Clin Soc Work J (2013) 41:249–257
DOI 10.1007/s10615-013-0437-2

ORIGINAL PAPER

Clinical Practice with Older LGBT Clients: Overcoming Lifelong Stigma Through Strength and Resilience

Kristina M. Hash · Anissa Rogers

Published online: 29 January 2013

Abstract This article provides an overview of the unique challenges and strengths of the older lesbian, gay, bisexual, and transgender (LGBT) population and the theories and evidence-based interventions that can be used to work with them in a clinical setting. Two case studies will be used to highlight potential issues in clinical social work and provide guidance for intervention with LGBT older adults. The article concludes with a summary and implications for clinical social work practice.

Keywords Older adults · Gay men · Lesbians · Bisexual · Transgender · Mental health

Introduction

Currently 40 million in number, the population of older (65+) Americans continues to grow rapidly. In fact, this group is projected to reach 72 million by 2030 (Vincent and Velkoff 2010). As the number of older adults rises, so does the subpopulation of older individuals who identify as lesbian, gay, bisexual, and transgender (LGBT). Though the exact number of older Americans who identify as LGBT is difficult to ascertain, their numbers are estimated at one to three million, growing to six million by 2030 (Crisp et al. 2008). Along with the growth of the older LGBT population comes an array of complex economic, psychosocial, and interpersonal issues that often create barriers to the well-being of those who identify with this community. These individuals also bring to their situations a variety of strengths that can be utilized to improve well-being. It is imperative that social work practitioners are informed about the unique issues, needs, and strengths of this population and also possess the skills to support the growth and vitality of older LGBTs. This article will discuss these issues as well as how specific theoretical approaches, evidence-based intervention, and the conceptualization of strengths can be applied to clinical social work with these individuals.

K. M. Hash (✉)
West Virginia University, P.O. Box 6830, Morgantown, WV 26506-6830, USA
e-mail: kmhash@mail.wvu.edu

A. Rogers
University of Portland, Portland, OR, USA

Aging and Older LGBT Individuals

Older LGBT individuals experience challenges similar to their non-LGBT counterparts, including chronic health conditions, need for care, and financial difficulties (Orel 2004; Williams and Freeman 2005). They also face unique issues in older age related to their sexual orientation and gender identity, including stigma and discrimination, special health and mental health concerns, and unsupportive policies and services (D'Augelli et al. 2001; Donovan 2001; Fredriksen-Goldsen et al. 2011; Hash 2006). While these difficult experiences can create a host of problems for LGBT individuals, they can also help them develop unique skill sets or strengths that their non-LGBT counterparts do not necessarily benefit from as they age.

Stigma, Discrimination, and Self-Identity

Older adults often face stigma and discrimination by a society that undervalues age and celebrates youth. Older adults who identify as LGBT must confront ageism in

addition to lifelong negative attitudes and poor treatment related to their sexual orientation or gender identity. This enduring stigma and discrimination has ramifications for the ways in which older LGBT people perceive themselves, their relationships, and their opportunities and resources.

Older LGBT people often describe themselves as being twice hidden—they are invisible because they are older and because they are members of a sexual or gender minority group (Blando 2001). This dynamic can have negative impacts on well-being, particularly self-image, and this may be particularly true for gay men. For example, one study by Schope (2005) suggested that gay men tended to view the aging process more negatively because of the effort needed to sustain a positive self-image in the face of societal homophobia. This effort, according to study participants, becomes even harder with older age, particularly in light of how harshly the gay community tends to judge gay men and their appearance. Conversely, lesbians in this study viewed aging as a much more positive experience and expressed stronger, more positive self-images than gay men. This may be because older lesbian women tend to have more social networks comprised of lesbians from different age groups; are more revered by younger lesbians for their wisdom and perceived political power; tend to reject age-related and normative beauty standards; and generally are positively influenced by views and attitudes supported by the feminist movement.

Negative attitudes can often translate into action and the current older cohort of LGBT individuals also comes from a time period when harassment and violence against them were much more common and socially sanctioned. This population has faced significant oppression throughout their lifetimes, including ageism, racism, sexism, homophobia, and heterosexism. As a result, a major obstacle for this cohort has been managing hatred and discrimination over time and integrating it with a changing sense of identity as they age (Morrow 2001). Indeed, many older LGBT adults feel vulnerable in their neighborhoods; do not feel part of the gay community; experience the ramifications of ageism and homophobia; fear continued poor treatment as they age; and have strong, painful memories of and residual trauma from being criminalized, stigmatized, and terrified because of their sexual identity. Consequently, many older LGBT adults fear coming out and are concerned about further abuse, neglect, violence, and discriminatory treatment by service professionals and the larger community (Stein et al. 2010).

