7.24 LGBTI Perspectives on Clinical Issues and Approaches in Later Life

Jennifer Hillman, Department of Psychology, Berks College, The Pennsylvania State University, Reading, PA, United States

7.24.1 Introduction

The purpose of this chapter is to provide up to date, clinically relevant information regarding our growing, and increasingly ethnically and racially diverse, older lesbian, gay, bisexual, transgender, and intersex (LGBTI) adult populations. The acronym LGBTI is intended here to represent a broad, overarching umbrella term that includes older adults who not only self-identify as LGBTI, but those who identify as queer, same gender loving, men who love men, women who love women, on the down low, questioning, asexual, pansexual, demisexual, questioning, female-to-male (FTM) transgender, male-to-female (MTF) transgender, post-operative, trans, butch woman, feminine man, two-spirit, gender nonconforming, gender fluid, non-binary, androgynous, hermaphroditic, and different in sexual development (DSD), among others. Vital historical, cultural, national, and legal influences upon older LGBTI adults will be reviewed, along with pervasive disparities in caregiving burden, poverty, substance abuse, intimate partner violence, sexually transmitted infections including human immunodeficiency virus (HIV) and human papilloma virus (HPV), the screening and diagnosis of various cancers, clinical depression, and social isolation.

Evidence of older LGBTI adults' resilience and personal strengths will be highlighted, along with clinical applications related to culturally competent practice. Specific recommendations related to mental health care providers' intake procedures, physical office spaces, and staff training will be offered along with information about evidence-based interventions including life review, psychological acceptance, and music and art therapy, and taking an interdisciplinary approach to care. Recommendations for future research that focuses upon underrepresented LGBTI older adult populations including older bisexual, intersex, and minority LGBTI adults, the effectiveness of telepsychology with older LGBTI adults, and interventions designed to reduce health disparities, will follow. Clinicians will also be encouraged to seek additional training and continuing education in relation to LGBTI older adults, draw upon a number of identified organizations and resources, and engage in advocacy on behalf of older LGBTI adults.

7.24.2 Evolving Demographics and Distinct Populations

Unfortunately, no national surveys, including the US Census, provide reliable information regarding the numbers of older Americans who identify themselves as LGBTI (American Association of Retired Persons, AARP, 2018). However, experts estimate that in the US, alone, nearly 2.7 million adults aged 50 and older and 1.1 million adults aged 65 and older currently identify themselves as LGBT (Fredriksen-Goldsen and Kim, 2017). Experts also estimate that between 0.02% and 1.7% Americans may identify as intersex (Sax, 2002). Based upon a US population of 46 million Americans age 65 and older, and 112 million Americans age 50 and older those estimates translate into potential populations of 8280 to 782,000 intersex American age 65 and older, and 22,400 to 1,904,000 intersex Americans age 50 and older. The predicted doubling of the entire US older adult population by the year 2060 is expected to lend exponential growth and increasing ethnic and racial diversity to older LGBTI populations (Ortman et al., 2014).

Also note that LGBTI adults are likely to be underrepresented in population studies and research (Hillman, 2017). Bisexual adults are typically underrepresented in epidemiological and research studies, both because bisexual adults often identify their sexual orientation as lesbian, gay, or heterosexual, based upon the gender of their current or last partner, and because bisexual adults are often overlooked in research programs and social service delivery, in general (AARP, 2018). Transgender and intersex older adult populations can also be expected to be overlooked in population surveys because they may identify themselves as male or female, consistent with their preferred or postoperative gender, rather than transgender. Still other older LGBTI adults may be underrepresented in research and other studies because they are fearful of disclosing their sexual minority status to anyone outside the LGBTI community.

Although the Centers for Disease Control defines older adults as individuals age 60 and older, many researchers and organizations that serve older LGBTI adults (e.g., American Association of Retired Persons, 2018; Forge [For Ourselves Reworking Gender Expression], 2019; Services and Advocacy for GLBT Elders, SAGE, 2019) define older adults as individuals age 50, or even 45, and older. This lower age limit of 45 and 50 versus 60 and 65 is chosen purposefully to acknowledge the impact that life-long stigma and discrimination can have upon LGBTI adults' physical and mental health (The Facts on LGBT Aging, 2019). Additional estimates suggest that by the year 2020, more than 20 million older Americans self-identified as LGBT or had a history of engaging in same-sex behaviors and romantic relationships (Fredriksen-Goldsen et al., 2018). This surge in the older LGBT population can be linked to both the overall increase in the number of aging Americans, in general, and the increased likelihood of self-disclosure among younger LGBT cohorts.

Older LGBTI populations are often combined to represent an overarching sexual minority group even though lesbian, gay, and bisexual adults are identified by their minority sexual orientation, transgender adults are identified by their gender identity, and intersex adults are identified by differences in the development of their sex characteristics. Also note that intersex adults may, via their external genitalia, have been identified as such at birth, or may not be identified or aware of their intersex status until years later. Adults who identify as intersex because they share inconsistencies between their assigned sex at birth and their internal sex organs or chromosomes often do not learn of this inconsistency until puberty or years later (APA, 2006). Many older intersex adults report that they only learned of their differences in sexual development when they were in their fifties; parents and physicians often kept this vital information secret. In sum, it is essential to acknowledge that while older lesbian, gay, bisexual, transgender, and intersex populations all share an underlying, sexual minority status, each of these older LGBTI populations remain unique and distinct (Institutes of Medicine, 2011). Also note that membership in one older LGBTI adult population does not preclude membership in other; older transgender and intersex adults may identify simultaneously as lesbian, gay, or bisexual.

7.24.3 Historical, Cultural, and Legal Influences

Older LGBTI adults' lives are often significantly, and unfortunately negatively, influenced by stigma and discrimination related to underlying cultural norms, historical events, legal precedents, and religious beliefs, among others. Most older adults LGBTI grew up during a time when homosexuality was considered both a crime and a sign of mental illness, and transgender and intersex individuals were not even acknowledged as a part of society. Concealment of one's sexual orientation and gender identity was common (Driscoll and Gray, 2017) and often deemed necessary to avoid verbal and physical abuse, job loss, home loss, criminal charges, involuntary commitment to a mental institution, excommunication from the church, and being shunned by friends, family, and the community at large, among others. Although the life of each older LGBTI adult is unique, understanding and acknowledging the impact of typically shared cultural, legal, and historical experiences and norms among different age cohorts of older LGBTI adults is essential (APA, 2012, 2014a, 2015).

Older LGBTI Americans who are part of the oldest-old population (age 80 and older), for example, share very different experiences than older LGBTI adults who are part of the American Baby Boom generation (who were born between the years 1946 and 1964; see Kimmel et al., 2006, for a review). Older LGBTI adults who are part of the US oldest-old population grew up during the 1950's when their own President, Dwight Eisenhower, ordered in 1953 that homosexuals should be fired from all government jobs and Senator James McCarthy initiated a series of investigations and hearings designed to root out disloyal Americans labeled as communists, associates of communists, and as traitors, as well as those identified by McCarthy's men as habitually drunk, morally weak, financially irresponsible, and sexually perverted. *Sexual perversion* included participation in same sex behavior and relationships, and those caught faced significant, negative social, economic, even physical health consequences. *Homosexual* Americans were routinely fired from federal and other jobs and often become the target of verbal harassment and even physical violence. This aspect of McCarthyism, that targeted Americans with a minority sexual orientation (or gender) throughout the 1940's through the 1960's, is referred to as *the Lavender Scare*.

In response to these discriminatory historical events and overwhelming fear of disclosing or having their sexual (or gender) orientation discovered, members of the oldest-old LGBTI population spent the majority of their lives being indoctrinated into a culture in which they were not allowed to be legally married, that engaging in same-sex relationships was not only sinful but criminal, and that they were unfit to serve in their own country's government or military. The majority of LGBTI adults who lived during this era carefully concealed their sexual minority status from others, including their own family members, friends, and even opposite sex spouses. When Congress passed legislation *for the treatment of sexual psychopaths* in 1948 (Adkins, 2016), individuals who expressed a preference for same-sex relationships could be sent to jail or to a mental institution, where their purported mental illness could be treated with things like shock treatment, hormone injections, and lobotomies (Hillman and Hinrichsen, 2014).

During this same era, intersex adults' only representation in society was that of openly mocked, ridiculed, and exploited performers who appeared in circus freak and side-shows. The only way that American LGBTI adults could disclose their sexual or gender identify minority status without significant fear of reprisals was to travel to select neighborhoods in the few gay-friendly cities like San Francisco or to tourist destinations that became associated with theater groups and flamboyant lifestyles like Key West, Florida, and various neighborhoods on Fire Island, New York. Few LGBTI adults were even aware of or wealthy enough to pursue those options.

In response to these legal prohibitions, secret government investigations, and commonly occurring discriminatory acts leveled against LGBT populations during the 1950's, American older LGBT adults from the current generation of oldest-old adults,

compared to those in the current generation of Baby Boomers, are significantly more likely to have married (and later divorced) an opposite sex partner and have adult children and grandchildren (Gambino, 2014). LGBTI adults in the current oldest-old age cohort, also compared to LGBTI Baby Boomers, also more likely to possess internalized stigma related to their minority sexual orientation and gender identity, and are significantly less likely to disclose their LGBT status to a health care provider (AARP, 2018).

In contrast, older LGBTI Baby Boomers grew up during the late 1960's and 70's when civil rights for many Americans began to change. The Stonewall Riot of 1969 (see Columbia University, 2011), in which LGBT adults physically fought back, for the first time, against police harassment in front of the Stonewall Inn in New York's Greenwich Village, marked the beginning of the US gay rights movement. Four years later, in 1973, the American Psychiatric Association removed homosexuality from their official list of mental disorders (see Kimmel et al., 2006). Also during this era, many states repealed laws against same sex behavior, and LGBTI adults began to serve in the military as long as they kept their sexual orientation a secret.

