AGING AND SEXUAL MINORITIES: EXPLORING THE HEALTH AND PSYCHOSOCIAL ISSUES OF OLDER LESBIAN, GAY, BISEXUAL AND TRANSGENDER (LGBT) INDIVIDUALS

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Few studies have been carried out that examine the effects aging has on the health of older LGBT individuals. This is a matter that warrants further research, for approximately half a million gay men and lesbians turn fifty each year. As the number of aging LGBT persons grows, so does the need for competent clinical care that addresses the unique health and psychosocial issues of this population. It has been shown that discrimination against LGBT persons exists in the medical setting. Additionally, the literature suggests that medical students do not receive sufficient training regarding sexual minorities. Educating primary care physicians, medical students and other health professionals on how to communicate more effectively with aging LGBT patients can lead to improved health outcomes. This is a goal of public health. The IRB-approved study described in this thesis aimed to provide the Allegheny County Area Agency on Aging (A.C.A.A.A.) with information about the health and psychosocial issues of older (≥50) LGBT individuals living in the Pittsburgh area. Over a two-month period in 2006, a comprehensive survey was dissemintated at a variety of locations frequented by LGBT persons. The survey included questions about demographics, quality of received health care, openess about sexual orientation with one's primary care physician, end-of-life and legal issues, and questions that addressed pertinent LGBT health and psychosocial issues. Results of the survey

indicated that the majority of the sample's respondents (N=79) reported being in good health, receiving competent health care from primary care physicians, being open with their doctors about sexual orientation, and experiencing minimal discrimination from health care providers due to sexual orientation. These positive findings differ from the somewhat discouraging information presented in the literature review. Despite this, the survey results may inspire more rigorous studies to be carried out in the future that address the health and psychosocial issues of older LGBT persons. Further studies may also bring about positive changes in medical schools' curricula, not to mention changes in public health policies that address the nation's aging population as a whole.

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PREFACE

I would like to thank Drs. Martha Ann Terry, Patricia Documét and Anthony Silvestre for their valuable support and input regarding this final paper. You made this process much easier for me with your humor, empathy and life experiences. Kudos also go out to the effervescent Tammy Thomas for helping me to navigate my way through the practicum/internship process, and Natalie Arnold for her endless smiles and knowledge of class registration. A special thank you is given to the priceless Joanne Pegher. Her willingness to answer my questions about the graduation process was much appreciated. I must say that the Department of Behavioral and Community Health Sciences is comprised of some of the most knowledgeable, laid-back, whimsical and supportive individuals I have ever met in academia; these qualities were much appreciated during a difficult time in my life.

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1. INTRODUCTION

The health care needs of lesbian, gay, bisexual and transgender (LGBT) persons are frequently overlooked in the clinical setting. Physicians often underestimate the number of LGBT patients they see in their practices and assume that a patient's sexual orientation does not influence the quality of health care received (Harrison & Silenzio, 1996). Additionally, the health issues facing older gay men and lesbians are often comparable to their heterosexual counterparts, but many older LGBT patients remain reluctant to reveal their sexual orientation for fear of discrimination in the health care system (Harrison and Silenzio, 1996). This reluctance to reveal sexual orientation creates a barrier between the doctor and patient and hinders effective health communication. If primary care physicians are unaware of their patients' sexual orientations, relevant health issues may be missed in the clinical interview. For instance, lesbians have an increased risk of morbidity and mortality from ovarian, lung, and breast cancer, heart disease and stroke than heterosexual women (Harrison and Silenzio, 1996), while gay men are at higher risk for HIV, STDs, gastrointestinal infections and hepatitis B (Harrison and Silenzio, 1996). LGBT patients are better served by the medical profession when they are comfortable in communicating their medical histories and symptoms to their physicians.

Homophobia and training on LGBT issues are rarely addressed in medical school or in the clinical setting (Murguia, 1999). Without sufficient training about these matters, health care

professionals may make assumptions about the LGBT patients they assess. This may lead to medical treatment that is based on an incomplete history. The lack of sufficient training about LGBT issues may partly be the result of the lack of research studies that have been carried out to determine the unique health and psychosocial needs of this population.

The Gay and Lesbian Medical Association (GLMA) has recommended that more research be conducted on the health issues of the LGBT population, while the American Medical Association (AMA) has stated that training physicians about LGBT health issues should be carried on after medical school in the form of continuing education (Murguia, 1999). If these recommendations are followed, physicians and other health professionals will begin to build a welcoming environment in which to treat their patients. Existing research that addresses patient-doctor rapport mentions that a positive relationship between clinician and patient is a predictor of compliance with medical advice and treatment, as well as overall satisfaction with medical care received (Harrison and Silenzio, 1996).

This thesis will (1) investigate the literature that addresses the health and psychosocial issues of older LGBT persons; (2) present several research questions regarding LGBT patients and their physicians; (3) describe in detail the methodology that was used to conduct the Persad Center[1] study ; (4) draw conclusions from the data that were collected and analyzed from the study; (5) describe limitations of the study; and (6) discuss recommendations for training physicians and other health professionals around LGBT health and psychosocial issues.

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[1] A non-profit mental health counseling center that serves the LGBT community in Southwestern, PA

2. BACKGROUND ON THE HEALTH AND PSYCHOSOCIAL ISSUES OF OLDER LGBT PERSONS

The following literature review will explore issues related to aging, such as social support networks, theories on aging, assisted living and nursing care, end-of-life matters and health communication. Although these topics are relevant to most aging persons, emphasis will be placed on older LGBT individuals.

2.1 AGING AND ITS IMPACT ON THE LGBT COMMUNITY

In 2010, the baby boom generation will begin to turn 65. It is estimated that by the year 2030 there will be 70 million older persons (age 65+) living in the United States, which is expected to represent 20 percent of the U.S. population (Rice and Fineman, 2004). Aging LGBT persons are represented in this percentage; recent estimates put the number of older LGBT people at 1.75 to 3.5 million, with approximately 500,000 gay men and lesbians turning 50 each year (McMahon, 2003).

The growing elderly population will impact the nation on a number of levels. Despite numerous studies carried out in recent years to examine the effects aging has on issues such as quality of health care delivery, housing, and supportive services, comparatively less research has

been conducted to determine the needs of older LGBT individuals. This may be partly attributed to the difficulty in acquiring adequate sample sizes, which appears to stem from the reluctance of older gay men and lesbians to disclose their sexuality (Donahue and McDonald, 2005). Additionally, it is also the result of theories and models that have been constructed with the heterosexual view in mind regarding individuals and society (Claes and Moore, 2000). The federal government has also helped to perpetuate this problem, for *Healthy People 2010* (HP 2010), which outlines an action plan for the health of all American citizens, overlooks the specific health needs of the LGBT population. To supplement what HP 2010 lacks, experts on LGBT health constructed a companion document entitled *Healthy People 2010: A Companion Document for Lesbian, Gay, Bisexual and Transgender (LGBT) Health* (Mail and Safford, 2003).

Though ageist attitudes continue to prevail, growing older is now being seen in a more positive light. This is in part the result of senior role models who have demonstrated what it means to age successfully. In addition, the aforementioned baby boom generation is a catalyst for rethinking how one should enter his/her senior years. Proponents of a positive vision for aging cite several quality of life issues, not bound by a person's sexual orientation, necessary for successfully growing older. As proposed by Funders for Gay and Lesbian Issues (2004), these include:

- Maximizing one's physical and emotional well-being throughout the aging process;
- Maintaining the highest possible degree of autonomy and independence for as long as possible;
- "Aging in place" in one's own neighborhood or community within a context of respect, safety, and support;
- Remaining actively engaged with social networks, including chosen and biological families; and

- Pursuing social, recreational, intellectual, spiritual, and creative activities that provide a sense of stability, fulfillment, and vibrancy throughout the life cycle.

What affects LGBT wellness at any age? Mail and Safford (2003) identify four influences on health that need to be considered: heredity; environment; availability and utilization of health services; and lifestyle. Heredity is described as the internal variable, or host, of health status, which gives the individual little control over his/her inherited genetic blueprint. The environment is an external factor that influences people. Air, water, biological and chemical contaminants, poor housing and animal vectors all comprise external factors that influence our health. In addition, the external sociocultural environment is necessary to consider. It is comprised of the people with whom we interact (workplace, family, religious institutions, and the like) and has the ability to enhance or reduce a person's self-esteem and self-efficacy.

It is becoming an art form to successfully utilize available health care services in a country in which managed care activities inundate the private sector and the health system rapidly changes. Mail and Safford (2003) make a point which is applicable to the LGBT population in relation to improper use of the health care system. They write, "…inappropriate utilization of the health care system occurs when either an individual or provider 'medicalizes' an individual's life, reducing all problems to medical terms or failing to perceive the presenting problems in the context of the whole person (i.e., one who has a life outside of the physician's office)" (p. 185).

If health care providers do not consider the complete health and psychosocial aspects of their patients, how can they provide competent care that leads to better health outcomes? Rather, this possibility is reduced. To further support the claim that primary care physicians may be out of touch with their LGBT patients, it is noted that the most current edition of *The Office of Practice of Medicine (2003)* makes no reference to the words lesbian or gay (Makadon, 2006).