Older adults identifying as transgender or bisexual often face greater challenges than their gay and lesbian peers with regard to stigma, discrimination, and self-identity (Fredriksen-Goldsen et al. 2011; Grant et al. 2011; Persson 2009). Many in this subgroup have faced even more rigid barriers to self-expression and more complex layers of discrimination. For example, many bisexual individuals point out that they have been largely ignored, and even shunned, by the gay and lesbian community, and feel they must take on a lesbian or gay identity to be accepted (Keppel 2006). Transgender individuals argue that their situation is not related to sexual identity—their issues and concerns tend to be far different than those of the LGB community—and as a result, their experiences and needs tend not to be represented in the larger discussion of discrimination and self-identity development (Crisp et al. 2008). In terms of violence and harassment, transgender elders also experience much higher rates of physical and verbal violence (Fredriksen-Goldsen et al. 2011).

Health and Mental Health Concerns

With regard to health and mental health, older LGBT individuals experience challenges similar to their non-LGBT counterparts, including chronic health and mental health conditions and perceived stigma of utilizing mental health services (Orel 2004; Williams and Freeman 2005). However, being in a sexual or gender minority group, again, poses unique challenges. With regard to physical health, those in the LGBT community often experience high rates of disability, obesity, and HIV (Fredriksen-Goldsen et al. 2011). In terms of mental health, LGBT elders may experience higher rates of substance abuse, depression, loneliness, and suicide than older adults who identify as heterosexual (Fredriksen-Goldsen et al. 2011). Further, abuse and violence, common experiences for many in the LGBT community, also cause life-long health and mental health problems (Fredriksen-Goldsen et al. 2011; Kidd and Witten 2008; Morrow 2001). Transgender elders are thought to be at an even greater risk for developing health and mental health problems (Fredriksen-Goldsen et al. 2011). And, because of self-identity issues as they age, gay men may also be more susceptible to mental health issues in older adulthood (Kertzner 2001).

Experiences with Policies and Services

Older LGBT adults also face unique issues such as discriminatory policies and the lack of legal recognition and protection of relationships, denying them a multitude of rights and benefits such as end-of-life decision making and retirement and Social Security benefits (Averett et al. 2011; D'Augelli et al. 2001; Donovan 2001; Hash 2006). These barriers can prevent individuals from seeking and securing needed services for health and mental health.

Because many older LGBT adults have been bound by both societal and moral pressures to be silent and invisible, and due to their experiences with institutional discrimination, they may delay or even avoid seeking health care and other

services. For example, many older adults in the LGBT community are intensely private, which can put them and their special needs at high risk for being neglected by staff in hospitals, medical offices, nursing homes, senior centers, or community agencies. Further, older LGBT adults may avoid seeking services all together because of past experiences of discriminatory or insensitive physicians, law enforcement personnel, and other service professionals (Moore 2002). In fact, research in this area indicates that the majority of older LGBT adults strongly resist the idea of using care managers, adult daycare, assisted living facilities, or skilled nursing facilities, primarily because of past experiences but also because of fears that staff will not be knowledgeable about LGBT concerns and issues (McFarland and Sanders 2003). Older LGBTs are particularly hesitant about receiving institutional care, as it can be difficult to find facilities where they feel welcome, comfortable, and safe. Indeed, many older LGBT adults talk about needing to "go back into closet" when they move into a care facility (Cahill and South 2002).

Transgender elders may experience even greater challenges in accessing health and mental health care (Fredriksen-Goldsen et al. 2011; Grant et al. 2011; Persson 2009; Williams and Freeman 2005. A significant barrier to care for many of these individuals is the limited number of health care providers who have the knowledge necessary to provide appropriate care, particularly those seeking sex-reassignment therapies and procedures. Some transgender elders face problems finding providers willing to listen to their concerns and provide safe and affordable care. Indeed, many of these individuals cannot pay for the majority of sex-reassignment therapies and procedures that are available, even if they can find a professional they trust (Fredriksen-Goldsen et al. 2011). These issues may lead to transgender individuals undergoing procedures or interventions that are not effective, not aesthetically pleasing or acceptable, or that may even be dangerous (Persson 2009; Williams and Freeman 2005).

Strengths and Resilience of the Older LGBT Population

Though many have faced lifelong stigma and fear of discrimination (Brotman et al. 2007), older LGBT individuals may also have advantages as they age. For example, many have felt marginalized early in life and experienced the loss of relationships in the process of coming out, and as a result have built strong, alternative support networks (Berger and Kelly 2001; Grossman et al. 2000; Metlife 2010). As research indicates that while support from parents, siblings, and other relatives tends to be unlikely or unreliable, older LGBT adults are likely to receive advice, emotional support, and socialization from partners and close friends (Grossman 2000; Masini and Barrett 2008). These networks may mitigate mental health problems, as support from friends predicts decreased anxiety, depression, and internalized homophobia, which speaks to the protective effects of supports beyond the traditional familial network (Masini and Barrett). In addition, these support networks often provide caregivers who can offer instrumental care and emotional support when a member of the LGBT community becomes ill (Grossman et al. 2005).

