

# Illness Management in Older Lesbian, Gay, Bisexual, and Transgender Couples: A Review

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## Abstract

More openly sexually and gender diverse people are aging into later life across the world as generational transitions occur. People identifying many different ways beyond cisgender and heterosexual are diverse with respect to many other characteristics and sociopolitical locations across the globe and may thus experience a wide array of health journeys both individually and as partners in intimate relationships. In this review article, we summarize the major contributions of and ongoing gaps in existing studies about such couples' experiences of chronic disease management in later life. We focus on three key groups of findings from prior research about the health of older sexually and/or gender diverse couples: care practices, unmet needs, and diverse resources. We outline priorities for future research within and across these topic areas and in varied locations, with unique recommendations for scholars in both academic and clinical settings. These recommendations support greater integration of such populations, topics, and needs in existing discourse on aging and late life. Likewise, recommendations from this review illuminate potential best practices for engaging and serving these elders in both academic and applied settings.

## Keywords

gender/sexuality, age discrimination/stereotypes, caregiving and management, quality of life

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In recent years, scholarship examining the lives, outcomes, and experiences of lesbian, gay, bisexual, and transgender (LGBT)<sup>1</sup> people has exploded throughout the social sciences and across the globe (Barringer, Sumerau, & Gay, 2017; Schrock, Sumerau, & Ueno, 2014; Worthen, 2013). Within such scholarship, an overwhelming and common pattern concerns massive health disparities in every aspect of health care access, experience, and utilization by members of these populations (Miller & Grollman, 2015; Nowakowski & Sumerau, 2017). Furthermore, such studies reveal that medical and other care providers, in many cases, have limited and sometimes no knowledge concerning the care needs, support structures, and preferences of LGBT people (Rider, McMorris, Gower, Coleman, & Eisenberg, 2018). Although such studies are beginning to close gaps in social scientific recognition and understanding of LGBT health and broader care needs (to varying levels in different parts of the world and within each community of varied sexual and/or gender diverse groups), we know far less about the needs, experiences, and outcomes of older LGBT people overall or the ways older LGBT people may be best served by elder care practitioners and providers (see also Ramirez-Valles, 2016).

In this review article (see Table 1 for relevant terminology), we examine existing studies about LGBT later-life care, needs, and resources to outline patterns for further study by both academic researchers and elder care practitioners. To this end, we specify patterns in the existing literature as pathways for understanding and responding to the needs of aging LGBT people. Specifically, we do this with an eye toward better health and care outcomes, aging processes, and resource allocation in the coming years as more openly LGBT people reach later-life stages. In so doing, we seek to set the stage for greater integration of LGBT populations, topics, and needs in existing discussions of the needs of later-life populations, and best practices for speaking to

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**Table 1.** Conceptual Terminology.

