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**Coping Strategies Used by LGB Older Adults in Facing and  
Anticipating Health Challenges: A Narrative Analysis**

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**Abstract**

Given that lesbian, gay, and bisexual (LGB) older adults face notable health disparities compared to their heterosexual counterparts, there is a need for understanding how LGB adults cope with health challenges in late life. The current study analyzes narratives from nine LGB adults age 65 and older living in an urban area in the Southeast U.S. Participants spoke of coping strategies related to health promotion behaviors, shifting perspectives of health and body, trusting in spirituality for comfort, and accepting the end of life. We discuss implications for social services professionals who work with older LGB adults and for future research.

*Keywords:* aging; health; gay; lesbian; bisexual; coping

## **Coping Strategies Used by LGB Older Adults in Facing and Anticipating Health**

### **Challenges: A Narrative Analysis**

Although there are few national or population-based studies of lesbian, gay, and bisexual (LGB) older adults, estimates from scholars suggest that somewhere between 1.75 and 4 million adults age 60 and older identify as LGB or transgender (LGBT; Administration on Aging, 2014). Just as there is expected to be a significant growth in the general population of adults over age 65 in coming decades, the number of older LGB adults is predicted to double between 2010 and 2040 (MAP & SAGE, 2010). As LGB members of the Baby Boomer generation - many of whom have been out for much of their adult lives (Barker, Herdt, & de Vries, 2006) - reach the age of 65, there will be increasing needs for social services providers who understand and are prepared to meet the unique needs of this aging population in an affirming manner.

Even with this pending shift in demographics, there continues to be a lack of research on older LGB adults – especially those over age 65 – about health challenges, health disparities, and coping strategies when dealing with these issues. Among NIH-funded LGBT research through the year 2011, for example, only 0.3% of all projects had studied adults over age 50; after excluding HIV and sexual health studies, this drops to less than .001% (Coulter, Kenst, Bowen, & Scout, 2014). However, a growing number of studies are documenting particular physical and mental health disparities impacting LGB compared to heterosexual older adults. Given emerging data about such disparities, understanding strategies that older LGB individuals use to cope with health issues in later life can inform social services practice with these populations. The present study aims to address these gaps in the literature. The authors will first provide an overview of research related to LGB health disparities and coping strategies used by this population in later

life. We will then detail study methodology, present findings of our narrative analysis, and discuss these findings in relation to social services practice and implications for future research.

## **Literature Review**

### **LGB Health Disparities**

LGB adults, also known as sexual minority adults, face particular health disparities that differ from heterosexual adults, including challenges related to their mental and physical health resulting from a lifetime of discrimination (Institute of Medicine [IOM], 2011). For example, a survey using population-based data from Massachusetts indicated greater rates of tension or worry, asthma, activity limitation, and lifetime victimization among LGB versus heterosexual adults (Conron, Mimiaga, & Landers, 2010). In this same survey, (a) gay men were more likely to be smokers and to have experienced sexual assault than heterosexual men; (b) lesbians were more likely to be obese, have risks for cardiovascular disease, and be current smokers than heterosexual women, and (c) bisexuals were less likely to have a regular health care provider and more likely to have experienced suicidal ideation in the past year, engaged in binge drinking or current smoking, reported fair/poor health, and demonstrated risk for cardiovascular disease compared to heterosexuals, among other disparities (Conron et al., 2010). Such disparities are likely to impact the life course of LGB adults, extending into late life due to ongoing risks including discrimination and violence (Fredriksen-Goldsen, et al., 2011).

While there has not been much research about health disparities by sexual orientation among adults over age 65, a recent analysis of population-based data from Washington state found higher rates of poor mental health, excessive drinking, and disabilities among the LGB adults age 50 and older compared to their heterosexual peers (Fredriksen-Goldsen, Kim, Barkan, Muraco, & Hoy-Ellis, 2013). Lesbian and bisexual women from this sample were more likely to