Often, older LGBT adults develop a great deal of resistance to and resilience around negative social constructions of homosexuality, contributing to their psychological and emotional health and positive adjustment. Some of the strengths older LGBT adults possess because of this process include adaptability, self-reliance, advocacy skills, crisis competence, and gender role flexibility, which can help them successfully adapt to aging (Crisp et al. 2008; Metlife 2010; Morrow 2001). For example, many older gay men have learned self-reliance, survival skills, stress management, and how to care for themselves earlier in life, so the aging process in this regard tends to be smoother for gay men than for many men identifying as heterosexual (Brown et al. 2001; Wight et al. 2012). Similarly, many older lesbian women have developed strong social support networks and advocacy skills (Averett et al. 2011). Thus, aging can be a period of significant empowerment for many LGBT individuals (Brown et al. 2001). Further, the "coming out" process for many older LGBT adults helps to develop coping techniques that are applied to the developmental tasks involved in the aging process, which can have psychological and social benefits well into older age (Orel 2004).

Theories and Models for Clinical Practice with Older LGBT Adults

Since empirical studies examining the lives of older LGBT individuals have only been conducted since the 1970s, it is not surprising that there are a lack of theories and models that specifically inform conceptualization of issues and needs facing this population or interventions that build on and support the strengths and resiliency of older LGBT adults. However, various existing theories and models have been adapted in attempt to help address issues for and guide work with those in this population. While there are limitations, these theories and models, combined with what is known from research with older LGBT adults, can provide guidance in understanding and applying interventions to alleviate problems experienced by older LGBT adults as well as capitalize on their strengths.

Theories of Lifespan Development and Adaptation

Traditional theories of lifespan development, such as those originated by Erikson (1950) and Levinson (1978), offer

general frameworks in which to understand issues and experiences common to those in later stages of life. Though criticized for being narrowly focused and largely representative of the lives of economically advantaged, heterosexual males (Kimmel 1978; Peacock 2000; Rogers 2010), this body of knowledge has been widely examined and adapted by researchers in this area.

In the final stage of Erikson's (1950) theory of psychosocial development, Ego Integrity v. Despair, older adults (60+) reflect upon and evaluate their lives. In the face of several challenges of old age, including the loss of roles, chronic health conditions, and the death of loved ones, a person must arrive at acceptance of his/her life, or the person will fall into despair. This despair can result in resentment over perceived failures of the past, depression, and the fear of death (Hooyman and Kiyak 2011; Rogers 2010). Humphreys and Quam (1998) note that the acceptance of one's life and self that marks ego integrity may be more complicated for LGBT clients. The societal stigma associated with "deviant" sexual orientations can adversely influence how a person views his or her identity and life. Despair can be influenced by the many losses that an older LGBT person experiences, including the loss of family and friends in the process of coming out and the loss of a partner that may not be fully recognized or supported by others. Although not addressed by Humphreys and Quam, transgender persons may be at a greater risk for despair given the indignity they face from society and the lack of understanding and support on behalf of loved ones. Moreover, older LGBT adults may have struggled in earlier stages of Erikson's theory, such as Identity v. Role Confusion or Intimacy v. Isolation, which could impact the tasks of the last stage. For example, some gay men may not have been conscious of or open about their sexual identity in adolescence; thus, they may not have accepted their sexual orientation until later in life. Likewise, gay men may have entered heterosexual marriages and not achieved true intimacy until later in life when they accepted a gay male identity and partnered with a man (Peacock 2000).

Levinson's (1978, 1996) "seasons of life" theories of lifespan development examine people's life structures, or primary patterns of individuals' lives at particular points in time, and the transitions necessary between eras in life for people to successfully develop into older adulthood. The fourth and final era is older adulthood, beginning at age 60. The transition to this era from middle adulthood may occur as the result of impending retirement and physical declines. The era itself often involves the adjustment to retirement, acknowledgement of physical and social losses, and acceptance of death (Hooyman and Kiyak 2011; Rogers 2010). As applied to older LGBTs, Humphreys and Quam (1998) note that this late life transition may involve an acceptance and openness about one's sexual orientation. For older transgender adults, this would include acceptance around gender identity.

While many practitioners may view the aging process as fraught with difficulties for LGBT older adults, using theories like Erikson's (1950) and Levinson's (1978, 1996), there are many opportunities to identify strengths and how they can contribute to the development of trust, identity, and ego integrity. For example, older LGBT adults who have been able to develop strong, supportive social networks or partnerships or who have successfully developed a strong sense of identity through the coming out process may not have any problems developing ego integrity. Similarly, older LGBT adults who have successfully responded to stigma and discrimination may develop a positive view of life and a strong sense of self and identity leading to stronger ego integrity.

Moving beyond theories of lifespan development, Friend (1990) expanded social construction theory to older gay men and lesbians. As understood from this perspective, older gay and lesbian adults build their identities based upon their exposure to socially constructed meanings of aging as a sexual minority. The "socio-historical" time period in which a person lives is critical to this identity formation (Kimmel 1978; Peacock 2000). For older LGBT adults today, this time period has been largely sexist, heterosexist, and homophobic. Friend (1990) posits that individuals' cognitive-behavioral responses to this context exist on a continuum. As such, some individuals accept and internalize negative messages about their orientation while others resist such messages and do not integrate them into their identity. By internalizing negative messages, older LGBT people may experience stress, isolation, negative self-image, or lack of intimacy. Conversely, accepting one's true sexual identity without accepting negative messages can help older LGBT adults adapt more effectively with the aging process through developing more effective advocacy skills, flexible gender roles, and support systems.