Term	Definition
Gender binary	The social and biological classification of sex and gender into two distinct oppositional forms of masculine and feminine selfhood.
Trans	A Latin prefix meaning “on the other side of.” Often used as a prefix before “man” and/or “woman” or as a prefix before the word “gender” to signify a person who does not identify with their sex assigned at birth.
Cis	A Latin prefix meaning “on the same side as.” Often used as a prefix before man or woman to refer to someone whose current gender identity/expression aligns with their sex assigned at birth.
Transgender <sup>a</sup>	An umbrella term referring to all people living within, between, and/or beyond the gender binary, which may also be used to denote an individual gender identity.
Cisgender	An umbrella term referring to people who conform to the gender binary by interpreting their gender identity as congruent with the sex they were assigned by society.
Cissexism	An ideology that assumes cisgender identities are superior to and more authentic than transgender identities.
Cisnormativity	An ideology that assumes and expects that all people are and should be cisgender by disallowing transgender experience and enforcing cissexism in belief and practice.
Ze, zir, hir, zirsself, they, them, themself(ves)	Gender neutral pronouns that allow one to refer to people without assuming their gender and/or gendering them in the process.
Transman	An identity referring to people socially assigned female at birth who transition (socially, biologically, or both) to living as men/male.
Transwoman	An identity referring to people socially assigned male at birth who transition (socially, biologically, or both) to living as women/female.
Intersex	An identity referring to people whose biological credentials do not fit within binary conceptions of gendered and sexed bodies.
Gender queer/fluid/variant	An identity referring to people who reject gender labels and live as women, men, neither, and/or both in varied situations over the life course.
Agender	An identity referring to people who reject gender labels because they do not feel or believe that they have a gender or in the socially constructed system suggesting all people should conform to gendered systems.
Bigender	An identity referring to people who live as both women and men, but shift their self-presentation and identity in relation to various contexts or feelings over the life course.
Trans* <sup>b</sup>	An abbreviation used to refer to transgender people as a whole regardless of individual gender identities and/or transgender as an umbrella term for gender nonconformity.
Bi	A Latin prefix meaning “two.” Often used in front of the word “sexual” to refer to people who experience attraction to people with multiple gender and sex identities (i.e., my body type and others or my gender and others). Although anti-bi groups have sought to redefine the two to conform to the gender binary (i.e., a form of biphobia and monosexism), bi people, activists, and history have sought to refute such claims throughout the past few decades and consistently defined it in the above manner since before the origins of modern science or society.
Pan	A prefix derived from Greek meaning “all” or “across.” Sometimes placed in front of the word “sexual” to refer to someone who experiences attraction to people across a variety of genital configurations and/or gender identities and/or with little regard to gender at all.
Poly	A prefix derived from Greek meaning “many.” Often placed in front of the word “amorous” to refer to people who have the potential to engage in relationships with multiple people at the same time.
Mono	A Latin prefix meaning “one,” “only,” or “single.” Sometimes used before the words “sexual” or “amorous” to refer, respectively, to (a) a person who experiences attraction to only one sex or gender and/or (b) a person who engages in relationships with only one person at a time.
Bisexual	A term referring to people who experience attraction to people with genders or bodies that are like their own and different from their own to varying degrees over the life course.
Pansexual	A term referring to people who experience attraction with little consideration of gender and/or varied sex organs.
Sexually fluid/queer/variant	An identity referring to people who reject sexuality labels and live as monosexual, bisexual, neither, and/or both in varied situations over the life course
Bi+	An umbrella term referring to anyone who does not experience monosexual patterns of desire and attraction.
Monosexual	An umbrella term referring to people who experience attraction to only one sex or gender.
Polyamorous	A relationship structure where a given person may have multiple partners at one time.
Monogamous	A relationship structure where a given person has only one partner at a time.
Monosexism	A system of inequality that assumes monosexual identities (heterosexual, gay, lesbian) are superior to and more authentic than bi+ identities.
Mononormativity	An ideology that assumes and expects that all people are and should be monosexual and monogamous by disallowing bi+ and polyamorous experience and enforcing monosexism and compulsory monogamy in belief and practice.

Note. The list in the table contains terms relevant to the current discussion but is by no means exhaustive. Furthermore, it is important to note that (consistent with other social constructions), these terms may shift over the course of time and in relation to varied social situations and contexts.

<sup>a</sup>Although we focus on gender in this table and the article, each of these terms has a corollary in relation to “sex” labels, see Eisner (2013) and Stryker, (2017) for more discussion on these terms and definitions and broader glossaries related to sex/gender/sexual diversity.

and serving these populations throughout our academic and applied endeavors.

It is important to remember, however, that no single review is exhaustive. Rather, like any other review, here, we utilized specific methods for sampling the literature. Specifically, we sourced works in gerontology, geriatric medicine, aging studies, LGBT studies, sociology, psychology, public health, and interdisciplinary medical sciences. We found these works in databases including Medline, JSTOR, SocINDEX, PubMed, OVID, and Google Scholar. Finally, we specifically searched for “health and aging” and then narrowed the search to articles within health and aging focused on “sexualities,” “gender,” “LGBT,” “LGBTQIA,” “LGBTQIAP,” “transgender,” “lesbian,” “gay,” “bisexual,” “homosexual,” “transsexual,” and “pansexual.” We then did this with just “health,” with just “aging,” and with just “elders.” With these things in mind, we now turn to some important considerations for future analyses and theorizing concerning variation in LGBT aging.