Older transgender Americans share a similar but also different history when compared to their older lesbian, gay, bisexual, and intersex peers (See Stryker, 2017, for an overview). Like their older LGB counterparts, they share a history that included fear of disclosure, a lack of understanding among health care professionals, the risk of being labeled a criminal, significant social stigma, and wide-ranging experiences of discrimination. When the oldest-old and Baby Boom transgender American were coming of age, individuals who questioned their gender identity or presented in ways that contradicted traditional, binary gender identification were viewed as mentally ill and often suffered significant discrimination including acts of physical violence (Stryker, 2017).

In terms of early medical approaches to transgender adults, the progressive US endocrinologist Harry Benjamin attempted to treat *transsexuals* in the 1950's by prescribing hormones and referring them to European surgeons for sex reassignment surgery (Stryker, 2017). At that point in time, no American physicians would agree to perform what we now identify as sex-affirming surgeries. Benjamin and his colleague Dr. David Cauldwell coined the term *transsexual* to differentiate this group of patients, who wanted to claim a full time identity as a member of the opposite sex look by permanently altering their physical appearance to match that of the sex they felt they truly already belonged to, from patients who were transvestites, who preferred to dress and often assume the role of someone playing the opposite sex, but had no interest in surgically altering their body and assuming an opposite sex identity full time.

Unlike his American contemporaries, including Cauldwell, Benjamin believed that psychoanalysis was a useless treatment for transsexual patients, who not only wanted to look physically like a member of the opposite sex, but who already felt as though they truly belonged to, and desperately wanted to physically become a member of, the opposite sex. Benjamin referred to the opposite sex that these patients claimed they already belonged to as their *psychological sex* (This term would later be changed to *gender identity*). Benjamin also noted that his transsexual patients regarded their genitals and secondary sex characteristics as hideous deformities; many stated that they only way they would ever feel positively about their bodies would be to literally, physically remove them. In contrast, Cauldwell believed that transsexual individuals were mentally ill.

In 1954, Christine Jorgensen became the first American to publicize her transgender status, including her participation in sex affirming surgery (initially described in the media as a *sex change*) in Denmark. Ms. Jorgensen became a national media sensation when newspapers across the country showcased *before and after* pictures of her transformation from a tough soldier serving in World War II to a beautiful blonde bombshell. With the increasing visibility of transgender adults in US culture and the widespread use of the term sex change, it became increasingly difficult for the medical establishment to assert that transgender adults were mentally ill, especially when their colleagues in Europe appeared to successfully treat transgender adults with surgical, rather than psychological, intervention. 1966, Benjamin published his formative text, *The Transsexual Phenomenon*. Within a year, Johns Hopkins University opened the first US clinic for the diagnosis and treatment of transsexual adults, and within ten years more than 40 universities offered such clinics. By the 1960's and 1970's, transgender health care was even more readily available. However, many transgender adults could not afford the high cost associated with treatment, lived in rural areas that were too far to travel for treatment, or were afraid to seek out treatment. Transgender adults typically feared discrimination including ostracism from family and friends, the loss of one's job and housing, verbal harassment, and physical violence. Transgender adults at this time were also expected to transition to either female or male; alternative forms of gender identity (e.g., non-binary, genderfluid, genderqueer) were not yet recognized.

By 1980, the American Psychiatric Association made the controversial decision to formally identify gender identity disorder as an official a mental disorder. Ostensibly, this formal diagnosis was intended to officially recognize transgender individuals and formalize their needs for diagnosis and treatment (Stryker, 2017). However, transgender Americans were not yet afforded any legal protection against discrimination in housing, employment, and other settings. It was not until 2012 that the American Psychiatric Association and the World Health Organization both removed gender identity disorder from their list of official mental disorders and introduced the term gender dysphoria, designed to account for the distress experienced by transgender adults whose assigned sex was incongruent with their experienced gender (see Heffernan, 2012). In terms of intervention, The American Medical, Psychiatric, and Psychological Associations concurred that the most appropriate treatment for gender dysphoria was to provide hormones, support social transitioning, and offer gender-affirming surgery (American Task Force on Gender Identity and Gender Variance, 2008).

In terms of current access to transgender health care and these recommended treatments, however, current cohorts of older transgender adults in the US are significantly more likely to depend upon Medicaid (in response to limited income and disability status), when compared to their heterosexual peers (McQuillan, 2019). The implications of this reliance upon Medicaid for current and future generations of older American transgender adults are insidious. Current cohorts of transgender elders were more likely to pursue surgical options for gender reassignment when they were older versus younger adults, typically because they could not afford the high cost of sex-affirming surgery when they were young and middle-aged adults. It often took decades

to save up for the cost of sex affirming surgery and hormonal treatments, which were not covered by government health care or private insurance plans (Hillman, 2012).

Medicare's ban on coverage for sex affirming surgery and related kinds of transgender health care in 1981 was not lifted until 2014 when Denee Mallon, a 74-year-old transgender MTF US Army veteran, challenged the ruling and won (Gambino, 2014). It also was not until 2016, with the passing of the Affordable Care Act, that Medicaid began to provide coverage for medically necessary, gender-affirming surgeries (McQuillan, 2019). However, inconsistent with federal policy, seven states report that they explicitly deny Medicaid coverage for sex affirming surgery and only 20 states report explicitly that they provide Medicaid coverage for sex affirming surgery (Movement Advance Project, 2019). However, just because Medicaid and Medicare provide coverage for transgender health does not mean that it is easy to obtain in the US; access to care continues to be a significant barrier. In addition, the cost of gender affirming surgery, even for transgender older adults with additional, private insurance coverage, typically exceeds $100,000 (Jones, 2019).

Although Europe served as a leader in the development of transgender health care, including sex affirming surgeries, significant challenges for transgender Europeans, including older transgender Europeans, remain (see Dunn, 2017). Although European physicians pioneered sex affirming surgeries, many transgender individuals in Europe are either unable to afford the cost of such gender affirming procedures or need to spend years on government wait lists to receive such care (e.g., up to four years in Belgium; Brussels Times, 2020). Current cohorts of older transgender Europeans also grew up under discriminatory practices in which more than 20 European nations required that transgender adults could only have their preferred gender legally recognized once they provided proof that they were unable to have children (Dunn, 2017). This *sterilization requirement*, eventually denounced by the European Court of Human Rights in 2017 (TGEU, Transgender Europe, 2017), typically forced transgender adults to subject themselves to state medical exams (and procedures) to demonstrate that they were either born with an inability to bear children or that they underwent surgery that rendered them unable to have children.

Current generations of older European and US intersex adults, including oldest-old intersex elders and those born after World War II (e.g., US Baby Boomers), share many similar early experiences. Members of these older adult cohorts who were born with ambiguous or atypical external genitalia were treated quite differently than children born with differences in sex development today (See Reis, 2009, for an extensive review). Throughout the middle ages, infants born as intersex were often labeled as monsters or abominations. Throughout the last century, infants born with ambiguous or atypically appearing genitals were typically whisked away from their unsuspecting birth parents by doctors and nurses who then rushed them into surgery to *correct* or *repair* their genitals. The goal of these physicians, who often operated on intersex children without parental input, was to give that child external genitalia consistent with either the typical male or female phenotype. The prevailing belief was to provide intersex infants with a clear, unambiguous sexual (and gender) identity, as soon as possible, to promote normal, emotional development.

Examples of these reconstructive surgeries, designed to *correct* an intersex infant's genitals, included reducing the size of an enlarged clitoris, removing gonads or testicles, and artificially creating or changing the size of a vagina. Many of these children were also placed on lifelong hormone replacement therapy. Also note that during this era, surgical errors that occurred during a male infant's circumcision, including severe damage or even amputation of the penis, often led to that physician's unilateral decision to further alter the baby's genitals. Physicians reasoned that since they could not restore the child's male genitalia, they could surgically construct phenotypically female genitals, and encourage parents to provide that child with a new, corresponding female identity (see Diamond and Sigmundson, 1997).

Throughout the last century, children born in Western hospitals and other medical settings were typically whisked away from their parents, without much of an explanation except that there was an emergency. The parents of these infants only learned what happened to them when they were returned hours, or even days, later. Upon being reunited, parents learned that—without their knowledge or consent– their baby had been subjected to permanent, life altering surgery. Physicians commonly advised these frightened and confused parents to raise their child in accord with their new, surgically assigned sex. Parents were also commonly advised to keep their child's medical history a secret from everyone, including the child themselves, to avoid identity confusion. In response, current generations of older adults born as intersex were raised by parents who were made to feel ashamed for giving birth to them; these negative emotions could certainly lead to conflicted and distant parent-child relationships.

To compound the emotional challenges that older intersex adults face, the reconstructive genital surgeries they were typically subjected to as infants often led to permanent scarring, nerve damage, chronic pain and discomfort, incontinence, and infertility. As children, these individuals commonly experienced feelings of confusion, shame, fear, and anxiety surrounding their bodies, and frequent visits to the doctor. Many doctor's visits included being told (and certainly not asked for their assent) to take off their clothes to pose for full body nude and close up photographs of their genitals. These pictures were often published in medical journals and textbooks, without the child or parents' knowledge or consent. Many of these children also described being taken to the doctor for regularly scheduled injections, without being told what they were being injected with and why.

Understandably, current generations of older intersex adults in the West struggled both before and after puberty with their sexuality, sexual orientation, and gender identity, as well their relationships with siblings, friends, significant others, and authority figures including their parents and healthcare providers. Throughout childhood and much of their adult life, older intersex adults experienced intense embarrassment, confusion, and shame about their bodies and their sexual and reproductive functioning. Consistent reports suggest that many older intersex adults only learned about the vital details of their own medical history, including their intersex birth status, reconstructive genital surgeries, and years of hormone treatment, when they were 50 to 60 years old. Many of those now elderly intersex adults only learned the details of their medical history after they demanded (InterACT & Human Rights Watch, 2017) or accidently gained access to their medical records.