Practice Models and Approaches to Intervention with Older LGBT Adults

While theories can help practitioners understand the unique experiences and issues of older LGBT adults, several practice models have also been developed to assist in this work. These range from guidelines for practice to specialized support groups and approaches to individual therapy. In 2011, the American Psychological Association (APA) adopted the Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients (APA 2012). In addition to considering the issues faced by LGBT individuals, the guidelines suggest acknowledging the time period in which individuals live and come out and the

additional challenges in aging posed by sexual minority status and discriminatory policies. Further, the impact of multiple minority statuses including age, gender, ethnicity, and disability, should be considered. Practitioners can also help older LGBT adults manage challenges in aging by supporting the use of coping mechanisms they have developed through dealing with and managing heterosexism. Again, practitioners can capitalize on the strengths of older LGBT adults that have been developed by dealing with and managing multiple minority statuses and navigating discriminatory systems.

Related to these guidelines, Crisp et al. (2008) suggest a competency-based model of "age competent and gay affirmative practice" (p. 6), which helps focus on and further develop strengths and resiliency of older LGBT adults. This model blends culturally competent knowledge, attitudes, and skills for work with LGBT individuals with the ten geriatric competencies of the Council on Social Work Education (CSWE) (Rosen et al. 2000). Understanding the aging process; recognizing personal biases and dispelling myths about aging; upholding self-determination of older clients while considering legal and safety issues; and providing and linking older adults and their families to appropriate services are a few of the skills covered by the CSWE geriatric competencies. Recently, the competencies have been expanded to 50 practice behaviors (Damron-Rodriguez 2006). A few of the competencies are specific to LGBT persons, including respecting the diversity among older adults and their families. At an organizational level, the competencies require adapting policies and services to meet the needs of diverse older adults and addressing barriers and discrimination that may impede their well-being and ability to access needed services.

Group settings, such as Gays and Lesbians Older and Wiser (GLOW), can be an effective modality to address challenges faced by those in this community by building support networks with other older LGBT adults who share similar experiences and backgrounds (Slusher et al. 1996). Building networks takes advantage of a strength that many older LGBT have developed through necessity and it can have many health and mental health benefits for individuals, as was discussed earlier. Other interventions such as telephone support groups specifically target older LGBT caregivers and the special needs and concerns they have given discriminatory services and policies. Telephone support groups have also been utilized for isolated LGBT caregivers, like those living in rural areas (Coon 2005; Moore 2002).

Many individual-based interventions are effective for intervention with older LGBT adults. David and Cernin (2008) recommend the use of evidenced-based approaches with particular attention to "common factors" or components that have proven effective across various therapeutic approaches. One of the common factors focuses on the importance of the "match" between the therapist and the client. Although research is inconclusive on this issue, matching older LGBT adults with LGBT therapists may be beneficial. A therapeutic alliance between the therapist and client, in the context of a relationship built on empathy and positive regard, is also a common factor and recommended for this population and should involve a match between values and agreed upon treatment goals. In addition, psychotherapy with this population should take into account the unique developmental issues and cohort effects of this population while also valuing the experiences of each individual.

In working with this population, Keppel (2006) stresses the importance of therapists looking at a client "through several lenses at once" (p. 88). Hence, the lenses of age and sexual orientation are crucial in understanding the whole person. For older adults who identify as bisexual, it is imperative to consider the higher level of oppression that comes with being both older and bisexual. Historically, the current older cohort is unlikely to have been exposed to images of bisexuals, and any existing messages around bisexuality were likely to have been negative. Further, many older bisexual adults have experiences of being stigmatized or even disconnected from and oppressed by the gay and lesbian community. Thus, older bisexual individuals often do not mention bisexuality as their primary reason for seeking help. Instead, they will discuss topics that they feel are more acceptable such as loss and depression. Clients are much more likely to identify their orientation if they sense the therapist to be open and supportive.

With regard to intervention, there are many approaches that effectively address issues faced by the older LGBT population and that consider complex characteristics around context and identity. Satterfield and Crabb (2010) provide an example of using cognitive behavioral therapy (CBT) for depression. To develop a plan for treatment, the authors combined literature regarding depression among older adults and ethnic minorities as well as literature on lesbian, gay, and bisexual developmental psychology. The authors propose determining the role that sexual identity, internalized homophobia, and stigma and discrimination have played in the presenting problem while identifying strengths and successful coping techniques such as the development of unique social supports that clients have utilized in overcoming challenges associated with being a member of a sexual minority population.