### **A Note on Similarities and Differences in LGBT Aging**

Before proceeding with our review of existing literature concerning LGBT later-life needs and experiences, it is important to note that the acronym LGBT (as well as other acronyms in use throughout the world) represents a wide variety of people, experiences, and health and care needs. Worthen (2013) stressed the importance of disaggregating LGBT populations for understanding the needs, experiences, and perspectives of groups captured within this umbrella term. Disaggregating the LGBT population is especially important in relation to health and well-being because some issues LGBT people face are very similar in terms of impact upon health outcomes, aging experiences, and population needs, whereas others are very different depending on the community we are seeking to understand and serve (Cragun & Sumerau, 2015). This is also the case because gender and sexuality do not necessarily operate in the same fashion in such cases, and thus some may face sexual needs but not gender ones, gender needs but not sexual ones, or both sexual and gender needs related to their sexual and/or gender identities (Miller & Grollman, 2015). As such, we begin this review by disaggregating groups under the LGBT moniker in terms of lived experiences that may facilitate similar and different needs in later-life care, health care provision, and social support.

It is important to keep in mind that although lesbian, gay, and bisexual communities experience contemporary society as sexual minorities, this is only true for some members of the transgender population. Situations and needs related to health and aging that specifically relate to the experience of life as a sexual minority often do not operate in similar ways for monosexual heterosexual people, regardless of gender identity (Schrock

et al., 2014). At the same time, there are often distinct experiences with both aging and health care that arise for bisexual people that monosexual lesbian and gay people do not face, and other issues that gay and lesbian people face that are not the same for non-monosexual people (Barringer et al., 2017). Moreover, any of these relations can become compounded in the case of LGB people who are also transgender, intersex, and/or cisgender women (Nowakowski & Sumerau, 2017). Understanding and speaking to the needs and experiences of LGB aging populations thus requires examining how sexualities affect health and aging and how different gender identities may intersect with these experiences.

At the same time, however, research has long noted that gender itself exerts significant impacts on health, aging, and well-being throughout the life course (Nowakowski & Sumerau, 2015a). Although much of this research focuses only on cisgender women and men, emerging research suggests even more dramatic relationships between transgender identities and overall health, health care experiences, and health outcomes over the life course (Miller & Grollman, 2015; Rider et al., 2018). Such findings suggest that transgender people of all sexualities face significant health care needs, risks, and obstacles throughout their lives (Sumerau, Cragun, & Mathers, 2016). Cisgender, transgender, and gender nonconforming lesbian and bisexual women may also have many concerns people who identify as men do not share, regardless of sexual identification (Sumerau et al., 2016). These observations reveal the importance of systematically examining gender in our attempts to understand both aging in general and the specific needs of aging LGBT populations.

Alongside these observations, it is further important to note that LGBT populations, like members of heterosexual, cisgender populations, experience significant variations in health and aging related to race, class status, religion, ability, and geographical context (Grollman, 2014; Ramirez-Valles, 2016). Although most scholarship tends to treat LGBT populations as a unified whole, emerging studies—within and beyond health and aging scholarship—reveal that such an approach may miss important variations within such communities as well as significant needs some portions of the population have that other portions do not have at the same level, if at all. As Steele, Collier, and Sumerau (2018) noted in relation to criminological studies, fields throughout the social sciences must move past uniform approaches to LGBT populations to explore the ways variations in social status within such populations shape specific outcomes, experiences, and concerns (Worthen, 2013).