Current cohorts of older intersex adults in industrialized, Western nations may be already familiar with, or surprised to learn about, updated nomenclature and clinical recommendations in work with intersex children and their families today. In response to previous, unilateral and secretive practices involving children identified initially as hermaphrodites in the 1940's and 1950's and then as intersex in the 1960's (Dewhurst and Gordon, 1969), the term *different sex development* (DSD) has been promoted as a more affirming and descriptive alternative to the terms intersex, disordered sex development, and atypical sex development. The term DSD is intended to avoid the negative connotations associated with referring to parts of someone's body as atypical and, therefore, pathological or diseased (Wiesemann et al., 2010). Current clinical recommendations (American Academy of Family Physicians, 2018) advise against performing reconstructive surgery on healthy intersex infants, and focus instead upon immediately informing and educating parents, conducting genetic testing, offering individual and family therapy, and allowing the child to grow old enough to actively participate in, and ultimately drive, treatment planning. These contemporary recommendations for treatment of intersex infants and children are diametrically opposed to those imposed, unilaterally, upon current cohorts of intersex elders.

It also remains essential to identify these historical and contemporary Western approaches to intersex and transgender issues as representing only one subset with multifaceted, global perspectives. For example, consider that Christianity, the most practiced religion in Europe and the US, espouses that god, described as male (e.g., *He*), created man and woman (i.e., Adam and Eve), reflecting a clear, binary approach to sex and gender. In contrast, Hinduism, the most practiced religion in India and Nepal, identifies gods (very simplistically, here, due to space constraints) as a collection of male, female, hermaphroditic, and genderless deities (e.g., Krishna, Lakshmi, Ardhanarishvara, and Braham, respectively) who are able to change their sex and gender at will. These Hindu beliefs promote a more fluid, non-binary approach to sex and gender. Historical and contemporary Indian culture reflects such a non-binary approach to sex and gender, in which individuals known as *hijaras* (alternatively identified as enuchs, intersex, and transgender) are not viewed as male or female, but as members of a unique third gender. Historically, discriminatory practices toward hijaras in India can be attributed, in part, to nearly a century of British rule that introduced laws and social mores that criminalized and denigrated sexual and gender expression inconsistent with, and outside of, marriage between a heterosexual man and woman (Biswas, 2019; Hossain, 2017). However, in response to contemporary, increasing levels of social acceptance, India's Supreme Court officially granted hijaras the right to legally identify themselves as a unique, third gender in 2014.

As noted, knowledge of different age cohorts' experiences as members of individual LGBTI populations is essential. An older LGBT adult's culture, religion, nationality, and legal protections are often confounded, and common experiences shared by members of the same age cohort can significantly influence their relationships with their partners, community, health care providers, and mental and physical health (AARP, 2018; APA, 2012, 2014a, 2015). Also consider that when the current cohort of US LGBTI millennials age into older adulthood, they will share a completely different history (i.e., coming of age when same-sex marriages were already legal, hate crimes against LGBT adults were considered a federal crime, the first openly gay candidate competed in a Presidential primary, the American Psychiatric Association removed gender identity disorder from its list of mental disorders, and children born as intersex were typically given control over their own bodies) when compared to those in the oldest-old and Baby Boom cohorts.

Information about the country in which an older LGBTI adult currently resides, as well information about their country of origin, along with their often closely linked cultural norms, is essential. Related legal protections, penalties, and cultural norms, whether espoused in one's current country, or shared or internalized as a child or younger adult before becoming an immigrant, can significantly influence older LGBTI adults in numerous ways. Specifically, cultural norms can influence an older LGBTI adults' willingness to disclose their minority status to health care providers, and even limit their participation in medically recommended, potentially lifesaving health care screenings.

For example, older LGBTI adults raised within traditional Latino (as opposed to more modern Latinx) culture grew up knowing that anyone identified as LGBTI would suffer significant stigma and discrimination, and often be targeted for physical violence (see Jeffries, 2009). Older LGBTI adults also learned very early in their lives that being labeled as a gay man was fraught with particular peril. Gay Latino men were typically shunned by friends and family members, excommunicated from the church, and targeted for verbal and physical abuse, especially by other men. Being gay was equated with the lowest social status and it brought shame and humiliation upon both that man and his extended family. In large part due to fear of disclosing an LGBTI identity, these typically denigrated, shunned, and abused LGBTI adults essentially became invisible within Latino culture. Many older Latino LGBTI adults remain fearful of disclosing their LGBTI status.

Researchers commonly attribute much of the pervasive, intense negativity toward the LGBTI individuals in Latino culture to two primary factors, Catholicism and machismo. Under Catholicism and its traditional dogma, participation in same-sex sexual activity (and masturbation) is considered sinful and evil. Latino machismo (Fernandez et al., 2008; Jeffries, 2009) ascribes clear, narrowly defined roles and traits to men and women. According to machismo, *real* (i.e., socially acceptable) men are dominant, brave, and full of bravado. This cultural norm also asserts that Latino men suffer from overwhelming, virtually unmanageable sexual needs and urges that must be met. A corollary of machismo is that the perfect Latino woman is always passive, receptive, and accommodating to her family. She is also expected to be responsive, at all times, to a male partner's sexual needs. Machismo makes it clear that heterosexuality is the only socially acceptable, openly displayed sexual orientation within Latino culture.

It also is essential to note that there are some critical differences between the way that Latino culture, compared to some others, identify an individual as gay. In Latino culture, men are gay if they participate in same-sex romantic relationships or self-identify as gay. In addition, however, Latino men are irrevocably identified as gay the moment they experience any anal penetration, whether the penetration occurs with a penis, a sex toy, or any other object including the gloved finger of a health care provider who is performing a digital rectal exam. Consistent with the cultural norm of machismo, men who are raped are identified as gay; giving

consent is irrelevant. Men who participate in medically recommended digital rectal screenings to assess their prostate health and check for symptoms of colorectal and other cancers are identified as gay; the purpose of the penetration is irrelevant. And, men who allow themselves to be penetrated by a female partner during consensual sex are identified as gay; the sex or gender of the penetrative sex partner is irrelevant. In sum, machismo dictates that men who experience anal penetration, for any reason or with anyone even if it occurs without their consent, immediately lose their high, male social status and are viewed as humiliated, emasculated, weak, passive, and submissive, with the same, or lower, social status afforded to women who are also typical recipients of penetrative sex (Jeffries, 2009). In contrast, other cultures only view men who self-identify as gay or who participate in same sex romantic relationships or consensual same-sex activity as gay; being subjected to rape or participating in a penetrative medical procedure has no bearing on a man's sexual orientation.

Also note that in Latino culture, men who engage in male to male, penetrative sex, but function as the insertive partner (i.e., *activo*), this same-sex activity is generally tolerated. Unlike the recipients of penetrative male sex who are labeled and shunned as gay, Latino male *activos* face no such negativity or cultural sanctions. In fact, insertive male to male sexual behavior, including both anal and oral sex, appears to be tolerated and even accepted in Latino culture because *activos* are credited with assuming the dominant, typically masculine role. Ironically, both machismo and Catholicism both contribute to the cultural acceptance of penetrative, male to male sexual activity. Machismo asserts that men suffer when their overwhelming, insatiable, and virtually uncontrollable sexual needs are unmet, and that most men still have such unmet needs even after having sex with multiple female partners. Because Catholicism precludes the use of masturbation an acceptable outlet, these Latino men's overwhelming and unmet sexual needs can literally drive or force them into having penetrative sex with a male partner in order to find relief.

Despite this tacit and quiet cultural acceptance of men who act as *activo* with a male sex partner, however, Latino men typically refuse to identify themselves as gay or bisexual. Latino men typically become offended and angry if someone even asks if they have a gay or bisexual orientation. Consistent with these cultural norms older Latino men, versus older non-Latino Black and older White men, are significantly more likely to refuse to answer questions in research regarding participation in same-sex activities (Jeffries, 2009). Also note that, while most older Latino men who engage in insertive and receptive same sex behavior vehemently deny having a gay or bisexual orientation, they may feel comfortable identifying themselves *on the down low*. This term, which also appears in African American culture, is intended to alert others that men's participation in same-sex behavior is to be kept secret, ostensibly from female partners. Describing themselves as on the down low also allows older Latino and African American men to admit to engaging in same-sex activity and relationships, without suffering from the stigma and discrimination that their culture associates with a gay or bisexual orientation.

Similarly, many older African American men (and women) who engage in same-sex behavior and same-sex romantic relationships may prefer identifying themselves as *same gender loving*. The use of this term among the African-American community has been endorsed as a way to: avoid being labeled as lesbian, gay, or bisexual, which can be considered a White, European construct; avoid being labeled as MSM (men who have sex with men) and WSM (women who have sex with women) which include the hierarchical terms *male* and *female*; affirm their unique, African American cultural identity; and promote a message of anti-hate and discrimination (Truong et al., 2016).

Both older and younger LGBTI Japanese adults commonly conceal their LGBTI status from others, including members of their own family, to avoid significant discrimination. Although transgender performers with Japan's entertainment industry are often recognized as celebrities, transgender adults who do not enjoy such notoriety are often faced with discrimination and disdain. To legally change their gender, transgender Japanese adults must meet a variety of criteria, including those that violate their basic human rights. They must be willing to have their sex organs examined to ensure that they are consistent with the gender change they are requesting (They must have already paid for, and completed, sex-affirming surgery). They must also be unmarried, have no children under the age of 20, and have their ovaries or testicles surgically removed (i.e., become sterilized). Although this law was challenged in 2019 in the Japanese Supreme Court, the final decision was to retain the law as written (Associated Press, 2019).

In addition to Japan, other nations maintain laws that violate the human rights of LGBTI adults. LGB adults in South and Central Asian countries, including Bangladesh, Bhutan, India, and Pakistan, are denied the right to marry and can be harassed by the police and sent to prison; transgender adults in those countries can be tortured and denied basic human services. In Middle Eastern countries including Afghanistan, Brunei, Iran, and Saudi Arabia, disclosure of one's LGBTI status can lead to abuse, incarceration in prison, and even execution.