Lastly, the authors discuss how lifestyle choices influence one's health. Lifestyle can be defined as behaviors that are determined by an individual's decision making abilities, which can lead to both negative and positive health outcomes. For instance, highly active antiretroviral therapy (HAART) has brought about a decline in the mortality rate of gay men, thereby extending length and quality of life (Dolcini, Catania, Stall & Pollack, 2003). It may be hypothesized that with the advent of viable treatments to prolong the life of those who are living HIV/AIDS, certain individuals may be more apt to engage in higher risk behaviors that lead to the transmission of the HIV virus from one to another.

2.2 LGBT SOCIAL SUPPORT NETWORKS AND MENTAL HEALTH

As previously discussed, the presence of social networks in an LGBT individual's life is a factor that favors positive aging. A robust social support network is not only a vehicle for easier acclimation to the effects of aging on mental and physical health, but it is also a tool to help alleviate the stigmatization that LGBT persons experience because of their sexual orientation (Grossman, D'Augelli & Hershberger, 2000). A study carried out by these authors to assess social support networks of LGB (note that transgender was not included) persons over the age of 60 seemed to support this assertion. The social support networks of 416 older (ages 60 to 91) LGB persons were studied, with each person averaging six persons in their support networks. They used the "Support Network Survey" (SNS), which captured various demographic and Likert scale data. This instrument has been used previously in studies of homosexual men, and lesbian and gay youth, and it has demonstrated face validity and reliability. Results of the study

revealed that participants whose support networks were comprised primarily of those who knew about their sexual orientation reported higher life satisfaction. In addition, friends and acquaintances provided the highest level of social support, whereas emotional support was the greatest from partners and relatives.

There was a period in history when mental well-being did not seem to be a viable option for gay and lesbian men based on outdated beliefs. D'Augelli, Grossman, Hershberger & O'Connell (2001) provide historical background about a stance previously taken by the American Psychiatric Association (AMA) on gay/lesbian/bisexual mental health and lifestyles:

> Although homosexuality was removed as a mental disorder from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973, another fourteen years would transpire before the disorder "ego-dystonic homosexuality," the diagnosis for people who found their sexual orientation distressing, was eliminated from the DSM. Lesbian, gay, bisexual (lgb) adults of earlier generations were not only considered "mentally ill" by mental health professionals for most of their adult lives, but they also knew that their sexual desires were deemed immoral by society, and that their sexual activities were illegal. This pervasive stigma was a major contributor to the invisibility of older lgb adults. They were born in a period when most lgb people concealed their sexual orientation from family, friends, and employers. To avoid rejection, some decided to follow a "heteronormal lifestyle," including marriage and child-rearing (p. 149).

Taking the above into account, it is easier to understand the cohort effect on those LGBT persons who lived through this time period; and still, despite the AMA's current view of alternative sexual orientations, today's conservative political and religious climates seem to echo the attitudes expressed above.

To better understand mental health status among older LGB (again, transgender is not included) individuals, D'Augelli, Grossman, Hershberger & O'Connell (2001) carried out a study that was identical in the number of persons and age range to their previous study that sought to evaluate social support networks of older LGB persons. This study's sample was obtained from participants in various social and recreational programs. Self-esteem, internalized

homophobia, drug and alcohol use, loneliness and suicidality were used as measures of mental health. The instruments utilized were the "Rosenberg Self-Esteem Scale" (RSES), which has shown satisfactory validity and reliability when used with the geriatric population; fifteen items from the "Revised Homosexuality Attitude Inventory" (RHAI), which measures internalized homophobia using a Likert scale rating; the "UCLA Loneliness Scale," which has demonstrated discriminant validity and has been shown to associate with theoretical constructs revolving around loneliness; a 10-item "Alcohol Use Disorders Identification Test" (AUDIT), with a score of zero indicating a non-drinker and 40 being the highest possible score; and finally the "Drug Abuse Screening Test" (DAST), which examines the harmful outcomes of drug abuse over the last 12 months, with a score of zero meaning no drug use and ten indicating significant difficulties.

Regarding the study's outcomes, greater mental well-being was correlated with lower internalized homophobia, increased self-esteem and less loneliness; however, compared to their lesbian counterparts, gay men reported higher rates of alcohol abuse, suicidality and internalized homophobia in relation to their sexuality. Limitations of this study included use of a convenience sample, due to fiscal restraints. The study also was biased toward those older LGB persons who were more active in social activities and open about their sexuality.

In regard to the term internalized homophobia, there are those theorists who criticize the use of this term due to its sociopolitical consequences and unquestioned operationalization and conceptualization; "i.e., to repathologize the 'sick' lesbian or gay individual and focus attention away from the more salient issues of cultural and institutionalized heterosexism" (Williamson, 2000, p. 97).

It is suggested that internalized homophobia may influence how one copes with health outcomes or accesses health resources, although there is no apparent indication that it impacts directly on the progression of disease (2000).

2.3 THEORIES OF AGING WITHIN THE LGBT COMMUNITY

Perceptions of what it means to age vary within the LGBT community. Schope (2005) carried out a study to learn more about how gay and lesbian individuals view the aging process. Results showed that gay men had a more negative view about growing older than lesbians, and they were found to be more ageist and influenced by how others viewed their physical attractiveness. Alternatively, older lesbians appeared more secure in later years and tackled ageism directly. Schope provides additional background about factors that have influenced the views and self-perceptions of older gay men when writing, "Before the Stonewall riots[2], older homosexuals were often portrayed by popular literature and in films as lonely, deviant, and pathetic individuals with little motivation or reason to live. This perception was held not only by heterosexual society but was also internalized by the homosexual individuals themselves" (p. 24).

The theories of *accelerated aging* and *crisis competence* attempt to explain how gay men experience aging. The theory of *accelerated aging* purports that gay men view themselves older

[2] A series of historic riots by gay and transgendered people that occurred New York City's Greenwich Village in June of 1969

than their comparably aged heterosexual counterparts. However, despite a prior study of forty-three gay men under the age of sixty-five who described themselves as being old, there is no valid evidence to demonstrate that gay men feel older sooner. In fact, it is thought that once navigating through the proverbial mid-life crisis, gay men cope just as well as their heterosexual equals (Schope, 2005).

The theory of *crisis competence*, on the other hand, maintains that gay men deal with aging more successfully than heterosexuals. Schope (2005) writes, "Having reconstructed their social and sexual identities through the coming out process, older gay men may develop skills that allow them to adjust to the aging process. Some older gay men have reported that growing older is exciting and satisfying and that they are not only 'surviving' but also 'thriving'"(p.25). This is encouraging; however, despite the optimism of this theory, older gay men not only face the shared, age-related issues of their heterosexual peers but also continued oppression in society. It is even suggested that older gay men who have remained in the closet may be happier than those who have experienced a challenging coming-out process (Schope, 2005).

2.4 CARING FOR LGBT PERSONS OUTSIDE OF THE HOME

A fear shared by many aging persons is that of being institutionalized in a personal care facility or nursing home, should they become unable to care for themselves. This includes older LGBT individuals. In addition to the loss of independence, many experience apprehension about living in a setting where sexual orientation is not accounted for, or where discrimination occurs due to

one's being lesbian or gay (Claes and Moore, 2000). Johnson, Jackson, Arnette & Koffman (2005) build on this:

> As GLBT people grow older and rely more and more on public programs and social services for care and assistance, they may have less independence from heterosexual institutions. The fear of experiencing discrimination can reinforce social isolation, placing people at higher risk for self-neglect, decreased long-term quality life, and increased mortality (p.88).

The majority of existing studies that have assessed the experience of older LGBT persons have focused primarily on disproving the misconceptions of the LGBT lifestyle (Johnson, Jackson, Arnette & Koffman, 2005). In addition, most studies have been carried out in larger cities and have not explored the discrimination that older LGBT persons experience in care facilities. To address this, Johnson, Jackson, Arnette & Koffman carried out an exploratory study that sought to better understand the perceptions of bias and prejudiced behaviors in care facilities. The study's sample population was comprised of a total of 127 respondents: fifty-six gay men, sixty lesbians, nine bisexuals and two transgender persons. The respondents were recruited at a variety of LGBT-welcoming locations throughout the Spokane, Washington, area. The questionnaire included eight demographic items, nine questions about attitudes regarding choices of retirement care facilities, suspected discrimination in the facilities and sources of discrimination, and one question that assessed level of openness about one's sexual orientation to others.

Results of attitudinal questions dealing with perceived discrimination in care communities revealed that 73% of the respondents believed that discrimination against LGBT individuals occurs; 60% indicated that they did not believe they received health and social services comparable to those received by heterosexual residents; 74% believed that these facilities were not inclusive of sexual orientation in their anti-discrimination policies; and 34%

said they would conceal their sexual orientation if moving into this type of environment. In addition, the study's participants who believed that discrimination occurred in these care facilities felt that it came from care staff, administrators and residents. Variables such as gender, age, income, education, religion and relationship status had minimal effect on the results measuring attitudes.