Although we are unable to fully accomplish these endeavors with the present literature, throughout this piece we direct readers to consider these aspects in future works. Put simply, here, we provide a baseline view of the literature that may be used to fashion

LGBT-inclusive research methodologies and designs throughout aging studies. We then turn to a specific disaggregated case—transgender experience—to demonstrate the usefulness of specific study of populations within the larger acronyms alongside studies of sexual and/or gender diverse populations as a whole. We utilize both these endeavors—an aggregated and a disaggregated option—both because such endeavors will be necessary for understanding the specific and general aging and health needs of LGBT populations occupying different social, regional, and global locations and because such observations suggest future studies in need of both execution and publication in broader aging and health fields concerning LGBT people as a whole and specific groups within such populations. With these things in mind, we turn to a review of the major themes in existing literature in hopes of facilitating future studies that systematically outline and respond to issues related to LGBT aging, health, and well-being over the life course.

## Themes in Studies of LGBT Health and Aging

In the following sections, we outline prominent themes in the literature concerning LGBT later-life experiences, care, and outcomes. Although the literature is relatively small at present, observations from it may be useful for continued study and future research and intervention projects. As such, we outline the three major themes—social support, health provision, and aging resources—in the existing literature and then utilize the case of transgender health care experiences in earlier life to point out likely concerns upcoming as more and more openly LGBT people enter later life and the literature on aging, later life, and health. Although we treat these sections individually, it is important to note, as suggested above, that they often overlap in concrete settings, life courses, and practice for LGBT people.

### Social Support

Social and medical researchers have long noted the importance of social support for both aging processes and health outcomes (Cragun & Sumerau, 2017; Nowakowski & Sumerau, 2015b). Put simply, social support refers to the mechanisms and resources whereby people can go for help, acceptance, care, and affirmation in the course of their lives. Whether such support comes from personal or broader organizational sources, it often plays a substantial role in the experience of aging as well as the development and reaction to health experiences, outcomes, and understandings over time (Link & Phelan, 1995). As such, it is not surprising that the bulk of studies of LGBT later life experience focus on social support or that lack of social support is one of the primary factors in LGBT aging and health-related outcomes and experiences.

Most of the studies focused on this topic point out disparities LGBT elders face in relation to others concerning social support. Examining this specific issue, for example, Brennan-Ing, Seidel, Larson, and Karpiak (2013) noted that LGBT older adults are much less likely to have or report spouses or children who can serve as anchors for social support in their lives. Rather, members of these communities typically rely more heavily on families of choice (i.e., families composed of multiple adults built during adulthood in response to lack of familial or other connections from younger periods of the life course) as they age. However, this means their networks are often older and composed of less legally recognized (if at all) connections when navigating hospitals, care centers, or living arrangements in later life. In fact, Brennan-Ing et al. (2013) noted that this factor alone could play a powerful role in the overall health disparities noted between LGBT and cisgender, heterosexual populations.

In fact, researchers have noted the ways the broad-scale pattern above impacts social support in general for LGBT elders. Expanding beyond questions about spouses and children, for example, Croghan, Moone, and Olson (2013) found that LGBT elders are less likely than any other group to have access to any available caregivers in later life. Furthermore, discrimination against LGBT elders in relation to many structural components of later life, such as housing, medical access, and legal standing for taxes and ownership, is not yet outlawed in all areas (ERC, 2014). For example, neither Florida nor Georgia—the states where all of our contributing authors are based—has yet passed specific legislation outlawing discrimination against LGB or T identified people, despite having laws addressing discrimination based on both age itself and other intersecting characteristics such as race and disability. This is also the case in relation to federal legislation in the United States and some other countries even though there are now nations and places within nations that do offer explicit legal protections. The lack of explicit legal protections in spaces devoid of such laws often results in situations where resources or official connections people may use for support in later life become closed off to LGBT elders (The Equal Rights Center, 2014). As a result, LGBT elders often have to rely heavily upon proxy caregivers (MetLife, 2010) and care facilities (Porter & Krinsky, 2013) compared to cisgender, heterosexual people.

