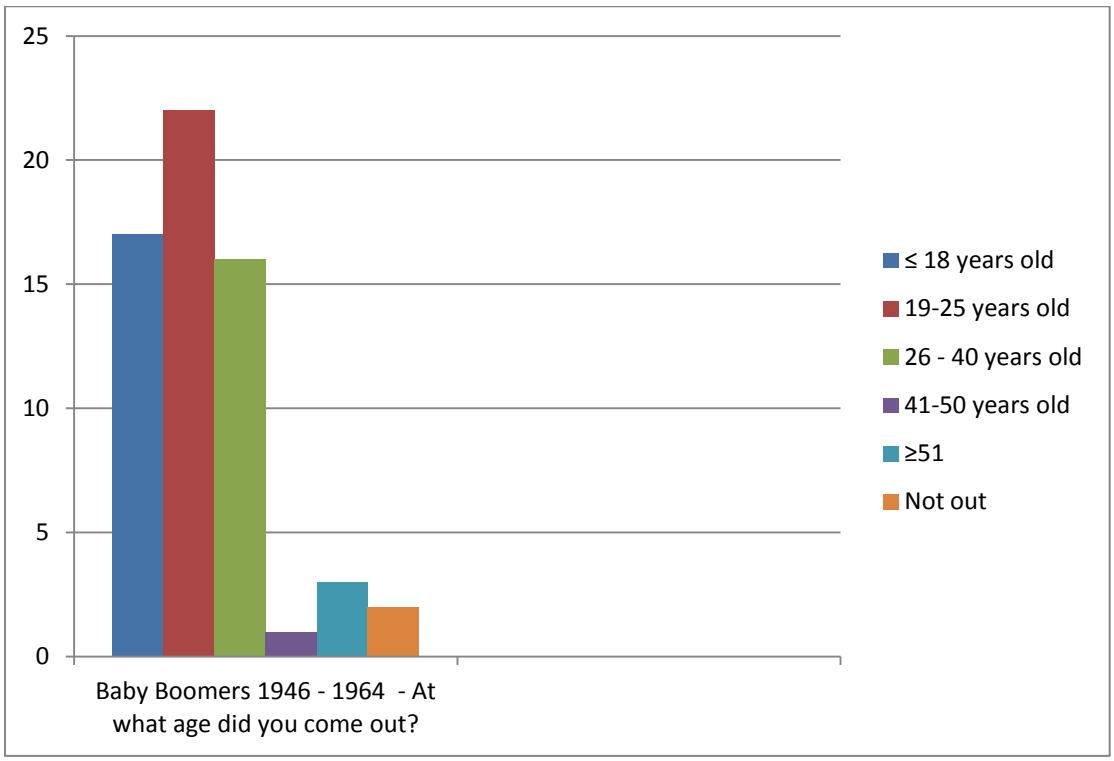

Figure 8. Survey Question 7: At what age did you come out? Response Count = 61; *answered question*, 61; *skipped question*, 0.

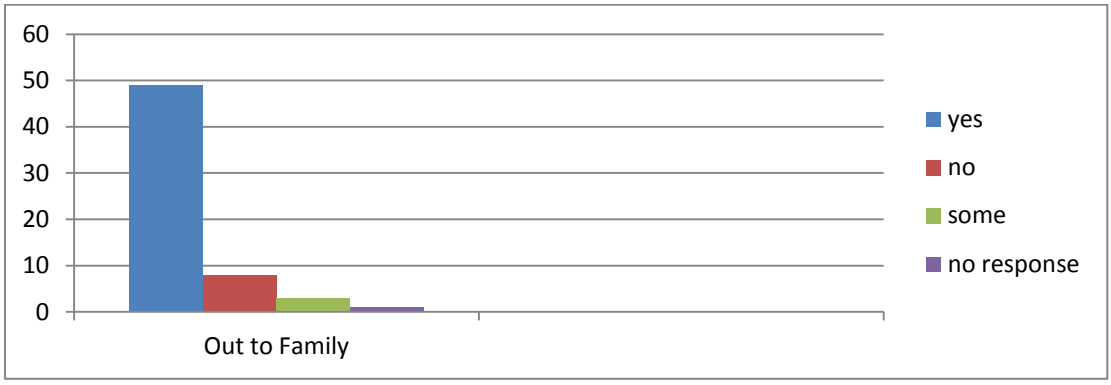

Figure 9. Survey Question 8: Are you out to your family? Response Count = 60; *answered question,* 60; *skipped question,* 1.

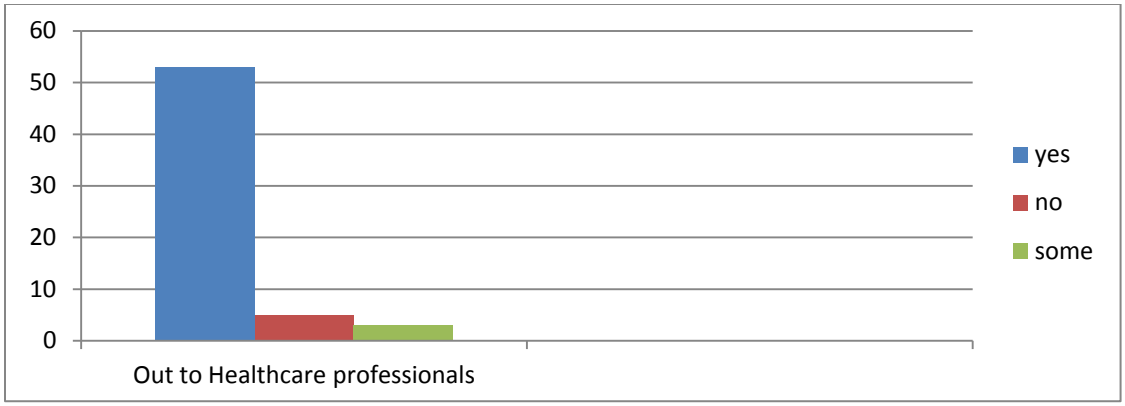

Figure 10. Survey Question 9: Are you out to your medical care provider i.e. Primary Physician, Nurse Practitioner, etc? Response Count = 61; *answered question,* 61; *skipped question,* 0.

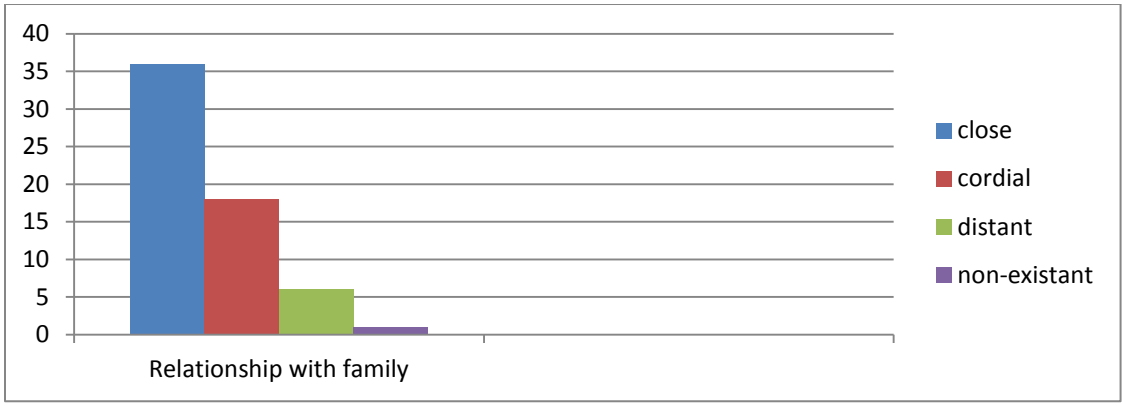

Figure 11. Survey Question 10: How would you describe your relationship with your family? Response Count = 61; *answered question,* 61; *skipped question,* 0.

Table 3.

Types of Responses, Percentages and Counts for Survey Question 10.

Response Type	Response Percentage	Response Count
Close	59.0	36
Cordial	29.5	18
Distant	9.8	6
Non-existent	1.6	1

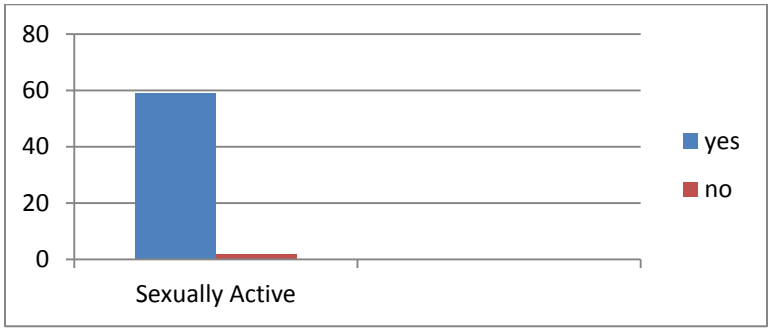

Figure 12. Survey Question 11: Are you sexually active? Response Count = 61; *answered question*, 61; *skipped question*, 0.

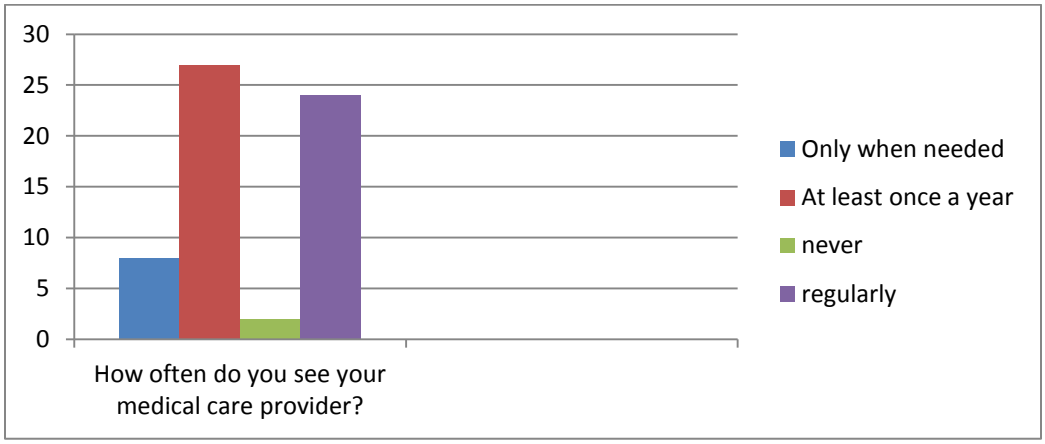

Figure 13. Survey Question 12: How often do you see your medical care provider? Response count = 61; *answered question*, 61; *skipped question*, 0.

Table 4.

Responses, Percentages and Counts for Survey Question 12.

Response	Percentage	Count
Only when needed	13.1	8
At least once a year	44.3	27
Never	3.3	2
Regularly	39.3	24

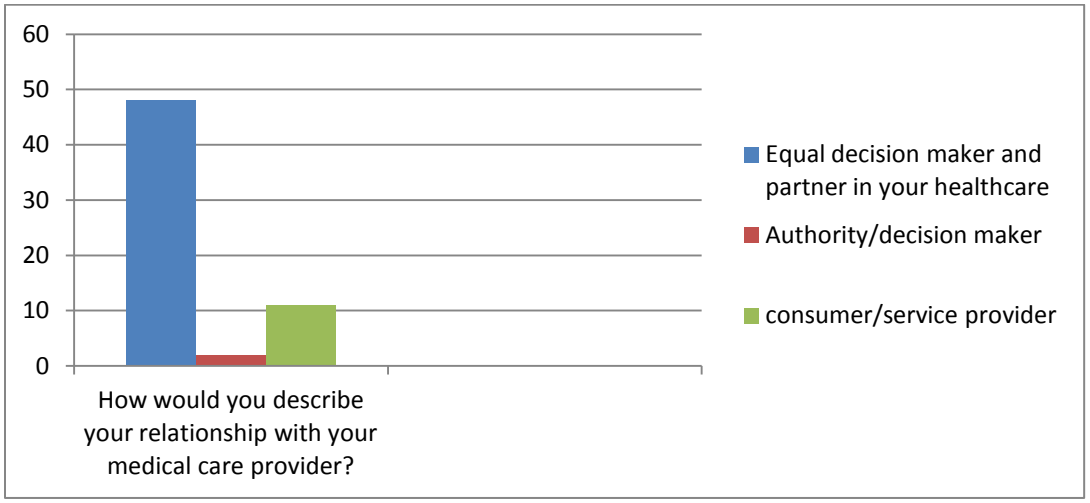

Figure 14. Survey Question 13: How would you describe your relationship with your medical care provider? Response count = 61; *answered question,* 61; *skipped question,* 0.

Table 5.

Responses, Percentages and Counts for Survey Question 13.

Response	Percentage	Count
Equal decision maker and partner in your healthcare.	78.7	48
The authority/decision maker in your healthcare	3.3	2
You are the consumer and they are the service provider.	18.0	11

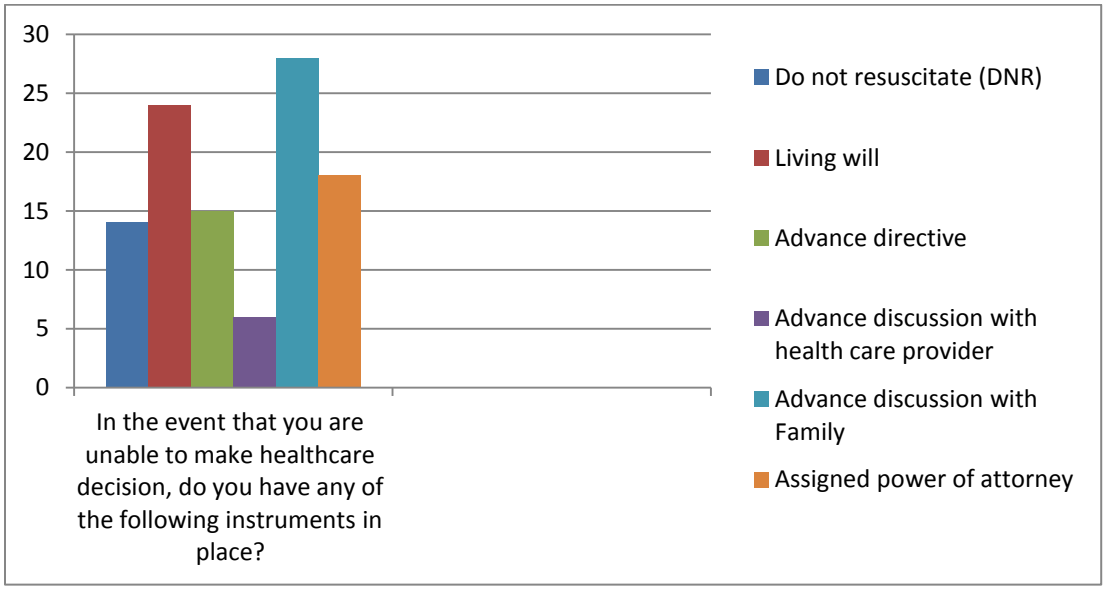

Figure 15. Survey Question 14: In the event that you are unable to make your own healthcare decisions, do you have any of the following instruments in place? (check all that applies). Response count = 61; *answered question*, 45; *skipped question*, 16.

Table 6.

Responses, Percentages and Counts for Survey Question 14.

Response	Percentage	Count
Do not resuscitate order (DNR)	31.1	14
Living will	53.3	24
Advance directive	33.3	15
Advance discussion with healthcare provider	13.3	6
Advance discussion with family members, including partners/ extended family	62.2	28
An assigned healthcare power of attorney	40.0	18

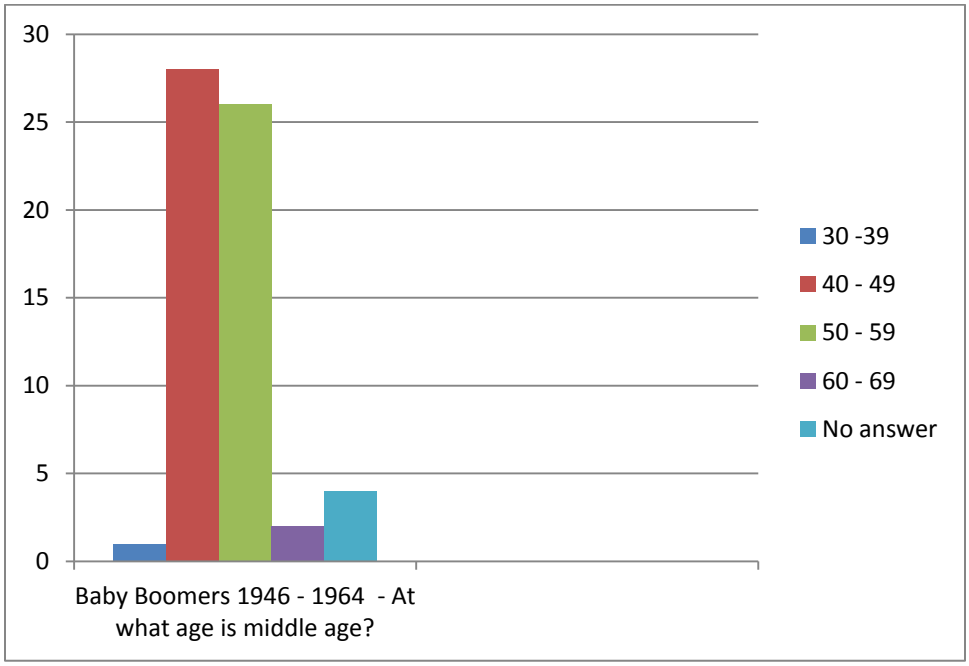

Figure 16. Survey Question 15: What age is middle age? Response Count = 61; *answered question,* 61; *skipped question,* 0.

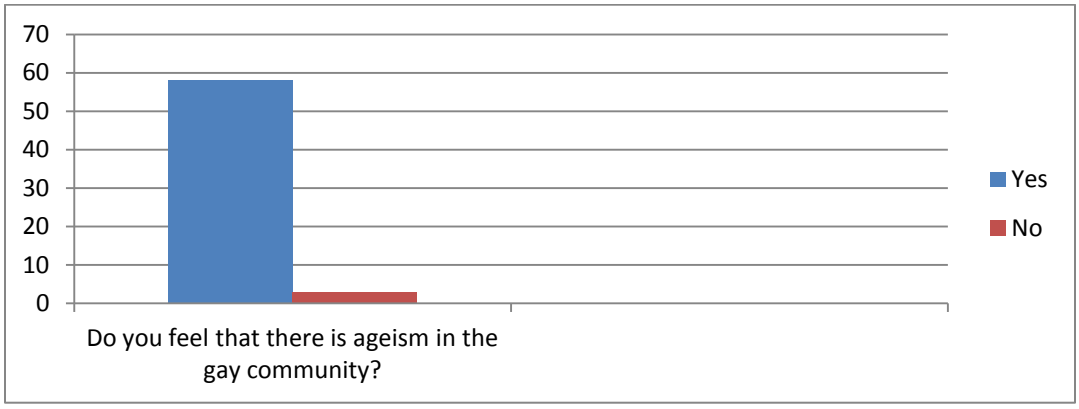

Figure 17. Survey Question 16: Do you feel that there is ageism in the gay community? Response Count = 61; *answered question,* 61; *skipped question,* 0.

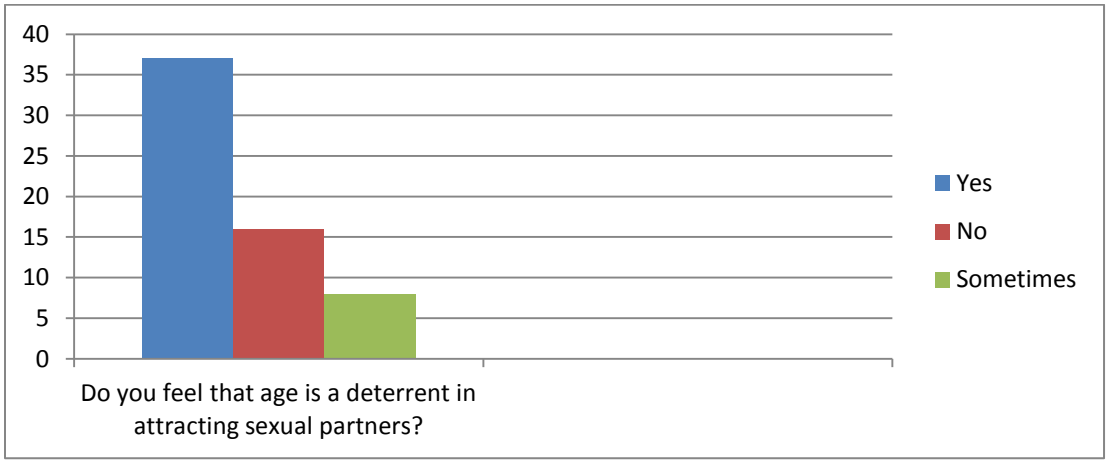

Figure 18. Survey Question17: Do you feel that your age is a deterrent in attracting sexual partners? Response Count = 61; *answered question,* 61; *skipped question,* 0.