face obesity and cardiovascular disease risks, while bisexual and gay men had poorer overall physical health and were more likely to reside alone than heterosexuals (Fredriksen-Goldsen et al., 2013). Older LGB adults also face particular barriers related to social support systems and service provision, both of which may make it more challenging for them to seek out help and address health needs. A sizeable amount of research has documented issues of homophobia, biphobia, and lack of LGBTQ cultural competence among health care and social services providers (Erdley, Anklam, & Reardon, 2014; Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014; Morales, King, Hiler, Coopwood, & Wayland, 2014; Orel, 2014). Further, compared to heterosexuals, LGB adults face a greater likelihood of rejection and estrangement from their families of origin (Almack, Seymour, & Bellamy, 2010) and fear of discrimination from service and health providers (Bolderston & Ralph, 2016; Fredriksen-Goldsen et al., 2011; Whitehead, Shaver, & Stephenson, 2016), both of which can complicate the process of aging and attempts to address health challenges in later life. When they do not feel they can trust health care providers, LGB older adults are less likely to disclose their sexual orientation (Boehmer & Case, 2004; St. Pierre, 2012), and this affects providers' ability to adequately serve this population. Given the documented health disparities impacting this population and the barriers they face in accessing health and social services, there is value in understanding strategies this population uses to cope with such challenges and remain resilient in later life.

### **Coping among LGB Adults**

There is a sizeable body of research on coping strategies among general populations of adults and the connection to physical and mental health (for example, see Austenfeld & Stanton, 2004; Lewinson, Hurt, & Hughes, 2015; Park, Sacco, & Edmondson, 2012; Penley, Tomaka, & Wiebe, 2002; Stanton & Snider, 1993), as well as coping among older adults in relation to health

challenges (Conner et al., 2010; Dunn & Horgas, 2004) and mortality risk (McDougle, Konrath, Walk, & Handy, 2016). Previous studies of coping identify active and passive strategies people use to appraise and manage stress-related situations (Lazarus & Folkman, 1984). Active coping includes both preventative and proactive efforts to minimize risky outcomes and/or mitigate the effects of existing challenges (Straud, McNaughton-Cassill, & Fuhrman, 2015). Individuals employing active coping skills will find solutions to problems, cognitively reframe situations to manage unpleasant emotions, or seek social support while addressing difficulties. Unlike active strategies, passive coping involves avoidance of stressors. To avoid problems, individuals may deny difficulties exist, detach or distract themselves from stressful challenges, or internalize distress resulting from negative experiences (Cramer et. al., 2016). Resources used to cope with stressors may be intrapersonal, such as having optimism or a sense of self-efficacy, or interpersonal, such as having social support or access to community programming (Taylor & Stanton, 2007; Yeung, Lu, Wong, & Huynh, 2016). Internal and external coping resources act as protective factors that encourage resilience in the face of adverse conditions (Maschi & Morgen, 2014).

There is great value in understanding the coping strategies and resources that are effectively used among sexual minority seniors considering the multiple risk factors they face in relation to health disparities, homophobia, ageism, marginalization based upon other identities (e.g., race, gender, ability), and other factors. Much of the previous research on coping among LGB adults has focused on comparing different types of coping in relation to mental health or coping with one's sexual orientation. A study of 50 gay men during the 1980s AIDS epidemic documented the positive association of active-behavioral coping with self-esteem and lower mood disturbance, whereas avoidance coping was related to lower self-esteem and greater



depression (Namir, Wolcott, Fawzy, & Alumbaugh, 1987). In studies of sexual minority adults, researchers have noted the importance of emotion-focused coping self-efficacy related to one's sexual identity in addressing the impact of stigma on health (Denton, Rostosky, & Danner, 2014). Among sexual minority women, maladaptive coping (such as self-blame and behavioral disengagement) is a particularly strong predictor of poorer physical and mental health (Lehavot, 2012), and those who experience greater internalized homophobia are more likely to use avoidant coping strategies and thereby experience worse mental health (Szymanski & Owens, 2008).

Turning to research on older adults, sexual minority seniors may face particular challenges related to coping with ageism, especially as social services for LGB and transgender people tend to target younger adults (Erdley et al., 2014). Yet, lifetime experiences of stigma and discrimination related to a sexual minority identity (or other marginalized identities) and the coping strategies that have enabled one to endure such challenges can prove useful in combating ageism in later life (see, for example, Woody, 2014). One study that examined successful aging among older sexual minority adults highlighted the importance of health promotion behaviors, a positive sense of sexual identity, and social support in relationship to physical and mental health, regardless of one's age cohort (Fredriksen-Goldsen, Kim, Shiu, Goldsen, & Emler, 2015). Recent work by Putney, Leafmeeker, & Hebert (2016) proposes a model of adaptive growth among older lesbians, based on interviews with 12 (primarily white) women, half of whom had past or current notable health issues. Their work identified the use of social support, spirituality, and resistance to cultural norms as methods of coping.