These patterns suggest a wealth of opportunities for intervention and study of the paucity of later-life options and support for LGBT elders. Furthermore, we do not yet know how such patterns may be similar or different in the cases of people who are both LGB and T or in different racial, class, gender, religious, or other communities within the broader LGBT population. Considering that such issues are necessary to understand to propose effective community-level interventions and protocols,

this represents a sizable gap that scholars of later-life experience could provide much advice and impact on in the coming years. To do so, however, the study of social support options for LGBT elders will need dramatic expansion throughout the social sciences.

### Health Providers

Although less central than social support in broader medical literatures or in the case of the LGBT older adults, another theme in the existing literature concerns experiences and interactions with medical providers. Considering that medical providers, mirroring broader patterns in science overall in the past few decades (Cragun & Sumerau, 2017; Nowakowski, Sumerau, & Mathers, 2016; Sumerau, Mathers, Nowakowski, and Cragun, 2017) often have, at best, limited education or knowledge about LGBT lives, needs, and biological experiences, this finding is also not surprising in terms of areas in need of critical attention related to LGBT older adults. Here, we outline the major observations about medical provision in existing literature and propose pathways for future study.

As part of their broader analysis of needs and experiences of LGBT elders, Brennan-Ing et al. (2013) also explored experiences with health providers. In so doing, they learned that health issues—throughout the life course—were often missed as a result of two ongoing patterns in medical and LGBT relationships. First, doctors were often ignorant of the lives and bodies of LGBT people; as a result, they missed important aspects of care necessary to understanding experiences common within LGBT communities (see also issues of the journal *LGBT Health* for other examples related to aging). Second, as noted in other studies across the sciences (Reisner et al., 2015), many doctors did not know patients were LGBT because many LGBT people are afraid to disclose their sexual and/or gender identities to medical providers as a result of long-term abuses, mistreatments, and other discrimination against LGBT people in medicine (Croghan et al., 2013) and service providers' general lack of training on LGBT lives, bodies, and issues (Porter & Krinsky, 2013).

Although each of the patterns noted above in relation to provider experiences are common throughout the life course for most LGBT people, they create specific concerns and issues for LGBT people in later life. What might integrated sexual and gender health protocols mean for LGBT elders as such programs develop? How might LGBT people occupying other social locations with reasons to distrust or avoid medicine (e.g., poor people and people of color) face similar or even more accentuated negative experiences with providers? Maybe equally important, what can be done to shift relationships between providers and LGBT elders as well as other portions of LGBT populations? These are just a few of the questions later-life scholars and practitioners may bring into existing literature in time.

### Aging Resources

The final major theme in the literature concerns a lack of resources for aging in healthy ways among existing LGBT elders (Ramirez-Valles, 2016). Put simply, aging well takes resources, opportunities, and access to networks and other social goods that LGBT people—and especially BT people (Miller & Grollman, 2015)—are often locked out of, throughout their lives or at least after coming out as openly LGBT people in the midst of broader cisgender, heterosexual populations. Although such literature that includes or focuses on LGBT elders is quite small at present, some patterns outlined in large evaluations provide a snapshot of aging issues facing LGBT elders.

The patterns in question paint a rather difficult picture for both LGBT elders and the people seeking to provide services to this group (Fredriksen-Goldsen, 2011; Hughes, Harold, & Boyer, 2011; Movement Advancement Project, Services & Advocacy for GLBT Elders, 2017). Despite the existence of the Older Americans Act in 1965 and the 2010 push and funding for “Promoting Appropriate Long Term Care Supports for LGBT Elders” (Hughes et al., 2011 for a recap of this history), many agencies continue to report little to no outreach to LGBT communities; limited information or education about the needs of LGBT elders; comfort responding to HIV-influenced outcomes, smoking to ease discrimination- and poverty stress-related outcomes, and other long-term care needs of many LGBT elders; and little infrastructure for managing the often worse economic and health care access realities of many LGBT elders (Movement Advancement Project, Services & Advocacy for GLBT Elders, 2017). Although there appears to now be widespread recognition of the different aging trajectories and health needs of LGBT elders, translation of this information into service provision, resources, and interventions remains a work in progress.