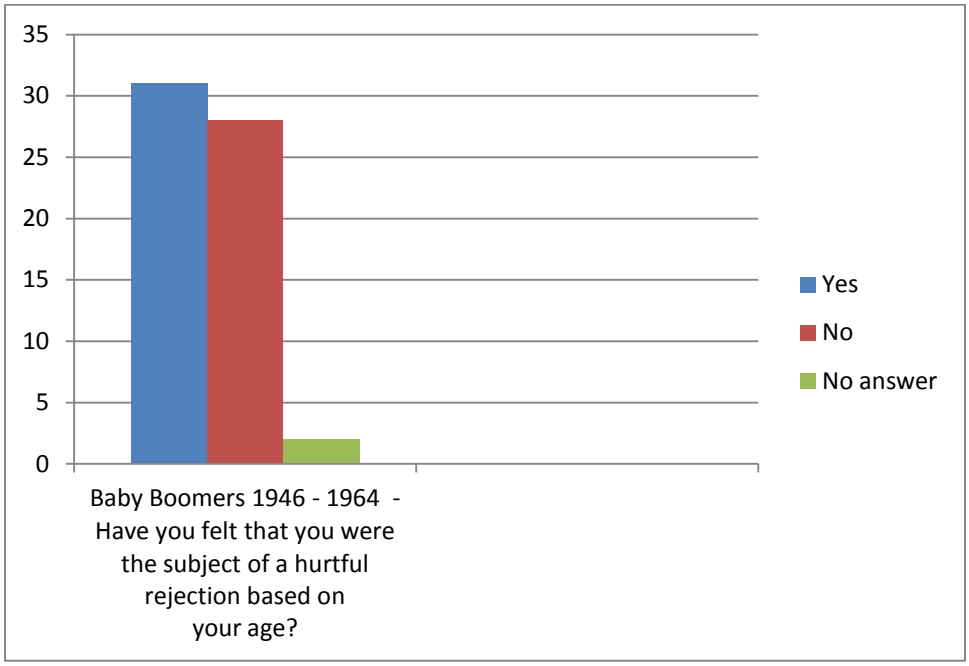

Figure 19. Survey Question 18: Have you felt that you were the subject of a hurtful rejection based on your age? Response Count = 61; *answered question,* 61; *skipped question,* 0.

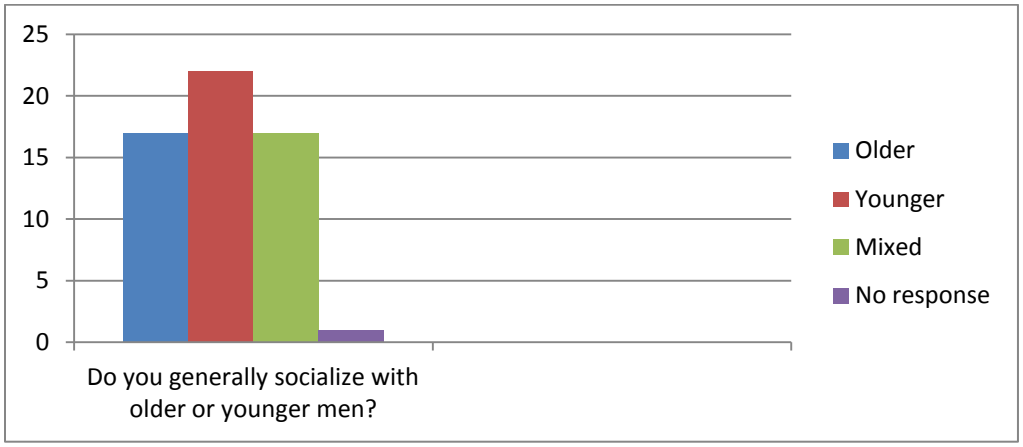

Figure 20. Survey Question 19: Do you generally socialize with older or younger gay men? Response Count = 61; *answered question*, 61; *skipped question*, 0.

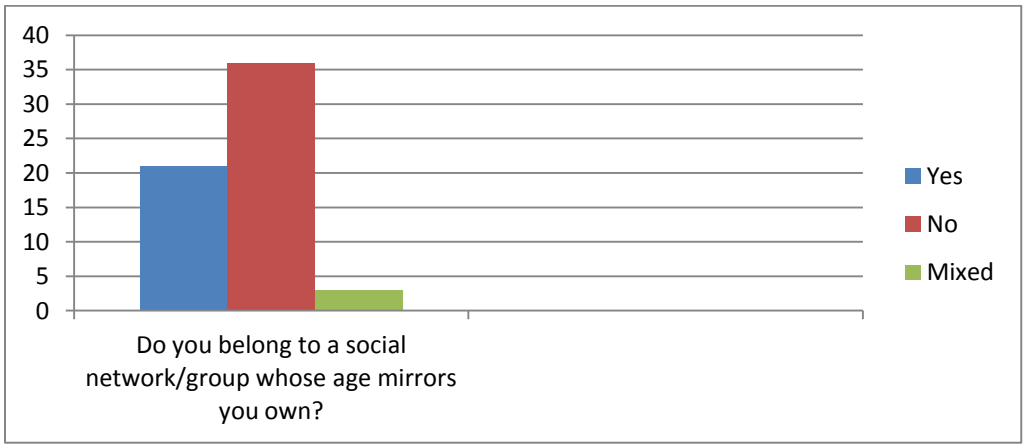

Figure 21. Survey Question 20: Do you belong to a social network/group whose ages mirror your own? Response Count = 61; *answered question*, 61; *skipped question*, 0.

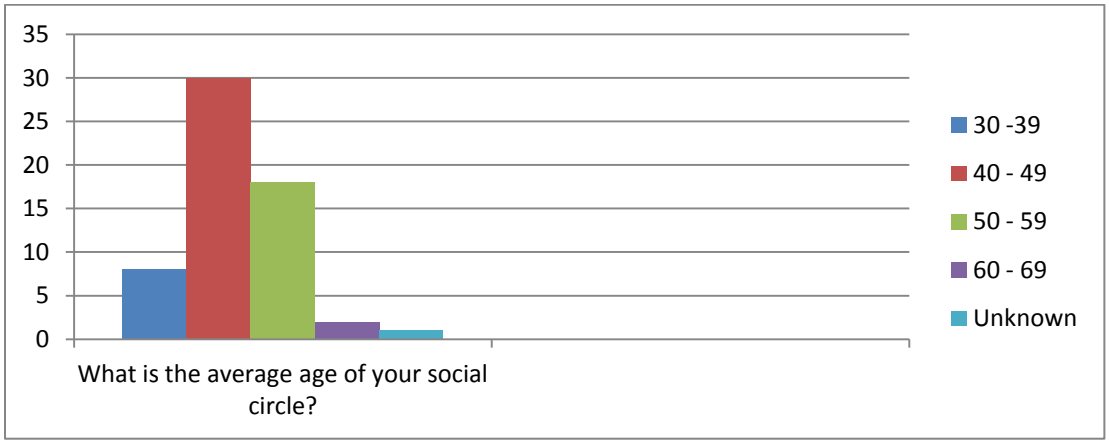

Figure 22. Survey Question 21: Do you belong to a social network/group whose ages mirror your own? Response Count = 61; *answered question*, 61; *skipped question*, 0.

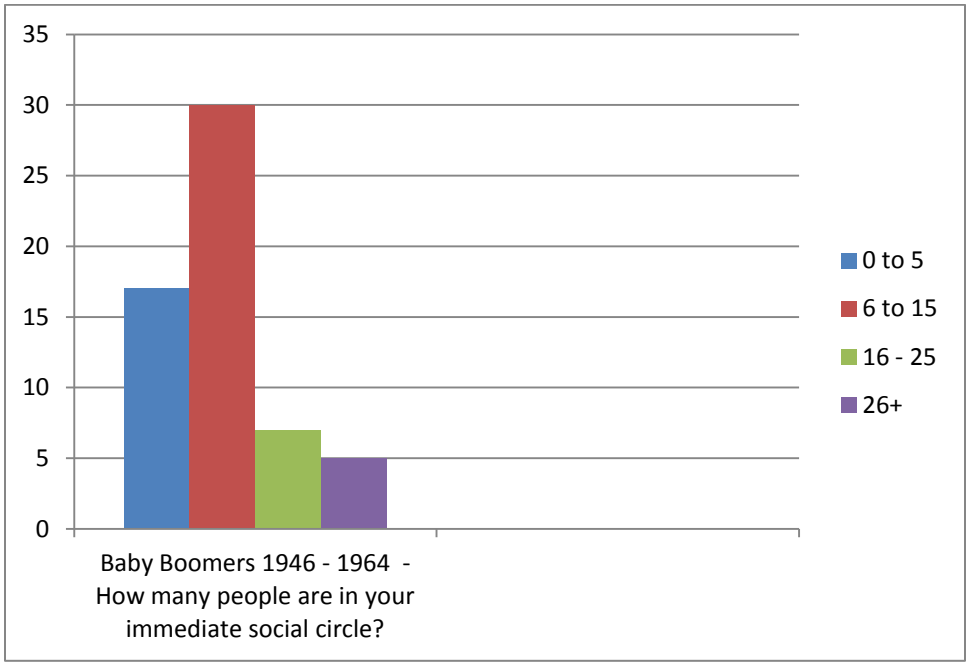

Figure 23. Survey Question 22: How many people are in your immediate social circle? Response Count = 61; *answered question*, 61; *skipped question*, 0.

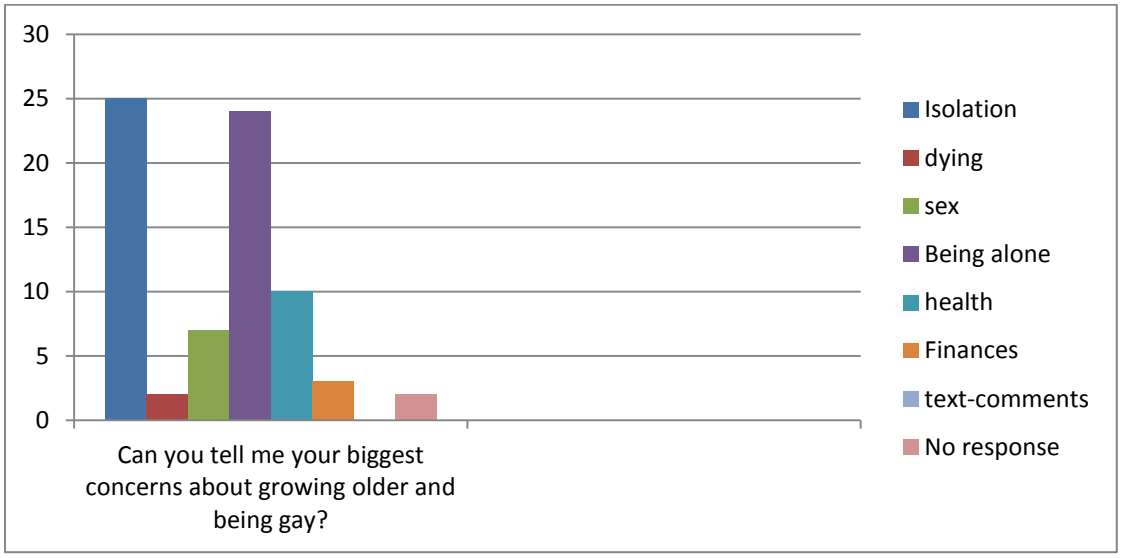

Figure 24. Survey Question 23: Could you tell me what are your biggest concerns about growing older and being gay? Response Count = 61; *answered question,* 61; *skipped question,* 0.

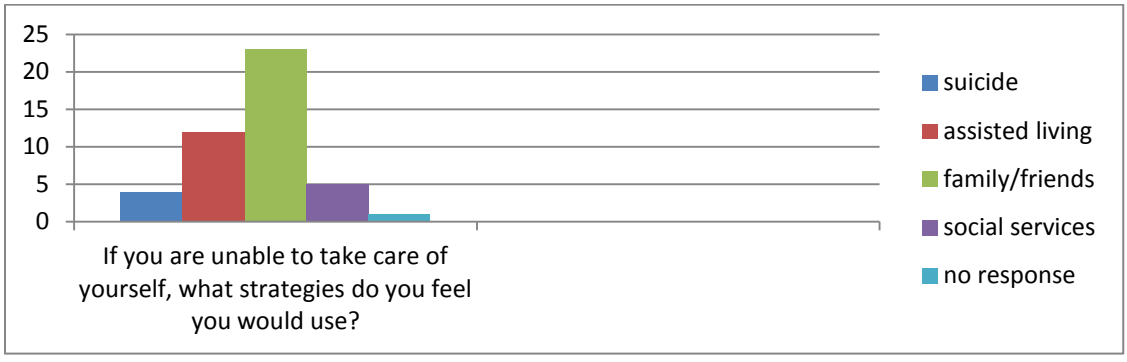

Figure 25. Survey Question 24: If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing, retirement communities....). Response Count = 61; *answered question,* 61; *skipped question,* 0.

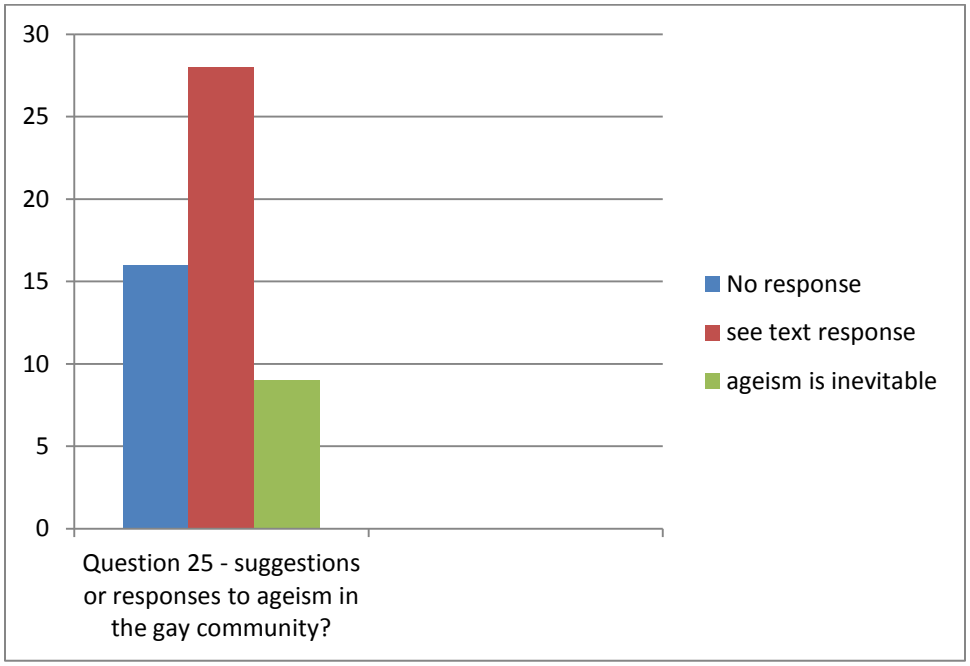

Figure 26. Survey Question 25: Do you have any suggestions/recommendations concerning the issue of ageism in the gay community? Response Count = 55; *answered question,* 55; *skipped question,* 6.

Data analysis is currently underway to identify trends and outliers, however, no statistical analysis was planned to undertake any correlation with the US annual income data and the cross-associated questions. This information sampling, however, could be an area of further research in the future.

One correlation that was examined was the relationship between the participant's income and their frequency in seeking health care to determine whether the income categories could be simplified for analyses (see Figures 27-29). A chi-square analysis was conducted to examine associations between respondents' income and the frequency of healthcare appointments. Not surprisingly, the analysis indicated there was a

significant association between respondents' reported income and reported health seeking frequency.

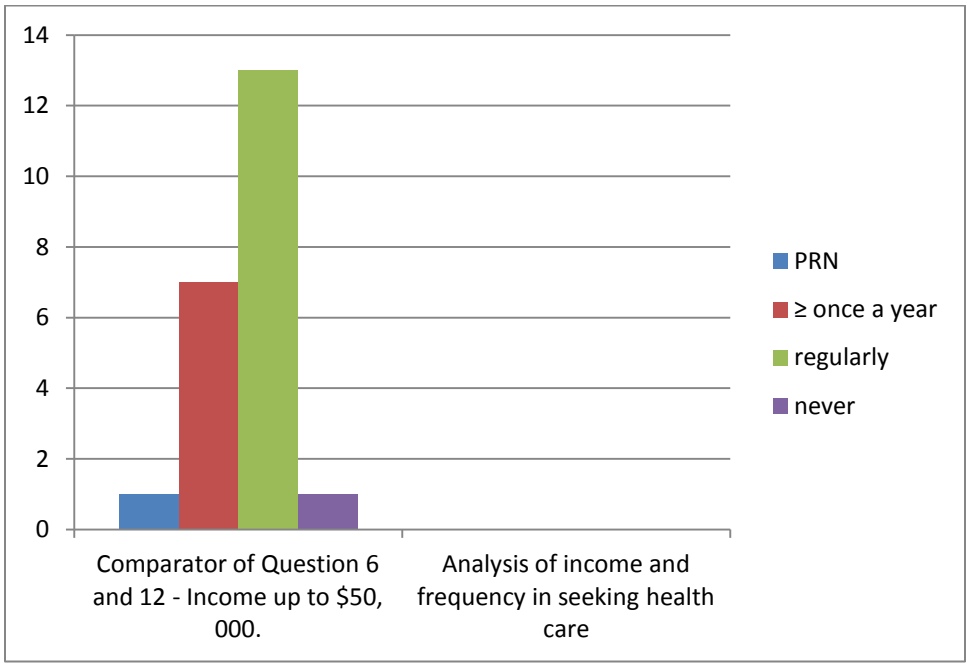

Figure 27. Comparison of Questions 6 and 12 for those with income up to $50,000.

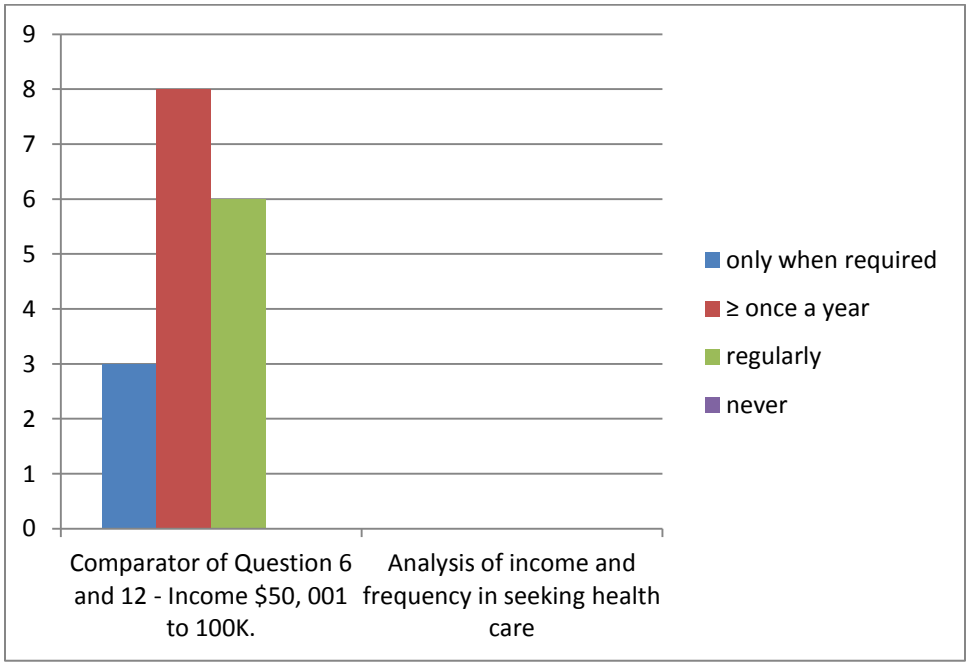

Figure 28. Comparison of Questions 6 and 12 for those with income between $50,000-$100,000.