Comparisons can also be made between the stigma associated with LGBTI status in traditional Latino, African American, and Japanese culture with the acceptance of *two spirit* people in various Native American tribes (e.g., Lakota, Mohave, Crow, and Cheyenne). As noted by experts from the Indian Health Service (2020), an individual identified as two spirit should not be viewed automatically as gay, or as being represented the same way in different tribes. The term two spirit was given to individuals who could be identified as male, female, or intersex. Most two spirit people participated in activities identified as both male and female, and they were often assigned additional roles as healers, shaman, or ceremonial leaders based upon their unique status.

Depending upon the tribe, two spirit Native Americans wore different clothing and displayed personality traits in accord with their unique status. A two spirit individual's gender was not described as male or female, but as a separate, unique gender. Many two spirit people participated in both short and long term sexual and emotional relationships, typically with other two spirit individuals, and they were often described as being *lucky in love*. In response to outside influences like missionaries and government representatives, two spirit traditions became lost or were driven underground in the face of significant discrimination and violence (Indian Health Service, 2020). In response, an oldest-old LGBTI Native American elder, compared to a Native American Baby Boomer, is more likely to have internalized positive versus negative cultural norms in relation to their LGBTI status.

Although older LGBTI adults, as a group, share similar life experiences in terms of compromised legal rights and fear of discrimination, their experiences are certainly not identical. For example, many older bisexual adults report feeling discriminated against by their older lesbian, gay, and heterosexual peers because they are accused of *choosing to play both sides* in order to gain a competitive advantage by increasing their selection of potential partners, and of *choosing to fit or blend in* with heterosexuals when they are with an opposite sex partner (Hillman, 2012). Of all older LGBTI populations and age cohorts, oldest-old transgender adults have enjoyed the least amount of legal protection for the least amount of time, and are the most likely to have experienced more, and more severe, episodes of discrimination (AARP, 2018).

A specific example of different yet shared experiences among older LGBTI age cohorts includes the AIDS epidemic that occurred throughout the 1980's. Although current populations of LGBTI Baby Boomers all survived the epidemic, gay and bisexual Baby Boomers had a very different experience, overall, when compared to their lesbian, transgender, and intersex peers. Gay male Baby Boomers typically share vivid memories of losing partners, friends, and other loved ones during the AIDS epidemic. Although older lesbians may have had similar involvement in caring for sick gay men, losing just as many friends and loved ones, and advocating for their community (Hillman and Hinrichsen, 2014), they did not lose their partners to this new disease. Note that this does not make older lesbians' experience during the AIDS epidemic any more or less traumatic than older gay men's experience– just different). A subsequent challenge for the current cohort of gay male Baby Boomers, who typically suffered multiple personal losses during the AIDS epidemic, is that they face growing older with significantly fewer friends, diminished social support networks, and the death of a partner, when compared to their lesbian Baby Boom counterparts (Rosenfeld et al., 2012).

Additional differences among older LGBTI populations (see Porter et al., 2016; Services and Advocacy for GLBT Elders, SAGE, & the National Center for Transgender Equality, NCTE, 2012) include the limited legal protection that older transgender adults in the US share when compared to their older gay, lesbian, and bisexual counterparts. Many states fail to provide transgender adults protection against discrimination in employment, private housing, and shelters even when they grant those same rights to LGB adults. When compared to their LGB peers, older transgender adults also typically report experiencing more, and more intense, episodes of discrimination across a variety of settings when compared to their LGB peers.

7.24.4 Pervasive Economic and Health Disparities

Both the National Academy of Medicine, formerly known as the Institute of Medicine (2011), and the National Institutes of Health (see the Supporting Older Americans Act of 2020) have prioritized older LGBT adults as at-risk and underserved populations who face significant challenges, including pervasive economic, social, and mental and physical health disparities. As defined by the Federal Government's Healthy People 2020 initiative (Office of Disease Prevention and Health Promotion, 2020), a health disparity represents a clear and specific difference in health outcomes between two or more populations, based upon a series of social, economic, and environmental disadvantages.

An older LGBTI individual's sex, age, race, ethnicity, culture, age cohort, geographic location (e.g., urban, suburban, or rural), sexual orientation, and gender identification all play a role in their ability to obtain and sustain good health and health care. Health disparities among older LGBTI adults in the US include higher prevalence rates of various chronic illnesses and cancers, increased participation in certain high-risk behaviors, and increased risk of being diagnosed with certain mental health disorders (Fredriksen-Goldsen et al., 2013). Available research suggests that these health disparities appear similar among older LGBTI adults in different countries (Barrett et al., 2014; Hughes, 2018).

Extensive reviews indicate that LGBT adults, compared to their heterosexual, *cis*-gender peers, have higher rates of smoking, alcohol use, recreational drug use (Institute of Medicine, 2011; Office of Disease Prevention and Health Promotion, 2020), and caregiving burden (AARP, 2015). Compared to their heterosexual and *cis*-gender peers, adult lesbians are four to 10 times less likely to obtain mammograms and pap tests; gay men, and particularly gay men of color, are at increased risk for contracting HIV, HPV (responsible for causing throat and anal cancers), Hepatitis C, and other sexually transmitted infections; lesbians and bisexual females are more likely to suffer from obesity; and transgender adults are more likely to experience victimization, be diagnosed with a mental health disorder, attempt suicide, and are significantly less likely to have health insurance. When compared to young adult and middle-aged heterosexual and *cis*-gender peers, older LGBT adults who experience additional minority stress due to ageism are more likely to live in poverty (Friedriksen-Goldsen et al., 2013), have difficulty performing activities of daily living (ADLs; Conron et al., 2010), experience intimate partner violence (IPV; Forge, 2019; Hillman, 2020), have limited options for LGBTI-friendly social services, and suffer from social isolation (Institute of Medicine, 2011; Office of Disease Prevention and Health Promotion, 2020).

Additional differences in economic, physical, and mental health disparities emerge among individual, older LGBT adult populations. For example, compared to the 26% of heterosexual older adults who live in poverty (O'Brien et al., 2010), 33% of older lesbian and gay adults, 47% of older bisexual adults, and 48% of older transgender adults live in poverty (Fredriksen-Goldsen et al., 2012; Fredriksen-Goldsen et al., 2013). Older lesbians are more likely to be disabled, diagnosed with depression (Fredriksen-Goldsen et al., 2013), and engage in excessive drinking and smoking (Conron et al., 2010) when compared to their heterosexual peers. Older bisexual adults are more likely to have internalized social stigma, conceal their sexual orientation from others, and have limited access to health care (Fredriksen-Goldsen et al., 2012) when compared to their older lesbian and gay peers. And, older gay men are significantly more likely to engage in binge drinking, smoke (Fredriksen-Goldsen et al., 2013), and be diagnosed with HIV when compared to their heterosexual peers (Centers for Disease Control and Prevention, 2018). Older bisexual and

lesbian women are significantly more likely to experience intimate partner violence (61% and 44%, respectively) than older bisexual (37%) and gay men (26; Walters et al., 2013).

Although limited information is available from large-scale studies, findings from smaller studies and convenience samples indicate consistently that older transgender adults face significantly greater health and economic disparities than their LGB peers. For example, transgender adults are more likely to suffer from chronic health issues including arthritis, depression, high blood pressure, obesity, asthma, chronic obstructive pulmonary disease, HIV infection, dementia, diabetes, congestive heart failure, chronic kidney disease, schizophrenia, and substance use disorder and suffer from strokes than their *cis*-gender peers (Dragon et al., 2017). In terms of sexual health, transgender adults face a higher risk of polycystic ovarian disease, endometrial cancer (Moore et al., 2003), and HIV infection, coupled with a lack of routine medical care that includes screenings related to breast, gynecological, and prostate health (Hillman, 2017). Reports also exist in which transgender elders who broach the subject of gender affirming surgery with a health care provider are often questioned about whether they really need such extensive and expensive treatment at their advanced age (Silverskog, 2014).

Transgender elders are also more likely to report internalized stigma, lower levels of social support, greater levels of stress (Fredriksen-Goldsen et al., 2013), and greater episodes of intimate partner violence (up to 50%; Brown and Herman, 2015) when compared to their *cis*-gender peers. Based solely upon their gender identity, however, transgender adults are more likely to be refused admittance to shelters for victims of domestic violence (Hillman, 2020). Older transgender adults are also significantly more likely to attempt suicide than a *cis*-gender peer (Office of Disease Prevention and Health Promotion, 2020). In relation to economic disparities, transgender elders have access to significantly fewer financial resources when compared to younger transgender adults (Hartzell et al., 2009) and are less likely to have health insurance (Porter et al., 2016), in part due to large scale discrimination from insurance companies. Older Black transgender adults appear to face additional challenges and discrimination including health care refusal, being harassed by the police, increased rates of HIV infection, and being a victim of family violence (SAGE & NCTE, 2012).

Because no large scale, systematic research has been conducted regarding the lives and experiences of older intersex adults, research findings on older intersex adults' health disparities are quite limited. Based upon the unilateral approach to intersex children taken by the medical establishment during the last century (Reis, 2009), it is easy to imagine how difficult it must be for current cohorts of older intersex adults to interact with, much less develop a sense of trust, with health care providers. Older intersex adults' consistent reports of feeling confused, fearful, and ashamed of their bodies could be expected to interfere with their ability to engage in close relationships with parents, peers, and significant others. Based upon various case reports (also see Reis, 2009), older intersex adults who married often cloaked their relationships, and their bodies, in secrecy. Some older intersex adults have described how they never allowed themselves to appear naked in front of their spouse and how they only allowed themselves to have sex when they were in bed with all the lights turned off. The social pressure of having to maintain such clandestine identities, even from their own spouse, represents a completely different experience than those expected by young intersex adults today.

Older LGBTI adults who are members of additional minority groups shoulder further economic and health disparities. Older LGBTI adults age 80 and older (i.e., the oldest old) are significantly more likely to live in poverty than their 50 to 79-year-old young-old and middle-old peers (Fredriksen-Goldsen and Emlet, 2012; O'Brien et al., 2010). Oldest-old LGBT elders are also significantly less likely to receive appropriate assessment or treatment from health care providers when compared to their 50 to 79-year-old peers. This discrepancy is believed to occur, in part, because oldest-old LGBT elders, compared to their young-old and middle-old peers, are significantly less likely to disclose their sexual orientation or gender identity, or any episodes of physical, psychological, or sexual abuse, to health care professionals (Fredriksen-Goldsen et al., 2015). Unfortunately, studies show that more than 10% of older LGBT adults have been denied health care, or received inferior health care, based upon their minority sexual orientation or gender identity (Fredriksen-Goldsen et al., 2011).