Application of Theories and Practice Models: Case Examples

Ellen

Ellen is a 62-year-old Caucasian female who is retired and holds an Associate's Degree in business. In the recent past,

she served as the primary caregiver for her "friend" Judy. She uses the term "friend" as she has used it most of her life and explains, "Partner is more of a 80s and 90s word." Judy suffered from a number of heart and vascular conditions for which Ellen provided care "on and off for her for 25 years." During that time, Ellen remembers constantly running to the emergency room in the middle of the night while trying to maintain her full-time job. She states, "I had an office job during the day and a nursing job at night;" she did not receive any help from Judy's family and did not feel comfortable talking to coworkers about having a significant other who was ill. In terms of her interactions with medical professionals, she felt that these professionals were always looking around for Judy's "husband, sister, or mother." In attempts to be recognized by the doctors, Ellen would say things like, "I'm her best friend" or "she lives with me." Judy always avoided setting up advanced directives, and Ellen claims that she herself has always been far too independent to have joint property or bank accounts. After one hospital stay, Judy recovered at her daughter's home. It was then decided that Judy needed 24-h care and that it was best for Judy to remain at her daughter's home. The move was "tough" on Ellen, and she claims that she got through it with the help of her friends (a female couple). Although sexual orientation was an "untouchable" subject in her family, Ellen's sister recognized that she was suffering the loss of her friend of 25 years. Following the relocation of Judy, it took Ellen a year to get back on her feet and feel comfortable in her home again without Judy's presence. She also got "tired of being a third wheel" in her group of friends and often felt lonely and isolated. She began to see a therapist and describes the therapist as a "strong point" in her transition from the caregiving role. Initially, she admits that she had a lot of "squeamishness" about going to a therapist and thought "there is nothing wrong with my mind." With the encouragement of her therapist, she "got a life" and learned about the gay community. She is now in a relationship with a woman 10 years her junior, is taking much better care of herself, and is a "much happier person." She visits Judy occasionally, but often finds it upsetting because Ellen finds that, "she is just not taking care of herself."

Charles

Charles is a 74-year-old African American transgender person. Charles was born a female but identifies as a male. He does not refer to himself as a "transsexual" and is non-operative, meaning he has not undergone surgery to alter any biological sex characteristics. He reports that from an early age he felt like he was "trapped" in the wrong body and would often sneak into his brother's closet and secretly try on his clothes and underwear. He would also lock the bathroom door and practice urinating while standing up. His parents thought he was just a "tomboy" and would start acting more like a girl during his teenage years. They insisted on putting him in dresses, despite his persistent resistance. During puberty, Charles became very depressed. The physical changes were a constant reminder of the inconsistency between his developing female body and his male gender identity. He contemplated suicide but could not bring himself to attempt it because of his religious upbringing and beliefs.

After graduating from high school, Charles moved to a larger city to start a new life where he could finally live as a man. He legally changed his name and began to dress as a male full-time. His family knew of these changes but still referred to him by his birth name and biological sex. Even though he has never consistently taken hormones, he says he can "pass" as a man in most situations, is happy, and feels comfortable in his own skin. After being "outed" by coworkers in his job at a factory, he found work in gay and lesbian bars and bookstores. Although the wages were low, he felt accepted and at home in these settings and made many longtime friends. He dated several women and "even lived with a few" before meeting his "girlfriend," Gina, of 22 years. The couple currently lives in a subsidized apartment complex and often has difficulty paying their bills.

Charles confesses that his relationship with Gina has always been "fiery" and that their fights become physical at times. Lately, their arguments have become more frequent and are escalating in terms of violence on the part of Gina. He has told Gina that it may be better if they lived apart, and he even applied for his own apartment in the same building. Each time he brings this up, she threatens to tell the whole apartment building that he is really a woman. This concerns him because since they have been together he has had decreasing contact with friends and family. He has heard about a local LGBT organization that specializes in providing services to older members of the community. When Gina leaves to shop for groceries, Charles calls the organization to discuss alternative housing options.

Application of Theories and Practice Models to Cases

Ellen and Charles have experienced issues similar to those faced by many older adults, including chronic illness, caregiving, loss, relationship problems, and financial difficulties. These issues were compounded, though, by factors unique to the LGBT population. To begin, Ellen and Charles did not have the advantage of being legally married to their partners. This would exclude them from numerous benefits allotted to couples with legally recognized relationships, including hospital visitation and health care decision-making as well as tax benefits. The two have also

experienced discrimination throughout their lives by family members, employers, and health care professionals because of their sexual orientation and gender identity. Ellen and Charles also have both built resilience throughout their lifetimes, resulting in many personal strengths to help them meet the challenges of this stage of their lives.

In applying Erikson's (1950) theory in Charles's case, a social worker might help him reflect on his journey around gender identity development and how this has been integrated into his identity as an older adult. For Charles to achieve ego integrity, according to Erikson, he must accept his identity as male and the ways in which this identity affects his relationships and interactions with the outside world, including any losses he may have experienced (or will experience) because of his gender identity and aging process. While it appears that Charles has accepted his male identity, he may face challenges in the future as he ages since he has not undergone any sex reassignment procedures. These could include illnesses such as cervical cancer or osteoporosis, which could impact his identity as male as well as force him to confront the loss of health and lead to despair.

