The effect of marginalization on the healthy aging of LGBTQ older adults

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Abstract

The intersection of sexual orientation, gender identity/expression, healthy aging, and community resources can be framed as a human rights issue that affects the psychological well-being of people within the aging lesbian, gay, bisexual, transgender and queer (LGBTQ) population. Depending on the country and/or culture in which one resides, being an older adult can be celebrated or stereotyped as chronically ill, useless, or uninterested, as well as by other demeaning characteristics. Members of the LGBTQ community may have arrived at stages of older adulthood after experiencing life-long marginalization within a heteronormative environment, geographical location and/or social groups throughout their development. Thus, older LGBTQ adults can be subject to varied levels of bias and oppression which may ultimately impact their “aging well.” This paper will explore the role of marginalization on the aging-well process among older LGBTQ populations as well as underscore resilience, coping and adaptation within this rapidly expanding and diverse community.

Keywords: Older adults; marginalization, healthy aging, LGBTQ

Introduction

This paper explores the role of marginalization on the aging-well process among older LGBTQ populations while underscoring resilience, coping and adaptation within this diverse and expansive community. Sijuwade’s (2009) work on attitudes towards older adults conceptualizes the context and dilemma of aging: Aging occurs in an environmental context, ranging from the micro scale of the family system to that of the macro scale of community and society. This context provides the attitudes, stereotypes and age norms which determine age appropriate behavior for the aged (i.e. social-image). (p. 1)

Using Sijuwade’s (2009) social-image concept, the LGBTQ aged can be seen as having at least two images of themselves (i.e. self-image) - LGBTQ and an older adult - and an image of how they feel that ‘others’ in society perceive them (i.e. image of social image) as both LGBTQ and as an older adult. Thus for all sub-cohorts within the older adult population, interactions of the aged within the social environment results in their self-image being reinforced by the social image, in positive or negative contexts. Understanding and examination of the critical role of adaptation, coping and resilience is essential, as such skills afford the ability to handle adversity and challenges successfully, while maintaining good physical and mental health behaviors. (Fredriksen-Goldsen, Kim, Emlet, et al., 2011).
Ageism and Homophobia

Grant (2010) defines ageism as “…prejudicial feelings or actions based on beliefs about the limitations of abilities due to age….institutional ageism manifests in the policies that do not address the needs of older adults or treats older adults with demeaning attitudes and disempowerment” (p. 13). Societal examples of ageism can include: 1) a lack of focus on elder issues; 2) invisibility within society; 3) limited media content such as a “speciality” section; 4) paternalistic treatment; and 5) a focus on shortcomings and illness rather than strengths and contributions (Anguera, 2005).

The practice of ageism has significant consequences for those impacted. These consequences are evidenced by practical and psychological reactions. Stereotypes may become self-fulfilling prophecies, while those suffering ageist attitudes may be “forced” to conform to the stereotypes in order to gain visibility or recognition. The subsequent loss of freedom and self-efficacy due to exclusion from normal social interactions and social relationships can lead to loss of essential social supports, lowered self-esteem as well as personal happiness. The implications of ageism as it pertains specifically to the aging LGBTQ community has yet to be fully explored throughout the literature.

The World Health Organization in many of its publications refers to the concept of “healthy ageing” as the development and maintenance of optimal mental, social and physical well-being and function among older adults. This is most likely achieved when communities in which older LGBTQ adults live can provide safety, promote health and well-being, health service access and utilization as well as community programs to increase socialization and prevent or minimize disease. Physical and mental health issues among older adults may be a reflection of the consequence of lifespan healthcare disparities. According to the World Health Organization (WHO), social determinants of health include the conditions in which people are born, grow, live, work and age. Such circumstances are shaped by the distribution of money, power and resources at global, national and local levels.