Older LGBT adults living with HIV are more likely to experience discrimination and victimization, experience the death of a same-sex partner, to live alone, be single, have lower levels of social support, have higher rates of depression, anxiety, and suicidal ideation, live below the poverty line (Fredriksen-Goldsen and Emlet, 2012), report feeling lonely, demonstrate increased emergency room use, and engage in various high risk sexual behaviors when compared to their older LGBT peers who are HIV negative (Fredriksen-Goldsen et al., 2011). Older LGBT adults in rural, compared to urban, areas have a lower household income and are less likely to disclose their sexual orientation to friends and family members (Lee and Quam, 2013). Although older LGBTI adults who live in urban, versus rural, areas tend to experience less age and LGBTI-related stigma and discrimination, they can and do experience such LGBTI-related negativity (e.g., Hinrichsen, 2010) including harassment and physical violence. Living as an older LGBTI adult in a LGBT-friendly city or neighborhood does not provide blanket protection. Older LGBT adults who identify as Black, Latino, HIV positive, and non *cis*-gender are also more likely to develop cognitive impairments, due in part to an increased risk of social isolation, depression, obesity, heart disease, tobacco use, and barriers to health care utilization (Alzheimers Association, 2016).

The intense fear that most Latino men maintain about being labeled gay, and subsequently ostracized and discriminated against by members of their own culture, lends itself to significant negative health consequences. Empirical research studies confirm that older Latino men, when compared to their non-Latino peers, possess overwhelmingly negative attitudes and significantly lower rates of participation in medically recommended colo-rectal cancer screenings that include a digital rectal exam (Fernandez et al., 2008). The older male Latino participants in this study explained that they would not subject themselves to a digital rectal exam that *violated their manhood*, *insulted their virility*, and *took their virginity*. When the Latino female partners of the men in this sample were asked to respond to such statements, most responded in ways that were also consistent with machismo, with statements like, *men do not do*

that (i.e., allow themselves to receive anal penetration). Because older gay and bisexual men face significant, increased risk for HPV infection and related anal cancers (National LGBT Cancer Network, 2020), older Latino men's intensely negative cultural attitudes and refusals to engage in medically recommended cancer screenings, which includes older Latino men who have sex with men, are particularly worrisome.

Factors that appear to drive older LGBTI adults' economic and health disparities include ageist, heterosexist, and *cis*-gender social and cultural norms (e.g., machismo), experiences of victimization, individual and institutional-level discrimination, minority stress associated with age, sexual orientation, gender identity, and sex characteristics (Zeeman et al., 2019), external and internalized stigma, higher rates of chronic illnesses like depression, obesity, and heart disease, and participation in high risk activities like smoking, substance abuse, and unprotected sex. Additional factors that may both foster and perpetuate health disparities among older LGBTI adult populations include limited access to health care (e.g., a lack of insurance coverage, mobility challenges due to disability, poverty), low numbers of culturally competent care providers, limited legal protection against discrimination, a lack of social support, and a history of negative experiences with authority figures including health care providers. It remains vital to examine the aforementioned factors and mechanisms that may underlie older LGBT adults' health disparities in order to develop guided interventions, update public policies, and create positive change (Fredriksen-Golden and Hoy-Ellis, 2017).

7.24.5 Evidence of Resilience

Although older LGBTI adults typically face a variety of challenges including stigma, discrimination, pervasive economic, social, and health disparities, underrepresentation in research, often limited legal protections, and inadequate numbers of properly trained, culturally competent providers, empirical research has revealed consistently that older LGBTI adults also demonstrate significant resilience (Orel and Fruhauf, 2015). Resilience can be defined as an individual's ability to cope, adapt, and *bounce back* from adversity, trauma, tragedy, threats, and other significant stressors (APA, 2020b). Resilience has been studied among older adults and can be viewed as a flexible (Bowling et al., 2019) and dynamic, versus static, construct (Allen et al., 2018). Factors that support resilience among older adults include the development of supportive relationships, participation in health and wellness behaviors, participation in leisure activities, the development of mindfulness, the use of religious and spiritual practices (Allen et al., 2018), a belief that life is inherently meaningful, participation in consistent self-care, optimism for the future, and altruism (Bolton et al., 2016). It also is essential to note that resilience does not require a positive outcome in response to adversity and trauma (Allen et al., 2018), but evidence of adaptation and mindful acceptance (Windle, 2011). It is also critically important to note that resilience among older adults can be learned (APA, 2020b).

Older LGBTI adults engage in resilience from a lifespan perspective (see Allen et al., 2018) and must typically respond to age- and LGBTI-related adversity that can range from normative age-related changes to major LGBTI-related trauma. Older adults, in general, appear to benefit from the *positivity effect* (Carstensen and Mikels, 2005) in which they tend to focus upon positive events in their past and their experience in the present, rather than worrying about the future. A resilient 72 year-old older gay man might demonstrate this *positivity effect* by focusing upon how much he enjoys being out and being part of his town's gay neighborhood, and by reminiscing proudly upon his involvement in a local gay rights protest shortly after the formative Stonewall Riots of 1969. This resilient older gay man would also be less likely to dwell upon his fear of being admitted to a non-LGBTI-friendly nursing home or other long-term care facility. Note that although a resilient older adult demonstrates the positivity effect by not ruminating upon their worries about the future, they may still experience negativity and remember negative events, as well as have some anxiety and concerns about their future. The difference is resilient older adults do not avoid or ruminate upon such negativity. Research also suggests that older adults who practice such resilience enjoy a better quality of life, better mental health outcomes, and even live longer (MacLeod et al., 2016).

In response to situations and stressors that cannot be changed, older adults who display psychological acceptance (Hayes et al., 1999), in which they are able and willing to mindfully experience their (often unpleasant) thoughts and feelings, rather than choose to avoid them, demonstrate better health outcomes, problem solving, and productivity (Butler and Ciarrochi, 2007). Accordingly, resilient LGBTI elders could be expected to make and acknowledge realistic appraisals of events, but focus upon more positive than negative events in their past, focus upon living in the present moment, and avoid dwelling needlessly upon fear they have for the future (e.g., Carstensen and Mikels, 2005). Resilient older LGBTI adults can also be expected to minimize the impact of LGBTI-related discrimination either by working to address or change the situation, or by accepting that the situation that cannot be changed in that moment. Accepting that the situation cannot be changed does not mean that the older LGBTI adult is happy about it. Rather, they can mindfully experience those typically negative thoughts and feelings (e.g., Lyons, 2016) rather than engage in avoidant behavior including drug and alcohol use, disordered eating, unprotected sex, and other potentially high-risk behaviors.

To illustrate the extent to which older LGBTI adults demonstrate resilience from a lifespan perspective, nearly 90% of older LGBT adults in the Aging with Pride: National Health, Aging, Sexuality and Gender Study (Fredriksen-Goldsen et al., 2015) reported feeling *good* about being part of their LGBT community, although bisexual women and transgender adults agreed less. Additional findings from this large-scale study suggest that older LGBT adults engage in a variety of health prevention and quality of life affirming activities. Nearly 40% of the older LGBT respondents participated in church or other spiritual activity at least once a month, 67% reported that they have someone available to help them with shopping, cleaning, and other daily tasks if they become sick, 82% have someone to talk to about their personal and other problems, and 83% have a companion or friend available to join them in enjoyable activities. In terms of practicing wellness, 82% of the older LGBT adults engaged in moderate physical activity (e.g.,

walking briskly, vacuuming) and 51% engaged in intense physical activity (e.g., aerobics, heavy yard work) at least once a week. Consistent with the development of resilience related to mindfulness, more than 90% of the older LGBT adults engaged in leisure activities including meditation, art, and photography.

Resilience is typically developed with age (Bolton et al., 2016), and members of individual older LGBTI adult populations may differentially develop and display resilience. For example, older gay men who lived in large urban areas during the US AIDS epidemic in the 1980's typically suffered the loss of numerous friends and partners to a frightening new, apparently untreatable disease while their older lesbian peers who lived in rural areas of the country during the historic AIDS epidemic were typically spared the experience of such overwhelming personal losses. Such older gay men who lived in urban areas during the AIDS epidemic, who often lost their partner and entire social support network in a few short years, may use this traumatic experience, from which they eventually recovered, as comparison for their current life stressors (Fredriksen-Goldsen et al., 2015). When faced with being laid off from a job or receiving a diagnosis of cancer, a resilient older gay men may express sentiments like, *Well, compared to what I went through in the 80's, when virtually everyone I knew and loved died from AIDS, this really doesn't seem like such a big deal. If I could get through that [AIDS epidemic], I know I may not like it, but I can probably get through anything.*

7.24.6 Future Research Directions

Researchers have described the double jeopardy that older LGBT adults typically face in relation to the minority stress and related stigma and discrimination that they experience due to both their advanced age and their sexual minority status (Meyer, 2003). Accordingly, older LGBTI adults who share membership in additional minority groups can be expected to face even greater, synergistic challenges. Unfortunately, older minority LGBTI adults remain significantly underrepresented in research. Most NIH research regarding older LGBTI adults, for example, has focused specifically upon HIV/AIDS-related issues, representing a clear disparity in funding priorities (Voyles, 2015). Also consider that the US government only mandated the inclusion of adults age 65 and older in federally funded research by 2019 (NIH, 2017). It is interesting to note that this national mandate also provides investigators with a significant loophole; the NIH requires researchers to include participants aged 65 and older *or* provide an acceptable justification for excluding them (e.g., suggesting that a separate, age-specific study would be preferable; reporting that the researchers will collect or analyze data using pre-enrolled participants).