One strength of this study appears to be the ability to use some recommendations gleaned from the respondents (e.g. sensitivity/diversity training programs) when carrying out future endeavors addressing the needs of older LGBT persons. The authors identify two primary weaknesses of their study. The term "health care provider" was not included on the questionnaire, therefore leading to a lack of knowledge about how openness (or lack of) with one's primary care physician may correlate with the level of suspicion one feels about care facilities. Secondly, the respondents of this study may have had different ideas of what the term "retirement care facility" meant. The authors mention that the interpretation of this term could range anywhere from a continuum of care community possibly housing thousands of people to a skilled care facility with fewer than one hundred residents (Johnson, Jackson, Arnette & Koffman, 2005).

2.5 END-OF-LIFE ISSUES IN THE LGBT COMMUNITY

Issues of end-of-life care are pertinent to all persons regardless of sexual orientation. The LGBT community, in particular, has a vested interest in end-of-life matters such as advance care planning and physician assisted suicide (PAS). Previous studies addressing gay men with

HIV/AIDS seemed to indicate a high, or higher, rate of support for PAS than the general population (Stein and Bonuck, 2001). Additionally, the HIV/AIDS epidemic's disproportionate impact on the gay and lesbian community quickly brought many face-to-face with issues of bereavement and mortality (Blank, 2006) and shed light on issues that were previously unvisited regarding same sex couples such as hospital visitation rights with a terminally ill loved one, spousal benefits, and claims to insurance policies.

In a 1998 study, Stein and Bonuck disseminated a 64-item survey entitled "Health Care Attitudes in the Lesbian and Gay Community," over four months (March-June) to several large social service and health care organizations in New York City. The goal was to capture a sufficient sample size representative of LGBT persons living in metropolitan area. The survey addressed basic demographics and asked questions related to advance care planning and end-of-life issues such as preferences about approaches to care (aggressive vs. palliative care), support for euthanasia and PAS, conversations with health care providers on advance care planning, desired surrogate decision makers, familiarity with and completion of health care proxies and living wills, and experiences with unpaid caregiving during the previous year. Five hundred seventy-five surveys were completed and used for data analysis.

One of the study's findings was that 77% of the respondents reported having no prior discussions with their health care providers regarding who would make medical decisions for them should they become unable to do this on their own. Despite the lack of doctor/patient communication about this issue, 41% of the respondents thought about it *very much*, while 34% of the sample though about it *somewhat*. In other words, the majority of those who reported no prior discussions with their doctors thought about the topic at some point.

2.6 HEALTH COMMUNICATION WITH LGBT PATIENTS

Effective verbal and non-verbal communication between patients and their physicians is necessary for improving health outcomes (Harrison, 1996). HP2010 states that health communication can influence health promotion and disease prevention in a number of contexts, such as: 1) health professional-patient relations; 2) individuals' adherence to clinical recommendations and regimens; 3) individuals' exposure to, search for, and use of health information; 4) construction of public health messages and campaigns; 5) dissemination of individual and population health risk information, that is, risk communication; 6) images of health in the mass media and the culture at large; and 7) education of consumers about how to gain access to the public health and health care systems.

Despite recent progress that has been made with the acceptance of sexual minorities in our society, there are still LGBT individuals who are reluctant to reveal their sexual orientation to physicians or other health professionals. Additionally, it is reported that lesbians and gay men avoid treatment and prevention services more than their heterosexual counterparts (Bonvicini and Perlin, 2003). Reasons for this include perceived and experienced homophobia in the health care setting, fear of a negative response from the health care provider, and jeopardizing quality of health care provided (Hinchcliff, Gott & Galena, 2005). These fears are not completely unfounded as this quote reveals: "A 1998 survey of nursing students showed that 8 to 12% (depending on whether the respondent rated gay, lesbian or bisexual) despised lesbian, gay and bisexual people, 5-12% found lesbian, gay and bisexual people disgusting and 40-43% believed that lesbian, gay and bisexual people should keep their sexuality private" (Public Health- Seattle and King County, n.d., p 2). In addition to these disturbing findings, it has been reported that

lesbian, gay and bisexual persons who choose not to disclose their sexual orientations to their doctors are at higher risk for depression and suicide (Neville & Henrickson, 2005).

Health studies of gay men have focused primarily on AIDS, HIV infection or substance abuse (Beehler, 2001). However, few studies have considered risk behavior and HIV prevalence among older (≥50 years of age) men who have had sex with men (MSM) (Dolcini, Catania, Stall & Pollack, 2003). Additionally, there is minimal literature that addresses HIV infection in transgendered persons (Dean, Meyer, Robinson, Sell, Sember, Silenzio, et al., 2000). A physician's knowledge of this unique population and its risk factors for HIV transmission is crucial, for needle sharing is frequent among transgendered individuals who obtain black market silicone and hormones (Dean, Meyer, Robinson, Sell, Sember, Silenzio, et al., 2000).

Although the A.M.A. removed homosexuality from its list of mental disorders in the early 1970s, medical school and residency training courses have not advanced quickly enough to address the needs of LGBT persons (Polansky, Karasic, Speier, Hastik & Haller, 1997). Additionally, few journal articles have been written that address medical students' knowledge, attitudes, and clinical skills related to the health care of LGBT patients (Sanchez, Rabatin, Sanchez, Hubbard & Kalet, 2006). If physicians are to deliver quality health care to LGBT individuals, they must be aware of their own biases and prejudices. Culturally competent health care delivery to vulnerable populations, such as gay men and lesbians, comes from adequate preparation during medical school (McGarry, Clarke, Cyr & Landau, 2002). Educating future physicians about the distinctive medical and psychosocial issues of LGBT persons can help to reduce the obstacles LGBT patients encounter when working with the health care system, as well as enable physicians to effectively treat their LGBT patients (McGarry, Clarke, Cyr & Landau, 2002). It appears that some progress has been made, for in 1996 the AMA made the

recommendation that better efforts be carried out to educate physicians and medical students about the health care needs of lesbians and gay men in the United States (McGarry, Clarke, Cyr & Landau, 2002).

To better prepare internal medicine residents to work with lesbian and gay patients in the clinical setting, McGarry, Clarke, Cyr & Landau (2002) carried out a three-year pilot study with thirty-seven postgraduate residents (approximately twelve residents per year) at Rhode Island Hospital, Brown University. The study's sample was composed of nine men and twenty-eight women. A total of thirty-four residents reported being heterosexual, two identified as being homosexual, and one reported being bisexual. A three-hour educational seminar (see Table 1 below) was the intervention chosen for this study. It was hypothesized that this intervention would better prepare residents to work with lesbian and gay patients. Anonymous surveys were completed by participants prior to the intervention to assess their current knowledge of gay and lesbian health and psychosocial issues, as well as their own comfort level in working with this population. Additionally, a survey was administered after the seminar to determine its effectiveness. Primary outcome measures included a change in the level of participants' preparedness in dealing with lesbian and gay patients, as well as change in their comfort level. Other study variables included residents' prior education about gay and lesbian health care as well as whether having gay or lesbian family members or friends influenced the primary outcome measures. Results revealed that all thirty-seven (100%) participants thought it was important to provide quality health care to gay and lesbian patients and to learn about lesbian and gay health issues. Thirty-five (95%) participants reported that they felt more competent after the seminar about delivering excellent health care to gay and lesbian patients. Increased levels of

comfort in discussing sexual or psychosocial issues with this population were also observed in the results.

Table 1. Components of the Rhode Island Hospital, Brown University Seminar (adapted from McGarry, Clarke, Cyr & Landau 2002, p. 245)

Video

- Barriers to healthcare
- Role of presumed heterosexuality
- Open Discussion

Didactic Lecture

- Historical treatment of gays/lesbians

- Lesbian health issues:
  -cervical cancer
  -breast cancer
  -ovarian cancer
  -sexually transmitted infections
  -sexual practices

- Gay men's health issues:
  -viral hepatitis
  -sexually transmitted infections
  -anal cancer
  -sexual practices

- Taking a gender-neutral social and sexual history

Case Discussion

- 19-year-old man in his first year of college struggling with his sexual identity. He seems depressed to his friends who encourage him to seek help from a physician. Residents have an open-ended discussion about how the physician handles several visits with the young man

An issue warranting attention is the initial meeting between physician and patient, which often leads to the assumption of heterosexuality. Heterosexism [3]can adversely affect services received by LGBT persons, while creating the possibility of misdiagnosing a patient or failure to

[3] The assumption that a person is heterosexual

recognize serious health issues (Faria, 1997). For example, assuming the patient to be heterosexual, a physician may not consider that the patient may engage in various types of anal sex such as penile/anal intercourse or fist fornication, which may lead to rectal tears and/or ruptures, possible peritonitis and sexually transmitted diseases (gonorrhea, AIDS, syphilis, anal warts or hepatitis B). This demonstrates how poor communication can lead to the wrong assumption, compromised treatment and possible negative health outcomes; but it also raises the issue of sexuality, which tends to be a taboo subject when working with older patients. Older persons tend to be viewed as being asexual or in need of clinical treatment if showing an interest in sex (Price, 2005). Knowledge about sexuality (of any orientation) in a person's later years assists the physician in his/her assessment of the patient and the delivery of quality health care.