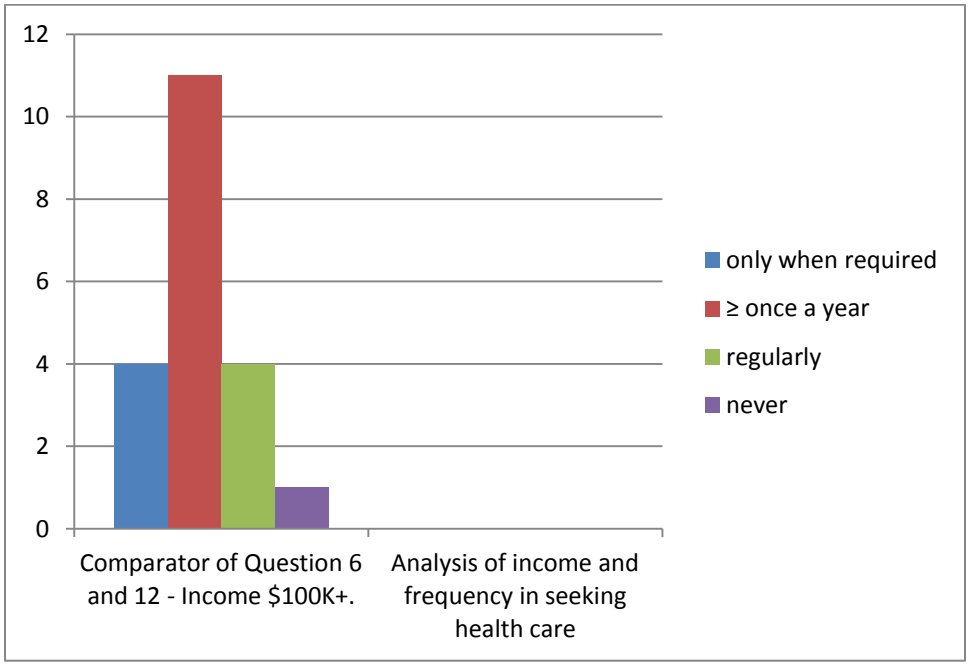

Figure 29. Comparison of Questions 6 and 12 for those with income over $100,000.

In one of the survey questions, the respondents were asked whether the physician's opinion had any effect on the gay elders' medical decisions. Seventy-eight percent (n = 48) defined their relationship as being equal decision makers. A second category that was highlighted by this survey indicated respondents classified their relationship with their HCP as that of a consumer/provider (N = 11, 18%). Only two respondents identified their relationship with the healthcare provider as being the authority and decision maker in the medical treatment (N = 2, 3%).

This finding was unexpected as historically many older individuals traditionally have been acculturated to view themselves as dependent on the "opinions" of their healthcare professionals. It was believed prior to this sampling that a larger proportion of the gay men being a part of this generational acculturation would have deferred exclusively to the physicians professional opinion, opting for the establishment of an authoritarian role for the healthcare provider.

It would appear that a shift between the role of healthcare provider, which has been traditionally defined as paternalistic, to one that fosters a partnership in which patients and advocates play a more pronounced role in their treatment has taken place. It would be near impossible to determine whether as I postulate, that in the event of aging elders would self-closet as they grow older and more infirm. This is another area of future studies that could be undertaken.

In the Graying of the Pink survey, respondents showed much variability in disclosure or "outing" to healthcare providers. Twenty-two percent of the respondents "rarely" or "never" discussed sexual orientation with healthcare providers (N= 13, 21%).

This figure confirms that data and research that were previously cited validate the significant percentage of the study cohort "at risk" of inadequate or insufficient levels of communication with the healthcare provider. This finding confirms the fear factor as previously discussed, and further illuminates the concern of an individual's ability to openly discuss the most intimate areas in their lives.

An analysis of survey responses from those who did disclose their sexual orientation with healthcare providers demonstrated that the degree of "outing" correlates to another question regarding the number of annual doctor visits. Survey respondents who also disclosed their sexual orientation were more likely to have reported at least one plus healthcare visits per year (see Appendix B).

Their responses provide supporting data to the theories concerning 1) the willingness of an individual to access needed and preventative healthcare services, and 2) the level of sexual orientation disclosure to family and healthcare providers.

Some of the respondents were far more pessimistic about the reality they believed they are facing. They included a perception of pervasive negative attitudes toward older adults in general, and gay and lesbians in particular. Their reported comments indicated there was an overall feeling of a loss of power, loss of self-efficacy, and terror associated with aging alone.

Speaking directly to the noted concerns of the GLBT elders (my survey respondents) and listening to their voice to frame their own discussion, I have discovered several other needs that I previously had not deemed imperative. These include the need for social support as a number of the responders identified fear of being alone or

loneliness, need for adequate housing as they grow older and are unable to fend for themselves, the fear of assisted living or nursing home required because of infirmity, and finally the fear of a loss of sexual activity.

The subject of housing is beyond the scope of this paper, but offers another research opportunity for future projects and inquiry. Briefly, however, it is necessary to provide a glimpse of the subject, primarily due to the fact of it being identified in the volunteer research surveys as one of the areas that the study participants identified as a concern.

One of the respondents noted that GLBT couples face institutional inequality. This inequality can be defined as unequal treatment in hospital visitation rights, health care decision making, nursing care policies, Medicaid regulations, Medicare and Social Security coverage, pension and tax regulations, housing rights, and other issues that fundamentally affect the gay and lesbian elder's financial security, health status, and quality of life. [Of a late note, with the recent changes in marriage equality and federal courts removing the ban on federal recognition of same-sex marriages, many of these issues have been remedied and may no longer apply].

Other respondents expressed a fear of accessing healthcare services, like long-term care facilities, skilled nursing facilities, and retirement homes. In the literature review, it was noted that many GLBT elders are forced to turn to formal long-term care systems to help them with their housing requirements especially when they become infirm and less able to live alone.

These long-term solutions such as assisted housing and long-term nursing homes, offer an important alternative to long-term care provided in one's home or in other community settings. However, these types of settings further diminish the individual's well-being by removing their autonomy and independence. As well as isolate the social interactions of the GLBT individual and their community. This move to the assisted living can also cause undue fear and reinforce the belief that the GLBT elder must remain or return to the "closet."

The often hidden nature of GLBT elders means that many elder-care housing and long-term care providers are not aware that they are serving GLBT seniors, perpetuating the invisibility of this population and the lack of attention paid to their specific needs. It is expected that in the past, incidents of homophobia or discrimination may have occurred due to social and cultural norms, what is surprising is that this type of activity continues today. It would appear that the data collected substantiated other research in the field Amber Hollibaugh stated, "…homophobia is the last thing you want to deal with" (O'Brian 2006).

In a recent BBC program on Elderly Facing Homophobic Abuse, (Elderly facing Homophobic Abuse 2012) the reporter followed a wheelchair bound lesbian who continued to live in her home but required assistance with daily care. She encountered home health workers refusing to dress, bathe, and assist with her personal needs, once they became aware of her sexual orientation. In another example, two lesbian partners required additional assistance with their daily care, but when a facility was chosen and the administrators became aware of the women's relationship, the facility required that

they define their relationship as "sisters" should they choose to enter that retirement facility (Redd 2012).[3]

In a survey of social workers in New York State nursing homes conducted in the mid-1990s, the majority reported intolerant or condemning attitudes toward gays and lesbians (Fairchild, 2002). One of the respondents to the Graying of the Pink *survey* wrote "We need to attack intolerance. I'd prefer to live in a community where diversity was the norm. My fear is living in a community where I am shunned because of my sexual orientation".

This form of outright discrimination is changing and will continue to change with the recent Supreme Court decision on marriage equality. However, at the start of the research project GLBT elders in relationships faced an additional layer of discrimination in institutional care settings since their relationships were neither formally recognized nor legally protected under the law. These seniors faced the very real risk of being denied the visitation privileges that heterosexual spouses enjoy such as the ability to make healthcare decision concerning treatment or end of life decisions. In the event that both individuals were unable to remain together due to poor health, they also risked being separated from their partner and forced to live in separate facilities.

Discrimination in housing and public accommodations is a major concern, not only of gay and lesbian elders, but for transgendered individuals as well. Transgendered elders are extremely vulnerable to discrimination by homeless shelters, retirement

[3] Huffington Post, http://www.aol.com/video/retirement-home-told-lesbian-couple-they-have-to-act-like-sisters-to-fit-in/517681496/

communities, nursing homes, assisted-living facilities, and other settings (Minter 2003). Although direct questions concerning housing was not included in this survey, the responders did identify that housing was an issue in the free text section of the survey.

Some of the respondents were far more pessimistic about the reality that they believed they are facing. They included a perception of pervasive negative attitudes toward older adults in general, and gay and lesbians in particular. Their reported comments indicated that there was an overall feeling of a loss of power, loss of self-efficacy, and terror associated with aging alone, loss of sexual identity and in particular ageism in sexual activity and attracting sexual partners.

These fears and personal experience may have shaped many of the GLBT individuals' decisions and points of view. This is the backdrop that sets the stage for the discussion on the fundamental issue of issues associated with GLBT elders and intersects with the issue of disclosure and rights when accessing medical care. This is the setting for the dichotomy that exists between the GLBT elder/patient and the greater culture/society and medical profession at large.

Chapter 4

Results

As we have established, what is missing from current research is the connection with the study cohort group of GLBT seniors and the barriers to optimum health care and long-term health outcomes. Though academic research into the lives of GLBT elders has increased in recent years, there is still a lag. "More research is needed on the lives, circumstances and social support of midlife and older lesbians and gay men, who comprise an estimated 10% of the general urban adult population" (Barker, Herdt, & de Vries, 2006).

The sources presented in this research dissertation represents a dramatic shift of thinking in a relatively short time as exampled in the *Journal of American Medical Association* (JAMA), May 1, 1996, Vol. 275, No.17 issue that contained an article on the "Health Care Needs of Gay Men and Lesbians in the United States" (Davis, Genel, & Howe, 1996). "A substantial number of studies involving gay men and lesbians have subsequently appeared in the medical literature that provide a better understanding of health issues related to sexual orientation and behavior…, including that of *reversal of sexual orientation* [emphasis mine] in selected cases," however, in the December 2009 *Sexuality Research & Social Policy Journal* article, "GLBT Aging and Rhetorical Silence," the author is quoted as stating that "the exclusion of lesbian, gay, bisexual, and transgendered (GLBT) elders from queer and gerontological theories has resulted in the silencing of GLBT older adults and their experiences…elders without adequate social or

material supports…renders elders invisible in queer theory and queerness invisible in gerontological theory" (Brown, 2009).

These two articles written in the years 1996 versus 2009, represents the ideas surrounding a diametric shift in concerted interest and research in the field of GLBT studies. It represents the idea that changing orientation was an acceptable "treatment" in 1996 as opposed to the outspoken activist discussion of queer theory in 2009. This shift has created a unique space that has opened dialogue and began to establish a framework that may provide a more in depth review of the field of GLBT gerontology, GLBT experiences, and the medical professions' viewpoints.

Multiple studies of many types of providers (doctor, nurse, physician-assistant, student, and trainee) have shown that prejudice against GLBT patients is decreasing; however, it is still not acceptable. The change in physicians' attitudes, as shown through surveys conducted between 1982 to 1999, indicate dramatic improvement. In the survey conducted in 1982, 46% of the physicians noted that they would discontinue referrals to a gay pediatrician and 39% felt uncomfortable providing care to gay patients. In the more recent 1999 survey, the shift on the question of referrals slid from 46% to 9%, and the 39% who felt uncomfortable providing care to gays slipped to 19% (Smith & Mathews, 2007).

This window of opportunity has come about due to progressive changes and a shift in the political landscape, moving past the 1970s reforms in laws to decriminalization of homosexuality, striking down state sodomy laws, ensuring equal

opportunity in government jobs, and having the diagnosis of homosexuality removed from the APA DMS-III[4] handbook.

For many "older" gay and lesbian elders, who implicitly or explicitly pass as heterosexual, living as homosexuals has been a lifelong survival strategy. Lesbian and gay elders are among the most invisible of all Americans, but as a group they can be found across races, ethnicities, religions, social-economical and geographical locations. These elders, the invisible population, suffer from a double stigma in society; a hidden sexual population as well as an aging population heretofore having little scholarly attention and few representations in research studies.

"Gerontologist and clinicians working with older adults are aware that the aging experience of racial and ethical minorities often differs from the majority population's experience of aging" (Thompson, 2008). Using this principle of minority populations, we can deduce that a significant number of GLBT elders' experiences would differ from the experiences of their heterosexual counterparts.

The National Coalition for GLBT Health in a letter to Centers for Medicare and Medicaid Service illuminated that a "growing body of knowledge demonstrates that the GLBT population faces significant health disparities and barriers to accessing healthcare coverage and services." It goes on further to highlight data drawn from the *Healthy People 2020* reports stating that various initiatives are being undertaken, but that a recommendation from the Institute of Medicine to collect data on gender identity and

[4] American Psychiatric Associations, Diagnostic and statistical Manual of Mental Disorders Manual, http://www.psychiatry.org

sexual orientation as part of the accurate health histories will begin to identify the specific health needs of GLBT patients and better provide the full scope of preventative care leading to population-level health outcomes (Health, 2012).

Historically, in restating this theme, many older GLBT people have responded to pressures of discrimination by concealing their sexuality in settings where being "out of the closet"[5] could result in societal action against them. This, broadly defined for the purposes of this research, might hinder their access to quality care and have a longer affect on their health outcome.

Geriatric studies and research has been expanding during the past 25 years. Social scientists and governments have begun to recognize the importance of this growing population and the impact of this group on the social structures of society, "as baby boomers morph into a seniors' boom, the quality of life is going to become a central challenge to our health[care] system" (Marwick, 2000). Quality of life seems to be a measurement for aging well.

With better aging processes or strategies in place, an increase in life expectancy rates will contribute to the growth of the overall elder population. In broader terms, the life expectancy rates not only amount to an increase in the elder boom, but to large numbers of much older individuals with commensurate health care and other aging-

[5] "Out of the closet" is a shortened version of "coming out of the closet." As individuals begin to disclose their sexual orientation to others, the process of coming out is a challenge, it involves adopting a non-traditional sexual identity, restructuring one's self-concept, and changing one's relationship with society (The impact of internalized homophobia on outness of lesbians, gay, and bisexual individuals, *The Professional Counselor: Research and Practice*, April 2011, Vol. 1. Issue 3).

related needs. "The fastest growing population segment is the oldest-old. In 1900, there were about 122,000 people 85 years-old and older; less than 1% of the total population. By 1990, the oldest-old numbered 3.0 million persons. By the year 2050, those 85 and older will represent almost 5% of the population."[6] These rates will translate into much longer periods of retirement for individual seniors, and more extensive reliance on services such as housing, health care, and social services.

Facing the prospect of an elder population "explosion," social services and medical providers will be required to address issues never seen before. With the increase, however, the medical systems will be taxed; high numbers, higher demand, and reduced accessibility. The need for accessible and comprehensive health services, prescription drug coverage, and long-term care will be applied across the board to all seniors.

In an op-ed article published in the *Advocate*,[7] the authors commented that "we must reach out and address the fundamental issues that result in different health outcomes for the GLBT community. "Homophobia, biphobia and transphobia, family and community rejection, ignorance, and misinformation in the media and in health care settings are just the beginning of our work" (Vargas & Innis, 2012). I will be returning time and again to the idea of cultural minority and comparing it to cultural competences in later sections as well as discussing further the ideas on social determinants.

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[6] Veterans Administration Geriatric Training center Module 17.

[7] The Advocate: The Advocate is the oldest continuously published U.S. Gay periodical still in existence. It has chronicled the history and culture of the GLBT community for 40 years. http://www.sgn.org/sgnnews35_37/mobile/page30.cfm

The idea and concepts of equitable and patient-centered care is highlighted in the Joint Commission's recently adopted patient-centered communications standards. The commission identifies that "patient's bring specific characteristics and non-clinical needs to the health care encounter that can affect the way they view, receive, and participate in their health care" (Cordero & Tschurtz, 2012). As Hector Vargas stated, disparities exist and the discussion is not just within the GLBT community, but "has penetrated the wider health and policy world" (Vargas & Innis, 2012).

Gay and lesbian elders notwithstanding will also face a variety of special health concerns and barriers to health care. "There are unique health risks of gays and lesbians that are important to the clinician in determining an accurate diagnosis, providing medical education, and arriving at an appropriate treatment plan…. Many of these health care risks are not addressed because of a lack of communication based on a number of common assumptions, including the assumption that the patient is heterosexual" (Bonvicine & Perlin, 2003).

With the number of aged increasing, and statistical models projecting a rapid growth as reflected in this statement from the Veterans Administration Geriatric Research, Education & Clinical Center office, "by 2030, the number of older Americans will have more than doubled to 71.5 million, or one in every five Americans. By 2050,

that number will grow to 80 million Americans over 65, with 18 million over 85 years of age."[8] It is a imperative that a fuller understanding of the aging experience is researched.

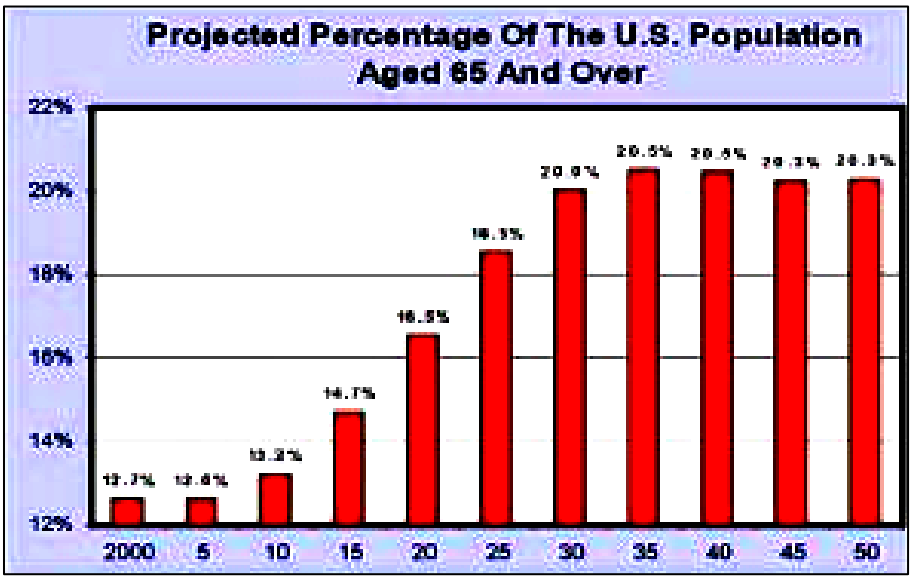

Figure 30. Projected Percentage of the U.S. Population Aged 65 and Over.

Generalizations can begin to provide the 10,000 foot view, however, specific and unique experiences must be more closely examined. As a group GLBT elders have experienced seminal events, whether through epidemics of AIDS or life cycle aging. It is not unusual for any group of seniors to experience the dying off of their friends, contemporaries, wives/husbands, and even children. This natural life process generally extends over a number of years and creates a new level of isolation and vulnerability.

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[8] Geriatrics, Palliative Care and Interprofessional Teamwork Curriculum Module # 1: Introduction to Aging Editors Judith L. Howe, PhD; Barbara Morano, LCSW; Annette M. Atanous, MSSW. http://www.nynj.va.gov/docs/Module01.pdf

This process results in seniors left with few remaining social connections or attachments as they age. The connection between strong social support and the optimal physical and mental health in an aging population is clearly evident in the body of medical and academic literature. The loss of these connections can and does create an effect on the overall health of individuals. (Stroebe, Schut, & Stroebe, 2007)

When one discusses overall health outcomes, a successful outcome is generally defined within the context of quality of life. If gay and lesbian elders do not access adequate or appropriate health care or social services they may need due to perceived homophobia or institutionalized heterosexism, the outcome is impacted.