Understudied and underserved older LGBTI adult minority populations that would benefit significantly from an increased focus and inclusion in research include Asian, Black, Hispanic, Pacific Highlander, Native American, Aboriginal and other indigenous groups of older LGBTI adults, as well as physically disabled, cognitively impaired, conservatively religious, immigrant, veteran, and rural older LGBTI adults. Because limited data is available, older bisexual and intersex adults would also benefit from such a specific focus, and recruiting for inclusion as participants, in both large-scale population and clinical studies. Priority can also be given to international studies of LGBTI elders, including those who live in countries that criminalize same-sex behavior, fail to provide legal protection against discrimination toward LGBTI adults, and fail to acknowledge a transgender citizen's preferred gender identity, and also in countries that provide LGBTI-related legal protections, LGBTI-affirming cultural attitudes, and integrative ve LGBTI health care. To fill existing gaps in the literature, both qualitative and quantitative research are needed to identify older LGBTI populations' unique experiences, needs, and health disparities. The development of effective innovative strategies for recruiting and including older LGBTI adults in research, especially longitudinal research with stratified samples, remains essential.

Consistent with the theory of minority stress (Meyer, 2003), in which internalized stigma, discrimination, resilience, strength, adaptation, and social support interact to influence an older LGBTI adult's mental and physical health, additional research is needed to identify and examine the ways in which older LGBTI adults develop and demonstrate adaptation and resilience. For example, do certain types of social support (e.g., in-person, online, familial) differentially protect older LGBTI elders from the negative effects of discrimination? Can older LGBTI adults be taught, either via therapeutic interventions or within the context of support groups, to increase their resilience and decrease their levels of stress? How could older Latino adults be convinced that men who participate in medical procedures that involve penetration and who are victims of rape are not automatically denigrated and labeled as gay? It also is vital to both develop and assess the extent to which continuing education and other interventions are effective in developing culturally competent and older LGBTI affirming practice among mental health care providers, as well as other professionals including physicians, nurses, nursing home staff, nursing home administrators, home health care workers, hospice workers, police and correction officers, ombudsmen, and clergy.

Telepsychology has been identified as a potential resource for connecting increasing numbers of older LGBTI adults, particularly those with mobility issues and in rural areas, with limited numbers of appropriately trained therapists. Questions remain, however, regarding the extent to which older LGBTI adults have access to, and are comfortable using, the required technology, which may include smart phones, computers, and reliable internet access. Limited financial resources among older LGBTI adults who, as a population, face increased risk of living in poverty, could certainly serve as a barrier to purchasing the requisite items and services. It also remains unclear how comfortable older LGBT clients feel discussing LGBTI and aging related issues in an on-line versus in-person format, particularly in relation to perceived confidentiality.

With the advent of the coronavirus pandemic in 2020 and the resultant need to protect older and immunocompromized adults via social distancing, the Centers for Medicaid and Medicare relaxed HIPPA and other regulations to allow more individuals, including older residents in long-term care settings, to participate in telemedicine to both begin and continue psychotherapy, and to engage in clinical assessment. In response, many mental health care providers answered the proverbial call and engaged

in teletherapy for the first time, both via the internet and over the telephone. Research is needed to examine the extent to which older LGBTI adults and their therapists engaged in telepsychology, including both therapy and assessment, and why. Research is also needed to examine older LGBTI adults' first-person experience with various modes of service delivery and types of therapy (e.g., telephone versus virtual face-to-face delivery; individual versus group therapy) along with empirical clinical outcomes.

7.24.7 Clinical Applications and Recommendations

Working effectively with older LGBTI adults and fostering an older LGBTI adult friendly, culturally competent practice requires a detailed, multifaceted approach. A critical first step to providing an older LGBTI adult affirming practice includes a careful review of the physical environment. Therapists are also responsible for providing their staff with older LGBT adult-affirming training and supervision in sensitivity and inclusive language training. Therapists need to be aware of the significant impact that stigma, discrimination, age cohort, diversity, a history of trauma, and health disparities, among other factors, typically have upon older LGBTI adults. The use of evidence-based therapies that can be adapted easily for work with older LGBTI-adult clients (e.g., life review, reminiscence, trauma therapy, development of resilience, and music and art therapy) is also essential. Therapists' participation in related continuing education and self-assessment of their attitudes toward LGBTI-issues and aging represents yet another requisite for culturally competent practice. Finally, therapists can consider engaging in advocacy to help address to the economic, social, and health disparities commonly experienced by older LGBTI adults.

Fortunately, the American Psychological Association and other researchers provide such clinical guidelines for practice with lesbian, gay, and bisexual (APA, 2012), transgender and nongender conforming (APA, 2015), and older adult clients (APA, 2014a). This portion of the chapter is intended to examine the intersectionality of these guidelines in work with older LGBTI adults (e.g., Hillman and Hinrichsen, 2014; Porter et al., 2016). Based upon these resources and APA guidelines (2012; 2014a,b, 2015), a variety of clinical applications and practical recommendations will be provided.

For most older LGBTI adults, their attitudes and assumptions about working with a mental health provider, and about psychotherapy itself, develop long before their first actual intake or therapy session. In other words, the first step in becoming a culturally competent provider has nothing to do with conducting psychotherapy itself, but making sure that they encounter a safe, affirming physical and social environment as they prepare to engage in therapy. For example, various aspects of therapists' office buildings, waiting rooms, and web sites, as well as the behavior of their staff members, creates a powerful first impression, and these factors are all associated with a therapist's ability to provide a culturally safe environment (Crameri et al., 2015) for older LGBTI clients. Older LGBTI and other minority adults who have typically experienced stigma, discrimination, and limited access to health care can be particularly attuned to environmental cues both in and outside their therapist's individual office including parking lots, hallways, waiting rooms, and bathrooms.

To illustrate the importance of environmental factors, consider an older LGBTI adult who took the brave step to attend therapy for treatment of their depression. On the day of their appointment, they fold their walker, place it in the backseat of their car, and drive to the therapist's office. When they arrive at the building's parking lot they discover that the one dedicated, handicapped accessible parking space is already taken. They consider canceling their appointment out of anxiety and frustration but decide to drive around until they can find an available parking space. After parking, and their long, slow trek to the building's entrance, they enter the lobby to find a series of narrow hallways that make it difficult to maneuver around corners and past other people.

After locating their therapist's reception area, they quickly scan the waiting room and notice colorful framed pictures of individual people, families, and pets, but sigh when they realize that *none of these people look like me*. Glancing at the hetero and *cis*-gender centric fashion and lifestyle magazines scattered around the waiting room they think, *None of these magazines are geared for people like me, either. Who knows if I am going to fit in here, and whether this therapist is going to understand anything about me?* Feeling increasingly anxious, they decide to go to the bathroom. They head down the hallway and freeze when faced with the choice of going into either the men's or women's room. They agonize, *What if I choose the "wrong" one? What if someone challenges me about whether I belong in there? Plus, it takes me forever to maneuver around with my walker*. Transgender adults face increased risk of violence when using public bathrooms, and older transgender adults may feel particularly vulnerable when they have challenges with mobility (SAGE and NCTE, 2012).

After turning away from the gender specific bathrooms they approach the receptionist who smiles and hands them an intake form. As they begin to fill it out, they recognize many of the same items they have seen in the past on other health care providers' forms like *What is your sex? Please circle male or female* and sigh. They also notice that nothing on the form asks them to identify a preferred pronoun or any family members by choice. At that point, they scratch out their name, toss the intake form in the closest waste basket, and decide to go home. They chide themselves, *Why did I get my hopes up and think that this therapist would be any different?* Leaving the building, they stumble and almost fall because they did not notice that the flooring in the entryway changed from tile to carpet. They drive home feeling tired, alone, and even more depressed.

Imagine how different this older LGBTI adult's experience would have been if their first impression of their new therapist were influenced by other factors. What if they had been able to park in a second handicapped accessible space, and to maneuver their walker easily down a series of wide hallways? What if instead of becoming even more anxious they could have relaxed for a few moments in an all gender, private bathroom? Imagine how comfortable they might have been if they noticed an LGBTI-friendly rainbow sticker on the door to the waiting room and, once inside, noticed a framed picture of a family with someone they can

identify with (i.e., *someone who looks like me)*. Also imagine how relived they might have felt when asked on the intake form to identify their preferred pronoun and any family members by choice, and then discovered a pamphlet in the waiting room about caregiving that included information about a local and online support group for LGBTI caregivers.

Clients' initial interactions with the physical environment associated with health care providers, including office buildings, options for parking and public transportation, reception and waiting room decorations and displays, as well as their initial interactions with their receptionists, billing specialists, other office staff, and even janitorial and security staff are often overlooked in relation to cultural safety and competence in work with older LGBTI adults. The American Psychological Association (2020a) endorses the use of universal design, which refers to the planning and creation of physical environments that are the most useable by the most people, including older LGBTI adults, without requiring any adaptation. An example of such universal design is the installation of curb cut outs and ramps in a therapist's office parking lot. These curb ramps and cut outs will benefit both clients who use a wheelchair and clients who push a stroller.

In terms of office signage and décor, a recent study also confirmed that most middle-aged and older LGBT adults would welcome the posting of LGBT-friendly signs and symbols like rainbows and pink triangles by LGBT-friendly health care providers, service agencies, and businesses, AARP, 2018). Please refer to **Table 1** for a related list of recommendations designed to help therapists create a culturally safe and competent older LGBTI adult practice. Specific suggestions are offered for providing older LGBTI adult-friendly intake forms, building and office design, all gender bathrooms, and waiting room décor, informational brochures, and appropriate supervisory and general education practices.