Van Wagenen, Driskell & Bradford (2013) have put forth a conceptual model of successful aging among LGBT older adults that includes not only individuals who avoid

physical, mental, and socioemotional challenges related to aging, but also those who are “surviving and thriving” (successfully coping with problems) and others who are “working at it” (some coping with effort). Some of the coping strategies named in this study include having a positive attitude, expanding one’s social network especially among the gay community, applying for disability insurance for functional impairments, and seeking mental health therapy. However, coping strategies were not thoroughly explored per se, as their study primarily focused on developing a conceptual framework of successful aging.

### **Current Study**

Despite a growing body of research documenting health disparities that affect LGB adults and extend through later life, few studies have looked at how this population copes with current or anticipated health challenges. The purpose of the present study, then, is to address these gaps in the knowledge base through narrative analysis of interviews with nine LGB older adults. Our research question is: what stories do LGB older adults (age 65+) tell about ways they cope with experienced or anticipated health challenges?

### **Methods**

This study used an embedded mixed methods design (Creswell & Plano Clark, 2011) with a predominant qualitative component (interview) that was supplemented with collection of brief quantitative data (pen and paper survey); for the purpose of answering the research question of interest related to coping, we focus on analyzing the qualitative data. This study’s methods were approved by the Georgia State University Institutional Review Board.

### **Recruitment**

In order to be eligible to participate in this study, individuals had to identify as lesbian, gay, bisexual, or same-gender-loving, be age 65 or older, and live in a large city in the

Southeastern U.S. where the study was being conducted. Nine LGB older adults were recruited via word of mouth by identified gatekeepers in the metropolitan area to participate in this study. Targeted outreach to LGBT communities and LGBT-affirming faith-based organizations allowed us to reach a sample that was diverse with regard to relationship status, race, and income.

### **Data Collection**

Potential participants were screened via phone or email for eligibility. Once determined eligible, the individual selected a date, time, and location for a private interview. Although these interviews were planned to be one-to-one, the very first respondent asked if she could be interviewed alongside of her partner, who was also LGB and over age 65; this was done in three cases—twice where both individuals were eligible to participate, and a third time where a partner was too young to qualify (and was not a research participant), but still contributed to the conversation. Before each audio-recorded interview, participants signed a consent form. Everyone who started an interview was offered \$10 remuneration for participation.

Interviews were guided by semi-structured questionnaires and lasted approximately 45-75 minutes. Each interview was conducted by either the PI (first author) or a trained graduate social work student (fifth author). The interview covered various topics, such as health statuses and concerns, advance care planning, and aging-related needs. After finishing the qualitative interview, all participants completed a brief survey that included demographic questions as well as items related to social support, connection to the LGBT community, depression, and life purpose (i.e., drawing meaning from one's life and intentionally setting goals to guide one's behavior; see Boyle, Buchman, Barnes, & Bennett, 2010). Interview data were transcribed verbatim and pseudonyms were assigned to maintain respondent anonymity when detailing specific health concerns within publications. For rigor in the study, we enhanced trustworthiness

of methods by creating an audit trail, conducting data analysis as a team, presenting exemplars (sample narratives) when discussing findings, and carrying out an audibility check, which involved having a second person listen to recorded interviews and correcting any transcription errors (Suter, 2009).

### **Data Analysis**

Since we were interested in the story LGB older adults told about ways they coped with health challenges or the anticipation of health challenges, we used a narrative analysis (Riessman, 2008), which is helpful for understanding perceptions of experience across time within the context of dynamic lives. This approach allowed us to examine interview data as text and focused on capturing discernible stories shared by the participants. The process involved listening to recorded interviews and reading transcripts repeatedly to identify individual accountings of health experiences. We were concerned with the *content* of the stories told rather than the precise mechanisms of how a story was being constructed using language (Riessman, 2008). We pieced sentences and paragraphs of text about “health experiences” together to allow a broader narrative of health to emerge for each participant, then across participants. As a research team, we compared independent findings and engaged in discussions until we reached agreement about health narratives and ways LGB older adults used coping strategies to address health challenges. Findings presented below answers our research question, “What stories do LGB older adults (age 65+) tell about ways they cope with experienced or anticipated health challenges?”