One example of institutionalized heterosexism can be found in the intake forms, requesting information on marriage status. Historically, the forms would have single, married, and divorced. Barring the recent changes in marriage, and the ongoing redefinition within the state government bodies, how does one define a life lived with a same sex partner for 30 years? The default that every patient is heterosexual with medical histories and questionnaires formatted to an audience that reflects this point of view immediately creates a barrier. One of the flaws in the literature research reviewed includes questions about sexual orientation or gender identity in the field of aging.[9]

It is difficult to quantify how many GLBT older adults are accessing or refusing to access mainstream services when agencies do not ask relevant demographic or social

[9] The 2010 Government Census was the first to include questions relating to same sex households and individuals living together outside of the family model; mother, father, children, relative. http://www.census.gov/prod/cen2010/briefs/c2010br-14.pdf

questions. The lack of data collection on GLBT older adults effectively obscures any unmet needs and potential vulnerabilities of this group, thereby inhibiting academic research on the size of the population or the study of this group's experience.

In an attempt to begin to collect information, Census reports in 2010 begin the process of collecting data that could be synthesized into usable information, however, the obscurity of the questionnaire and the relevant application to define GLBT individuals remains to be seen.

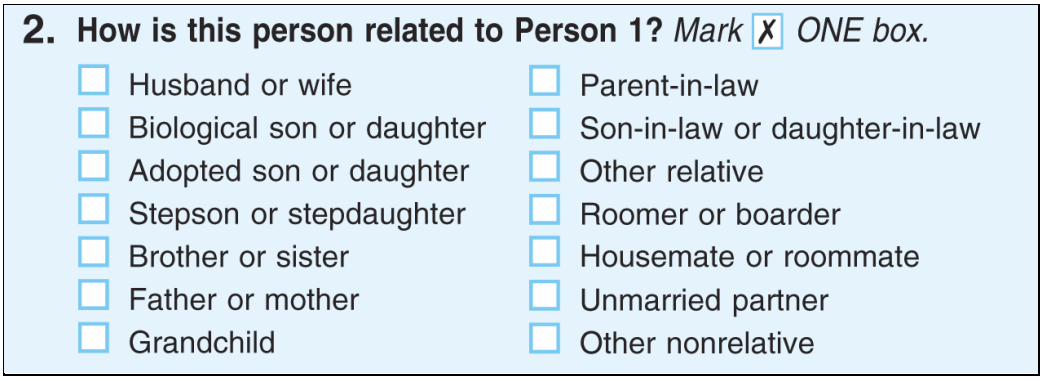

Figure 31. Relationships.[10]

As this paper has shown, without significant research into the hidden lives of GLBT elders quantitative analyses of the cause and effect of discrimination and homophobia on this cohort will continue to remain unknown. A key component of this study is to review and present research data that validates the premise of one researcher

[10] http://www.census.gov/prod/cen2010/briefs/c2010br-14.pdf

who suggests "older gay men and lesbians, out of fear of discrimination are five times less likely to access health care and social services" (King, 2010).

My supposition is that discrimination/homophobia influences health outcomes. Discrimination/homophobia can be described as: active and/or passive, overt as well as covert, and implicit and/or explicit. The stakeholders affected by this topic include the aging GLBT patients, the physicians/healthcare professionals, and institutions of health care, government, and academic bodies. In a study conducted in 2001, 75% of the respondents reported not being completely open about their sexual orientation to health workers (Pearlberg, 2004).

In the survey developed as research for this dissertation, Graying of the Pink Survey Results (see Appendix F), the respondents to question 9, Are you "out" to your medical care provider (i.e., primary physician, nurse practitioner, etc.)? answered in the affirmative, 10% of the 61 subjects queried were not "out" to their healthcare providers. The results for question 12, How often do you see your medical care provider? revealed that the responses "only when needed" (13.1%) and "never" (3.3%) totaled 16.4% of the 61 surveyed group.

The Alliance Healthcare Foundation conducted a survey in 2004 to identify the healthcare needs of LGBT seniors in San Diego County. This report ,referenced later in this section, identified a number of areas to be researched including issues with healthcare providers. In their results of the needs assessments (n=298) of the 102 women that completed the "outness" to healthcare providers 22% "rarely" or "never" discussed issue of sexual orientation with their healthcare provider an additional 20% only

discussed it "sometimes." Results for men in the same study (n=196) indicated that 23.9% "rarely" or "never" discussed, and 20% "sometimes" discussed sexual orientation.

This represents a sizable number of patients not discussing a fundamental aspect of their lives that would impact their long-term health outcome. This correlation, if extrapolated to the overall GLBT elder population, represents a significant number of individuals who have adapted an approach to health care that may not be in their long-term health outcome's best interests.

One can make the supposition that this finding can be explained away based on simple factors that include economics, education, and even geographical location (urban versus rural). However when the responses are evaluated and outliers identified, one is able to eliminate the possibility that factors leading to nondisclosure or to discussion of sexual orientation are more complex and complicated than just the differences based on economics, education, and geography.

To help eliminate and narrow the impact of this assumption, this paper's survey was conducted utilizing volunteers from both the San Francisco and New York area, a typically higher concentration in population of GLBT individuals, negating the argument that rural versus urban areas would skew the results. It is generally acknowledged that urban areas would provide a safer or rather less focused attention of the comings and goings of minority groups.

Expectations of urban "outness" findings for this study however, revealed that the belief that urban GLBT elders would be more "out" was unfounded. There is a significant percentage of individuals that remained either partially or completely in the

closet with family, friends, fellow workers, and medical healthcare providers. The correlation of (urban versus rural) variable along with education were not assessed with this current survey.

Traditionally, rural areas with their more rigid social expectations and historic customs may influence GLBT individuals from "coming out." The presumption of this line of reasoning is that a larger GLBT population would be found in urban environments (hence the study group for San Francisco and New York) and that this group would be more open to freely discussing their sexual orientation for this research as well as with their healthcare provider.

Unfortunately, the Graying of the Pink survey did not query the respondents on their level of education, to help provide this missing information, the researcher reviewed the findings from a similar study conducted in San Diego (Alliance Healthcare Foundation, 2004). In this study, the respondents (n=225, 165 men, 60 women) reported that a majority of the GLBT survey responders had at least a bachelor's degree (60.1%). The breakdown indicated that 25% had completed a bachelor's, 24.2% completed a master's degree, and 9.8% completed a post-master's degree including M.D., Ph.D., or J.D.

This study also surveyed incomes, reflecting that most San Diego LGBT seniors reported incomes in the lower to middle income ranges from ≥$10,000 (13%); $20,000-$29,000 (19.6%); $30,000 - $39,000 (15.7%); and $50,000+ (21%). The San Diego study reflects a lower than average income compared to the one completed by this researcher but that may be indicative of the ten year span between studies.

In the survey developed for this paper when the factors of economics are evaluated in combination with questions concerning outness to healthcare providers, and how often they saw their healthcare provider did not correlate to the mean average for individuals (n=61) who identified that 5% of the survey either "rarely" or "sometimes" saw a healthcare provider.

The results indicated that two respondents reported an annual income of 0-$50,000, which corresponds to the San Diego County survey, however, this study's survey indicated that three reported an income of $51,000 -$100,000, and an additional two reported incomes of over $100,000 yearly, thereby drawing the conclusion that the frequency in seeing a healthcare provider does not immediately correlate to the income levels of the gay men participating in the study. These results would appear to contradict earlier studies on the impact of economics and health.

Much research has been conducted on health seeking behavior tied to economic disparity. In the CDC Health Disparity and Inequality report, *Education and Income in the United States from 2005 through 2009*, a number of social determinants that impacted the overall health of the general population were revealed.

The CDC study identified that "the socioeconomic circumstances of persons and the places where they live and work strongly influence their health…the risk for mortality, morbidity, unhealthy behaviors, reduced access to healthcare, and poor quality of care increases with decreasing socioeconomic circumstances" (CDC Health Disparitites and Inequalities Report, 2011).

This report has implications that can be employed to assess the same factors for the GLBT population, notwithstanding variability and exclusion of outliers; the findings provide further areas for future research projects, especially in light of the findings from this current research study and historic studies conducted on both the general population and the GLBT sub-group within the population.

Returning to the results of the Graying of the Pink survey, question 13 asked the respondents to "describe your relationship with your medical care provider"; the answers were divided up between three types of relationship descriptions: 78.7% of the 61 respondents answered that they shared equal decision making and partnering in their health care. Remarkably, only 3.3% answered that they were the authority and decision maker, while the remaining 18% reported that they were the consumer and their medical provider was a service provider. The initial results from the survey completed by the gay men would indicate that they are knowledgeable, aware, and are in control of their overall healthcare strategies. This however, is in direct conflict with larger studies conducted.

Subject survey data and government studies like the Missouri Foundation for Health Study (MFFH) have documented evidence indicating that members of the GLBT community resist or delay seeking health care from mainstream healthcare providers.

These results seemingly are in direct conflict with the findings from the survey completed by this researcher. One explanation that came from the apparent discordant results and analysis of the survey and published study results could potentially be explained by a shift in the cultural accepted norms and outness of the GLBT population.

This supposition, however, would not bear out as indicated in the 2012 (MFFH) Study (Winter, Editors Barker, & McAuliffe, 2012) that validated and further pronounced those surveyed had not sought health care on at least one occasion as a result of their sexual orientation,[11] cultural knowledge or competency,[12] and financial inequality.[13] It may be that avoidance is based on previous homophobic experiences or more subtle experiences of heterosexism such as the assumption that a client is heterosexual.

The MFFH results and conclusions drawn from the few studies cited would indicate and highlight that many healthcare providers may not have the specific knowledge in particular areas of concern for their gay and lesbian patients and, as a result, gay and lesbian patients may not feel comfortable, safe, or confident that the healthcare providers are unbiased and adequately aware of issues directly affecting GLBT elder health. A further expansion of this discussion is included in the next section and includes a more thorough look at the crux of this papers hypothesis on internal and institutional homophobia.

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[11] This study indicated that more than one third of the gay and lesbian young people have not disclosed their sexual orientation to their doctor. (Winter, Editors Barker, & McAuliffe 2012).

[12] Fewer than 15 of 5,704 primary care physicians in the state have registered as GLBT affirming in the Gay and Lesbian Medical Association's online provider network.

[13] GLBT Families in the US are more likely to be poor, underemployed, and multiracial than non-GLBT families.

Summary

Though this study is primarily focused on gay men, lesbians as a group should be further researched to determine the unique challenges that lesbians face as well as the health issues of other women. However, in this research it is evident that many lesbian health issues are also social issues involving a lack of access to health care that is lesbian focused, or at least respectful and accepting of a lesbian lifestyle.

The purpose of further research would be to address barriers to access of appropriate health care for lesbians, in recognition that lesbians are less inclined to seek health care than heterosexual women (Winter, Editors Barker, & McAuliffe, 2012). Many of the issues appear to be shared experiences that include a lack of acceptance of a gay or lesbian lifestyle or hatred toward gays and lesbians, heterosexism, a lack of recognition of lovers and families in the health system,[14] and poverty and the inability to afford or purchase health care (Winter, Editors Barker, & McAuliffe, 2012).

This study recognizes that health inequalities exist and it is possible that these issues would equally impact gay men and lesbians, given that most of the issues are related to sexuality, not gender.

In recognition of the health inequalities these issues are presented as they highlight the health care concerns of the gay and lesbian community in a local context and significantly inform the design of this current study.

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[14] Joint Commission on Promoting Health and Equity and Patient-Centered Care Video Transcript.

Chapter 5

Assessing Attitudes of Healthcare Professionals and GLBT Elders

This next chapter will discuss the attitudes of healthcare professionals toward the GLBT population and individual patients. Another component of the discussion is establishing or illuminating the attitudes toward GLBT professionals in the medical field, as well as the missing voices of the GLBT patients and survey participants.

Included in this section are several surveys that have been obtained through literature reviews. Both quantitative and qualitative data are used to highlight responses to the questionnaires and to provide a better understanding of the key component to this dissertation.

As previously stated the perceived necessity of GLBT individuals having to remain silent or closeted about their sexual orientation may be based in historic factors. How the individual navigates the healthcare system and culture, and the interaction between the healthcare providers and the patient are areas that intersect with the internal/external homophobia and the institutional history.

Christopher Banks, a researcher at the University Institute for Social Research, conducted a literature review on the human impact of homophobia on Canada (Banks, 2003). A question that he posed was, "Compared to the general population, do GLB patients have increased rates of health and social problems resulting from homophobia?" He cited previous research on the principle that the chronic stress of coping with social

stigmatization and societal hatred is the primary reason for homophobia's negative effects. His research included the conceptualization that homophobia is a component of minority stress, and the theory that "GLB are subjected to chronic stress related to the stigmatization, internalized homophobia and actual events of discrimination and violence" (Banks, 2003).

My contention is that both the stakeholders of GLBT elders and the medical establishment through historic precedence of institutional heterocentric perspectives, homophobia/discrimination, and inadequate education/training/research, share responsibility at the intersection of patient and healthcare provider. This viewpoint is shared and presented for peer review in articles outside of the United States medical establishment.

'The attitudes of all medical professionals and medical students are very important due to their capacity to influence the physician-patient relationship, which can in turn influence the treatment and its outcome" (Dunjic-Kostic, et al., 2012).

The presentation of institutional heterocentric and homophobic perspectives will be a key discussion in this section, for to establish these hinge pins allows for the closure of the arguing points of this research as it also brings us back to the beginning.

I state that GLBT baby boomers and the healthcare providers may explicitly, overtly, and institutionally be hindering the health care seeking behavior of GLBT patients through social ignorance, standardized medical training practices, and

heteronormative[15] standards. Additionally, the intersections of discrimination and homophobia, and their impact within medicine require further investigation to define how healthcare professionals interact with the GLBT community and specifically individually.

In the review of literature for this dissertation, a question formed that relates directly to the GLBT elder experience and impacts the very basis of this dissertation. Does the fear of bias, discrimination, or homophobia impact the GLBT elder, hampering their health seeking behavior, and does this avoidance contribute to the overall long-term health of the GLBT elder?

National surveys show that less than one-half of all GLBT adults disclose their sexual orientation to healthcare providers (American Medical Association, 1996), however, the finding from the survey conducted by this researcher appear to be in somewhat of a dispute with these results.

In the national studies, women are less likely than men to disclose their sexual orientation to their doctors with bisexual individuals having rates of disclosure lower than 25% (Witech-Combs, 2002). Additionally, healthcare providers outside of urban areas are unfamiliar or culturally ignorant of the GLBT community (Healthy People, 2010). In a supporting article, the results published indicate that only 11%-37% of primary-care physicians routinely take a sexual history from new adult patients (American Medical Association, 1996).

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[15] Heteronormative standards as defined represents the prevailing notion that all persons are heterosexual, thereby making any other invisible. It defines heterosexual society as the universal norm.

According to the American Association of Physicians for Human Rights survey conducted in 1994, 67% of the practitioners surveyed said they knew of GLBT patients who either had received substandard care, or were denied care, based on their sexual orientation (Always Your Choice, 2003).

In the Human Rights survey the respondents also reported that they had personally witnessed colleagues giving reduced care or denying care to GLBT patients because of sexual orientation with 88% reporting that they heard their colleagues make prejudiced comments about the patients.

One American Medical Association (AMA) survey conducted in 1996 noted that general practitioners and internists felt "nervous" with GLBT patients (American Medical Association, 1996). The article also indicated that in 1994 the Gay and Lesbian Medical Association had conducted a study of their membership, 700 of the 1300 members responded. A majority of the responders (59%) indicated that "they felt they had suffered discrimination, harassment, or ostracism from the medical profession because of their sexual orientation" (American Medical Association, 1996).

Kimmel and Harrington in their book, *Midlife and Aging in Gay America,* discuss concerns with the textbooks currently used for teaching the healthcare profession. In many cases courses are "sensitive to diversity issues, they usually only include coverage of racial and/or ethnic differences…and [do] not address the issues and needs of other minority groups" (Kimmel & Harrington, 2001).

In a presentation to the Institute of Medicine's Committee on Lesbian, Gay, Bisexual and Transgender Health Issues and Research Gaps and Opportunities

conference in 2010. Dr. Jason Schneider discussed the current mission of the Gay and Lesbian Medical Association (GLMA). His statement included discussion of health disparities affecting the GLBT populations as being significant, "while there are many factors that contribute to health disparities…those that deserve special emphasis are negative attitudes toward GLBT people and the lack of appropriate education among health professionals," he further elaborated that to reduce disparities "minority stress, healthcare systems, and healthcare professionals must become more inclusive and responsive to the needs of GLBT populations" (Schneider, 2010).

It is the position of this researcher that good communication is directly related to a patient accepting and following through with a physician's advice and treatment. Openness is of prime importance when discussing intimate details in an unbiased, safe, and non-judgmental setting and is an essential need of the gay and lesbian senior.

The impact of this specific belief (that I will generalize as cultural or institutional heterocentric practices as well as homophobia) on the group as a whole or individually can be extremely detrimental to gay and lesbian elders.

I postulate that exponentially, just at the time of life when their health care needs are growing, their reluctance to access medical care increases. Subjectively, could full disclosure invite ridicule, unfair treatment or, worse yet, callous and biased treatment at the hands of their healthcare professionals? This question cannot be generalized or universally answered as each individual is negotiating and strategizing outcome on their individual unique and historical perspective.

In one article reviewed, the authors state that "Lesbians in particular have difficulty disclosing their sexual orientation to providers, possibly due to continuing stigma, and to have less of a choice of finding gay or lesbian providers" (Klitzman & Greenberg, 2002).

If we accept that this fear or belief represents an immense barrier to accessibility, which can play a large role in a patient's willingness in seeking treatment or following through with a referral, then we must identify the factors that perpetuate and maintain it.

I present that the data reviewed as well as the absent research will support the premise that the GLBT patient perceives bias and this perception affects their health seeking behaviors. In effect, this belief that disclosing their orientation directly proportionally affects the quality of health care they receive.

Conversely, if an individual withholds information from the health care profession, that action also has an impact on the individual's health outcome, "one of the most significant medical risks of these populations [GLBT] is avoidance of routine health care and dissatisfaction due to fear of stigmatization by the medical community" (Dahan, Feldman, & Hermoni, Sexual Orientation, 2007). The fear creates a barrier to open communication thereby shrouding the patient in the default cloak of heteronormative understanding. If the patient's sexual orientation is not disclosed then by definition they remain "closeted" to the healthcare provider.

To illustrate the degree of openness/disclosure or "outness" of the gay and lesbian population this research study conducted a 25 question survey that included information on a variety of areas specific to the gay and lesbian experience of growing older.

In the Graying of the Pink survey, GLBT seniors showed much variability in "outness" to healthcare providers, 22% (out of 61) respondents "rarely" or "never" discussed sexual orientation with healthcare providers. It provides insight into this cohort group and possibly validates the fear as previously discussed and illuminates further the concern of an individual's ability to discuss openly the most intimate areas in their lives.

An open dialogue would benefit the patient by providing the physician with "just the facts, ma'am."[16] Research shows that healthcare providers who do not know the sexual orientation of their patients may make clinical errors regarding diagnosis, risk assessments, treatment, or preventative cure (Dean et al., 2000).

The simple assumption of heterocentricity could prevent practitioners from forming an accurate and complete picture of each patient's personal history, risk factors, and health-related needs—information that directly affects the quality of care as well as the long-term health outcome. The larger discussion of this idea and the factors that contributed to this issue will be presented later. It is intended here to notify the reader of the ideas.

Many lone GLBT elders become reliant on formal care-giving services sooner than elders who can turn to family members and partners for informal support and financial assistance. Promoting a universal "successful aging strategy" for any senior would encompass a variety of quality of life (QOL) issues regardless of their sexual orientation. These issues or needs include maintaining physical and emotional well-

[16] Dragnet television series ran from 1951-1957 with Jack Webb playing the character Joe Friday whose catch phrase was "just the facts, ma'am."

being, self-determination or autonomy/independence, and aging in their own community or home with respect, safety, and support as has been previously noted.

Again, geriatric research has shown that remaining actively engaged with a social network or support framework, and the ability to pursue social, recreational, and/or intellectual or spiritual activities has contributed positively to the overall health and outlook of the geriatric population.

The need for accessible and comprehensive health services, prescription drug coverage, and long-term care will be applied across the board to all seniors. Gay and lesbian elders notwithstanding will also face a variety of special health concerns and barriers to care. These include HIV/AIDS, other sexually transmitted diseases (STD), breast cancer, substance abuse, mental health, hate violence, and elder abuse.