Therapists are also responsible for educating their interns, postdocs, and office staff about the use of inclusive language and cultural sensitivity in their interactions with clients (APA, 2014b), including older LGBTI-related adults. Staff may be unfamiliar with the challenges that older LGBTI adults often face including mobility issues, wheelchair and walker use, having people question whether they should be allowed to use a gender specific bathroom, being fearful about meeting with a health care provider based upon a history of being treated poorly and discriminated against (e.g., being refused care, called insulting names, and addressed intentionally by a non-preferred pronoun). Therapists are also responsible for providing ongoing supervision of office staff (APA, 2014b; Bent et al., 1992) including their use of older LGBTI-affirming, inclusive language and behavior. Providing staff education and training, alone and in isolation, is insufficient. It also is important to note that neither therapists nor staff members can immediately, easily, and successfully put what they have learned into practice. Providing ongoing, regularly scheduled supervision that uses a supportive, rather than punitive, approach is essential.

Although psychologists are not legally or ethically required to provide educational materials, sensitivity training, and supervision for the employees in their office or building who are not directly responsible for client care and record keeping (APA, 2014b; Bent et al., 1992), including any employee who has the potential to interact with older LGBTI clients, like janitorial and security staff, in formal or informal training and supervision is recommended. Respectfully informing support staff, including janitors, repair persons, mail distribution clerks, and security personnel, about how important they are in being able to provide everyone in the building, including clients, with a safe and affirming environment, can help increase their participation in formal and informal training opportunities and supervision. Therapists are also encouraged to examine their own attitudes about older (APA, 2014a) and LGBTI (APA, 2012, 2015) adults. This practice is especially important for therapists who are from a culture or religious affiliation that does not provide an LGBTI affirming orientation (Pachankis and Goldfried, 2004); taking a non-judgmental, mindful approach to examining one's attitudes is recommended. Providing an affirming environment, which includes culturally appropriate interactions with all staff and building employees, along with therapists' insight into their own knowledge and attitudes, can help many older LGBTI adults feel comfortable enough to begin or continue treatment.

Therapists are encouraged to acknowledge age and cohort differences among older (APA, 2014a) and LGBTI adults (APA, 2012, 2015). An important way to acknowledge and respect different age cohorts of older LGBTI clients is to ask those clients about their preferred self-identifiers and terms, and to follow their lead in their use of language related to their sexual orientation, gender identity, body parts, and sexual activities (Hillman, 2012; Porter et al., 2016). For example, although some younger LGBTI Baby Boomers may endorse, and identify with, the term *queer*, their oldest-old LGBTI counterparts are significantly more likely to recall the use of *queer* as a highly offensive slur, and fail to understand why any LGBTI individual would choose to identify themselves that way. An oldest-old intersex elder may prefer to refer to themselves as a hermaphrodite or intersex because those are the only terms that they are familiar with; intersex adults may be unaware of the recent use of the term DSD (different sex development), designed to help minimize negativity and stigma. In relation to these significant age-related cohort differences in the use of LGBTI terminology, it remains essential to ask each older adult client respectfully and without judgment what term or label they prefer to identify with, and why.

Because members of older LGBTI age cohorts are more likely to have experienced discrimination in their previous interactions with health care providers when compared to individuals from younger LGBTI age cohorts, therapists can make it a priority to ask an older LGBTI client about their previous experiences with health care providers (Porter et al., 2016). Asking older LGBTI clients about previous and current barriers to accessing health care (i.e., for older transgender adults on Medicare, the supply of physicians who perform gender reassignment surgery and accept Medicare as payment is far exceeded by demand; McQuillan, 2019) is essential. To help foster trust in the therapeutic relationship, therapists can inquire about and discuss LGBTI clients' expectations for therapy, acknowledge differences in power between the therapist and client, and carefully review issues related to confidentiality and mandatory reporting. Because both oldest-old LGBTI elders and LGBTI Baby Boomers share an increased risk for depression, social isolation, caregiving burden, internalized stigma, and discrimination, when compared to their younger and middle-aged LGBTI peers, therapists are encouraged to screen older LGBTI clients for depression, loneliness, and suicidality (Fredriksen-Goldsen et al., 2011).

Table 1 Recommendations for older LGBTI adult-affirming practice

Intake and other forms
Review paper and online forms for inclusive language
State clearly that this information, as part of their medical record, will be kept confidential
Inquire about relationships and not just marital status (e.g., *Do you have a significant other, partner, or spouse?*)
Inquire about *family members by choice*
Include multiple options for sexual orientation (e.g., lesbian, gay, bisexual, questioning, same gender loving, on the down low, men who love men, women who love women, queer, asexual, pansexual)
Include multiple options for gender identification (e.g., transgender, two-spirit, nonbinary, genderqueer, MTF, FTM, butch woman, feminine man, other)
Include multiple options to indicate different sex development (e.g., intersex, different sex development, disorder of sexual development, hermaphrodite, other)
Ask clients to identify their preferred pronoun (*Do you like to be referred to as she/her, he/him, or they/them?*)
Provide written materials with at least a 14-point font and offer large print versions upon request, which can be accomplished easily with an office copier or printer
Physical environment
Review environmental factors related to street parking, parking lots, building entryways, hallways, reception areas, waiting rooms, bathrooms, and individual offices
Aspire to principles of universal design
When possible, provide more handicapped parking spaces than required by local codes
Provide curb cuts and ramps for accessibility
When possible, make hallways and doorways at least 36 inches wide to allow easy access for walkers, wheelchairs, and scooters
Ensure that all flooring, from the building entry to practitioners' individual offices, is free from obstacles.
Mark all changes in flooring height and type clearly, with both brightly colored floor tape and hazard signs
Post nondiscriminatory statements that equal care will be provided to all clients regardless of age, sexual orientation, gender identity, ethnicity, race, religion, and physical ability and attributes
Display symbols associated with LGBTI pride and acceptance including rainbow flags and pink triangles
Provide magazines (e.g., *Out*, *Metro Weekly*, *The Advocate*, *AARP Magazine*, *Reader's Digest Large Print Edition*, *Reminisce*) and newsletters (e.g., service and advocacy for lesbian, gay, bisexual, and transgender elders, SAGE, and forge) from organizations that serve LGBTI and older adult audiences.
Provide a selection of educational materials (e.g., signs, pamphlets, informational websites) related to older LGBTI adult issues including caregiving, substance abuse, HIV infection, intimate partner violence, elder abuse, smoking cessation, and how to seek help for discrimination in housing, employment, and healthcare, among others
Display images of older LGBTI individuals, couples, and families (e.g., older same-sex couples; families with two same-sex parents or grandparents)
Display images of individuals, couples, and families from a variety of racial, ethnic, and cultural backgrounds
Display images of individuals, couples, and families that feature people who use wheelchairs, walkers, scooters, prosthetic limbs, hearing aids, insulin pumps, white canes, seeing eye dogs, and other service animals
Therapists can celebrate National Coming Out Day, World LGBT Pride Day, AIDS Day, Grandparents Day, National Disability Day, the Paralympics, and other older and LGBTI adult affirming events.
Identify and provide referral lists of local older LGBTI-friendly mental and physical health care providers, religious organizations, senior centers, lawyers, social service agencies, and community organizations
Provide information for online and available, local, in-person support groups for older LGBTI adults (e.g., LGBT Caring Community Online Support Group, https://www.caregiver.org/lgbt-caring-community-online-support-group; ElderTG online support, https://forge-forward.org/aging/listservs/; LGBTribe Members, https://support.therapytribe.com/lgbt-support-group/)
Bathrooms
Provide gender neutral (or all gender), companion, and family-friendly bathrooms that include handicapped accessible stalls, changing tables, and mirrors within individual stalls
In multi-person bathrooms provide stalls with little or no gaps between the doors, floors, and walls to extend maximum privacy.
Whenever possible, provide at least one single person, gender neutral (or all gender), companion, or family-friendly bathroom that is lockable and handicapped accessible
Install non-skid flooring in all bathrooms
Install grab bars in as many individual bathroom stalls as possible, not just in handicapped accessible ones
Post signs and provide take away information (e.g., a business size card or pamphlet that can be tucked unobtrusively inside a pocket or purse) about intimate partner violence and elder abuse, and contact information to obtain immediate help
Training and supervision
Therapists can mindfully examine their own attitudes about older and LGBTI adults, especially if their culture or religious affiliation is not LGBTI-affirming
Seek out formal and informal continuing education opportunities to increase cultural competence in work with older LGBTI adults
Seek out continuing education courses related to issues that often face older LGBTI adults including depression, substance use, HIV infection, caregiving, and interpersonal violence
Participate in peer consultation or clinical supervision with both age and LGBTI affirming therapists
Join older LGBTI adult affirming professional organizations (e.g., APA Division12, Section II, Clinical Geropsychology and APA Division 44, The Society for the Psychology of Sexual Orientation and Gender Diversity)
Therapists can train everyone on their staff, from receptionists, office managers, and billing and insurance specialists to janitorial staff, about the use of inclusive and LGBTI-affirming language
Practitioners can make diversity (e.g., the inclusion of older LGBTI adults) a priority when hiring new therapists and staff members
Therapists can network with members of local, regional, and national older and LGBTI friendly professionals and organizations

Regardless of their age cohort and individual LGBTI group membership, older LGBTI adults typically share profound losses related to both aging (e.g., normative age-related changes, age-related stigma and discrimination) and their LGBTI status (e.g., social, economic, and health disparities, the impact of stigma and discrimination). For example, an older gay man might have losses that include: the death of his partner and most of his friends during the AIDS epidemic, which is linked to the loss he expects to endure when he has to enter an impersonal, non-LGBTI affiliated nursing home because he has no immediate caregiver, and being too afraid to come out to his parents when they were still alive, losing the opportunity to interact with, and potentially be loved and accepted by them, as his most authentic self. An older lesbian may have losses that include never having a child of her own because neither legal adoption nor in vitro fertilization was available when she and her partner were younger, and losing her hair during treatment for cervical cancer; over the years she did not participate in routine gynecological exams or pap tests because both she and her health care provider assumed that, as a lesbian, she had no need for such screenings.