Members of the LGBTQ community may have arrived at stages of older adulthood after experiencing marginalization within a heteronormative environment of “pervasive and invisible norms of heterosexuality” (Warner, 1991), geographical location, and/or social groups during their younger years. Marginalization refers to non-inclusion of a group within mainstream society that is denied both concrete goods (i.e. housing) and/or social goods (i.e. the ability to express their voice and participate actively within society). (Young, 2004) The denial or inhibition of such rights is evidenced in discrimination and oppression that relocates a group’s ability to participate within normal societal activities. For the aging LGBTQ population it is often homophobia, defined as “the feelings and/or actions based on hatred, aversion or fear of same sex attraction and sexual behavior…that creates the barriers between groups” (Grant, 2010, p. 13). Homophobia can be expressed by individuals, groups, communities, and societal institutions via systemic discrimination related to public policies including employment, housing and marriage equality, among others. Depending on the country and/or culture in which one resides, being an older LGBTQ adult can be celebrated or stereotyped as chronically ill, useless, uninterested, as well as by other demeaning or derogatory characteristics. Thus, older adults in the LGBTQ community are often subject to varied levels of ageism, bias and oppression, which may ultimately impact their “aging well.” The intersection of gender identity/expression, sexual orientation, healthy aging, and community resources can be framed as a human rights issue that affects the psychological well-being of people within the aging LGBTQ population. This becomes a human rights issue because aging well should be open to all human beings “equally and without discrimination” (United Nations Human Rights, Year?)

Marginalization

Like with all groups that are marginalized, the impact of marginalization among older LGBTQ adults is problematic as it prevents individuals and groups from full participation within society. On the social level, marginalization prevents members of such marginalized groups from obtaining necessary resources for everyday living. Among the areas in which LGBTQ older adults may be affected are health, housing, social participation, civic engagement, and employment – the areas identified by the World Health Organization as key for healthy aging (2002). Responses to marginalization vary, and among the positive psychological consequences is resilience in the face of adversity, which can lead to personal and social action, hardiness and coping. Author, year find that such resistance can change an individual’s psychological mindset from hopelessness to an increased sense of worthiness and inclusiveness within society. Members of the LGBTQ aging community that are marginalized are often perceived as and treated as “others” creating a system of subordination and power leading to many psychological effects such as dehumanization and feelings of powerlessness over one’s own life. Marginalization can also be structural and enforced through mandatory retirement ages, policies regarding same-sex marriage and/or inheritance laws.
In addition to the social isolation marginalization can cause, the psychological effects can be as devastating. Hohler (2010) examines the impact of marginalization as a painful and traumatizing experience for many older LGBTQ adults. When affected by marginalization, individuals often feel excluded, are not taken seriously or valued, have no right or opportunity to speak out or be heard. Marginalized groups such as the aging LGBTQ community often express frustration that they are never asked directly about their life situation or needs. Systematic elimination of a group’s voice or a failure to think about what a group may offer to the discussion can cause despair, altered states, serious illness, chronic exhaustion, and/or suicide ideation (p. 7).

Intersectionality: Walsh (2011) examines individuals as a composite of their particular demographics which creates intersecting forms of oppression for many members of the LGBTQ community. For many LGBTQ older adults, the oppression encountered with regard to age and sexual orientation or gender identity is even more complicated by race, ethnicity, or socioeconomic status, among other factors. An additional challenge is that many LGBTQ elders face significant barriers to aging in safe and affirming environments whether with family members or in assisted living facilities or nursing homes. As older adulthood presents new challenges, such as needing specialized facilities, LGBTQ older adults may be forced to reconsider their identity and status in society and at times may be forced to “re-closet” their identities. Additional challenges such as an HIV positive status may create even more of a differential acceptance both within and outside of the LGBTQ community. What is most significant to assess with regard to all of these matters is the older LGBTQ adult’s level of resilience relative to their prior experiences and resources they may have had access to across the lifespan.