This creates an interesting opportunity for many scholars focused on later-life experience, evaluation, and outcomes. Specifically, the recognition that such services and knowledges are necessary for the growing LGBT elder population means that evaluations, needs assessments, and especially summary-surveys of the population within and outside of care facilities are deeply important at present. If we know now that the needs are different and the resources are lacking, this then suggests much work is to be done in evaluating and understanding these needs, attempts to meet them, and long-term effects of such efforts over time. Here, aging scholars may create tremendous impact via integrating LGBT elder needs and aging resources into existing and new applied projects seeking to service and understand diverse communities of elders.

### What About Tomorrow

Although the existing literature on LGBT elders suggests issues in need of research and intervention at

present, it is also important to ascertain what issues may be upcoming for our fields with more and more openly LGBT people aging in many countries. To do this, however, it is important to ascertain the health and aging needs of these communities at younger ages as such efforts will foreshadow the types of interventions and resources necessary for later-life care. As this focus on the needs of younger LGBT people has become increasingly visible in medical sciences, we now utilize illustrations from studies of transgender health needs earlier in the life course to posit other areas of research that may be useful for aging scholars as we prepare for the influx of openly LGBT elders in our research and practice agendas in the coming years.

We also focus specifically on transgender health care here as an example of the ways researchers may disaggregate LGBT communities to pay specific attention to a given population. Although an article does not allow space for doing this with each of the populations in the LGBT umbrella (much less other populations throughout the world of sexual and/or gender diverse people), we use this focus on transgender health care as an example of focusing attention within a given part of the broader populations, and how such efforts both shine light on issues specific to a given population and potential issues other populations may or may not face in relation to their own gender, sexual, and broader health care needs over the life course. To this end, we offer this explicit case as an example and call for other researchers to pay more attention to specific populations within sexual and/or gender diverse populations more broadly.

As such, although we focus on the transgender case here both to provide a guide for researchers preparing for future later-life issues and needs and because this community typically gets even less attention in science and medicine to date than LGB people, we suggest similar analyses could provide frameworks for aging research related to gender and sexual minorities more broadly. Furthermore, we would again suggest, as also noted by others (Movement Advancement Project, Services & Advocacy for GLBT Elders, 2017), more attention to variations within transgender and other LGB populations in these endeavors. With that said, here, we outline what emerging studies of transgender health at middle and early ages tell us about potential needs and issues for LGBT elders in the years to come.

Research shows that transgender people currently experience high levels of stigma and discrimination resulting in increased rates of psychological distress and other mental health problems compared with cisgender adults (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; James et al., 2016; Kosenko, Rintamaki, Raney, & Maness, 2013; Sevelius, Patouhas, Keatley, & Johnson, 2013). Among the many negative health outcomes of this stigma and discrimination are high rates of depression, anxiety, suicidality, and tobacco and substance use among transgender populations (AJHP Voices, 2017;

Bockting et al., 2013; Cocohoba, 2017; Institute of Medicine [IOM], 2011; Spicer, 2010). These findings suggest we may need to be prepared for LGBT elders managing many chronic conditions and later-life manifestations of long-term stress exposure at present and in years to come.

Alongside these needs, the processes of stigma and discrimination faced by transgender individuals vary from region-to-region within the United States and are highly class dependent as health care access in the United States is dependent on access to insurance that covers trans-related expenses, such as hormone replacement therapy (HRT) and various gender affirming surgeries. Even with insurance, many insurance companies deem transgender-related costs “cosmetic” and deny claims based on this categorical exclusion (Rosh, 2017). In non-U.S. contexts, such as in the Canadian universal health care system, disparities in health care access still exist due to issues such as outright denial of care to transgender patients who identify in varied ways or an inability of providers to provide culturally competent health care (Giblon & Bauer, 2017). Similar to current patterns of LGBT populations (Movement Advancement Project, Services & Advocacy for GLBT Elders, 2017), the limitations in aging, medical resources, and access will likely continue to shape much of the experience and care needs of elders to come.