The universal needs of the gay and lesbian population may not always be met by society, however if there is a lack of information and research in this area, identification of any needs becomes hindered. Access for gay and lesbian elders to appropriate health-assessment, treatment, and prevention services could be hampered by healthcare providers ignorantly assuming that all patients are heterosexual and not delving into the specific healthcare issues relevant to this social group.

Unfortunately, a large number of gay and lesbian elders are hesitant to access services as previously stated, having come of age at a time of acute homophobia at every level of society, including within social services and the medical profession. As such, there is often a concern that by accessing health care or other specialty services, gay and lesbian elders may be inviting judgment or condemnation. This internal homophobia or

fear could be conceived as both a survival strategy and a hindrance in the long-term goal of a successful health outcome.

The two issues with most significance or potential impact on the two groups is appropriate education of healthcare providers and educating the GLBT community concerning the need for disclosure about their unique health issues.

If we accept that homophobia both internal and institutional exists and are barriers to the medical outcome of patients, examining a means to diminish the cause of this would include education. The IOM publication defines and categorizes language in structures that best describe the idea of the internal and institutional homophobia as *personal-level barriers* and *structural barriers*:

> Personal-level barriers are created by the attitudes, beliefs, and behaviors of individuals within the health care system—both providers and patients. Individual expressions of sexual and transgender stigma create significant personal barriers for LGBT people attempting to access high quality care" (Committee on Lesbian, Populations & Medicine, 2011, p.62).

> Structural barriers relate to the health care system at the institutional level. These barriers operate regardless of the attitudes of individuals. Examples of such barriers include an employer-based health care system that limits LGBT individuals' access to marital benefits, including eligibility for health insurance; lack of training in LGBT health received by providers; and insurance practices that limit the types of care covered for LGBT individuals. (Committee on Lesbian, Populations & Medicine, 2011, p. 64)

In an editorial presented in the *Open Medical Education Journal*, a discussion on why culture matters in medical education ventured to define cultural competence and diversity. The authors stated that characteristics of culture ignore features such as age, gender, sexual orientation, socioeconomic status, and regional or family customs. In the author's own words "cultural competence is often used synonymously with cultural

diversity, cultural sensitivity and cultural awareness, although each term signifies something different" (Vaughn & Baker, 2009).

Perhaps this is why the presentation to the IOM Committee on Gaps in Research and Opportunities key points "was to make cultural competency training specific to GLBT populations a standard component of all health professional training curricula" (Schneider, 2010).

The Joint Commission in 2010 released revised standards for effective communications, cultural competency, and patient-centered care. The Commission upheld the principle that patients bring unique needs to the health care encounter "that can affect the way they view, receive, and participate in health care" (Joint Commission, 2012). The Commission stated that "research has demonstrated that incorporating the concepts of cultural competence and patient and family-centeredness into the care process can increase patient satisfaction and adherence with treatment," included in this was the right to "receiv[e] care free from discrimination" (Joint Commission, 2012).

Recent publications have included many discussions concerning the role that cultural competency play in medicine. Karen Cheung's article on "What's Missing from Physician Core Competencies" highlights that the biggest gap is in communication skills (Cheung, 2012). It is interesting to note that as early as 1985, Medical Education Journals included articles such as "Bringing the Homosexual Patient Out: Teaching the Doctor's Role" highlighted the fact that "little attention was given in medical school curriculum to providing care for the 5-10% of the population that was homosexual" (Bauman & Hale, 1985)

The study results found that the medical students who had undergone primarily small group discussion had become "more accepting toward homosexuals, thus enabling them to accept and better care for homosexual people" (Bauman & Hale, 1985). In an article published in 2012, statements were presented that still reflect the sustained negative attitude toward GLBT people, "although the number of physicians holding negative attitudes toward homosexuality is declining, there are still those who would not accept a homosexual applicant to a medical school, and those who would not trust a homosexual colleague" (Smith & Mathews, 2007).

It would appear that the goal of cultural competence training and the approach to health care emphasizes an awareness and understanding of how professionals can most effectively interact with people from other cultures. And yet, there lingers significant articles that would dismiss the goal of cultural awareness. "Medical students, during their studies, as well as young doctors, during their residency, often do not receive comprehensive education on different sexual orientations. In addition, senior doctors lack practical skills in addressing unique healthcare needs of homosexual patients which are often minimized or ignored" (Dahan, Feldman, & Hermoni, Sexual Orientation, 2007) continue to dispute this viewpoint.

The goal of education of health providers and educating the GLBT community to their unique health issues feed into the goal of providing a support environment and non-judgmental access to health providers. The traditional gay health issues such as safe sex education and HIV/AIDS health promotions are areas of significant concern in the community, but are not the only health care issues related to gay men's health. Both

access to, and quality of, health care for the GLBT community are important areas of concern.

Referring back to the idea on structural barriers, the lack of training in the health needs of LGBT patients and cultural competence has lead to continued poor patient/provider communication and is strongly associated with adverse health behaviors such as decreased levels of adherence to physician advice; yet, many providers are not trained to provide care for LGBT individuals, and providers themselves report a lack of knowledge about the issues facing their sexual- and gender-minority patients. Particularly for transgender patients, access to providers who are knowledgeable about transgender health issues are critical. In fact, few physicians are knowledgeable about or sensitive to LGBT health risks or health needs (IOM, 2011).

To complicate or exacerbate the issue, medical schools teach very little about sexuality in general, and little or nothing about the unique aspects of lesbian, gay, and bisexual health, and it is rare for medical students to receive any training in transgender health. While the Association of American Medical Colleges issued recommendations for institutional programs and educational activities to address the needs of LGBT patients in 2007, including training in communication skills regarding sexual orientation and gender identity, it is not evident that all medical schools have embraced these recommendations.

The Lesbian, Gay, Bisexual, and Transgender Medical Education Research Group, a group of medical students at Stanford University, surveyed deans of medical education at 116 universities in the United States and Canada. They found variability in

the content and quality of the LGBT-specific instruction medical students received, with HIV, sexual orientation, and gender identity being the most common LGBT topics included in the curricula. Fully 70% of the deans rated their school's curriculum in this area as "fair" or "worse" (Obedin-Maliver, 2011).

The attitude of medical professionals toward LGBT patients can influence the patient's willingness to seek medical treatment, follow through with medical plans or referrals, and impact the patient-provider communication, thereby affecting the long-term health outcome. It is a reasonable conclusion that LGBT individuals coupled with the aging experience would retreat and potentially re-enter the closet.

The aging experience by nature of the pathology of aging tends to negate or diminish the power of the individual. Strong men and women find that the power that they once had as individuals negated under the paternalistic medical model that contributes to the ever-widening gulf between physician and patient. The underlying issue of hierarchy redefines the individual patient into that of being a "vulnerable" patient. This identification as a "vulnerable" patient should afford any elder in need with the same ethical rights accorded to any class of at-risk person. How can one determine whether an individual is vulnerable? What situations or occurrences could impact the quality of care given to someone? Does the role of the physician coerce the patient into the paternalistic role of a child? In the gay and lesbian elder population does disclosure truly impact the quality of care given?

Each of these questions is a core consideration from the gay and lesbian elder. Is it their belief that based on historic precedence, disclosing their orientation will directly

and proportionally affect the quality of health care they receive? Could full disclosure invite ridicule, unfair treatment, or worse yet, callous and biased treatment at the hands of their healthcare professionals? As we have discussed earlier, the current research and studies on healthcare professional's attitudes toward LGBT patients show a lack of substantive training in LGBT health issues, and poor core competencies in communications. Our findings will shift to the individual barriers that may impact the open relationship and honest disclosure of important medical information.

I would reiterate the argument that good communication and rapport are highly related to a patient accepting and following through with a physician's advice and treatment. Openness in being able to discuss these intimate details in an unbiased and non-judgmental setting is an essential need in the treatment of the gay and lesbian seniors. The barriers, as evident from the research, would indicate that the two main points for preventing appropriate healthcare is homophobia (fear) shared by both institutions; healthcare professionals and GLBT patients.

Many of the research respondents from the Graying of the Pink survey identified areas of concern that included the feeling that society saw them as diametric opposites. The We-right-good vs. Other-wrong-bad. These fears have the potential to drive GLBT individuals back into the closet, creating a barrier to accessing benefits necessary for optimal physical and mental health.

Some of the respondents from this study were far more pessimistic about the reality they believed they are facing. They included a perception of pervasive negative attitudes toward older adults in general and gay and lesbians in particular. Their reported

comments included that there was an overall feeling of a loss of power, loss of self-efficacy, and terror associated with aging alone.

This finding is not isolated. Amber Hollibaugh, a senior strategist at the Gay and Lesbian Task Force, focuses on GLBT-aging issues stated, "Because GLBT elders tend to age alone, we're more dependent on these systems [existing social services networks]… homophobia is the last thing you want to deal with" (O'Bryan 2006).

Many of the issues that confront the GLBT aging community are complicated and interwoven. There are unique health risk issues of gays and lesbians that are important to the clinician in determining an accurate diagnosis, providing patient education, and arriving at an appropriate treatment plan. One of the most significant medical risks of this population includes avoidance of routine health care and dissatisfaction with health care. Within the broad range of issues, there are some issues of particular emphasis and crisis. (Bonvicine & Perlin, 2003)

In reviewing the literature of GLBT community health issues many referenced concerns over depression, anxiety, suicide, isolation, marginalization and homelessness. The lack of appropriate, assessable and affordable counseling services for GLBT was also highlighted. As evident with the Transgender Health Disparities study there is a lack of knowledge of their needs by most health professionals.

These health risks include HIV/AIDS, other sexually transmitted diseases (STD) and sexually transmitted infections (STI), breast cancer, substance abuse, mental health, hate violence, mental illness, and elder abuse. The research is mounting with information more readily available to both the medical professional and the patient. Without the

openness and willingness to discuss sexual orientation, medical history, or neutral medical settings in the practice, this information may not be included in patient-physician discussions or treatment plans.

Though historically, the gay and lesbian community has been excluded from gerontological theory (McMahone, 2003) there are growing voices in both the GLBT community and the medical profession that are attempting to overcome the lack of past research. It is recognized that in the existing framework of heteronormativity, those with non-normative sexual identities have been excluded and are not necessarily reliable indicators of the gay man's experience of the aging process and negotiating life transitions (Lee, 2004).

And though there has historically been little public health infrastructure for funding and supporting research on the health of gay and lesbian elder populations (Shippy, 2001, p. 138), it is changing with the present administration and policy initiatives. A component of the Affordable Care Act includes addressing cultural competency and addressing the needs of the GLBT individual and families.

With changes coming to the medical definitive studies on the relative risk of individuals for specific health problems such as cancer, long-term use of hormone replacement in transgendered individuals, contraception studies in the lesbian population, or other diseases, which are quite rare according to Laura Dean's publication *Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns* may change. To this point, action by both grass root organizations and government/medical policymakers is

changing the very nature of research on minority groups and including diversity to include GLBT interests.

This institutional default of less than adequate research and the simple assumption concerning a generalized population of elders has prevented healthcare providers from forming an accurate picture of a GLBT individual's personal history, risk factors, and health-related needs; information that directly affects the quality of care as well as the long-term health outcome for any studied group.

Even though the universal needs of the GLBT population may not have always been met by society,[17] I believe in large part that it is due to invisibility. Access for GLBT elders to appropriate health-assessment, treatment, and prevention services could be hampered by healthcare providers ignorantly assuming that all patients are heterosexual (Rondahl, Innala, & Carlsson, 2006).

Unfortunately, I posit that a large number of older GLBT patients are hesitant to access services having come of age at a time of acute homophobia and discrimination at every level of society, including social services. Within the medical profession this represents the personnel level barrier. "Most GLBT elders do not avail themselves of services on which other seniors thrive. Many retreat back into the closet, reinforcing isolation" (National Gay & Lesbian Task Force, 2010). As such, the individual patient

[17] To this day, Dr. Hooker's study is the only paper referenced in detail on the main web site of the American Psychological Association in its discussion of gay and lesbian issues. It was one of the two upon which, in 1973, the APA decided to remove homosexuality from the list of psychological disorders. http://www.lifesitenews.com/news/archive//ldn/2007/jul/07071603

often has a concern that by accessing health care or other specialty services, they may be inviting judgment or condemnation. I wish to examine these fears (whether founded or imagined of discrimination and homophobia) that this population may have.

Results of an American Medical Association (AMA) survey conducted in 1991 noted that general practitioners and internists felt "nervous" with GLBT patients. This research was also identified in the National Coalition of GLBT Health letter to Centers for Medicare and Medicaid Services in May of 2012: "possible discomfort on the part of healthcare workers with asking questions regarding sexual orientation and gender identification, a lack of knowledge by providers of how to elicit this information and some hesitancy on the part of patients to disclose this information" (Inniss, 2012).

There is a symbiotic relationship that exists between a healthcare provider/professional and the patient. For to be ill, aged, or infirm means a loss of power or status. Strong men are reduced in later years to becoming more childlike, demure, and withdrawn. Women find that the power that they once had as individuals negated under the paternalistic medical model that contributes to the ever widening gulf between physician and patient. The underlying issue of hierarchy redefines the individual patient into that of being a "vulnerable"[18] patient (US Government, n.d.). This identification as a "vulnerable" patient should afford any elder in need with the same ethical rights accorded to any class of *at risk* vulnerable person.

[18] As defined by socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified to be at risk for health disparities.

How can one determine whether an individual is vulnerable? What situations or occurrences could impact the quality of care given to someone? Does the role of the physician intimidate the patient into silence through perceived or real homophobia? In the gay and lesbian elder population does disclosure truly impact the quality of care given?

Each of these questions is a core consideration for the gay and lesbian elder population. Could full disclosure invite ridicule, unfair treatment or, worse yet, callous and biased treatment at the hands of their healthcare professionals? Or is the perception of homophobia merely a perspective that is unfounded, and any barriers to appropriate health care the sole fault of the patient by remaining closeted. Is it their belief that disclosing their orientation will directly and proportionally affect the quality of health care they receive?

As previously noted, studies have documented cases where care was withheld and or denied. Can the responsibility of the patient to the health care process oblige the patient to disclose sexual orientation, sexual history, AIDS/HIV status when the specter of discrimination or homophobia is tacitly apparent?

In focusing on the experiences of the 61 study subject volunteers and how their unique gay experience intersects with their health care, their personal narratives (surveys and open ended questions) provide the subjective patient narrative that is missing from the current literature.

With regret, the inclusion of a more comprehensive and complete study subject cohort, to include lesbians, bisexuals, and transgendered subjects, failed. This study,

however, will present data from literature searches and published studies inclusive and in support of the broader GLBT community, citations and reference examples utilized will be considered based on the broader context of the aging GLBT health care needs.

The one group of stakeholders that I reached out to in my research was the aging gay baby boomer[19] community. Utilizing the social networking site, a survey was presented requesting volunteers to complete a 25 question survey. This survey was administered through an anonymous web-based hosted survey vendor (www.surveymonkey.com). The survey group consisted of respondents from the geographically diverse locales of New York metropolitan area and San Francisco area. The posting was directed to and posted for the "baby boomer age" individuals (N=236 with 61 completing or a 25.8% completion rate).

The survey included questions concerning basic demographics: age, race, marital status/partnered/single, religious affiliation, income, as well as questions on psychological and social profiling. Additionally, five open-ended questions were presented, so that the respondents could have an active voice in discussing their own experiences, expectations, and viewpoints on their own aging journey. The data analysis of the completed surveys will be presented later in this report.

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[19] Baby boomer is the name given to the generation of Americans who were born during the "baby boom" that followed World War II. The Boomers were born between 1944 and 1964. The oldest wave of the Baby Boomers is currently considering retirement options and looking at ways to make their elder years meaningful. http://humanresources.about.com/od/glossaryb/g/boomers.htm

To illustrate the degree of openness or "outness" of the gay and lesbian population, I conducted a 25 question survey that included information on a variety of areas specific to the gay experience of growing older. In the Graying of the Pink survey, gay baby boomer respondents showed much variability in "outness" to healthcare providers 22% (N= 62) respondents "rarely" or "never" discussed sexual orientation with healthcare providers. It clearly identifies that a significant percentage of the study cohort were at risk of inadequate or insufficient levels of communication with the healthcare provider. Perhaps it defines the "fear" as previously discussed and illuminates further the concern of an individual's ability to discuss openly the most intimate areas in their lives.

I would argue that good communication and rapport are highly related to a patient accepting and following through with a physician's advice and treatment. Openness in being able to discuss these intimate details in an unbiased and non-judgmental setting is an essential need of any patient population. An open dialogue would benefit the patient by providing the physician with "all the facts, ma'am."[20] Research shows that healthcare providers who do not know the sexual orientation of their patients may make clinical errors regarding diagnosis, risk assessments, treatment, or preventative cure (Dean et al., 2000).

An analysis of survey responses from those who did disclose their sexual orientation with healthcare providers demonstrated that the degree of outness correlated to the number of doctor visits. Survey respondents who also disclosed their sexual

[20] Dragnet television show from 1951-1959s – Jack Webb's Joe Friday character, line – "Just the facts, Ma'am", http://www.imdb.com/title/tt0043194/

orientation were more likely to have reported at least 1+ health care visits per year. Their responses provides supporting data to the theory concerning the willingness of an individual to access needed and preventative health care services and the level of sexual orientation disclosure to family and healthcare providers.

Many of these gay and lesbian patients might be more isolated, alienated, or reluctant to talk openly about their lives and their sexual practices even in the best of circumstances. Many of the respondents identified areas of concern that included the feeling that society saw them as diametric opposites; the We-right-good vs. Other-wrong-bad. These fears have the potential to drive GLBT individuals back into the closet, creating a barrier to accessing benefits/services necessary for optimal physical and mental health.

The issues that confront the GLBT aging community are complicated and interwoven. Within the broad range of issues, there are some issues of particular emphasis and crisis. The bulk of aging GLBT people are not wealthy, aging makes people poor, if they weren't already. "A significant number of study participants postponed needed medical care due to [the] inability to afford it, whether seeking care when sick or injured (48%) or pursuing preventative care (50%)…due to discrimination and disrespect, 28% postponed or avoided medical treatment when they were sick or injured, and 33 delayed or did not try to get preventative health care. Twenty-nine percent of respondents who were out or mostly out to medical providers reported they had delayed care when ill, and 33% postponed or avoided preventative care because of

discrimination by providers" (AHRQ, Health Disparities Report, 2011; Cook-Daniels, 1998).

Summary

The direct impact can be summarized thusly, direct open communication encourages patients to trust their providers and the resulting partnership facilitates or allows closer supervision of the individual's state of health. Additionally, this correlated to the respondent's reported relationship to the healthcare provider as equal decision maker in the heath care process. This was also reflected in the government report Healthy People 2020.[21]

Negating the cause for the reason for not fully disclosing pertinent medical information to a healthcare professional; the impact of that decision could hinder the health care of the individual because decisions could be made without a full medical history. Any decision would be based on an incomplete record. The final diagnosis would be suspect and flawed, if the provider unknowingly determined a course of action without the benefit of having all the facts.

The GLBT community faces an enormous challenge to educate the health care industry and providers about the special health care needs of its community. The health of the community is an important indicator of a shared view point. It illustrates the larger

[21] http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=25

picture of a society's view of those who are less able to care for themselves, and defines the responsibility of that society to those who are less advantaged.

The history of disability and disability theory speaks about "disability" in terms of temporal time. So, the able-bodied is seen as a temporary position in society; euphemistically it has been described as TAP, a temporarily abled person. As we age and become advanced in years, seniors experience the pathological effects of aging—loss of hearing, sight, mobility, etc. Thus, we all, if we reach that "golden age," will become more infirm—it is almost a certainty. As certain as the aging process is its affect on the general population will happen to all ethnic groups and cultural settings.

In the future, when we discuss geriatric research, we will have to first find a chair at the table for the gay and lesbian community then their experiences through the eyes of a recognized culture. Queer studies theorist like Evelyn Hooker's *Homosexuality* approaches the study of gay and lesbians as a distinct culture where they have a shared language, customs, and identity. Historically, society by and large marginalized the gay and lesbian experience and branded those "club" members as deviant, sinful, or criminal. Much of the ill-treatment of gays and lesbians was either at the hands of or caused by the medical establishment. Perhaps this is why the fear of the medical establishment remains today.