Another example of heterosexism is a doctor's assumption that a woman who speaks of her children or grandchildren is heterosexual. This may not be the case, for a number of older gay women pursue their innate sexual orientation later in life after having been married and raised children (Fullmer, Shenk & Eastland, 1999). The above assumption has its consequences, for health issues pertinent to lesbians may not be explored. For instance, previous studies have suggested that gay women are at higher risk for not receiving important preventive health services such as mammograms and Pap smears (Diamant, Schuster & Lever, 2000) and are less likely than heterosexual women to access and use health care services (Diamant, Wold, Spritzer & Gelberg, 2000). Additionally, substance abuse, HIV status, mental health issues, pregnancy and relationships issues are frequently not discussed with lesbian patients in the clinical setting (L.A. Gay and Lesbian Center, 2000).

A lesbian patient's willingness to disclose her sexual orientation may be reduced if she feels put off by her physician's heterosexist assumption of her. Additionally, some gay women

choose to hide their sexuality in order to receive medical treatment (Klitzman and Greenberg, 2002). Eliason and Schope (2001) name three factors regarding a lesbian patient's readiness to disclose her orientation to her physician:

- Personal attributes such as comfort level with her own sexuality, relationship status, and attitudes and beliefs about health care
- Health care context, such as characteristics of the health care provider (sex, age, race, perceived sexuality), past experiences with health care, and the current environment
- Relevancy, or whether sexual identity seemed relevant to the reason for the health care visit (p. 126)

A matter that a physician may need to consider in the clinical assessment is the subject of hate crimes against sexual minorities. White and Levinson (1995) report, "According to a study for the US Department of Justice, lesbians and gay men may be the most victimized group in the nation. The number of hate or bias crimes against lesbians, including verbal abuse, threats of violence, property damage, physical violence and murder is increasing each year" (p. 465). Older LGBT patients may present with symptoms of anxiety or depression due to experiencing a hate crime; however, they may be reluctant to reveal their experience to the doctor for fear of further discriminatory behavior. A sympathetic doctor with proficient clinical skills and knowledge of the LGBT population would serve this particular patient well.

2.7 THEORETICAL CONSIDERATIONS

Several theoretical frameworks are appropriate to consider when discussing the topic of health communication. As previously mentioned, physicians' existing prejudices about LGBT persons may influence the quality of health communication and health care delivery. Additionally, it has been reported that LGBT individuals may be reluctant to reveal their sexual orientation to their physicians for fear of discriminatory behavior or compromised treatment. These attitudes warrant further discussion as to what factors influence them.

Self-efficacy is a construct central to Social Cognitive Theory (SCT). It addresses an individual's self-belief in the ability to perform a specific behavior or task successfully (Locke and Sadler, 2007). The construct of triadic reciprocal determinism is also essential to SCT's theoretical framework. It describes how cognitive, behavioral and environmental factors operate interactively and serve as determinants of one another (2007). Regarding self-efficacy, Bandura (2003) writes:

> Self-efficacy beliefs regulate human functioning through cognitive, motivational, affective and decisional processes. They affect whether individuals think in self-enhancing or self-debilitating ways, how well they motivate themselves, persevere in the in the face of difficulties, the quality of their emotional well-being and their vulnerability to stress and depression, and the choices they make at important decisional points (p. 87).

One can put this in perspective by thinking about the initial clinical encounter between a physician and an older LGBT patient. The goal of the patient may be to obtain a thorough medical assessment; however, low self-efficacy and reluctance of the LGBT individual to reveal his/her sexuality may prevent the physician's solicitations of pertinent health and psychosocial information necessary for a competent clinical assessment, diagnosis and treatment plan. Subsequently, dissatisfaction with healthcare received may lead to the patient's severing ties

with the physician. The primary point is that people who do not believe they have the ability to bring about desired results with their actions have little reason to take action in the face of obstacles (Bandura, 2001).

Goal orientation is an additional construct that may be applied to the above example. This construct purports that people possess a learning, or performance, orientation toward tasks (Bell and Kozlowski, 2002). Two types of learning orientation are mentioned in the literature. An *adaptive response pattern* describes persons who persevere in the face of failure by utilizing complex learning strategies and pursuing tasks that are more challenging (Bell and Kozlowski, 2002). Conversely, a *maladaptive response pattern* describes persons who quickly retreat when faced with obstacles (2002).

It is hypothesized that learning orientation is positively correlated with performance, self-efficacy and knowledge (Bell and Kozlowski, 2002). For instance, the prior example of medical residents who participated in a three-hour seminar revealed that there was an improvement in their knowledge and sense of competency in working with LGBT persons. Although the study lacked empirical evidence that measured the concept of self-efficacy in the actual medical setting, the seminar most likely enhanced the residents' clinical competency. Additionally, the study's sample was composed primarily of heterosexual persons. It is possible that some of the residents held negative preconceived ideas about LGBT persons and found it challenging to consider the health and psychosocial issues of this population.

2.8 RESEARCH QUESTIONS

This literature review has provided information about the health and psychosocial issues of older LGBT persons. It has also inspired several research questions that this thesis will address. Based on the results of the Persad Center survey that was disseminated in the summer/fall 2006, this thesis aims to answer the following:

1. Is the disclosing of sexual orientation to one's primary care physician related to the quality of health care received by the older LGBT patient?
2. How do primary care physicians react upon being informed of the older LGBT patient's sexual orientation?
3. How many older LGBT persons have had a negative experience with a health provider due to disclosing their sexual orientation?
4. Is socioeconomic (SES) status related to the older LGBT individual's decision to disclose his/her sexual orientation to his/her primary care physician?

3. METHODS

The data discussed here were collected by means of an anonymous survey (see Appendix C) that was disseminated by the Persad Center during the summer and fall of 2006. The University of Pittsburgh's Institutional Review Board (IRB) approved the request to use these data for this thesis. I carried out no data analysis prior to the IRB's official approval. I was involved in the construction and distribution of this questionnaire within the community as part of my graduate internship at the Persad Center during the summer and fall of 2006. The results of my endeavors with the Persad Center are not deemed to be research in nature by the IRB. Any survey-related activities and their outcomes were carried out for the benefit of the Allegheny County Area Agency on Aging (A.C.A.A.A.), which will most likely use the information gathered from this community needs assessment for future program planning and resource allocation for older LGBT persons in Pittsburgh.

3.1 SURVEY INSTRUMENT

In the spring of 2006 the Persad Center was funded to assist the A.C.A.A.A. in gathering knowledge about the current health and psychosocial needs of Pittsburgh's older (50+) LGBT community. To help with this assessment, a 50-item questionnaire consisting of both qualitative

and quantitative measures was constructed over a one-month period (August, 2006). A Persad Center staff member and intern were involved in the construction of the survey instrument and its distribution among LGBT organizations and at LGBT social functions.

To obtain a better idea of how to develop the Persad Center questionnaire, surveys from prior LGBT community needs assessments in the United States were reviewed by the Persad Center staff member and intern. Basic demographic questions (age, income, ethnicity/race, sexual orientation and the like) were common to all examined surveys. In addition to demographics, the Persad Center survey included questions addressing issues relevant for older adults such as multiple health problems and more frequent trips to the doctor; access to health care and health insurance; and mental health conditions such as anxiety, loneliness, depression and bereavement over the loss of significant others, family and friends. Responses included yes/no, Likert scale ratings, and open-ended questions. Additionally, questions associated with satisfaction of received health care, openness about sexual orientation with one's primary care physician and/or specialist, knowledge of A.C.A.A.A.'s senior services and programs, and legal matters (will, living will and power of attorney [POA]) were included.

The initial version of the Persad Center survey was created using Microsoft Word software and submitted to the center's executive director for review. Feedback from her included rewording of various survey questions and elimination of redundant items. The Persad Center staff member and intern discussed the executive director's input and modified the survey accordingly. The survey was again submitted for review. Within the following week, the survey was approved by the executive director and ready to be distributed in Pittsburgh's LGBT community; before taking it out into the community, the survey was pilot-tested among several

members of the Persad Center's clinical staff. Feedback was positive, and clinicians reported that the survey was easy to understand, quick to complete and comprehensive in its content.

3.2 DISSEMINATING THE SURVEY INSTRUMENT WITHIN THE LGBT COMMUNITY

Upon approval from the executive director, the Persad Center staff member and intern discussed the best locations to disseminate the survey. Each individual compiled a list of familiar locales and organizations that catered to the LGBT community. Additionally, a thorough review was conducted of Pittsburgh's monthly LGBT newspaper, *Out*, to help identify other organizations that served the older LGBT population.

The first three questionnaires were completed by three older male individuals known to the Persad Center intern. Telephone calls were made to each person to explain the survey's purpose and to determine his interest in completing it. All were receptive to participation in the study. The intern carried out three home visits during the first week of September, delivering the questionnaire to the respondents. On each occasion, the intern instructed each person to take as much time necessary to complete the questionnaire. To remain unobtrusive, the intern sat in a separate room while each respondent completed the survey. The average time to complete the questionnaire was fifteen minutes. Each completed survey was numbered at the top right corner. The first completed survey was numbered as #1, the second as #2 and the third as #3. Subsequent surveys were sequentially numbered to correspond with their respective positions in a Statistical

Package for Social Sciences (SPSS) database, where data would be coded appropriately for answer choice and analyses.