In addition to stigma and discrimination, transgender people—mirroring past and present patterns in the broader LGBT population—face structural barriers to quality health, such as unemployment, homelessness, and lack of food (Raiford, Hall, Taylor, Bimbi, & Parsons, 2016; Spicer, 2010; Torres et al., 2015). Because many transgender people do not have insurance and/or have insurance that does not cover HRT, many obtain hormones on the street rather than from a licensed medical provider at the risk of obtaining hormones that have been altered or needles that are nonsterile. Without proper medical supervision and prescription, such individuals run the risk of HIV-infection and toxicity via excessive dosing (Cocohoba, 2017), which also mirrors earlier periods of LGBT experience (Sumerau et al., 2016). Similarly, many transgender people desiring HRT and who have been unable to access gainful employment, stable and affordable housing, and consistent meals often turn to survival sex work. Transgender women of color who engage in survival sex work, especially, report increased rates of HIV/AIDS (Baral, Poteat, Stromdahl, Wirtz, Guadamuz, & Beyrer, 2013; Herbst et al., 2008; Raiford, 2016; Rebhook et al., 2017; Sevelius et al., 2013). These patterns at varied ages reveal the importance of continuing even more imperative efforts to prepare care centers and practitioners for responding to later-life HIV-related needs and concerns.

At the same time, transgender people who experience gender dysphoria regarding their gender expression may experience negative mental and physical health

outcomes from a lack of access to medical transition. Transmasculine people who have not had top surgery, for instance, may bind their chest to create a flatter, more masculine-sculpted appearance. Negative physical health outcomes of binding can include chronic pain, overheating, dizziness, problems breathing, cuts and sores, fractured ribs, skin excess, potential changes in bone structure, and heartburn (Peitzmeier, Gardner, Weinand, Corbet, & Acevedo, 2016). Transfeminine people, however, may receive silicone injections that can be damaging to the body to create a more traditionally feminine body shape. As scholars focused on other aging contexts note repeatedly, more research needs to be conducted regarding specific gynecological issues facing postoperative transgender people (Trotsenberg, 2009) and the experiences and gender-related bodily adjustments and experiences undertaken by preoperative transgender people and those who do not desire any operations while still seeking to live as fits their gender identity.

Furthermore, both transmasculine and transfeminine people are at an increased risk of eating disorders. Due to a potential desire to be more muscular, to cease menstruation, or for body fat to be distributed away from their hips and chest, transmasculine individuals might excessively exercise or develop bulimia (Bockting, Knudson, & Goldberg, 2006). Because of the norms and expectations of many gay and bisexual male communities, transmen who are attracted to other men (a specific subpopulation of men who have sex with men, or MSM) are a specifically vulnerable population to eating disorders related to sexual desire and attraction (Bockting et al., 2006; Scheim et al., 2016). Likewise, transfeminine individuals may develop disordered eating habits to conform to conventional standards of feminine beauty. Medically transitioning transgender people may also face negative physical side effects from prolonged HRT use, though no longitudinal studies have been published on this topic to date and what side effects later-life care professionals need to be prepared for are, at present, hard to ascertain beyond current known side effects.

The context of health care is also an important consideration. Especially in rural areas, health care service delivery to transgender individuals is lacking (Logie & Lys, 2015; Seelman, Miller, Cline, & Fawcett, 2018). Community-based and patient-driven solutions to transgender health care inequity have been shown to decrease transgender health disparities and improve patient satisfaction (Eyssel, Koehler, Dekker, Sehner, & Nieder, 2017; Logie & Lys, 2015; Reisner et al., 2015). At the same time, however, trans-specific content is lacking in medical school curricula, as well as a lack of accepted methodology for teaching transgender topics to medical school students. As such, positive outcomes for transgender patients have been shown when physicians continue their education by attending trans-specific trainings and workshops (Khalili, Leung, & Diamant, 2015; Sekoni, Gale, Manga-Atangana, Bhadhuri, & Jolly,

2017). These patterns mirror issues for many LGB cis-gender people at present and may create another important area of concern and care-needs for LGBT elder programs.