Chapter 6

Homophobia: Internal and Institutional

There is a symbiotic relationship that exists between a healthcare provider/ professional and the patient. This ability to co-exist successfully mandates that an equality of presence is shared. This meaning of equality of presence is such that each party is equally invested in the venture and that the act of sharing is necessary to achieve a goal or outcome. When one party withholds, for our purposes, information, the second party is at a disadvantage and the relationship becomes unevenly weighted versus balanced.

The patient/physician relationship, for this discussion, is the equality of the patient and physician relationship defined within a decision making model. Any barrier that is created hinders the honest communication that is necessary to allow an equally balanced, successful symbiotic relationship impacts the overall relationship and thusly impacts the outcome.

Within the medical profession, the ethical principle of autonomy would suggest that patients' should always be fully informed, not only so that they can make the best possible decisions, but also because information helps them to make sense of and cope with illness. Physicians are ethically obligated to do good for patients (beneficence) and not to harm them (nonmaleficence). Information withheld by the patient prevents the healthcare professional from assessing and possibly diagnosing the illness correctly. Conversely, a patient is implicitly bound to provide the treating provider with an accurate

history of their illness or condition, for in the very details, the clues to the cure could potentially be found, or the omission of truth which would detrimentally impact the diagnosis, treatment and cure.

According to the government's *Healthy People 2002 Report* (Hoctel, 2002, Jan-Feb) research suggests that GLBT individuals face health disparities linked to societal stigma, discrimination, and denial of their civil and human rights. Discrimination against GLBT persons has been associated with high rates of psychiatric disorders, substance abuse, and suicide. Experiences of violence and victimization are frequent for GLBT individuals and have long-lasting effects on the individual and the community. Personal, familial, and social acceptance of sexual orientation and gender identity affects the mental health and personal safety of GLBT individuals.

The Belmont Report, intended for the guidance in protecting human subjects in research, presents an interesting correlation in that individuals should be treated as autonomous agents, that persons with diminished autonomy are entitled to protection. This respect for the person, though strictly speaking about research subjects, can be applied to the principle of GLBT elders. Beneficence is spelled out in the document as "be[ing] respect[ed] of their decisions and protecting them from harm, but also by making efforts to secure their well-being" (Belmont Report, 1979). "An injustice occurs when some benefit to which a person is entitled is denied without good reason, or when some burden is imposed unduly" (Belmont Report, 1979).

The very nature of medicine is both openness and trust, based on the belief that the healthcare profession has the qualifications, training, and education to treat the

complexities of modern medicine and illness. We as patients trust that the physician has met the requirements, we trust that our lack of understanding of the complexities requires our trust and belief in the physician. We take on faith that their treatment advice is correct, and we are open to taking their educated advice and trust that the treatment and medical plan will "heal" our bodies.

Then the question is: *Why would someone withhold vital information?*

While reading *Military Medical Ethics* vol. 1, chapter 1, a noted physician/ ethicist, Dr. Pellegrino, struck a nerve when he wrote "patients and physicians meet each other in an intricate matrix of psychosocial, cultural, and socio-historical phenomena that can modify the expression of medical ethics…there is a foundation for the duties of all health professions that is relatively constant across cultures, history and national boundaries" (Pellegrino, n.d.)

To dissect this quote or rather to interpret the content for my own benefit and that of my readers, the activities of health, illness, disease, treatment, recovery, etcetera becomes a complex dance. This dance is not only between the doctor and patient, and extrapolated beyond these two main characters to the other health professionals, e.g., nurses, dentists, social workers, and psychologists, but also the caregivers, family, friends, etc. The very nature of these relationships has the potential to hinder or help the health outcome and ultimately the fate of the patients/persons that may be affected.

When circumstances impede this dance, we stumble, and potentially fall or fail as the case maybe in reaching the appropriate conclusion. In discussing the structural

barriers impeding the GLBT elder from receiving appropriate and adequate care, we should examine the attitudes and perspectives of the health care professionals.

To simplify the discussion we will begin with the fear in discussing sexual health issues. In an article from 2005, "I dare say I might find it embarrassing: General practicioners perspectives on discussing sexual health issues with gay and lesbian patients," researchers presented the perspectives on the difficulties which physicians face when discussing sexual health issues with gay and lesbian patients. The results of their study found that non-heterosexual orientation could form a barrier to talking about sexual health matters for almost half of the general practice physicians sampled (Hinchliff, Gott, & Galena, 2005). Their findings also identified "that difficulties related primarily to ignorance of lesbian and gay lifestyles and sexual practices, and also included concerns about the appropriate language to use and assumptions about the nature of gay men's relationships."

If we accept that this fear or belief represents an immense barrier to accessibility which can play a large role in a patient's willingness to seek treatment or follow through with a referral, then we must identify the factors that perpetuate and maintain it.

I present that the data reviewed as well as the absent research, will support the premise that the LGBT patient perceives bias and that this perception affects the health seeking behaviors. In effect, this belief that disclosing their orientation directly and proportionally affect the quality of health care they receive.

Conversely, if an individual withholds information from the healthcare professional, that action also has an impact on the individual's health outcome, "one of

the most significant medical risks of these populations [LGBT] is avoidance of routine health care and dissatisfaction due to fear of stigmatization by the medical community" (Dahan, Feldman, & Hermoni, 2007).

Moving beyond just communication, the heteronormative standards, implied or overt, homophobia/ignorance, and discrimination can inhibit and prevent honest discourse. The impact of this barrier (that I will generalize as homophobia) on the group as a whole or individually can be extremely detrimental to gay and lesbians elders. Exponentially, just at the time of life when their healthcare needs are growing, their reluctance to access medical care declines.

The conclusion can be summarized thusly, direct open communication encourages patients to *trust* their providers and that *partnership* facilitates or allows closer supervision of the individual's state of health. This correlates to the current study's respondents reported relationship to the healthcare provider as equal decision maker in the heath care process.

Fear, as research has shown, creates the barrier to open communication, thereby shrouding the patient in the default cloak of heteronormative understanding. If the patient's sexual orientation is not disclosed then by definition they remain "closeted" to the healthcare provider. Fear is also shared by both patient and healthcare provider; it is inclusive as the definition also refers to a fear of, or aversion to, homosexuality and to lesbians, and gays (Rondahl, 2009).

Individually, interpersonal attitudes may be negative in one category and positive in another. This polar opposite creates a push-pull or ambivalence. One study suggests

that holding ambivalence toward a minority (GLBT elders) can intensify the person's response to group members, either positively or negatively (Eagly & Chaiken, 1998).

When GLBT individuals are faced with heteronormative assumptions the homosexual becomes invisible. This may lead to poor communication by leading the healthcare provider to ask the wrong questions and make incorrect judgments (Rondahl, Innala, & Carlsson, 2006). The conclusion drawn from this study indicated that unconscious heteronormative communication by healthcare staff contributed to feelings of insecurity and lead to misconceptions. This was mirrored in another study that examined heterosexism that was not specifically targeted at LGBT individuals (Burn, Kadlec, & Rexer, 2005).

In determining the impact that heteronormative and heterosexism has on the GLBT elder patient, it is necessary to ascertain how out or open the study population is. To illustrate the degree of openness/disclosure or outness of the gay and lesbian population the current study question survey included information on a variety of areas specific to the gay and lesbian experience of growing older.

In the Graying of the Pink survey, GLBT seniors showed much variability in outness to healthcare providers 22% (out of 61) respondents "rarely" or "never" discussed sexual orientation with healthcare providers. It provides insight into this cohort group and possibly validates the fear as previously discussed and illuminates further the concern of an individual's ability to discuss openly the most intimate areas in their lives.

In defining the attitudes of healthcare professionals, research into other (non-physician) healthcare providers must be collected and analyzed, for in many modern

medical practices and health care environments patients interact with other contributors and health team members. Physician Assistants, Nurses, and medical students could potentially interact with GLBT elder patients.

A survey study (Takaishi, Bunton, & Muma, 2006) was conducted in association with the American Physician Assistant Association to survey the attitudes and awareness of lesbian and gay patients. In surveying family practice physicians, it was determined that the response rate (n=168) results indicated that 82.3% and 84.4% of the sample, were aware of gay and lesbian patients in their practice.

The majority of the respondents appeared to have positive attitudes toward gay and lesbian patients in obtaining sexual history, providing care, and in attending continuing medical education sessions concerning gay and lesbian health issues. This preliminary study represented the first study findings that were positive overall, however, a larger scale study is recommended before the results and conclusions can be generalized for all physician assistants (Takaishi, Bunton, & Muma, 2006).

In this previous study the research team acknowledged that "the human nature of the healthcare provider gives rise to a multitude of emotions that may be evoked when providing healthcare to homosexual patients" (p. 158). Research shows that healthcare providers who do not know the sexual orientation of their patients may make clinical errors regarding diagnosis, risk assessments, treatment, or preventative cure (Dean et al., 2000).

This simple assumption [heterocentricity] could prevent practitioners from forming an accurate and complete picture of each patient's personal history, risk factors,

and health-related needs—information that directly affects the quality of care as well as the long-term health outcome. If conditions are present, it would generally be accurate to comprehend the reason that GLBT elders withhold information. The conditions which one would not feel comfortable in divulging sensitive details presumably could include either direct or indirect negative cues, attitudes, or personal interactions.

The personal interaction and amount of time that a patient spends with physicians may be minimal, however, the time that a patient spends with a nurse is far greater. It is necessary to examine registered nurses attitudes and homophobia toward gays and lesbians in the workplace (Blackwell & Kiehl, 2008). Even though the authors acknowledge that little information or research has been conducted studying any correlation between nursing care and homophobia, the authors present an interesting viewpoint.

Blackwell and Kiehl's working thesis for their research is that "perhaps education itself isn't significant without educational experience rich in sexual orientation issues…," they further postulate that "nurses increase their competency in providing services…by augmenting their knowledge, sensitivity, and awareness, and acquiring communication skills to relate to them (GLBT patients)"(2008, p. 31).

There may be a tendency to accept the idea that education alone is the cure for this disorder (homophobia), but it would be simplistic and unrealistic to expect an institutional structure such as medical education to drastically or dramatically alter their approach in teaching for a sub-group population.

Notwithstanding, there is evidence that this simplistic approach does not take into account the numerous other publications and abstracts that would directly challenge the 2008 research findings of Blackwell and Kiehl. In an article published in 2009, researcher Röndahl studied the experiences of gay patients concerning attitudes in nursing. Of the 25 respondents included in the study (15 women, 10 men) nearly all expressed a sense of insecurity in coming out to nursing staff (G. Rondahl, 2009).

Rondahl's article begins with the opening salvo "Many nurses find it difficult to show compassion and sensitivity, and to give gay patients nursing of a quality equal to that given to heterosexual patients" (2009, p. 146). Though his study included a small study cohort, and given the cultural differences between Scandinavian social contexts, the narrative generally echoes the sentiments that were shared in the narrative section of the Graying of the Pink survey.

Gaining access to appropriate health-assessment, treatment, and prevention services could be hampered by healthcare providers ignorantly assuming that all patients are heterosexual or by institutional heterocentric practices or moreover homophobia.

Communications skills of the providers themselves may alienate a section of any patient population. When research was conducted on the subject of communication skills between urban and non-urban residents, the findings indicated that "differences in perceived quality of communication could contribute to reduce use of preventative health care and indicates a need to improve healthcare provider/patient communication" (Wallace et al., 2008).

This barrier can create fear and represents an immense obstacle to accessibility which can play a large role in a patient's willingness to divulge the intimate details necessary when seeking treatment or following through with a specialist's health plan.

> Gay and lesbian patients of all ages still report negative reactions from service providers. These include embarrassment, anxiety, inappropriate reactions, direct rejection of the patient or exhibition of hostility, harassment, excessive curiosity, pity, condescension, ostracism, refusal of treatment, detachment, avoidance of physical contact, or breach of confidentiality (Brotman, Ryan, & Cormier, 2003).

Brotman, Ryan and Cormier further the evidence of discrimination, "some research has documented that homophobia and heterosexism are even more common in elder care systems than within the health care system generally." "Older gay men and lesbians who have come out to others often find themselves having to go back into hiding when they require health care services"(2003, p. 192).

It is generally acknowledged that historically, and in more recent research, links can be found in the connection between perception of fear of discrimination and attitudes toward GLBT elder patients. As previously indicated, lack of knowledge, limited exposure or awareness of GLBT presence, and minimal time spent in training in cultural diversity or cultural competency may have lead to the present outcomes in a number of studies.

How does one begin to address any issue of GLBT elder patients when studies reveal that the medical establishment remains archaic to the presence of GLBT healthcare professionals? Prior to 1993, the American Medical Association (AMA) bylaws made no reference to sexual orientation in the nondiscrimination clause. In fact, the AMA meeting in December 1989 proposed amending the clause so that membership could not

be denied, the floor debate was heated, and delegates presumed that the resolution intended to endorse an alternate lifestyle and was too prescriptive, the resolution failed (American Medical Association, 1989).

In a related study on harassment of lesbians as medical students and physicians the results found that "lesbians were four times more likely than heterosexual physicians to report ever having experienced sexual orientation-based harassment in a medical setting" (Brogan et al., 1999). Similarly, the special report by Dr. Nancy Robb published in the Canadian Medical Association Journal in 1996 reiterates the same conclusion as this previously cited study.

Citing interviews of students and fellow physicians, Dr. Robb reiterates that the medical establishment is slow to change. One of the interviewers remarked anecdotally, that "off-color jokes by students and later, insensitive remarks by surgeons on hospital wards reinforced his fears (homophobia) as did the curriculum, "We had one half-hour lecture devoted to sexual orientation and transsexuals," he then stated, "at least the professor did say that homosexuality isn't' considered a disease anymore" (Robb, 1996).

In later studies on gay and lesbian physicians, attention was given to the aspects and experiences while in training. One such study highlighted the results of the study in declaring, "Gay or lesbian medical students and residents experience significant challenges. For all participants, sexual orientation had an effect on their decisions to enter or remain in medicine" (Risdon, Cook, & Willms, 2000). The outcome of the study was that much energy was "spent navigating the training programs, which may be, at best, indifferent and, at worst hostile to their presence" (Risdon et al., 2000). In this same

article, the authors referenced American Association of Physicians for Human Rights survey that found 17% of gay and lesbian physicians reported being refused employment, medical privileges, referrals, or educational opportunities because of their sexual orientation (Schatz & O'Hanlan, 1994).

Homophobia in other forms is also present in medical training settings. A 1999 study on Medical Student homophobia, starkly indicated that the data indicated significant homophobia, with one quarter of the students reported believing that homosexuality was immoral and dangerous to the institution of family, expressing an aversion to socializing with homosexuals (Klamen, Grossman, & Kopazc, 1999). The shocking conclusion than can be drawn from the study indicates that if "left unchallenged, (homophobia) will hinder care provided to homosexual patients" (Klamen et al., 1999). In a later study conducted in Britain, the study assessed the medical students' attitudes toward male homosexuality. In this later study, a significant percentage (10% - 15%) held negative views (Parker & Bhugra, 2000).

How do we counteract the apparent failure in sensitivity and empathy by healthcare trainees, students, and qualified providers? As late as 2011, the New York Times ran a story by Dr. Pauline Chen with the headline reading "Medical Schools Neglect Gay and Gender Issues" (Chen, 2011).

One study suggested a critical intervention; to place the means of change in the hands of the medical education process. The authors cited that in 1994 the AMA issued a policy that committed to taking a leadership role in the education of physicians on current state of research and knowledge of homosexuality which should begin in the medical

school curriculum and continue throughout the medical education. (Kelley et al., 2007). Another study suggests that exposure to "teaching faculty that identify themselves as GLBT" (Curry, 2011) would effect change. The argument, however, is purely academic as discrimination/homophobia is not generally stopped due to visibility.

Summary

According to the surveys conducted, practitioners knew of GLBT patients who either had received substandard care or were denied care, there were reports that they witnessed colleagues giving reduced care or denying care to LGBT and attitudes of feeling nervous with LGBT patients. The impact of these results would generally confirm cultural or institutional heterocentric practices as well as homophobia.

The reports detail practices that would be unacceptable in the general population, but go more or less unchecked. The conclusion to be drawn is that circumstances do exist that prevent an open and honest discussion of GLBT issues with healthcare professionals. Whether this barrier can be categorically named as homophobia or not, the fear in all its shapes and sizes is impacting the health care of a number of GLBT elders. How to redress this issue is believed to be through education—in cultural competency and diversity training, however, currently little time is relegated to the training of medical students or practicing physicians.

In discussing the reasoning for teaching about the subject of GLBT issues, "even absent (of) the health and health care disparities, it would still be important for physicians

to understand the full range of human sexual behavior and to address the related psychosocial as well as overtly medical needs of the patients in their care" (Curry, 2011).

If we work from the premise that education is the main focus in addressing the issues surrounding homophobia and institutional ambivalence, then a look at the content of the medical training is necessary.

One of the most recent studies, the Stanford Study Survey, completed by 176 medical school deans or equivalent in both the United States and Canada included a review of preclinical, clinical, and combined hours dedicated to GLBT-related topics.

The findings from this study reported that forty-four medical schools reported zero hours during pre-clinical years (33.3%). The overall reported combined hours dedicated to GLBT content was five hours over a four-year period (Obedin-Maliver, et al., 2011).

If medical education curriculum in general is not inclusive of the unique and recognize the different aspects of the GLBT population, the outcome for this population will continue to be impacted with negative health outcomes for this group.

In 2003, a Canadian study was undertaken to investigate these very aspects. The study's goal was to explore a number of questions; the most striking and relevant for this paper is "Compared to the general population, do GLB have increased rates of health and social problems resulting from homophobia" (Banks, 2003). The findings demonstrated that equivalent rates of health and social issues without the existence of homophobia yielded startling conclusions.

Equivalent rates of health and social issues between GLBT and heterosexual populations: estimates of the annual number of pre-mature deaths.

Table 7.

The cost of homophobia.

Category	Heterosexual deaths per year	Homosexual deaths per year
Suicide	818	968
Smoking	1232	2599
Alcohol Abuse	236	1843
Illicit drug use	64	74

Source: (Banks 2003)

Clearly, the evidence is weighted and reflects a higher percentage of deaths than the general population. There is supposition that contends that although there may be an association between sexual orientation and several health and/or psychosocial problems, they cannot definitively be a result of homophobic attitudes and social prejudice (Fergusson, Horwood, & Beatrais, 1999).

The opinion of the Fergusson, Horwood, and Beatrais offered up three different reasons to support their position. They included: (1) associations are artifactual as a result of measurement and other research design problems, (2) a possibility of reverse causality in which people are prone to some problems (e.g. psychiatric disorders) and are more prone to experience homosexual attraction or contact, and (3) a possibility that

lifestyle choices made by GLB put them at greater risk of adverse life events and stresses that include risks of health and social problems independent of sexual orientation. These three alternative theories have not been accounted for in much of the conducted research according to Banks.

There appears to be little support or scholarly discussion found in the literature review that would support their theory. In fact, a number of studies exist within the literature that would indicate significant data to dispute the position.

Chapter 7

Conclusions

Much of the data presented as part of this study is encouraging, particularly in the field of gerontology research and government/academic funding of studies on GLBT populations in general and GLBT elder studies in particular. Also encouraging is the fact that a number of grassroots organizations have stepped into the discussion and are taking steps to identify and address the issues surrounding the GLBT elder needs. However, even given the social change in acceptance and decreased homophobia figures for healthcare professionals, the overall attitudes toward GLBT patients continues to remain.

The fact that sizable minorities are still encountering some or frequent discrimination based on either real or perceived GLBT status remains an issue. Professional organizations like the American Medical Association have adopted resolutions that support non-discrimination based on sexual orientation and expanded outreach to their members through internal committees and forming ad hoc panels to address past discrimination.

The formation of the Gay and Lesbian Medical Association continues to be a strong voice in the discussion of issues surrounding the GLBT community and population, and works to educate their fellow healthcare professional colleagues as well as the GLBT community and public at large.

One limitation of this study was the lack of adequate representation of lesbians, bisexual, or transgendered respondents. It is difficult to know how generalized these

findings are to the larger GLBT elder community. This study looked only at gay men as respondents for the survey, and as such may be biased as being more skewed from a primarily Caucasian, affluent, and educated population.