With regard to Ellen, a social worker could use Levinson's (1978, 1996) theory to understand the transitions she has recently experienced in her caregiving role and in her relationship with Judy, along with her sexual orientation and how well Ellen has integrated this into her self-identity as she has aged. The loss of these roles may significantly impact Ellen's work in this last stage, and it may be a focus of intervention. With both Erikson's (1950) and Levinson's theory, the social worker would want to keep in mind the unique struggles many older LGBT adults face including ageism, sexism, and heterosexism; loss of family and other social supports; and barriers to services as these all could significantly influence whether or not older LGBT adults successfully achieve tasks in the stages of older adulthood.

In both Charles's and Ellen's situations, their ability to positively accept their gender and sexual identities has left them more adaptable as they age and their circumstances around roles and relationships continue to change. This was accomplished despite encountering many barriers to this acceptance. For Charles, he managed to overcome family and religious pressures to take on a feminine identity as well as the resulting depression. Similarly, Ellen rose above the disapproval of her family and the insensitive behaviors of health care professionals and is now proudly engaged in a lesbian-identified community. They both now have support systems in place and a strong sense of self, which allows them to be proactive about untenable situations that may put them at risk for health or mental health issues.

For Charles and Ellen, it would be important for social workers to incorporate guidelines for practice (i.e. APA 2012; Crisp et al. 2008) in these two cases. Both individuals have extensive life experiences that could enrich or create barriers to their well-being as they age. Charles's ethnic background and gender identity, and the interplay between the two, should be explored in relation to how these aspects of his identity, in the context of his age cohort and aging process, impact his development, relationships with others, and ability to access resources. This would also be the case for Ellen, whose gender and sexual orientation leave her at risk for considerable discrimination. Further, the strengths of these two individuals such as their resiliency, adaptability, and capability for self-advocacy should be emphasized, supported, and strengthened.

Individual and group therapy approaches could be effective for both Ellen and Charles. Taking a common factors approach, developing a relationship of empathy and unconditional acceptance may be particularly important for older LGBTs. Having an LGBT therapist or practitioner may also ensure the best "match" for individual treatment. Charles, in particular, may feel better understood and supported by a member of the LGBT community. With an appropriately matched therapist, he could work to incorporate his gender identity into the context of his self-identity while addressing particular issues, concerns, and needs specific to his situation and relationship. Fortunately, Ellen has already had a positive experience in seeking help from a therapist, which may mean that she may be likely to seek similar services in the future if needed.

Being cognizant of not only the special issues faced by older cohorts of LGBTs but also the unique life trajectory and experiences of the individual would also be imperative in individual work with Ellen and Charles. While not discounting difficult experiences related to their LGBT status, it is also important to not assume that any problems experienced by Ellen and Charles are solely influenced by their sexual orientation or gender identity. For example, although Ellen experienced difficulties with professionals in the past, she has become more connected in the gay community and may have discovered a network of supportive professionals. She may have also limited her contact with family members who are not supportive of her partner relationship. Thus, her current issues may lie more with a concern for the well-being of a former partner who is now a friend.

While both have histories of loneliness and depression, cognitive behavioral therapy (CBT) may be used as an approach to individual therapy. This approach would focus on maladaptive thoughts and behaviors and could utilize techniques such as cognitive restructuring to identify and combat self-derogatory thoughts, relaxation exercises to reduce stress, and goal setting to decrease isolating behaviors. Approaches such as CBT could also help Ellen and Charles identify and practice successful coping mechanisms

and social supports they have built over their life courses to combat additional stigma or discrimination that they may face and help them prepare them for health, relationship, and role changes that may occur as they age.

Group work could also assist Ellen and Charles, providing connection to and support from others who share similar issues and discrimination. Given his troubled relationship with Gina, Charles' public identity may be challenged if she reveals his birth-sex to others, so he will need support in navigating his needs in the context of the challenges raised by his relationship. A group setting would help him talk and work through this difficult situation. He may also benefit from group support in dealing with issues of violence in his life and giving him the courage to leave the relationship. Perhaps with a group support, Ellen would have been able to continue in her caregiving role with Judy, enabling them to redefine and sustain their relationship. She may be faced with this situation again in the future—either as the caregiver or the person needing care. Intervention and support at that point may help her to remain in and strengthen her current relationship and enable her to have options in living and caregiving arrangements that help preserve dignity and self-determination. Fortunately, through an experience with a supportive counselor, Ellen has realized the benefits of seeking mental health services and supports.

Conclusion

With the growing population of those 65+, it is imperative that practitioners possess the knowledge, values, and skills to work effectively with older adults and their families. Competent and effective practice with older LGBT elders begins with an understanding of normative aging issues as well as the unique challenges faced by this population. The awareness of the strengths they have built throughout their lifetime to overcome barriers to their health and happiness is also essential. This understanding provides a foundation from which to identify appropriate theories and models of intervention for working with individual clients.