General concerns of the older adult population may be substantially exacerbated for LGBTQ older adults. As previously stated, ageism is a constant concern that may impact social and civic participation and employment for those older LGBTQ adults who are able to work and choose to work. Barriers to appropriate age-friendly services include the absence of such services and access issues. LGBTQ older adults should receive age friendly services that are LGBTQ competent and appropriate to meet their needs. Furthermore, financial security is a major focus for most older adults. The heterosexual population has more opportunities for access to financial security through marriage benefits, whereas LGBTQ older adults in the U.S. and in most non-Western societies have limited marital opportunities and thus no survivorship rights to social security, pensions and other financial resources granted to heterosexual spouses. Housing is another area in which there is a lack of affordable supply for older adults in general in the United States. Access to senior housing can be more limited for LGBTQ older adults due to marginalization on the basis of their sexual orientation and/or gender expression. Some LGBTQ older adult friendly housing is being built in the United States but there will be far fewer units than needed. Less so than in other countries, immediate and extended family members are considered a source of support for older adults. While rifts can occur in any family, those that identify as LGBTQ may have less harmonious family relationships due to their coming out and negative reactions. The role of birth families and families of “choice” provides yet another area for further examination related to the extent of support - or lack thereof - across the lifespan for members of the aging LGBTQ community.

Solutions

Solutions related to the resolution of marginalization for LGBTQ older adults must emanate from: 1) the mutual responsibility of both the LGBTQ and non-LGBTQ communities to provide a supportive environment and (2) through the opportunity for marginalized groups and individuals to seize every available opportunity to create positive and affirming change (Sargric, 2007). This notion fits firmly within the definition of a “healthy community”. According to The Community Toolbox, (2013) “Healthy communities are described as: “...one where people take care of one another; where people from diverse backgrounds mix comfortably and work together for the good of the community.”

In short, a healthy community is one in which all citizens can be assured of a decent quality of life. Solutions do not appear automatically even when there is agreement that a “private issue” has become a “social problem.” (Mills, 1959) Solutions to identified social problems at the public level begin with the perceived problem being raised to the level of public awareness through public activities (i.e. gay rights march). When a majority of the general public finds agreement that something is a problem it generally becomes labeled a “social issue.” The issue then finds a place on the public agenda. Depending upon the nature of the problem and needed solutions, the problem may be treated locally, at the state or federal levels of government. At the point concern for the problem reaches the governmental level, if accepted as a problem, it starts down the road of the formal policy making process. This is no guarantee however that solutions will be created. Problems are eliminated from the public agenda at any point in the process. The state turns the problem over to the federal government or the federal government decides it is a state issue or the problem is pushed so far down the policy agenda that it becomes buried in either ideology and/or process.
But perhaps more important than the policy making process itself are the people involved in the process. While marginalized groups tend to suffer from powerlessness (Young, 2004), which is both determined from the outside but also can be internalized, if they can be roused to action for common issues they will be compatible through their shared values and interests to hold them together or find capacity for consensus. National and international groups focusing on LGBTQ issues may have locally specific issues but all agree on the necessity of insuring the rights of this population receive equity in their different societies. The National Gay and Lesbian Task Force Policy Institute recommends that LGBTQ organizers and advocates “build holistic, strategic approaches to advocacy.” (Grant, 2010, p. 114) The same is equally true for older adults as well as when the groups consist of older LGBTQ persons.

Given the social and health political and service structures in the United States, solutions needed to be framed at the micro, mezzo and macro levels and range from service provider competency to policy changes. Typically the micro level is focused on programs and services with the people themselves as individuals, families and/or groups. A hallmark of social work interventions is to move towards client empowerment where they feel the need to attempt to remedy or change the oppressive situations. How individuals and groups respond is dependent on a variety of factors past and present. Sometimes the act of rebelling itself can change feelings of oppression and increase self-efficacy. (Burton & Kagan, 2005). Strength-based services facilitate empowerment.

At the mezzo or programmatic level there are a variety of ways that organizations can serve the LGBTQ older adult population. Not every LGBTQ person will want to receive specifically “LGBTQ” programming. It may be helpful if organizations provide more generic older adult programs, as well as older adult programs specifically for tailored for LGBTQ members, ultimately providing a full range of programming opportunities. Historically whenever group specific discrimination and marginalization occurs, those being affected often create their own sub-groups. This continues today in the U.S. with specific LGBTQ groups and organizations being developed. However, even these LGBTQ organizations have to assess themselves for their level of competency and age friendliness in order to accommodate the subgroups within both of these cohorts. Another strategic is to “create meaningful partnerships with aging agencies.” (Grant, 2010, p. 115) This recommendation can be applied in any country with an aging network. Macro level solutions can be both generic and apply across the globe such as in being “age affirming” as well as being country specific given the social, political and economic context. In the United States the Older Americans Act refers to “vulnerable senior constituencies” reflecting “those with the ‘greatest social need.” LGBTQ elders could be considered a specific subgroup under this category. In addition, research supports the notion that the various subgroups under the LGBTQ heading have different experiences and needs. For example, bisexual and transgendered old adults are typically more underserved than the more largely recognized gay and lesbian groups. (Fredriksen-Goldsen et al., 2011) Same sex marriage laws and redefinitions of “family” at the policy level would eliminate a number of barriers that create difficulties in social and financial support.