Since to a large percent all of the respondents indicated that they were out, there may be an issue that closeted gay individuals who might not be comfortable being a member of the GLBT community were not included in the sample. Future studies are needed to reach out to collect larger samples with more diversity to include lesbian, bisexual, and transgendered populations, so that they can be representative of a diverse and diffuse community. This also relates to another limitation in the study that of its diversity in makeup, such as various racial and ethnic minority groups, social/economics, education, and geographical locations.

The data collected and analyzed in this paper allows for comparisons with similar data that was previously collected. Although data show that there have been improvements in overall attitudes, acceptance, and general opinions concerning GLBT individuals, this data indicates that more work needs to be done to address homophobia and discrimination in the healthcare environment. Such longitudinal studies are critical for providing information and tracking progress in addressing the invisibility of GLBT elders, discrimination and homophobia in healthcare settings, education in cultural competence, and unique minority health risks and issues.

In summary, this paper described the overreaching arch that the GLBT elder community faces in the future. Homophobia through ignorance, institutional heteronormative practices, and the individual's reluctance to disclose orientation adds to

the burden faced by both patients and the healthcare profession. The question of how to alleviate the conditions that perpetuate the fear and mistrust of both the GLBT elders and the healthcare provider was presented through literature review, survey findings, and scholarly articles.

It was established that in order to be able to more fully comprehend and study the factors surrounding the historic and current factors that impact the treatment of GLBT elder patients, we must first understand the institution norms of heterocentric attitudes as well as the general attitude of healthcare providers. In identifying the needs assessment of both groups (GLBT elder and the medical establishment) and studying the ways in which we educate the healthcare industry and providers about the special healthcare needs of this community research may provide insight to not only the barriers that are present, but how to rectify their impact on both sides of the equation.

Medicine is both art and science. It is the art of understanding individuals in the context of disease, not just recognizing or diagnosing the pathological condition, but seeing that humanity remains, that the individual is cared for empathetically, respectfully, and with dignity, not just classified or labeled as a disease, a diagnosis, or referred to as another case.

By exploring medicine through the lenses of a multidiscipline collage of medical humanities, the historian, ethicist, sociologist, anthropologist, writer, artist, nurse, physician, or student of medical humanities gains insights into the very nature of the human condition. Students read of human suffering in the illness narrative, feel the emotions of the caregivers, experience the difficulties of healthcare professionals, and

come to accept that there is a greater need from the medical establishment to address the perceived notion that business has overtaken medicine in sickness and in health.

The insights from the study of medical humanities are valuable for both the aspiring clinician and anyone who will someday be a caregiver, get sick, become old, or require medical care. The study of bioethics and medical ethics offers a vital reminder and a touchstone that medicine is a social enterprise that must balance cultural values and moral principles with scientific breakthroughs in future research goals. The study of research ethics allows for a uniformed approach in dealing with the ever-increasing regulations, financial concerns, and conflict of interests that encircle this enterprise.

For medical humanities and their lofty goals of instilling empathy is but a distillation of how differing cultures interact where medicine and illness represent stakeholders in that culture. Through literature and the visual arts one can convey the personal experiences of sickness and healing in narrative, revealing the subjective side of clinical care or disease, allowing a discussion of wellness, illness, and experiences to be heard by all involved.

It is my belief and conjecture that Medical Humanities, as a discipline, offers the chance to heal the schism that has developed over the past 100 years—where the business of medicine has replaced the art of medicine. The dynamic relationship between medicine and those that it serves in the larger social world are partners that require a healthy symbiotic relationship.

The question I struggled with when I entered this program was: *What is Medical Humanities?* Having spent my youth and young adult life in the military, I came to

experience and expect a level of medical care that as a civilian I have rarely seen. This dramatic model change from the medical settings I experienced in the military and my civilian life, caused me to question the delivery of medicine and the way business directs health care, focusing on a perceived balance and spread sheet, and less on the individual experiencing the illness or malady.

So, Medical Humanities became the starting place of my exploration to find the answer to my question. By exploring medicine through the lenses of the discipline of Medical Humanities—the artist, musician, writer, historian, bio-ethicist, patient, healthcare professional, and student—I have come to realize the importance of the field and to recognize the value that offers a vital reminder that insights into the nature of the human condition, human suffering, personhood, and the responsibilities of individuals to one another in sickness and in health can be found.

The Business of Medicine in recent times has usurped the Art of Medicine, relegating the ideal of patient/physician relationships to a dispassionate business transaction, removing the idea of the Art of Medicine and healing touch to that of mechanical diagnostics and de-humanizing medical technician.

There is a perception that physicians themselves through their arduous training and grueling memorization of facts and figures approach the ill or sick individual first and foremost seeing them as their illness or condition, missing the fact that they are fellow human beings governed by emotions and illness, this may account for some physicians, but the medical humanities has shown me that there are still physicians that view the sick, dying, infirm, and medicine with empathy and care. Their stories must be

presented to the wider audience of students of medicine, nursing, and other healthcare professionals. For it is in presenting the wider viewpoint of empathy and caring that we will approach the issues and problems associated with the business of medicine and heal the rift that has occurred in the Art of Medicine.

In the future, when we discuss geriatric research, we will have to first find a chair at the table for the gay and lesbian community and view their experiences through the eyes of a recognized culture. Building on what has previously been published; the review of these early works was fundamental to the understanding of past research and provided a starting point for the course that I followed in this dissertation.

The role of this dissertation was to address the perceived notion and impact of homophobia, either real or imagined, and attempt to determine whether this directly affects the health outcome of GLBT elders. What was discovered is that barring the historic void of research on the GLBT elder, current gerontological research by grassroots organizations, academia, and government agencies is attempting to reconcile the deficits. The specific needs of any elder population can be generalized, however, when a sub-culture is identified, the unique needs of that group may be overlooked and could inadvertently impact the group in a negative manner.

This dissertation stumbled in its efforts to garner a cohort of lesbian survey participants. Though attempts were made within social networking web sites, no volunteers were found to participate or complete the survey.

Though this study is inclusive to all GLBT elders, and the literature review included all research parameters to include all GLBT research, the study volunteer body

of survey participants was wholly gay or bisexual men and, therefore, lacking in data on lesbian and transgender elder experiences.

The study design for this research was exploratory in nature, including both quantitative and qualitative dimensions. To that end, it was a success. With success one is placed in a dilemma, close the book or look to improve the original study parameters and objectives. To begin the process of questioning where improvement could be had in the future, researchers have to determine where inadequacies were found in the research. The survey questions were designed to collect data to explore the unasked questions, this was accomplished, however, having only the input of gay men, it was lacking in discovering the voices of lesbians and transgendered elders.

One of the confounding issues in the best of circumstances in conducting research and studies is the availability of a study population cohort. Negating the past exclusion of specific GLBT population/numbers from research projects, due to methodological limitation, or of uncertainty or lack of understanding; the tentativeness based on gaps of knowledge, invisibility of the group and the individual remains a leading cause of unanswered questions.

It should be noted at this time that the survey initially was intended to be used for both gay and lesbian subjects, however, little success was had in reaching out to the lesbian community and its members. It was determined that in order to move ahead with the research project, the inclusion of lesbians was not possible at this time.

The results of a lesbian study could result in additional information and data sets that would benefit further research at a later date. The information in chapter 3 deals

solely with the results of the gay respondents of the survey, however, where appropriate, lesbian similarities were included throughout the paper by referencing previous research and published literature, articles, and peer reviewed journal entries.

As I was in the final stages of writing the last chapter and summarizations, I found myself returning to the very beginning of my journey and asking myself, What is medical humanities? More importantly what did my research have to do with medical humanities or rather what did the subject of aging gay, bisexual, lesbian and transgender populations have to do with medical humanities. It is troubling to have worked for almost three years and never fully realized that one of the most important questions had yet to be fully answered and addressed sufficiently in my mind, "What is medical humanities?" This question has gnawed away at me for the better part of my doctoral course work and the academic pursuit of this research. The question, What is medical humanities? has stayed just beyond my grasp and eluded complete comprehension.

I believe I found the answer to this question for myself by exploring the meaning of illness, disability, and medicine through the lenses of the discipline of Medical Humanities. I, the artist, musician, writer, historian, bio-ethicist, patient, healthcare professional, educator and student have come to realize the nature of the human condition, human suffering, personhood, and the responsibilities of individuals to one another in sickness and in health are more fully understood and explained by medical humanities.

The value of my journey has brought meaning and understanding of the implications of medicine and my profession in medical research, resulting in the

recognition of the need to return to a more humanistic approach, for medicine is both art and science. The humanities are an integral and central aspect of medicine and always will be.

Though it may seem that the *business* of medicine in recent times has usurped the *art* of medicine, relegating the ideal of patient/physician relationships to a sterile, cold, clinical business experience, removing the notion of the art of medicine and healing touch to that of mechanical diagnostics and the de-humanizing medical technician, there is still hope. Recent changes in medical and pre-medical education/studies have embraced the ideals that studies in humanities bring awareness and exposure to a more fundamental/ earlier approach and understanding of medicine.

So, medical humanities became the starting place of my exploration to find the answers to the many questions that my research bears witness to concerning the state of medicine/health care today. And it begins to address in some small manner those medical humanities in and of itself is not a panacea that will cure the ills of medicine, but it does allow for a voice to be heard, and that voice can lead to a more full understanding of the experience of health and illness.

Appendix A

IRB APPROVED April 6, 2010 via e-mail – Dr. Larkin, Chair
Drew University IRB Submission Instructions

The following documents must be submitted for IRB review. These materials should be submitted both electronically and in hard copy. The electronic submission must be in the form of a single file. The hard copy submission should have all required signatures.

- A filled out copy of the Human Participants Research Review Form providing a description of the aspects of the research involving human participants;
- A copy of any consent and debriefing forms;
- All surveys, interview protocols, instructions, stimuli, and tests.

Only Drew faculty members may submit research for IRB review. If the research principal investigator is a student, the faculty advisor should submit the research for IRB review.

Projects Originating In:	**Should Be Submitted To:**
College of Liberal Arts	Jessica Lakin Associate Professor of Psychology Hannan House 102
Caspersen School of Graduate Study	Bill Rogers, Associate Dean of the Caspersen School S.W. Bowne
Doctor of Ministries Program	Carl Savage Director of the Doctor of Ministries Program Seminary Hall C12
Theological School	Art Pressley Associate Professor of Psychology and Religion Seminary Hall 208

Appendix B

Human Participants Research Review Form

1. Project Title: Focus Group - Solicitation of opinions and viewpoints on issues related to ageism in the gay/lesbian community and the impact of sexual identity on the delivery of health care for this aging community.

2. Principal Investigator(s): Terry Clark-German

   If student research, name of faculty sponsor: Dr Scibilia

   Name of anyone else involved in the study administration/data collection, if different from above: None

3. Address of Investigator(s): [redacted]

4. Phone: cell: [redacted]

5. Duration of the Project : 45 days
   (Approximate starting date and completion date of data collection):

6. Describe how the requirement to obtain training in the responsible conduct of research involving human subjects was met: Completed training via FDA, NCI, DHHS

7. Signature(s):

   Principal Investigator: _____

Date:_____

Principal Investigator: _____ Date:_____

If applicable:

Faculty Supervisor: _____ Date:_____

8. Human Participants: Number: 436

   Ages: 46-75

   Sex: M/F

9. Criteria for selecting participants (if any): The criteria for selection would be self-nominated members of a gay social networking internet site between the ages of 46 - 75.

10. How will the participants be recruited? On-line gay social networking site
    (If participants will be recruited at another institution, submit institutional consents.)
    A general invitation would be posted to the on-line social networking site addressed to the target age group. This invitation would request volunteers to participate in a 25 question survey. The survey would be administered through the internet site "Survey Monkey." IPO address tracking would be disabled - a feature of the survey monkey's menu, preventing the tracking of any IPO address. Amenity of individuals would be maintained by having no identifiable personal information contained or collected in the questions. The membership list of the social networking site utilizes "handles" and not names. This use of pseudonyms continues the confidentiality of the participants. Interaction between the researcher and the participants is minimized to prevent bias or skewed/flawed findings through leading questions. The volunteers would be requested to log into the survey monkey link provided to complete a self-reported 25 question survey - 20 questions are demographic/social/medical questions, remaining 5 are essay questions. The ability of the volunteer to skip any question is provided.

11. Brief non-technical description of research. Include purpose, methods, and the importance of the study. (Attach a copy of all surveys, interview protocols, instructions, stimuli, and tests.)

12. What will the participants be asked to do? Complete a 25 question survey.

13. Where will this research be conducted? On-line - using San Francisco and New York City as the two project targeted city sites.

14. What aspects of the study (if any) are kept secret from the participants? None

15. What are possible physical or psychological hazards for the participants? None

16. How will you protect participants from these hazards? Not applicable

17. How will you obtain advised consent from participants and/or legal guardians? (Attach copy of consent form.) E-consent rules as defined by the DHHS

18. How will you protect the confidentiality of your participants?

    _X_Identifying names or other data will not be collected

    ___Codes will be used and list of codes will be kept secure

    ___Other. Please describe:

19. For the majority of research projects, participants should be debriefed. Attach a copy of the debriefing form or explain why participants will not be debriefed. Debriefing would not be required-the collection of the questions is voluntarily, with the ability of the participant to opt out of any question. The information collected would be reviewed and analyzed to help focus the attention of the issues for further investigation in the proposed dissertation.

Appendix C

Introduction to Survey

A request or introduction to be a part of a focus group will be sent to individual men (age 46-75) that are members of an on-line social networking site. The introduction that will be sent to self-identified study volunteers includes the following wording:

Hello, my name is Terry Clarkgerman and I am attempting to gather information for my doctorate dissertation concerning the aging of the gay and lesbian baby boomers. Would you be willing to complete an on-line survey about your opinions and views and what you see as the important concerns with ageism and the GLBT community? The goal is to gather an equitable number of responders that will provide insight into issues and viewpoints that may not have been previously researched concerning issues related to health, social, end of life issues, and medical outness. This survey would be administered in both San Francisco and New York City with the mean accrual goal of approximately 250 invitees. Once that number is achieved, accrual of further participants would end. The survey questionnaire site would remain open until a total number of participants is reached or approximately 6 months. A review of the data at the end of this time would be initiated with data lock at the completion of the endpoints. The information gathered is primarily to be used to focus on defining issues and perspectives in shaping the opinions and viewpoints of my dissertation. This information could be used in the dissertation – with the possibility that essay questions could be cited or quoted in the dissertation. Your participation is volunteer and due to the design of the on-line questionnaire your anonymity is assured through this process, ensuring your personal health information and identify is blinded to both the researcher and other viewers who may review the information.

Appendix D

Survey Instructions

When a return reply is initiated by the volunteer and their acknowledgement and willingness to participate in this survey—a link is provided that would direct the individual to the survey site. In the case of a decline—then a simple thank you for your time would be sent.

If an individual agreed to be involved in the research group then the following information would be provided that would direct the participant to the on-line survey site "survey monkey". The link address would allow direct access to the survey questionnaire. The link address is automatically generated (unique to the survey) provide by survey company.

The following instructions would be sent to each of the participants:

Terry here - To maintain your individual confidentiality and allow your voice to speak directly -I have set up the survey using the on-line survey monkey website. There are a total of 25 questions that pertain to demographics, social, medical viewpoints, and several texted questions. The essay questions are really to get your viewpoints and opinions. I do appreciate your volunteerism and altruistic help that you have given to me on this project. Feel free to email me anytime to ask about the research and the project as a whole. Thanks Terry

Appendix E

Survey Questions

The website address: http://surveymonkey.com/s/(survey name) :

Actual website address - http://surveymonkey.com/s/DMHbabyboomerpinks

The following questions would be presented in the survey:

1. What is your age?
2. How do you define your race?
3. Are you single or partnered?
4. Do you live alone or with someone?
5. Do you have a religious affiliation? Would you please identify?
6. Would you please pick the appropriate income bracket?
   - 0-50K,
   - 50K-100K,
   - 100K+
7. At what age did you come out?
8. Are you out to your family?
9. Are you out to your medical care provider: i.e. Primary Care Physician, Specialist, Nurse Practitioner, etc.?
10. How would you describe your relationship with your family?
    - close,
    - cordial,
    - distant,
    - non-existent
11. Are you sexually active?
12. How often do you see your medical care provider?
    - only when needed, at least once a year, never, regularly
13. How would you describe your relationship with your medical care provider?
    - equal decision maker and partner in your health care?
    - authority/decision maker in your health care?
    - I am the consumer and they are the service provider?
14. In the event that you are unable to make your own healthcare decisions, do you have any of the following instruments in place? (check all that apply)
    - Do not resuscitate (DNR)
    - Living Will
    - Advance Directive
    - Advance discussion with medical provider
    - Advance discussion with family members/extended family?

an assigned health care power-of-attorney?

15. What is middle age"?
16. Do you feel that there is ageism in the gay community?
17. Do you feel that your age is a deterrent in attracting sexual partners?
18. Have you felt that you were the subject of a hurtful rejection based on your age?
19. Do you generally socialize with older or younger men?
20. Do you belong to a social network/group whose ages mirror your own?
21. What is the average age of your social circle?
22. How many people are in your immediate social circle?
23. Could you tell me what are your biggest concerns about growing older and being gay?
24. If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of extended family, relatives, formal assisted/nursing facilities, retirement communities....)
25. Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?

Appendix F

Survey Free Text Results

Display # 1 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday, April 12, 2010 9:36:02 AM

Response Modified:
Friday, April 12, 2010 9:51:06 AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
My biggest concern about growing older and being gay is the fear of isolation if my partner should die before I do.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
If my partner is still alive, he will be there to care for me, however if he should die first than I would hope that I could afford to be cared for by a nurse in my home or transition into an assisted living facility. A formal nursing home setting is a last resort.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I think the aging gay community needs to be more vocal and visible. Older gay people have so much they could teach the younger gay population if they would only listen.

Display # 2 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday April 9, 2010 9:46:38AM

Response Modified:
Friday April 9, 2010 10:24:07AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Vanity of course but that is just surface concerns, deeper is staying healthy and maintaining lifestyle I have, I guess the same as others no matter what the sexual orientation. As far as being gay, I would have to say being invisible to my community.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
My partner would help me but I would most likely want to be in an assisted living situation.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Just encourage everyone to realize they will be in the same situation (if they are lucky) and to not make others feel like they are less than. Just like the rest of all other western communities, we need to develop a more respectful attitude or even treasure their experience history.

Display # 3 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday April 9, 2010 10:22:28AM

Response Modified:
Friday April 9, 2010 10:28:14AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Dying eventually

Survey Question 24:

If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I have an entire support system in place, both with people and financially.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No

Display # 4 of 61 respondents

Response Type: Anonymous Response
Collector: New Link (Web Link)

Custom Value: Empty
IP Address: empty

Response Started: Friday April 9, 2010 10:45:59AM
Response Modified: Friday April 9, 2010 10:51:40AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Nothing specific to being gay, just all the problems of ageing.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
All of the above as needed.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I would encourage communal living.

Display # 5 of 61 respondents

Response Type: Anonymous Response
Collector: New Link (Web Link)

Custom Value: Empty
IP Address: empty

Response Started:
Friday April 9, 2010 11:22:39AM

Response Modified:
Friday April 9, 2010 11:36:33AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Money, mind gone.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Suicide, help of extended family, relatives

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
The community is so diversified not much works in my observation, have the older mentor the younger.

Display # 6 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday April 9, 2010 12:42:07PM

Response Modified:
Friday April 9, 2010 12:46:53PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Good sex

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Retirement communities

Survey Question 25:

Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Mentor group geared for the young (who want help)

Display #7 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday April 9, 2010 1:08:59PM

Response Modified:
Friday April 9, 2010 1:22:55PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I have a number of concerns about growing older, although I don't anticipate having to face the big ones—loss of independence, degradation of health, etc—for a very long time. I haven't stopped doing anything because of my age and in fact, because I have generally more time and a long more money, I have opportunities to do new and different things that just weren't open to me when I was younger. I don't think that many people my age put themselves in the "older" category.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Graduated assisted living, to be sure, with a one-way pre-paid ticket to Switzerland just in case**.**

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I'd suggest that we not make too much of this issue, if there is one. Yes, the boys can be nasty, but there's nothing new about that, nor is it any big deal. (And there are lots and lots of exceptions. I have suddenly become very attractive to group of very young men, something I find flattering but more than a little creepy.) And finally, my experience is that most older gay men have come into their own, they have figured out how to be happy—or, if not exactly happy, content—and they are almost uniquely kind to each other. It's almost as if we have all decided that the worked is a big place, big enough for all of us.