Though few in number, evidenced-based modalities have been developed to benefit this specific group of older adults. The literature in the area of LGBT aging can provide guidance for understanding and working with this population of older adults, including the selection, adaptation, and application of theories and evidence-based interventions (i.e. Crisp et al. 2008; Peacock 2000; Humphreys and Quam 1998). Practitioners can and should explore how existing frameworks and therapeutic interventions can be tailored to their elder LGBT clients within their particular agencies and practices. Evaluation and dissemination of such modalities, in the form of case studies or program evaluation, are highly encouraged and desperately needed in the field. The contribution of practitioners to increase breadth and depth in this knowledge base can advance a wider selection of effective intervention models and contribute to a better understanding of the unique health and mental health needs of older LGBT adults (Kidd and Witten 2008; Persson 2009; Williams and Freeman 2005).

Though we have made great strides in building our knowledge and practice base with regard to issues faced by older LGBT adults, much work remains in our efforts to promote positive identities and improve conditions that allow members of this population to thrive throughout the aging process. Much of this work can be achieved through expanding evidence-based theory, research, and practice in this area; providing education that accentuates and builds upon the unique strengths and resilience of older LGBT adults; and advocating for policy that averts discrimination and strengthens and honors their relationships.

Acknowledgments The authors would like to thank University of Portland social work students Annie Stroup and Rose Baber for their help on the research for this article as well acknowledge agencies and individuals whose diligent work has done so much to support older LGBT individuals. The Gay and Grey Program in Portland, Oregon, an affiliate of SAGE, works tirelessly to provide support and resources to older LGBT individuals to ensure equal access to services and benefits and to improve well-being for the community. Older LGBT individuals themselves, such as Robert O. Jones, have contributed the most by advocating for and developing supportive services and policies and by educating and inspiring researchers and practitioners in this field.

References

American Psychological Association. (2012). Guidelines for psychological practice with lesbian, gay, and bisexual clients. *American Psychologist, 67*, 10–42.

Averett, P., Yoon, I., & Jenkins, C. L. (2011). Older lesbians: Experiences of aging, discrimination and resilience. *Journal of Women & Aging, 23*, 216–232.

Berger, R. M., & Kelly, J. J. (2001). What are older gay men like? An impossible question? *Journal of Gay and Lesbian Social Services, 13*(4), 55–64.

Blando, J. A. (2001). Twice hidden: Older gay and lesbian couples, friends, and intimacy. *Generations, 25*(2), 87–89.

Brotman, S., Ryan, B., Collins, S., Chamberland, L., Cormier, R., Julien, D., et al. (2007). Coming out to care: Caregivers of gay and lesbian seniors in Canada. *Gerontologist, 47*(4), 490–503.

Brown, L. B., Alley, G. R., Sarosy, S., Quarto, G., & Cook, T. (2001). Gay men: Aging well! *Journal of Gay and Lesbian Social Services, 13*(4), 41–54.

Cahill, S., & South, K. (2002). Policy issues affecting lesbian, gay, bisexual, and transgender people in retirement. *Generations, 26*(2), 49–54.

Coon, D. W. (2005). Exploring interventions for LGBT caregivers: Issues and examples. *Journal of Gay and Lesbian Social Services, 18*(3–4), 109–128.

Crisp, C., Wayland, S., & Gordon, T. (2008). Older gay, lesbian, and bisexual adults: Tools for age-competent and gay affirmative

practice. *Journal of Gay and Lesbian Social Services, 20*(1–2), 5–29.

Damron-Rodriguez, J. A. (2006). Moving ahead: Developing geriatric social work competencies. In B. Berkman, et al. (Eds.), *Handbook of social work in health and aging* (pp. 1051–1068). Oxford, England: Oxford University Press.

D'Augelli, A. R., Grossman, A. H., Hershberger, S. L., & O'Connell, T. S. (2001). Aspects of mental health among older lesbian, gay, and bisexual adults. *Aging and Mental Health, 5*(2), 149–158.

David, S., & Cernin, P. A. (2008). Psychotherapy with lesbian, gay, bisexual, and transgender older adults. *Journal of Gay and Lesbian Social Services, 20*(1–2), 31–49.

Donovan, T. (2001). Being transgender and older: A first person account. *Journal of Gay and Lesbian Social Services, 13*(4), 19–22.

Erikson, E. (1950). *Childhood and society*. NY: W. W. Norton.

Fredriksen-Goldsen, K. I., Kim, H. J., Emlet, C. A., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., et al. (2011). *The aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Seattle, WA: Institute for Multigenerational Health.

Friend, R. A. (1990). Older lesbian and gay people: A theory of successful aging. *Journal of Homosexuality, 20*(3), 99–118.

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force.

Grossman, A. H., D'Augelli, A. R., & Dragowski, E. A. (2005). Caregiving and care receiving among older lesbian, gay, and bisexual adults. *Journal of Gay and Lesbian Social Services, 18*(3–4), 15–38.