The Shepherd Wellness Community[4] (SWC) was identified as a viable organization through which to disseminate the Persad Center questionnaire. SWC provides free dinners twice a month to those persons living with HIV/AIDS. Dinners are held every other Friday at the First United Methodist Church in Pittsburgh's Shadyside neighborhood. Persad Center staff secured permission from SWC's executive director prior to survey distribution, and two separate visits were made to the dinners (September and October 2006). A small table was set up near the entrance on each visit, and the survey was distributed by the intern on both accounts. Many attendees displayed interest in the study and asked to complete one. It was necessary on several occasions to specify that the survey was intended for older (50+) LGBT persons and completely anonymous. Persons who were not able to complete the instrument at the church were given a pre-addressed, postage-paid envelope in which to return it.

Outrageous Bingo[5] was another event identified as being suitable to collect surveys. Permission was obtained by Persad Center staff prior to the event, which was held on Saturday, October 14, 2006, at the Goodwill Industries building at 2600 East Carson Street on Pittsburgh's South Side. Doors for the event opened at 6:30 P.M. The Persad Center staff member and intern agreed to meet prior to this to discuss distribution of the survey instrument. It was decided that after the event was over, each would stand near an exit and give the surveys to receptive

[4] A social service organization in Pittsburgh, PA that serves those living with HIV/AIDS

[5] Event sponsored by Pittsburgh's Gay and Lesbian Community Center (GLCC) whose proceeds benefit the GLCC and SWC

individuals. A number of people stopped and asked what was being distributed. When informed that it was a survey for older LGBT persons, a number of individuals joked and said they were not old enough to complete it. Additionally, several persons identified as being heterosexual and therefore were not appropriate for the study. Several respondents who were given the survey also encouraged their friends who were at the event to take one to complete. Approximately sixteen surveys were distributed that evening. All respondents took the surveys and pre-addressed, postage-paid envelopes with them for completion and return at a later date.

Additional surveys were distributed to various other LGBT groups in the Pittsburgh area such as PFLAG[6], Pittsburgh Prime Timers[7], the RCC[8], and the MCC[9]. Again, permission was obtained before disseminating them to these groups. Surveys were also provided to the owner of A Pleasant Present[10] (Michael Ferraro), who gave them out to appropriate customers who wanted to take part in the Persad Center study.

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[6] Parents, Families & Friends of Lesbians & Gays (PFLAG) is a national non-profit organization

[7] A social organization for mature gay and bisexual men

[8] Renaissance City Choir is a non-profit organization that presents choral music and educates the public about the LGBT community

[9] MCC Pittsburgh is a part of the Universal Fellowship of Metropolitan Community Churches whose primary outreach is to LGBT people, family, friends and straight people who share the MCC's vision

[10] A gay owned Squirrel Hill business that sells a variety of fun and whimsical items

3.3 CONSTRUCTING THE PERSAD CENTER DATABASE

A total of eighty surveys were collected by the end of October 2006. Persad Center's executive director deemed this a sufficient number for gaining general knowledge about Pittsburgh's LGBT community.

Data were appropriately coded in the database using SPSS' numeric or string variable labels. The majority of the survey's variables were numeric in nature. For instance, sexual orientation was coded as follows: 1=gay; 2= lesbian; 3= bisexual; and 4= heterosexual. Other numeric variables were coded comparably such as 1= yes and 2= no, or 1= male, 2= female, 3= transgender (MTF[11]) and 4= transgender (FTM[12]). Anecdotal responses were assigned SPSS' string variable label and entered into the database verbatim.

Not all returned surveys were complete. Unanswered survey questions were coded with a discrete missing value of 99. A value of 98 was assigned to those questions that were non-applicable. For instance, the survey asked about openness regarding sexual orientation with one's children or grandchildren. For the childless person, a 98 was entered in each of these fields due to this being a non-applicable question. A discrete missing value of 999 was assigned to the variable of "oldest LGBT individual known" due to one respondent indicating that he/she knew someone ninety-nine years of age. Variables coded with a 99, 999 or 98 were not included in the denominator when carrying out data analyses.

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[11] Male to female
[12] Female to male

The database was checked for any out-of-range or inconsistent data. This was done by examining output results from various SPSS descriptive statistics (*frequencies* and *descriptive*) analyses. Visual inspection of the database also assured that the data were clean. One discrepancy found in the data related to sexual orientation. A sixty-year-old male respondent indicated that he was heterosexual. This particular survey's data were removed from the database due to this being a study of older LGBT persons.

For data analyses purposes, frequency tables were constructed to describe the population. Additionally, several variables were recoded. By recoding the variables of education[13] and income[14] into smaller groupings, I eliminated any contingency table cell values less than five. Had I not done this, I would have had to use Fisher's exact test. Two chi-square tests of independence were carried out to determine if a relationship existed between level of openness about sexual orientation with one's primary care physician and socioeconomic status (SES). The SES variables of education and income were assessed separately. One degree of freedom was present in each contingency table, and I also set the alpha level of significance for each at 0.05. A chi-square test of independence was also carried out to determine if any relationship existed between being open about sexual orientation with one's doctor and the quality of care received. However, two of the contingency table's cells had expected frequencies less than five, so Fisher's exact test results were used. The contingency table used in the data analysis had one degree of freedom. Additionally, the alpha level of significance was set at 0.05.

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[13] Codes: 1= bachelor's degree or lower; and 2= a master's degree or higher

[14] Codes: 1= annual income <$30,000; and 2= annual income ≥ $30,000

The completed SPSS database was saved on multiple data discs to assure that it would not be lost. Additionally, the database was e-mailed to several Persad Center staff members for review and analyses.

4. RESULTS

The following results are based on data from seventy-nine surveys disseminated for the Persad Center. It is not possible to present all of the results in this section due to the numerous variables that were included in the survey. What follows are some pertinent findings that will provide the reader with a better understanding of the respondents who participated in the study. Additionally, results that address the four research questions I proposed at the end of the background section will be discussed.

4.1 AGE, GENDER, RACE/ETHNICITY AND SEXUAL ORIENTATION

The ages of the study participants ranged from fifty to seventy-eight, with a mean age of sixty (59.71) and a median age of fifty-nine. The age with the highest frequency (mode) was fifty-three, which represented 8.9% of the study sample. Table 2 (below) provides a breakdown of ages by frequencies and percentages.

Table 2. Persad Center Survey Respondents' Ages

Age	Frequency	Percent
50	4	5.1
51	4	5.1
52	3	3.8
53	7	8.9
54	4	5.1
55	6	7.6
56	5	6.3
57	1	1.3
58	2	2.5
59	5	6.3
60	2	2.5
61	4	5.1
62	3	3.8
63	4	5.1
64	5	6.3
65	5	6.3
66	3	3.8
67	2	2.5
68	3	3.8
69	2	2.5
71	1	1.3
73	1	1.3
74	1	1.3
75	1	1.3
78	1	1.3
Total	**79**	**100.0**

The number of male respondents was more than twice that of females, with males comprising 67.1% of the study population and females representing 30.4%. MTF transgendered individuals comprised 2.5 % of the sample and no FTM persons were represented. Regarding race/ethnicity, Caucasians constituted 96.2 % of total survey respondents, African-Americans 2.5%, and Hispanic/Latinos 1.3%. One person did not indicate sexual orientation, so seventy-eight surveys

were used to calculate the percentages for this variable. They are as follows: 65.4% reported being gay; 26.9% identified as being lesbian; and 7.7% said they were bisexual.

4.2 EDUCATION

The majority of study participants were highly educated, with 32.9% of the sample having reported obtaining a master's degree. Only 2.5% of the participants reported not having graduated high school. Those who completed high school or a G.E.D. made up 16.5% of study population, 10.1% indicated having received a certificate from a vocational training school, 20.3% reported having obtained a bachelor's degree, and 17.7% reported having received a doctoral degree.

4.3 INCOME AND INSURANCE

The majority of survey respondents (21.5%) reported an annual income of $20,000-$29,999. Those who reported making less than $10,000 per year represented 8.9 % of the survey population, while those making $60,000 or more made up 16.5% of the sample. Figure 1 (below) provides a visual representation of the income levels of all study participants.