An older transgender woman may suffer loss related to her inability to obtain insurance coverage and pay for sex affirming surgery; she is also afraid that she will never be able to stop hating her body. She may also experience loss when, with her advancing arthritis, she is unable to put on many of her favorite necklaces by herself; wearing them has become an important way for her to enjoy and affirm her female gender identity. She also experienced loss when she was fired from an old job she had as a paralegal at a prestigious law firm because someone from the office spotted her going into a gay bar; she wonders if she would have gone on to law school if she had not been fired. An older intersex adult may have losses related to being born long before doctors stopped automatically performing *corrective* surgery on intersex infants; she lost the life she could have had including the ability to conceive a child and to live without chronic pain [from her sex reassignment surgery.] She feels angry, even though she tells herself she shouldn't, when she watches shows on the internet that feature young intersex adults who get to choose *willy nilly* what their sex and gender should be. Helping an older LGBTI adult acknowledge their unique losses mindfully, with psychological acceptance (Hayes et al., 1999), and then assisting and supporting as they work through their related grief, can be an essential part of treatment.

The requisite use of evidence-based interventions in therapy with older LGBTI adults is endorsed by APA guidelines (2012; 2014a, 2015). Fortunately, many evidence-based therapies including life review therapy, the promotion of resilience, trauma related therapies (e.g., EMDR; cognitive behavioral therapy), and music and art therapy can be adapted easily in work with older LGBTI-adult clients. For example, life review interventions have been shown to reduce symptoms of depression (Bohlmeijer et al., 2007), increase personal meaning, promote identity formation (Westerhof et al., 2010), increase life satisfaction, decrease feelings of hopelessness (Serrano et al., 2004), and reduce anxiety among depressed older adults (Korte et al., 2012) both living independently and in nursing homes. Life review can be particularly helpful in guiding older LGBTI adults to identify and work through life losses, to recall positive autobiographical events, to identify adaptation to previous life events, and to ultimately integrate the thoughts and feelings associated with those life events into a more cohesive sense of self. Life review therapy can be expected to foster resilience, often borne, paradoxically, through adaptation to traumatic events (Allen et al., 2018), among older LGBI adults.

Art and music therapy are also identified as empirically validated treatments that foster resilience and aid in the processing of trauma (Allen et al., 2018). Although art and music therapy, per se, are conducted by mental health practitioners with specialized education and training in those modalities, aspects of these therapies can be used as adjuncts within the context of traditional therapy (Allen et al., 2018) with older LGBTI adults. Homework assignments for older LGBTI adults, designed to incorporate art and music within both life review and cognitive behavioral therapy, might include drawing a picture or identifying a song that represents a favorite memory, an influential person in their life, their ideal self, current feelings, or a traumatic event that is difficult to discuss. Such homework assignments, which include related discussion in subsequent therapy sessions, are designed to help older LGBTI adults foster an increased sense of control, encourage nonverbal communication when verbal communication is difficult, explore emotional conflicts, overcome feelings of hopelessness, and create meaning through life review.

It also is important to note that in work with older LGBTI adults who are residents in long-term care or rehabilitation settings or require intensive medical management, therapists can obtain permission from those older LGBTI clients to engage in consultation with other care providers to develop more effective and comprehensive treatment plans (Porter et al., 2016). Consultation with professionals may include primary care physicians, psychiatrists, occupational and physical therapists, nurses, case managers, professional aides, nursing home activity directors, and others as indicated, and consultation with important people in the older LGBTI client's life may include partners, friends, relatives, family members by choice, religious leaders, and others as indicated. Taking an interdisciplinary approach (Hillman, 2012; Porter et al., 2016) can often provide older LGBTI adults with integrative care and support.

However, because many older LGBTI adults have a history of negative, unilateral, and discriminatory relationships with health care providers, care must be taken to have an open discussion with that client, including the reasons why the therapist believes the consultation will be helpful, and the goal of the proposed consultation. It is similarly vital for the therapist to provide full disclosure of the potential benefits and risks involved in consulting with different people (e.g., a family member by choice is not bound by any professional role or relationship to maintain confidentiality). The therapist and client should discuss: *What client information will be shared in consultation with each identified individual? Are there other people who the older adult LGBTI client would like to involve in consultation and why? Does the client want the therapist to share everything that is discussed during the consultation?* and *Does the older LGBTI client want the therapist to engage in consultation with certain individuals alone, or only if they can take part in the discussion?* It remains essential that an older LGBTI client can participate in this process with autonomy and without fear of reprisals.

Also consistent with APA guidelines (2012; 2014a, 2015) for culturally competent care, therapists are encouraged to seek out continuing education opportunities that provide up to date clinical recommendations for work with individual older LGBTI adult populations, specifically, and that focus upon issues of diversity, in general. Therapists are also encouraged to seek out formal and

Table 2 Resources for older LGBTI adults and their care providers

Accord Alliance, https://www.accordalliance.org/
American Association of Retired Persons' (AARP's) Pride Page, https://www.aarp.org/home-family/voices/lgbt-pride/?migration=rdrct
American Society on Aging's LGBT Aging Issues Network, https://www.asaging.org/lain
American Psychological Association's (APA) Division 44, The Psychological Study of Lesbian, Gay, Bisexual and Transgender Issues Committee on Aging, http://www.apadivisions.org/division44/leadership/committees/index.aspx
American Psychological Association's (APA) Office of Sexual Orientation and Gender Diversity, http://www.apa.org/pi/lgbt/resources/aging.aspx
GATE: Trans, Gender Diverse and Intersex Advocacy in Action, http://gate.ngo/
Gay and Lesbian Medical Association, http://www.glma.org/
Gerontological Society of America's Rainbow Research Group, https://www.geron.org/stay-connected/interest-groups#rainbow
HIV & Aging Blog of the American Academy of HIV Medicine, the AIDS Community Research Initiative of America (ACRIA) and the American Geriatrics Society (AGS), https://aahivm-education.org/hiv-age
Interact: Advocates for Intersex Youth, formerly the Intersex Society of North America, https://interactadvocates.org/
The Intersect Initiative, http://www.intersexinitiative.org/
Lambda Legal, http://www.lambdalegal.org/search/node/aging
LGBT National Senior Hotline, https://www.glbthotline.org/, (888) 234-7243
National Resource Center on LGBT Aging, http://www.lgbtagingcenter.org/
Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE), http://www.sageusa.org/
Transgender Aging Network also known as Forge (For Ourselves Reworking Gender Expression), https://forge-forward.org/aging/
U.S. Department of Veterans Affairs: Lesbian, Gay Bisexual & Transgender (LGBT) Service Members and Veterans, https://www.benefits.va.gov/persona/lgbt.asp
World Professional Organization for Transgender Health, www.wpath.org

informal continuing education related to the resilience that older LGBTI adults typically display, as well as the disparities they face in terms of their mental and physical health including caregiving burden, clinical depression, anxiety suicide, HIV infection, HPV infection, tobacco use, substance use, trauma, intimate partner violence, elder abuse, financial insecurity, barriers to healthcare, and challenges to autonomy in long-term care, among others. Please refer to **Table 2** for a list of resources designed to assist both older and LGBTI adults and their care providers. Seeking out clinical supervision and peer consultation in work with older LGBTI adults, with older LGBTI-affirming practitioners, when needed, is also essential.

Although it is not mandatory for culturally competent practice, the APA encourages therapists to engage in advocacy on behalf of older LGBTI adults for shifts in public policy, national funding and research strategies, changes to various country and individual US states' laws, and changes to health care providers' educational curricula. For example, the Centers for Disease Control could be encouraged to include older transgender and intersex adults in their population-based surveys, and the federal government could be lobbied to include both sexual orientation and gender identity as questions in the next US Census. US state representatives can be asked to support laws that prohibit discrimination based upon an individual's gender identity across a variety of settings including employment, housing, insurance coverage, placements in long-term care, public accommodations like restaurants, theaters, businesses, and bathrooms, and access to domestic violence and homeless shelters.

Individual states' representatives could also be lobbied, consistent with current federal guidelines, have their state provide explicit coverage for older transgender Medicaid recipients' health care, including sex affirming surgeries. Therapists could also help find ways to encourage more physicians to perform those sex affirming surgeries as Medicare providers, perhaps by providing increased reimbursement rates and encouraging those physicians to develop associations with university sponsored health centers. Professional organizations for mental health care providers (e.g., psychologists, licensed professional counselors, social workers, family therapists, certified addiction counselors, and case workers) and medical care providers (e.g., physicians, nurses, occupational and speech therapists, activity directors) can be encouraged to include training for the provision of culturally competent practice with older LGBI adults in their educational curricula, accreditation standards, and continuing education requirements. Within their own community, therapists can participate in local, older LGBTI charity and other events, join local older LGBTI-friendly organizations, and network with older LGBTI adults and their allies. Because many countries do not honor older LGBTI adults' basic human rights, therapists can also take an international approach and help push those nations to decriminalize non-heteronormative behavior and relationships, and extend legal rights and protections to older (and younger) LGBTI adults.

7.24.8 Conclusion

Nearly three million older Americans currently identify themselves as LGBT (Fredriksen-Goldsen and Kim, 2017). Older LGBTI adults' lives typically have been, and continue to be, influenced by economic challenges, limited legal rights and protections, mental and physical health disparities, and stigma and discrimination often associated with cultural norms and religious beliefs. Older transgender and minority LGBTI adults face additional economic and health disparities. Despite these significant challenges, older LGBTI adults appear to possess significant adaptation and resilience (Orel and Fruhauf, 2015). Nearly 90% of older LGBT adults in a national study (Fredriksen-Goldsen et al., 2015) reported feeling *good* about being part of their community, and most engaged in

both leisure and wellness activities at least weekly. Future research that focuses upon underserved and understudied populations of older bisexual, intersex, and minority LGBTI adults, the effectiveness of interventions to harness older LGBTI adults' resilience, and the experience and effectiveness of telepsychology among older LGBTI adults is recommended. To foster a culturally competent practice with older LGBTI adults, therapists can offer an older LGBTI-friendly physical environment, provide staff training and supervision, gain an awareness of the unique stressors and challenges faced by different age cohorts of older LGBTI adults, use evidence-based therapies including life review, psychological acceptance, and music and art therapy in work with older LGBTI adults, seek out continuing education related to older and LGBTI adults, and engage in advocacy on behalf of older LGBTI adults.

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