Grossman, A. H., D'Augelli, A. R., & Hershberger, S. L. (2000). Social support networks of lesbian, gay, and bisexual adults 60 years of age and older. *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 55B*(3), P171–P179.

Hash, K. M. (2006). Caregiving and post-caregiving experiences of midlife and older gay men and lesbians. *Journal of Gerontological Social Work, 47*(3/4), 121–138.

Hooyman, N. R., & Kiyak, H. A. (2011). *Social gerontology* (9th ed.). Boston: Pearson.

Humphreys, N. A., & Quam, J. K. (1998). Middle-aged and old gay, lesbian, and bisexual adults. In G. A. Appleby & J. W. Anastas (Eds.), *Not just a passing phase: Social work with gay, lesbian, and bisexual people* (pp. 245–267). New York: Columbia University Press.

Keppel, B. (2006). Affirmative psychotherapy with older bisexual women and men. *Journal of Bisexuality, 6*(1/2), 85–104.

Kertzner, R. M. (2001). Adult life course and homosexual identity in midlife gay men. *Annual Review of Sex Research, 12*, 75–92.

Kidd, J. D., & Witten, T. M. (2008). Understanding spirituality and religiosity in the transgender community: Implications for aging. *Journal of Religion, Spirituality and Aging, 20*(1–2), 29–62.

Kimmel, D. C. (1978). Adult development and aging: A gay perspective. *Journal of Social Issues, 34*(3), 113–130.

Levinson, D. J. (1978). *The seasons of a man's life*. NY: Knopf.

Levinson, D. J. (1996). *The seasons of a woman's life*. NY: Knopf.

Masini, B. E., & Barrett, H. A. (2008). Social support as a predictor of psychological and physical well-being and lifestyle in lesbian, gay, and bisexual adults aged 50 and over. *Journal of Gay and Lesbian Social Services, 20*(1–2), 91–110.

McFarland, P. L., & Sanders, S. (2003). Pilot study about the needs of older gays and lesbians: What social workers need to know. *Journal of Gerontological Social Work, 40*(3), 67–80.

Metlife Mature Market Institute. (2010). *Still out, still aging: The Metlife study of lesbian gay, bisexual, and transgendered baby boomers*. Westport, CT: Metlife.

Moore, W. R. (2002). Lesbian and gay elders: Connecting care providers through a telephone support group. *Journal of Gay & Lesbian Social Services, 14*(3), 23–41.

Morrow, D. F. (2001). Older gays and lesbians: Surviving a generation of hate and violence. *Journal of Gay and Lesbian Social Services, 13*(1–2), 151–169.

Orel, N. A. (2004). Gay, lesbian, and bisexual elders: Expressed needs and concerns across focus groups. *Journal of Gerontological Social Work, 43*(2–3), 57–77.

Peacock, J. R. (2000). Gay male adult development: Some stage issues of an older cohort. *Journal of Homosexuality, 40*(2), 13–29.

Persson, D. I. (2009). Unique challenges of transgender aging: Implications from the literature. *Journal of Gerontological Social Work, 52*(6), 633–646.

Rogers, A. (2010). *Human behavior in the social environment* (2nd ed.). New York: Routledge.

Rosen, A., Zlotnik, J., Curl, A., & Greene, R. (2000). *CSWE SAGE-SW national competencies survey and report*. Alexandria, VA: Council on Social Work Education.

Satterfield, J. M., & Crabb, R. (2010). Cognitive-behavioral therapy for depression in an older gay man: A clinical case study. *Cognitive and Behavioral Practice, 17*(1), 45–55.

Schope, R. D. (2005). Who's afraid of growing old? Gay and lesbian perceptions of aging. *Journal of Gerontological Social Work, 45*(4), 23–39.

Slusher, M. P., Mayer, C. J., & Dunkle, R. E. (1996). Gays and lesbians older and wiser (GLOW): A support group for older gay people. *Gerontologist, 36*(1), 118–123.

Stein, G., Beckerman, N., & Sherman, P. (2010). Lesbian and gay elders and long-term care: Identifying the unique psychosocial perspectives and challenges. *Journal of Gerontological Social Work, 53*(5), 421–435.

Vincent, G. K., & Velkoff, V. A. (2010). *The next four decades: The older population in the United States: 2010 to 2050, Current Population Reports* (pp. 25–1138). Washington, DC: U. S. Census Bureau.

Wight, R. G., LeBlanc, A. J., de Vries, B., & Detels, R. (2012). Stress and mental health among midlife and older gay-identified men. *American Journal of Public Health, 102*, 503–510.

Williams, M. E., & Freeman, P. A. (2005). Transgender health: Implications for aging and caregiving. *Journal of Gay and Lesbian Social Services, 18*(3–4), 93–108.

Author Biographies

Kristina M. Hash, LICSW, PhD is an Associate Professor in the School of Social Work and the Director of the Gerontology Certificate Program, Eberly College of Arts and Sciences at West Virginia University.

Anissa Rogers, MA, LCSW, PhD is a Professor of Social Work and Director of the Social Work Program at the University of Portland.