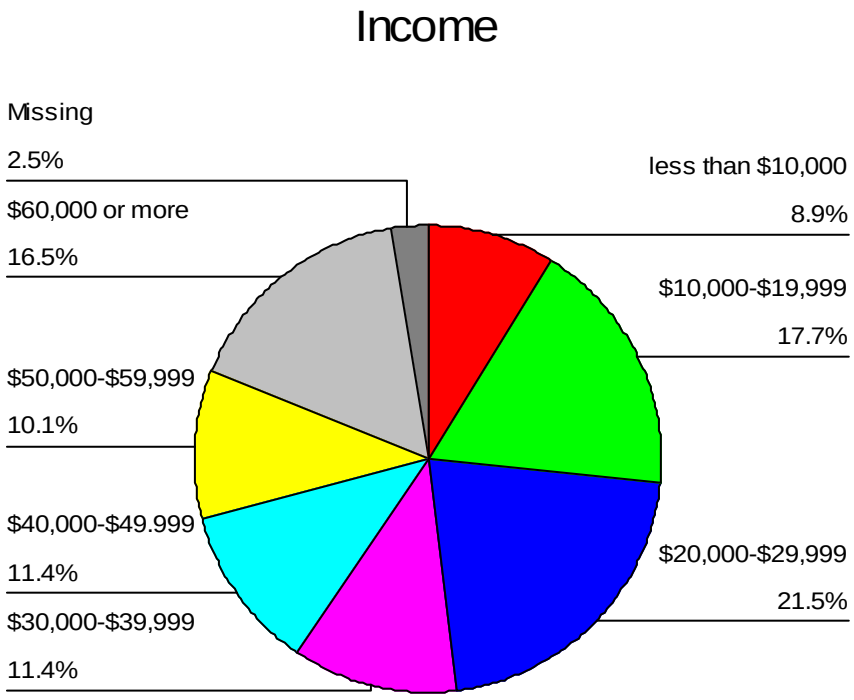

Figure 1. Persad Center Survey's Findings on Income

The following is a breakdown of the types of income received by the study participants: 53.8% reported receiving income from wages earned at a job; 32.1% mentioned receiving Social Security retirement income; 30.8% reported receiving a pension; 26.9% indicated having investments; 12.8% said they received income from Social Security Disability Insurance (SSDI); and 3.8% reported receiving Supplemental Security Income (SSI).

The study's findings revealed the following about insurance: 73.4% indicated having some type of private insurance; 30.4% reported having Medicare (possibly supplemented by a private insurance); 6.3% reported having Medicaid; and 2.5% mentioned having Veteran's Administration (V.A.) benefits.

4.4 HEALTH STATUS AND MEDICAL CARE

Regarding physical health, 40.5% of the study population indicated having excellent health, 45.6% reported that it was good, 12.7% reported it as being fair, while 1.3% mentioned that their health was poor. Physical mobility was also analyzed. Study results revealed that 54.4% indicated excellent mobility, 40.5% reported that mobility was good, 3.8% described it as being fair, and 1.3% described it as being poor. Regarding HIV status, 79.5% reported being HIV-negative, 12.8% indicated being HIV-positive, while 7.7% indicated not knowing HIV status.

The majority of study participants (98.7%) indicated having a primary care physician, and 93.5% reported having seen their doctors within the past eighteen months. Of the study participants who reported having a family doctor, 98.7% reported receiving competent/comfortable health care. Regarding sexual orientation, 84.2% of the population reported being open with their doctors about this aspect of their lives. Primary care physicians' reactions concerning their patients' sexual orientations were favorable; 72.7% of study participants reported receiving a positive reaction from their doctor, while 25.5% of physicians reacted neutrally about their patients' sexual orientation, and only 1.8% of study participants reported receiving a negative reaction[15].

[15] These results answer research question #2

Regarding the results relating to openness about sexual orientation with one's primary care physician and the quality of health care received, the findings indicated no significant relationship, for test statistics (2-sided=1.00 and 1-side=.840) were both greater than 0.05[16]. Additionally, there appeared to be no relationship present between level of income and degree of openness about sexual orientation, for the test statistic of .919 was greater than 0.05[17]. There also appeared to be no statistically significant relationship between degree of openness about sexual orientation and level of education, for a test statistic of .529 was obtained, which was also greater than 0.05[18].

Regarding negative experiences with health care professionals or their staff due to sexual orientation, results showed that 82.7% indicated not having had any negative experiences[19]. Additionally, 90.8% of the survey's respondents mentioned that they never felt the need for an advocate due to having negative experiences.

4.5 LIVING ENVIRONMENT

The Persad Center survey asked where one would expect to reside if unable to live independently. The majority (39.7) of study respondents indicated that they would expect to live in a retirement community, 28.6% said assisted living, 17.5% mentioned with family, and 14.3% said "other." Some interesting survey results were found regarding a question that asked if living

[16] Answers research question #1
[17] Answers part of research question #4
[18] Answers part of research question #4
[19] Answers research question #3

in an exclusively LGBT community in later years was preferable. Most respondents (64.3%) indicated that they would prefer living in this type of community. Some of the reasons given are as follows:

- "A large % of straights still don't understand"
- "Being with your own kind"
- "Fabulous clothes and parties"
- "Feel safe and welcome"
- "Most assisted living medical care is, at best, insensitive to gay feelings and needs"

Of the 35.7% who did not indicate wishing to live in an exclusively LGBT setting when older, some of the reasons given were:

- "I don't want to limit my circle of friends/neighbors"
- "Why do we need, or think we need, to be separated from everyone else?"
- "It's not a totally LGBT world…have many interests"
- "I like people not based on sexual orientation only"

4.6 FAMILIARITY OF AVAILABLE SERVICES

The Persad Center survey also assessed the level of familiarity study participants had of the A.C.A.A.A. The results are as follows: 6.6% indicated they were very familiar with the A.C.A.A.A.; 17.1% said they were somewhat familiar; 35.5% said they were mostly unfamiliar; and 40.8% indicated that they had never heard of it. When asked if they would seek the services of the A.C.A.A.A., 73.3% said yes.

Table 3. Familiarity with A.C.A.A.A.

Familiarity	Percent
Very Familiar	6.6
Somewhat Familiar	17.1
Mostly Unfamiliar	35.5
Never Heard Of	40.8

4.7 ISSUES AFFECTING EMOTIONAL HEALTH

The Persad Center survey also assessed the emotional health of its respondents. Results revealed that 82.1% of the study population had seen (or were seeing) a therapist or counselor for emotional health issues. Study participants were able to identify conditions for which they had sought help: 54% indicated that they had sought help for anxiety, 61.9% for depression, 14.3% for substance abuse, 14.3% for worrying about job-related matters, 20.3% for the loss of a partner, family member or friend, 11.1% for money matters, 38.1% for relationship problems, 17.5% for loneliness, 27% for sexual orientation, 3.2% for gender identity issues, and 9.5% for other issues. Table 4 on the following page provides a clear visual representation of the above findings.

Table 4. Mental Health Issues

Why Seek Help?	Percent
Anxiety	54%
Depression	61.9%
Substance Abuse	14.3%
Job-Related Matters	14.3%
Loss of Partner, Family or Friend	20.3%
Money Matters	11.1%
Relationship Problems	38.1%
Loneliness	17.5%
Sexual Orientation	27%
Gender Identity Issues	3.2%
Other Issues	9.5%

5. DISCUSSION

The purpose of the Persad Center study was to present the A.C.A.A.A. with a better idea of the health and psychosocial needs of Pittsburgh's aging LGBT community. It addressed issues that are relevant to most aging individuals regardless of sexual orientation. Some included physical and mental health; quality of health care received; income and health insurance; relationships with friends and family; end-of-life issues and legal affairs; housing; familiarity with senior services; and assisted living/nursing homes. Based on the study's findings, it may be argued that the needs of this population differ little from its heterosexual counterpart.

What is most striking to me is that the results of the Persad Center survey are incongruent with the literature review's findings. The background section presented a rather disheartening description of what it means to grow older as an LGBT person in the United States. However, results of the survey showed that older LGBT individuals in Pittsburgh (at least those sampled) are in generally good health, are open with their primary care physicians about their sexual orientation, receive competent health care, experience positive relations with their doctors, are well educated, and have a sufficient income.

A survey result the A.C.A.A.A. may find interesting was that the majority (40.8%) of respondents were unaware of its existence. The fact that almost half of the study sample was unfamiliar with its services and programs should indicate the need for a communication

campaign to effectively inform LGBT seniors about what it has to offer. Perhaps the study sample's lack of knowledge about the agency is related to a lack of need for its services. Those with fewer financial resources appear to benefit more from what this agency has to offer. Much of the Persad Center study sample was comprised of individuals from higher socioeconomic backgrounds who most likely had no reason to contact the agency.

The inability to live independently in one's home is a fear shared by many, and being placed in an assisted living or nursing facility is seen as an inevitable consequence of growing older. However, the trend is changing in favor of keeping people in their familiar environments with in-home assistance. This may be accomplished through free, or low cost, services provided by the A.C.A.A.A. (or similar agency) or with out-of-pocket resources. Additionally, recent times have seen an increase in the number of continuum of care communities being built for senior citizens, which range from independent living to skilled nursing and dementia care.

As mentioned earlier, the majority of Persad Center study participants indicated they would want to reside in a retirement community if unable to live independently. I think the wording of this survey question was poor and seemed to be contradictory. It addressed the inability to live independently, but then gave a choice of retirement community. An additional survey question that asked about preferred living arrangements after retirement also offered the choice of a retirement community. These two questions may have been confusing to the survey respondents. Perhaps saying continuum of care community would have been more appropriate regarding the first question, for it covers independent living to skilled care. The question was clumsy and the results captured by it may not be valid.

The findings also revealed that despite the majority of participants wanting to live in an exclusively LGBT community in later years, there were those who appreciate variety in their

social circles as some respondents indicated: “I don’t want to limit my circle of friends/neighbors” or “It’s not a totally LGBT world…have many interests.” Lastly, the comments made regarding wanting to live in an LGBT community for safety reasons and a sense of feeling welcome are valid, for the literature review gave specific examples of the discrimination experienced by older LGBT persons living in assisted living facilities.