Display #8 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday April 9, 2010 1:56:13PM

Response Modified:
Friday April 9, 2010 2:03:00PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Losing interest in sex

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Assisted living, nursing if needed

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Sexual attraction is idiosyncratic, but politeness should be a universal human trait

---

Display # 9 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday April 9, 2010 7:51:14PM

Response Modified:
Friday April 9, 2010 8:12:49PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Courage is not the absence of fear; it's taking action in the face of it! "OLD" is a perception…and as they say "perception is not always reality"..so I'm not concerned about growing OLD…I have several friends that are living with 20+ years with HIV and they truly are a hero/warriors of the community. I rest my case.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Move to a gay or gay friendly assisted living community

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
There are a few assisted living communities that are either gay or gay friendly

---

Display # 10 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Friday April 9, 2010 11:16:58PM

Response Modified:
Friday April 9, 2010 11:30:18PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Not looking forward to growing old alone…hopefully a partner will materialize at some point.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I would probably rely on my family and friends.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
There are some websites on the internet that are more elder-friendly (such as SilverDaddies, Daddyhunt, etc.) which have helped me feel less lonely and have afforded me some socializing with other gay men. Old age comes for us all. I think there's always been a lot of age discrimination within the gay community (i.e. references to "wrinkle rooms", referring to older gay men as "trolls") I frankly don't see those kind of attitudes changing anytime soon..but then again, people who hold those attitudes aren't really people I'm interested in interacting with anyway.

Display # 11 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Saturday April 10, 2010 1:20:11AM

Response Modified:
Saturday April 10, 2010 1:24:19AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Social services including both community and government based.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
More gay-centric housing developments like San Francisco's Open House (planned building for GLBT seniors)

Display # 12 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Saturday April 10, 2010 3:58:03PM

Response Modified:
Saturday April 10, 2010 9:14:27PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Ending up alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Not sure

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Just that older and younger gay people should be encouraged to interact

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Display # 13 of 61 respondents

Response Type: Anonymous Response

Collector: New Link (Web Link)

Custom Value: Empty

IP Address: empty

Response Started: Monday April 12, 2010 8:30:22AM

Response Modified: Monday April 12, 2010 8:35:22AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I am fortunate to be wealthy, I will hire in-home care. Having parents in nursing homes, I will avoid that scene if at all possible.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Despite having mostly younger friends, I think in part to coming out later in life, I go out of my way to bring my older (60s -70s) friends into my world.

Display # 14 of 61 respondents

Response Type: Anonymous Response

Collector: New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 8:37:40AM

Response Modified:
Monday April 12, 2010 8:44:10AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Deteriorating health

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
family

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Lets each one try to deal with our own ageism.

Display # 15 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 9:04:58AM

Response Modified:
Monday April 12, 2010 9:09:53AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Truthfully, dying alone in my apartment and not being discovered for days.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)

It depends on when it would happen, if it happened now I'd look for an assisted living situation. If it happened older, a nursing home.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Just be prepared to be independent as long as you can.

Display # 16 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 10:08:18AM

Response Modified:
Monday April 12, 2010 10:13:57AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Assisted living

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Promote greater discussion.

Display # 17 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 3:17:46PM

Response Modified:
Monday April 12, 2010 3:23:51PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
No particular concerns based on sexual orientation…general concerns about remaining fit and healthy…but I work hard at it.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Help of my 3 children and sisters

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
More advertising directed toward sexiness of middle age gay men….some very sexy guys in that age range!!

Display # 18 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 4:30:05PM

Response Modified:
Monday April 12, 2010 4:38:28PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Not having children to take care of me as I age. Sometimes feeling it hard to accept being and "elder" when you still feel like you're 30.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Partner, extended family, and assisted living.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No Response

Display # 19 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 4:49:14PM

Response Modified:
Monday April 12, 2010 4:54:42PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Not getting it up, being alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Perhaps a retirement community, but more likely suicide (I belong to the Hemlock Society)

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No, because I am probably ageist as well

Display # 20 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 5:09:46PM

Response Modified:
Monday April 12, 2010 5:15:37PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Biggest personal concern: as a LGBT-related issues-political & social—become more and more mainstream in our culture, I want my history to matter, i.e. I don't want my perspective dismissed merely because I'm an "older gay man".

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Nursing home

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No Response

Display # 21 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 5:21:22PM

Response Modified:
Monday April 12, 2010 5:30:13PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Finding long-term care for gay men

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Extended family and care

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?

Not really…youth is still most important. Gay live [sic] is very superfiscial [sic]..it would be nice to have senior gaycommunities [sic]..to retire and be cared for.

Display # 22 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 5:23:32PM

Response Modified:
Monday April 12, 2010 5:33:15PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Growing older is a privilege so I don't have much energy on that except I'm really athletic and I can feel my body hurt a little more as time goes on:)

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Depends on how bad but I'd probably got to my family first and the assisted living

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
It is natural thing whether you are gay straight or a woman in the hetero community people have the right to their preferences and should be respected. It just means you're not supposed to connect with these people in your life and that is ok, so my suggestion is to be authentic and the people who want to see you and connect with you will naturally do so and don't take it personally, everyone gets old.

Display #23 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:

Response Modified:

Monday April 12, 2010 5:36:56PM Monday April 12, 2010 5:40:20PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Lonesome in old age with no children

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Assisted living

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Oddly, enough, I think the twenty somethings are less prejudice than the 30/40 yr olds so there is hope.

Display # 24 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 5, 2010 7:29:20PM

Response Modified:
Monday April 5, 2010 7:49:40PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Assisted living retirement community

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?

I've been fighting my one man battle to convince gay men of my age around me to explore men of their own age as opposed to 25 year old twink gym boys, but, to no avail and I gave up the fight this year and stepped down from the soapbox I walked away from a group of "friends" (idiots! My age) because they didn't consider me good enough to pay attention to, with all my life experience, may accomplishments and 15 years of sobriety all they were interested in was who got a blow job at the gym so I left the 'nursery' which is where they all belong nothing will ever change them-you're dead at 40, if not before then I'm angry and disheartened.

Display #25 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 12, 2010 9:10:21PM

Response Modified:
Monday April 12, 2010 9:24:09PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone and/or not being able to compromise at this age

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Probably assisted living

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No. Men are men.

Display # 26 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:

Response Modified:

Tuesday April 13, 2010 12:01:18AM Tuesday April 13, 2010 12:17:09AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
All of the above as health deteriorates

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I think it mirrors the culture at large. Disdain rather than respect for the aged. Consequently, change of any measure is a tall order. I would like to see more respect for the experience and accumulated wisdom of seniors, but I believe it would take a major shift in the entire shallow material and beauty oriented culture we live in. It would take Madison Avenue having an epiphany that there is a way to make money on making "older" desirable, and so, lucrative.

Display #27 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 13, 2010 12:17:19AM

Response Modified:
Tuesday April 13, 2010 12:30:32AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone. Finding myself at a gay bar, still trying, hoping to meet someone.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I have not thought of that, but probably go to an assisted living situation.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I would love to see more gay retirement communities in NYC area. Would like to see more activities for the older gay person.

Display # 28 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 13, 2010 2:29:25AM

Response Modified:
Tuesday April 13, 2010 2:33:38AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Having less partners to chose from

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
friends

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
None

Display # 29 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:

Response Modified:

Tuesday April 13, 2010 3:26:15AM Tuesday April 13, 2010 3:29:29AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I get lots of attention since I have kept myself preserved well. Many men like that I am 65 years old. I am attracted to older men, so I'm happy lots of guys like older men.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Whatever I can afford. Not extended family**.**

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No.

Display # 30 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 13, 2010 7:15:06PM

Response Modified:
Tuesday April 13, 2010 7:39:13PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone, no place within the gay community

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Don't know

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?

More support groups for ageing men; identifying prominent role models.

Display #31 of 61 respondents

Response Type: Anonymous Response

Collector: New Link (Web Link)

Custom Value: Empty

IP Address: empty

Response Started: Tuesday April 13, 2010 7:40:28PM

Response Modified: Tuesday April 13, 2010 8:01:48PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I have a partner for the last 4 years, so my concerns are more about being healthy. If I became single again, my worry would be finding another partner, if that becomes an important goal for me

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I will depend on my close circle of friends, brother, and my partner

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I think it is vitally important to nurture a strong group of friends who you can depend on when one is in crisis. These friends love you for who you are, without such a circle, one can feel very isolated.

Display # 32 of 61 respondents

Response Type: Anonymous Response

Collector: New Link (Web Link)

Custom Value: Empty

IP Address: empty

Response Started: Tuesday April 13, 2010 8:08:01PM

Response Modified: Tuesday April 13, 2010 8:14:47PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Finding adult sexual partners and maintaining an active sexual life….sharing that with just one person.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Same-sex retirement communities, or suicide.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Fact of life.

Display # 33 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 13, 2010 8:58:12PM

Response Modified:
Tuesday April 13, 2010 9:08:33PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone and having no support network

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Assisted living facility or retirement community

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No Response

Display # 34 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 13, 2010 9:234:30PM

Response Modified:
Tuesday April 13, 2010 9:30:52PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Not having a job/not having enough money, not having health insurance, not having enough/any sexual partners, friends, or family

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I don't know

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I don't think there's anything that can be done about it. It's a societal problem, it just happens to be worse in the gay community.

Display # 35 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 13, 2010 10:19:13PM

Response Modified:
Tuesday April 13, 2010 10:27:55PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
The shallow concern of no longer being attractive to other men

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Help of friends (extended families); assisted living

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No

Display # 36 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 13, 2010 10:45:53PM

Response Modified:
Tuesday April 13, 2010 10:50:53PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
My concerns about growing old have nothing to do with being gay.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Support from partner, health care assistant, assisted living.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No

Display # 37 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Wednesday April 14, 2010 12:37:18AM

Response Modified:
Wednesday April 14, 2010 12:54:34AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Retiring in a large city. I'm a country boy at heart but my partner refuses to live outside of a major metropolis. Eventual death of members in my inner circle-difficult reality I'll have to face eventually.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I bought a long term care policy 5-6 years ago.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Don't know what to say, we live in a youth oriented culture-I constantly see online ads posted by guys my age looking for "younger bro" or such. As Rose Castorini mused in "moonstruck", I think its because they fear death, I don't turn down sex with a hot younger guy, when I'm approached, but I don't seek it out. I prefer guys who've been around the block and have their sh.. act together (amen!)

Display # 38 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Wednesday April 14, 2010 3:07:01PM

Response Modified:
Wednesday April 14, 2010 3:11:03PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Not being in a loving functional relationship.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Family, friends, social services

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No

Display # 39 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Wednesday April 14, 2010 9:43:09PM

Response Modified:
Wednesday April 14, 2010 9:52:37PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
If I become infirmed who will take care of me.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Extended family, retirement, nursing (if I can afford it)

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Well, the gay community is younger focused. I don't know what we should/could do about it. It is who we are.

Display # 40 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 8:48:08AM

Response Modified:
Sunday April 18, 2010 9:02:42AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
That I will die alone. That a strong need for primary relationship will not be desired with those I would wish to be emotionally involved. That gay men may always keep secrets and lose trust and respect as a relationship matures (loss of or lack of commitment)

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Extended family, relatives. I will always consider my children my legacy…a need I had which gay men have had to deny with the current social conditions of western society. At this time I am estranged from my youngest son and somewhat distanced by my other since I accepted and acted upon my own sexuality, after my ex-wife left me for reasons other than my sexuality (which I had hidden, even from myself, since my youth). Now the seeming odd puzzle pieces finally fit. My adjustment has left some of those I love the most confused…thinking that I have changed when I am the same person..just no longer escaping my natural attraction, romantically, to men.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
An open society with some sense of order and mutual respect beyond the physical. A change away from the narcissism which more mature gay men cannot fail to notice in the younger gay community. A lack of respect for the maturity of wisdom through aging.

Display # 41 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 2:57:48PM

Response Modified:
Sunday April 18, 2010 3:03:23PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Assisted living

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I've had more young (19-29 yr old) approach me as a "daddy" in the last few years. So maybe we should just take good care of ourselves and see what happens.

Display # 42 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 3:03:52PM

Response Modified:
Sunday April 18, 2010 3:06:31PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being left alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Extended family; social services

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No Response

Display # 43 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 3:07:35PM

Response Modified:
Sunday April 18, 2010 3:14:15PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Keeping my ass tight and my dick hard

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
What would be need so that I can still create. Am an artist [sic]

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Mentoring. There has been 20 years of gay men that have died. These men would have provided role models for the younger gay community, a legacy has been lost.

Display # 44 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 3:11:00PM

Response Modified:
Sunday April 18, 2010 3:16:14PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Rejection based on age

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Friends and family

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No Response

Display # 45 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 3:22:23PM

Response Modified:
Sunday April 18, 2010 3:29:25PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Wellness, ability to live long well (not frail or disabled – limit morbidity[sic]) and then die in my sleep

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
All of the above, hope my son will help, if I don't outlive him.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
A social marketing campaign would really help, especially since we are all living longer and that peak brain performance is now in the 60s+.

Display # 46 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 4:06:02PM

Response Modified:
Sunday April 18, 2010 4:13:36PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I have none about being gay. I am more concerned about aging and not being able to afford health care of basic expenses.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Extended family aid, or move to a warm foreign country and hire local native to assist my needs

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
None

Display #47 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 4:25:27PM

Response Modified:
Sunday April 18, 2010 4:34:45PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Not begin able to get around…but I guess this is not necessarily due to being gay.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Partner, relatives

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No…I've learned to not let it bother me as I am aware you can't avoid getting older unless you die young.

Display #48 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 6:00:19PM

Response Modified:
Sunday April 18, 2010 6:08:18PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone, dying without anyone knowing, not being the hot ticket anymore—being invisible and overlooked because of my age and aged looks.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I have a large family and a couple of close friends- I do think that I would be looked after – I'm not sure for how long.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
While profound- I'm not sure it's as much of a gay problem as much as an American culture problem. Ad and marketers are gearing fro constantly younger audiences.

Display # 49 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 6:08:40PM

Response Modified:
Sunday April 18, 2010 6:14:47PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Dying alone, spending too much time alone

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
At some point soon I will purchase a long-term care policy just in case I can't take care of myself. I do have relatives but I do not want to rely on them. I have saved a lot of money to make sure that I can take care of myself into retirement and beyond.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I think it would be a good idea for younger gay men to spend time with older gay men to understand how much the older generation sacrificed so that they could live the quality of life the younger generation is living today. Maybe the younger generation would be more responsible in how they act personally and sexually. The younger generation is incredibly irresponsible with their unsafe sex practices and drug use.

Display #50 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 6:51:14PM

Response Modified:
Sunday April 18, 2010 7:14:44PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Reaching the age when I can't take care of myself and I don't have nay potential support (friends, family) still alive. Many of my "social circle" died of aids in the 80's, 90's and of course no children.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Probably lean towards a gay retirement community. My dad is in an independent living community and it's kind of nice! I could deal with that, but would prefer to be around other gay men or women.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
By "ageism", I'm assuming you're referring to the younger gays snubbing older gay men in various ways. Of course, there is truth to that because our society treasures the young and pretty. However, there are also lots of gay men who are really interested in and attracted to mature men. Yea!!

Display # 51 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 8:09:48PM

Response Modified:
Sunday April 18, 2010 8:24:09PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Being alone, not having anyone to love, I don't want to be dependent on anyone…so few even now to share inner thoughts with…

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)

I would ask my daughter to assist me, if possible, otherwise I would resort to assisted living.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Our gay youth have become arrogant and too promiscuous. They have no connection with the activism of the past. They share little with and have disregard for those who prefer a family orientation. Stricter education in their sexual and emotional development is needed before their behavior brings about the return of the witch hunts.

Display # 52 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Sunday April 18, 2010 9:35:13PM

Response Modified:
Sunday April 18, 2010 9:44:50PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Not having someone young enough to be an advocate for me, If I became unable to make decision for myself or could not take care of myself. Fortunately, I have nieces and nephews to to [sic] that.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Relatives and close friends

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No

Display # 53 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 19, 2010 12:35:39AM

Response Modified:
Monday April 19, 2010 12:39:38AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Health, physical injury, chronic pain, being alone, financial security

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Lotto, prayer, faith, career as interior designer, social services

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No Response

Display # 54 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 19, 2010 3:21:20AM

Response Modified:
Monday April 19, 2010 3:25:19AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Benefits from govt [sic] being alone, had a partner but he moved away 19 years, assisted living

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Not much its only a number and some just act like its nothing [sic?]

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
No

Display # 55 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 19, 2010 12:09:08PM

Response Modified:
Monday April 19, 2010 12:15:37PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I just hope that I am not restricted in any way, such as walking. I want to be mobile when I am older.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I have 2 partners who would take care of me

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I think it would be great to have an extended care facility for gays and lesbians only, managed by gays and lesbians. Small apartments where gays could live and be checked on regularly.

Display # 56 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:

Response Modified:

Monday April 19, 2010 1:27:44PM Monday April 19, 2010 1:34:47PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
Having my husband/partner grow older with me.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Extended family mostly but I believe in preventative care, eat right, take care of ourselves, exercise, etc, and probably an assisted living situation should it come to that.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
We need to take care of ourselves as much as possible. Not bragging but I am 56 but guys guess me to be in late 40s and have the energy level of a much younger person. It's an easy thing to do.

Display # 57 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 19, 2010 2:04:06PM

Response Modified:
Monday April 19, 2010 2:16:13PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
That other gay men see the age and not the person…equally from the young and the old, limiting the prospects for a partner now that I am single.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
All of the above and in that order

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
Deglamorize "GAY" through the venues that educate our culture (literature, film, theater, etc.) sahow more of the real life that is not necessarily the popular "gay culture" in this "out" time there is a growing population of mature/older gays that struggle with life issues like the rest of society. We have become more "streamline"[sic] than most think.

Display # 58 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Monday April 19, 2010 8:15:31PM

Response Modified:
Monday April 19, 2010 8:27:24PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I won't have children to take care of me; the thought of being alone without a partner

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I have no idea.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I feel that as the gay community grows to reflect society at large, the issue of ageism will recede, although never go away.

Display # 59 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:

Response Modified:

Monday April 19, 2010 11:48:59PM Tuesday April 20, 2010 12:02:53AM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I've been single most of my adult life, I live alone, and although I'm not lovely, this not having a partner is getting tiresome and I feel like I'm missing out. Along with that, what happens when I get too old to car for myself? Not sure being gay has anything to do with my concerns, however…

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Extended family (or relatives if need be)…I also perform at assisted living facilities, not sure that would necessarily guarantee me access if I needed to move into one however.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
It's so ignorant. But when I was young I was ageist to some extent as well, so I understand it. I really do think it has subsided somewhat, except for the same-old "youth oriented" and "body beautiful" images used in advertising, etc. But that's just as much a hetero thing as well.

Display # 60 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Tuesday April 20, 2010 4:47:14PM

Response Modified:
Tuesday April 20, 2010 4:51:30PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
I don't have any concerns right now—except for being single, growing old and being single might become difficult in time—but I'll just have to wait and see.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
I would call on my staff and friends to assist in taking care of me.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
I think we as mature gay men and women should start creating our own environments for socializing and meeting each other, rather than wait for someone to do that for us.

Display # 61 of 61 respondents

Response Type:
Anonymous Response

Collector:
New Link (Web Link)

Custom Value:
Empty

IP Address:
empty

Response Started:
Wednesday April 21, 2010 12:42:33PM

Response Modified:
Wednesday April 21, 2010 12:49:26PM

Survey Question 23:
Could you tell me what are your biggest concerns about growing older and being gay?
That the wisdom doesn't get recognized.

Survey Question 24:
If you were unable to take care of yourself, what strategies do you feel you would use? (For example: The help of your extended family, relatives, formal settings like assisted living, nursing home, retirement communities….)
Howe with friends around.

Survey Question 25:
Do you have any suggestions/recommendations concerning the issue of ageism in the gay community?
That aged men don't crawl in a whole [sic] and act old. That they learn to tap into their youth to be able to communicate with younger men and pass on their wisdom, understanding, and life's experience.

End of Survey

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