In the transgender case specifically, for example, a survey of 141 obstetrics and gynecology (OBGYN) providers in the United States found that 35.3% and 29% reported feeling comfortable providing health care for male-to-female (MTF) and female-to-male (FTM) patients, respectively. Furthermore, only 38.4% were aware of the recommendations for MTF patients with prostate cancer, and 59.4% knew the breast cancer screening protocol for FTM patients (Unger, 2015). Even more importantly and mirroring other populations of the LGBT community, decisions regarding proper treatment for transgender patients are often based on clinical guidelines that are not supported by scientific evidence (Shuster, 2016). Strategies aimed at fostering resilience, such as connecting transgender youth with transgender adult role models, have been recommended to combat such structural barriers (Torres et al., 2015), but we will need evaluations over time to see what effects such attempts may have. Past experience in LG groups suggest the results may be mixed.

Like many sexual minority communities, transgender people report a general lack of trust in the health care system, in part due to stigma and previous negative experiences with health care providers (Eyssel et al., 2017). Public health efforts aimed at marginalized populations within the transgender community, such as trans women of color, can be very challenging (Sevelius et al., 2013), requiring intersectional approaches that combat structural inequities and discrimination (Seelman et al., 2018; Williams et al., 2017). As noted by the Movement Advancement Project, Services & Advocacy for GLBT Elders (2017), this is an issue creating tension and problems throughout LGBT communities, and one that exacerbates difficulties in aging, health, and care work for LGBT elders over time.

Although we could continue to offer similar portraits utilizing the case of lesbian, gay, or bisexual people—as well as subpopulations within each of these and transgender populations—to present examples, the end result is the same. There are many issues likely to be encountered in LGBT later-life care as a result of the many issues LGBT populations face with health-related and other mainstream organizations throughout their lives. Especially, as many later-life-focused organizations and providers noted extreme difficulties adjusting to openly LGBT elders in recent years (Hughes et al., 2011), these factors present challenges health and aging scholars can prepare for at present in hopes of easing such adjustment over time as more openly LGBT elders enter later life and facilities seeking to provide later-life care. Although there is no way to know how such dilemmas may play out or the ways current providers will respond to existing concerns, our discussion here paints a portrait of some of the ways emerging and growing openly LGBT

populations are likely to impact and reveal needs within our later-life care systems in the coming decades.

## Conclusion

In this review piece, we explored existing literature on the health and aging needs of LGBT people in later life. In so doing, we outlined some ways future studies of later-life care, health, and well-being could benefit—in both scholarly and applied terms—from integration of LGBT elder experiences, needs, and concerns. Specifically, we utilized this exercise to outline how patterns in the literature related to social support, interactions with medical providers, and aging resources suggest important avenues for scholars of health and aging to examine in the coming years. Furthermore, we utilized the case of transgender health experiences and outcomes in earlier portions of the life course to illustrate potential future needs and concerns for practitioners and scholars of health and aging when responding to increasing populations of future elders openly identifying and experiencing the life course as LGBT people. Our review suggests potential pathways for ongoing attempts to integrate LGBT elder care into the broader pursuits of health and aging scholars and practitioners.

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## Note

1. In this review, we focus specifically on lesbian, gay, bisexual, and transgender (LGBT) populations because (a) these populations are the focus of the bulk of the literature on sexual and gender diverse aging experience at present and (b) focusing on these populations in existing literature provides resources for summary and recommendations for the field. At the same time, however, we also encourage future research to more systematically include and analyze the aging experiences of other sexual and gender diverse populations including but not limited to ace, intersex, pansexual, queer, and poly populations.

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