Evolving competency: Service providers working with vulnerable or minority communities should continually audit themselves regarding whether or not they are “elder affirming” as well as culturally competent to work with older adults across the LGBTQ spectrum. The United States through the Department of Health and Human Services and the National Institute of Mental Health has compiled years of data (National Health Disparities Report, 2012) on healthcare disparities among groups including people of color, the poor and women, and has been expanding such research with regard to disparities among the larger LGBTQ community as well as for those that are older LGBTQ adults. Non-profit organizations in the United States such as Services & Advocacy for Gay, Lesbian, Bisexual & Transgendered Elders (SAGE) also have databases that can be used in planning solutions better assuring LGBTQ and older adult affirming healthcare could potentially improve the overall physical and mental health of individuals as well as affect healthcare costs over time. To reduce disparities in medicine, a workforce is needed that is knowledgeable about LGBTQ issues, inclusive of comprehensive assessment of the specific challenges related to the healthcare of LGBTQ older adults, and evaluate the propensity to provide culturally competent work with such individuals. Social inclusion or its opposite – social isolation – affects both mental and physical health. Thus funding and developing programs that reduce isolation, increase access to care, as well as provide quality care, will ultimately have a positive effect on many areas of concerns (Grant, 2010) related to LGBTQ older adult health.

The education and training of practitioners in these areas often falls to colleges and universities. However, no one discipline can or should have sole investment in the care of LGBTQ older adults. The field of social work focuses on a “person in environment” perspective calling for attention not only the individual yet also those forces within their communities which are helpful or harmful to their well-being. “Strength-based” practice is evidenced through empowering practice which leads to individual and group self-advocacy and efficacy. Community psychology also takes a “transactional view” considering the interrelations between the personal, relational and societal planes. (Burton &
Kagan, 2005). Within the field of medicine, “geriatric medicine” focuses on the maintenance of functional independence into late life. (Brummel-Smith, 2006). Perhaps the discipline that wraps the other disciplines together is that of public health whose goal is the promotion of the health and well-being of individuals as they age. (American Public Health Association).

Continued research is suggested with regard to aging in general, especially as the first cohort of American baby boomers is now 67 years old. The integrity of aging related research can only be maintained if members of the LGBTQ older adult community are included in research samples acknowledging the subgroups within the larger LGBTQ community. In addition to their inclusion in aging research, measures related to sexual orientation, gender identity, sexual health and behavior must be incorporated in order to allow accurate information to emerge. (Fredriksen-Goldsen et al., 2011). At the programmatic level, evaluation research is needed to focus on specific programs and interventions that are useful to the healthy aging of LGBTQ older adults. Establishing participatory methods as well as evidence-based intervention protocols will better ensure more effective and competent programs.

Conclusion

While the world typically focuses on younger age cohorts, the older adult population is the fastest growing segment of all societies, inclusive of members of the LGBTQ community. As science and medicine continue to produce break-throughs that support, maintain and extend physical health, the social aspects of aging must receive attention also. LGBTQ older adults regardless of any demographic, have common needs and issues. As practitioners and researchers continue to examine this cohort, there are also differences and disparities that do not necessarily begin in one’s later years, but certainly follow one as they age. Many of The World Health Organization’s publications focusing on aging duly note that ageing is the success of the 20th century and the on-going challenge of the 21st century and that the growing presence of older persons in our increasingly urban and globalized world reminds us of our common humanity in which we must be sensitive to meeting their diversity needs while promoting solidarity.

References

Chapter 51 - The effect of marginalization on the healthy aging of LGBTQ older adults