5.1 LIMITATIONS OF THE PERSAD CENTER STUDY

The results of the Persad Center survey cannot be considered representative of all older LGBT persons living in Pittsburgh. A convenience sample was used, and its size was not large, or random, enough to make valid assumptions about the LGBT community. Additionally, the study population was comprised mostly of gay white males, with less than half of the total sample being women. Few racial/ethnic minorities and transgendered persons were included in the study, which seems to be consistent with the literature review’s findings. Virtually no issues related to racial and ethnic diversity in the aging LGBT population were covered in the background section and minimal literature was referenced that spoke about aging and transgendered individuals. This was due to a lack of research articles to be found that discussed these topics.

Additionally, the majority of surveys were completed by persons who were recruited through organizations, and at events, that tended to be frequented by individuals who enjoy socializing and participating in LGBT activities. It may be hypothesized that LGBT persons who are socially active are more likely to locate LGBT competent health providers and are more

comfortable with their sexual orientation and proactive in how they approach aging (e.g. communicating effectively with health care providers, fostering strong psychosocial support networks, and living healthier lifestyles). If there is any truth to the above hypothesis, it would likely bias the Persad survey results in a positive direction.

If given more time, the Persad Center survey may have captured a sample that was more representative of the LGBT community in Pittsburgh. For instance, the annual LGBT Pride Festival that occurs every June was not a viable option for collecting surveys since the Persad study was carried out in September and October of 2006. Distributing the survey at this event may have reached individuals who participate in very few LGBT events other than this festival. I have also been informed that there is an annual African-American picnic for LGBT persons that would have been an appropriate venue to disseminate surveys. If a budget allowed, perhaps an online survey would have been useful in reaching individuals who stay at home and partake in few LGBT social activities. Lastly, snowball sampling may have been employed to collect additional surveys.

5.2 RECOMMENDATIONS FOR PHYSICIANS

I wanted to learn more about the University of Pittsburgh School Of Medicine's curricula to determine if courses on diversity training with LGBT persons were offered. I carried out several internet searches about the topic and visited the School of Medicine's website to see if I could locate anything relevant. The closest I came to finding anything related to LGBT issues was in

reference to the Graduate School of Public Health's Center for Research on Health and Sexual Orientation. [20]

With the above in mind, I decided to conduct short interviews about diversity training in medical school with two physicians with whom I work. One discussion was with a neurologist who received his medical education at Harvard Medical School, as well as additional training at Johns Hopkins. I asked him if he had received any training on health communication with diverse populations during his education. He explained that he was required to take several courses related to cultural competency and mentioned being involved in various role-playing exercises that addressed issues of diversity (race, age, gender, religious, and sexual orientation) in the clinical setting. The second physician (psychiatrist) I interviewed told me she had obtained her medical education from University of Pittsburgh. She reported having received training comparable to the neurologist's in learning how to communicate efficiently with diverse populations, and she spontaneously indicated that the topic of treating LGBT patients was included in some of her classes. The information provided to me by these doctors seemed to contradict the findings of a prior survey that showed that medical school programs in the United States devoted little attention to the topic of homosexuality (Ridson, Cook and Willms, 2000).

Effective health communication is vital to improving personal and public health. However, health communication activities seldom encompass LGBT persons or include the creation of health promotion campaigns targeted to this population (Gay and Lesbian Medical

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[20] I have since been informed that University of Pittsburgh medical students do receive training around LGBT issues and that the Persad Center is involved with this training

Association, n.d.). Belief systems, cultural and religious values, and life experiences are some factors that should be considered when developing health communication campaigns that seek to improve the interaction between physician and patient (National Institute of Medicine, 2002).

The concept of self-efficacy was mentioned earlier in the background section and relates to how the perception of one's environment can influence his/her behavior in a positive or negative manner. This idea may be applied to the physician who is treating an older LGBT patient. For example, if the physician is unable to adopt learning strategies that benefit the physician/patient encounter (e.g. how to communicate more efficiently with LGBT patients), effective health care delivery is undermined.

The construct of triadic reciprocal determinism would be relevant to the example given above, for it addresses how behavior, environment and cognitive factors influence one another. To illustrate how this construct may be used in a positive manner, one may think of physicians who realize that they hold deeply ingrained biases about LGBT persons. These physicians may take it upon themselves to learn more about the health and psychosocial issues of this population. Additionally, they may learn to monitor their tone of voice, body language, and phrasing of questions with LGBT patients. The change in the physician's behavior may create an atmosphere that is conducive to the delivery of competent clinical care.

What follows are some recommendations put forth by the Gay and Lesbian Medical Association (GLMA) that apply to physicians and other medical professionals. The purpose of these suggestions is to assist clinicians in creating a non-judgmental environment where LGBT patients can feel safe and comfortable enough to engage in an honest dialogue with their doctors about pertinent health and psychosocial issues. Although the recommendations are not written specifically with older LGBT individuals in mind, they are still highly relevant. All of the

recommendations listed are taken from the GLMA's *Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients*.

Create a Welcoming Environment

1. Participate in provider referral programs. Advertising your medical practice can provide a welcoming environment.
2. Include relevant information for LGBT patients if developing brochures or educational materials.
3. Conducting an open dialogue with a patient about their sexual orientation, gender identity/expression, and sexual practices means more effective and relevant health care.
4. Display LGBT-specific media, including local or national magazines or newsletters about and for LGBT and HIV-positive individuals.
5. Display brochures (multilingual when possible and appropriate) about LGBT health concerns, such as safe sex, breast cancer, hormone therapy, mental health, substance abuse, and STDs.
6. Post rainbow flag, pink triangle, unisex bathroom signs or other LGBT-friendly symbols or stickers. (p. 4)

General Guidelines for Forms and Patient-Provider Discussions

1. Intake forms should use the term "relationship status" instead of "marital status," and include an option like "partnered."
2. Adding a "transgender" option to the male/female check boxes on your intake form can help capture better information about transgender patients.
3. Approach the interview showing empathy, open-mindedness, and without passing judgment.
4. Be aware of additional barriers caused by differences in cultural norms, socioeconomic status, racial/ethnic discrimination, age, geography and physical

ability. Make no assumptions about literacy, language capacity, and comfort with direct communication.

5. Transgender individuals may have had upsetting past experiences with doctors in the past causing mistrust or fear. Take time developing rapport and trust with transgender patients. (p. 5)

Staff Sensitivity and Training

1. If possible, have openly gay, lesbian, bisexual and transgender people on staff. They can provide valuable perspectives about serving LGBT patients.
2. It is important for front-line staff to be trained in office standards of respect towards transgender people such as using their chosen name referring to them in their chosen pronoun.
3. Include training about the use of fitting language when addressing patients and/or their significant others.
4. Teach staff how to identify and challenge any internalized discriminatory beliefs about LGBT persons.
5. Have staff develop familiarity with pertinent LGBT health issues: impacts of homophobia, discrimination, violence and harassment; mental health issues such as depression and anxiety; substance abuse; safe sex; and intimate partner violence. (p. 15)

In addition to these recommendations, it would be practical for physicians to acquire sufficient knowledge about health issues that are more prevalent in the elderly population. For instance, age is the biggest risk factor for Alzheimer's disease (AD). An older LGBT patient may present with cognitive symptoms such as memory loss, language disturbance, and executive dysfunction. Additionally, the patient may not have a partner or significant other to serve as his/her health care proxy during the clinical interview. If the treating physician is ignorant about

AD *and* LGBT health and psychosocial issues, this severely compromises the quality of care that can be delivered.

Lastly, it is important to train professionals in other health care disciplines (e.g. nursing, social work, psychology, physical and occupational therapy) to work with the aging LGBT population. These professionals, along with primary care physicians, comprise a network of providers seeking to improve the public's health. Aging LGBT persons are best served when those providing medical care to them are educated about LGBT health issues, empathic during the clinical encounter, and non-judgmental about alternative sexual orientations.

6. CONCLUSIONS

The nation's population of older adults is growing rapidly. Advancing age brings with it health issues that require medical attention. Knowledge about senior health care has become more relevant than ever as the baby boomers approach age sixty-five. Aging LGBT persons are also to be found within the baby boom generation. Not only do they bring with them the health issues germane to growing older, but also specific cultural and psychosocial issues warranting attention and sensitivity. Competent medical care is delivered by health professionals who are educated, empathic and flexible in their abilities to work with diverse patient populations. These qualities serve not only the patients but also the quest for improved public health.

Based on the results of Persad Center's 2006 assessment of older LGBT persons in Pittsburgh, it appears that the majority of the sample's respondents reported being in good health, having positive relationships with their doctors, and receiving competent health care. However, existing literature about LGBT health issues is not consistent with these results. The knowledge gained from the Persad Center survey only provided a fraction of what should be known regarding older LGBT persons' health and psychosocial issues. Persad Center's current findings may inspire future researchers to carry out more rigorous studies of Pittsburgh's aging LGBT community.

The findings may also inspire the A.C.A.A.A. to focus its attention on resource allocation and program planning directed at learning more about Pittsburgh's LGBT seniors so that this population may be served more efficiently.

APPENDIX A: PERSAD CENTER APPROVAL LETTER

04-27-'07 09:56 FROM-persad center 4123032375 T-788 P002/002 F-966

5150 PENN AVENUE
PITTSBURGH, PA 15224-1627
P:412.441.9786/F:412.363.2375
WWW.PERSADCENTER.ORG

Mr. Thomas Baumgartner
University of Pittsburgh

April 26, 2007

Dear Mr. Baumgartner,

This letter confirms Persad Center, Inc.'s agreement for you to have access to the de-identified data from Persad's anonymous fall 2006 survey of 50+ LGBT community members. This data will be used by you for your study, "Assessing the Needs of Older Lesbian, Gay, Bisexual and Transgender (LGBT) Individuals in the Pittsburgh Community.

If there is anything else that Persad can do to support your study, please contact me at (412)441-9786 ext. 212 or at bhill@persadcenter.org.

Sincerely,

Betty J. Hill, MPM
Executive Director

APPENDIX B: IRB APPROVAL LETTER

University of Pittsburgh

Institutional Review Board

3500 Fifth Avenue
Ground Level
Pittsburgh, PA 15213
(412) 383-1480
(412) 383-1508 (fax)
http://www.irb.pitt.edu

Memorandum

TO: THOMAS BAUMGARTNER

FROM: SUE BEERS PHD, Vice Chair

DATE: 4/30/2007

IRB#: PRO07040083

SUBJECT: Assessing The Needs Of Older Lesbian, Gay, Bisexual and Transgender (LGBT) Individuals in the Pittsburgh Community

---

Based on the information provided to the IRB, this project includes no involvement of human subjects, according to the federal regulations [§46.102(f)]. That is, the investigator conducting research will not obtain data through intervention or interaction with the individual, nor will obtain identifiable private information. Should that situation change, the investigator must notify the IRB immediately.

Given this determination, you may begin your project.

If any modifications are made to this project, please contact the IRB Office to ensure it continues to meet the no human subjects determination. Upon completion of your project, be sure to finalize the project by submitting a termination request. Please be advised that your research study may be audited periodically by the University of Pittsburgh Research Conduct and Compliance Office.

APPENDIX C: SURVEY INSTRUMENT

A Needs Assessment Survey of Older (50+) LGBT Persons in Pittsburgh, PA

Please answer the survey as completely and accurately as you are able. All survey results are completely anonymous

1. Your age_____

2. Your gender identity: Male ____ Female ____ Transgender MTF____
   Transgender FTM____ Other____

3. Your race/ethnicity:
   African American ____ Asian/Pacific Islander ____ Hispanic/Latino ____
   Middle Eastern ____ Mixed Race ____ Native American ____
   Caucasian ____ Other ____

4. How do you describe your sexual orientation?
   Gay ____ Lesbian ____ Bisexual ____ Heterosexual_____

5. What is your zip code? _____-_____

6. Your annual income:
   Under $10, 000 ____ $10,000-$19,999 ____ $20,000-$29,999 ____
   $30,000-$39,999 ____ $40,000-$49,999 ____ $50,000-$59,999 ____
   $60,000 or more ____

7. The source(s) of your income (check all that apply):

Social Security Retirement ____ Employer Pension ____ Investments ____

Social Security Disability ____ SSI ____ Wages ____

8. Are you retired? Yes ____ No ____

If YES, at what age did you retire? ____

If NO, at what age do you plan on retiring? ____

I don't have a planned age____

9. What is the highest level of education you completed?

Did not complete high school _____Completed high school or GED_____

Vocational/technical certificate _____Bachelor's Degree_____

Master's Degree_____ Doctorate_____

10. Do you have any children? Yes____ No____ If yes, how many?_____

11. How would you describe your current relationship with your children?

Excellent_____ Good_____ Fair _____Poor_____

12. Have you ever experienced verbal or physical harassment because of your gender identity or sexual orientation?

Yes_____ No_____

13. Are you affiliated with any of Pittsburgh's Lesbian, Gay, Bisexual or Transgender (LGBT) organizations?

Yes ____ (if yes, please list below which ones) No ____

14. Do you participate in any **senior specific** activities or organizations in the Pittsburgh area?

Yes ____ (if yes, please list below which ones) No ____

15. Living situation:

Alone ____With Spouse/Sexual Partner ____Other Family ____

Roommate/Friend(s) ____Other ____ (please specify if you wish: _____)

16. Housing situation?

Own home/condo ____ Rent home/condo/apartment _____

Rent a room ____ Retirement community ____

Assisted living facility ____Other ____ (please specify if you wish: _____)

17. If not yet retired, which below indicates where you would like to live **when retired**:

Own home/condo ____ Rent home/condo/apartment ____ Rent a room ____ Retirement community ____ Assisted living facility ____ Other ____ (please specify if you wish: _____)

18. If you were not able to live independently, where would you expect to live?

Retirement community ____ Assisted living facility ____

With family ____ Other ____(please specify _____)

19. Is living in an exclusively LGBT community/facility after you retire preferable?

Yes ____Why?_____

No _____Why?_____

20. How is your health?

Excellent ____ Good ____ Fair ____ Poor ____

21. How is your mobility?

Excellent ____ Good ____ Fair ____ Poor ____

22. Whom would you seek if you needed assistance?

Partner/Spouse ____ Family ____ Friends ____ Other ____

23. HIV status: Negative ____ Positive ____ Don't Know ____

24. When was your last HIV test? _____ (never had one, check here ___)

25. What is your current health insurance?

Private Insurance/HMO ____Medicare _____Medicaid ____

VA Benefits ____Long-term care insurance ____None ____

Other ____ (please specify :_____)

26. Do you presently have a primary care physician? Yes ____ No ____

27. Have you seen your primary care physician within the past 18 months?

Yes_____ No_____

28. Is the care you are receiving from your primary care physician competent and comfortable?

Yes_____ No_____

29. Are you open about your sexual orientation/gender identity with your doctor(s)?

Primary Care Doctor? Yes ____ No ____

If yes, what was his/her initial reaction? Positive ____ Negative ____ Neutral ____

Specialist? Yes ____ No ____

Please specify specialty_____

If yes, what was his/her initial reaction? Positive ____ Negative ____ Neutral ____

30. Who else have you told about your sexual orientation/gender identity? Please check all that apply.

Children____ Caregivers_____ Coworkers_____Grandchildren _____ Parents _____

Siblings ____ Others___ Please specify_____

31. Have you ever had a negative experience with a health care provider or their staff, due to your sexual orientation/gender identity?

Yes ____ No ____

32. Have you ever felt the need for an advocate due to negative experiences with health care or social service providers?

Yes ____ No ____

33. Regarding your emotional well-being and quality of life, would you say things are currently:

Excellent ____ Good ____ Fair____ Poor ____

34. Have you ever seen a therapist or counselor for emotional issues? Yes ____ No ____

If yes, please check all that apply:

Anxiety___ Depression___ Substance Abuse___ Worries about job____ Loss of family/friends/partner ___ Money problems___ Relationship problems___ Loneliness___ Sexual orientation___ Gender identity___ Other___

35. How familiar are you with the services provided by Allegheny County Area Agency on Aging (A.C.A.A.A.)?

Very familiar ____Somewhat familiar ____ Mostly Unfamiliar ____

Never heard of A.C.A.A.A.____

36. Would you seek referrals from A.C.A.A.A. for services?

Yes _____ No_____

If no, why not_____

37. Do you have a will? Yes_____ No_____

38. Do you have advanced directives (medical power of attorney, living will) relating to your healthcare in case you become disabled? Yes_____ No_____

39. How old is the oldest LGBT individual you know? _____

40. How is his/her health?

Excellent ___ Good ___ Fair ___ Poor___

41. How is his/her mobility?

Excellent ___ Good ___ Fair ___ Poor___

42. If needed, who is his/her primary care giver?

Partner/Spouse____ Child____ Other Family _____ Friend _____

Don't Know _____

43. Can you identify any unmet needs that this person is coping with?

Yes____ (please specify: _____)

No ____

44. Have you ever been a caregiver for an older LGBT individual?

Yes ____ No ____

45. Are you currently caring for an older LGBT individual? Yes ____ No _____

If yes, what is his/her relationship to you?

Partner/Spouse ____Other Family _____ Friend _____

46. What services do you think are important for Pittsburgh's older LGBT community? (Please rank in order 1 to 5, with 1 being most needed and 5 being least needed)

LGBT Support Groups ____

Medical community sensitive to LGBT needs ____

In home care services sensitive to LGBT needs ____

Adult daycare services sensitive to LGBT needs ____

Senior center specifically for LGBT persons ____

47. Regarding housing options for Pittsburgh's older LGBT community, which of the following do you think it needs the most? (Please rank in order 1 to 4, with 1 being most needed and 4 being least needed)

In-home support services ____

Retirement community without medical care for LGBT persons ____

Assisted living facilities for LGBT persons ____

Nursing homes for LGBT persons ____

48. Please let us know any of your other thoughts regarding what providers should know about Pittsburgh's older LGBT community:

49. Please describe any activities/hobbies, memberships to organizations, religious/spiritual affiliations which contribute to your increased quality of life as an older LGBT individual.

50. What other comments would you like to make regarding any other concerns pertaining to the older LGBT community in Pittsburgh that are not addressed in this survey?

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS SURVEY!!

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