## **Findings**

### **Participant Demographics**

Nine adults participated in this project, including five cisgender (non-transgender) men and four cisgender women. Their ages ranged from 65 to 77, with an average age of 71. Two-

thirds (66.7%,  $n = 6$ ) were white/Caucasian, while 33.3% ( $n = 3$ ) were African American/Black. At the time of the interviews, 55.6% ( $n = 5$ ) of the participants were partnered or married (though not legally recognized in their state of residence at the time), while the remaining four participants were single. Four (44.4%) of the participants were parents, all from previous heterosexual relationships.

The sample was highly educated, with six participants (66.7%) having a graduate degree, two (22.2%) having some college education, and one (11.1%) having a high school diploma/GED. Monthly income (including Social Security) ranged from \$945 to \$5,000/month per individual, with a median of \$1,800/month. All participants had some form of health care. Most participants used the terms gay or lesbian to describe their identities; one person preferred the term same-gender-loving, one woman said she simply “likes having sex with women,” and one person said “mostly gay,” but identified as bisexual earlier in life. Five (55.6%) individuals said they were out to most people in their social network about their sexual orientation, two (22.2%) were out to everyone, and two (22.2%) were out to only a few close friends and/or family members.

### **Health Challenges**

Eight of nine of our participants had current or recent health issues, ranging from chronic diseases, such as cancer and arthritis, to acute conditions, such as dealing with the consequences of a recent fall. One individual, Liz (age 77), was the oldest person in the sample and also the only participant with no current physical or mental health challenges. Many of the other participants had more than one physical or mental health concern that they discussed during the interview. Within our results, we will detail some examples of health issues faced by participants

– such as acute conditions brought on suddenly and chronic conditions that affect one’s life for a long period.

[Insert Table 1 here]

Participants narrated stories about health challenges that fell within two categories of illness: acute vs. chronic. We named these narratives with in-vivo labels. Mia’s narrative, “being stricken instantly” describes the sudden and unexpected onset of illness. Her story represents the experience of five respondents. Jack’s and Mike’s narratives, “dealing with it for... years” describe experiences of managing long term chronic illnesses, which affected seven of the nine participants.

**Being stricken instantly.** Mia (age 72) described her overall health as near excellent. However, recently, she experienced a sudden shift in her wellness that made her acutely aware of the precarious nature of health. She explained:

If you would had asked me about my health previously, I would have rated it higher. But for some reason unknown to me, I had a bowel obstruction, a small bowel obstruction. I went into the hospital, and that totally blind-sighted me and changed my whole perception of wellness and health. But, I still think generally I am pretty good. It really made it clear to me how vulnerable and how frail health is, and how you can be stricken instantly and lose it all, or, you know, go into some type of less than ideal situation when I thought I was doing many of the things right. I had just started a vegetarian, semi-vegetarian lifestyle since I met Maggie [partner] about two years ago. I was exercising. I was active and getting proper rest. The weekend that it happened, we had just done a cleanse and it seemed poorly timed. Wow, how can this be happening to me?!

Mia found her health crisis hard to believe. When told that she needed to be hospitalized, she made the decision to wait a few days and get through the weekend. She did not understand the urgency of her situation and that bowel obstructions are life threatening, since they often require surgery and can be a symptom of a chronic condition, like colon cancer. Instead of going to the hospital, she went home and was subsequently readmitted into the hospital three days later. Mia recalled, “It really rattled my confidence about my own health and well-being. I’ve been hospitalized numerous times for surgeries, but, you know, it was always planned and elected, I could choose the days. I never had an urgent hospitalization.”

Like Mia, many of the other participants who experienced acute conditions were usually taken by surprise, and the experience changed their perceptions of their own health and wellness. This changing perceptions sometimes prompted a shift in health promotion behaviors, such as a change in diet or exercise. Facing an acute condition also revealed a vulnerability to participants—that a sudden change in health can happen to even the healthiest people who have been taking steps to care for themselves for much of their life. Experiencing an acute condition sometimes brought up feelings of disappointment or frustration – especially when affecting mobility or leisure activities –or anxiety around how long the condition would last.

**Dealing with it for ... years.** Jack (70) has been facing co-morbidities for a number of years, including issues with vision and hearing, as well as bone marrow cancer, which was diagnosed more than a decade ago:

Well, I can tell you what the main thing is that I’m dealing with for over 10 years— bone marrow cancer. It’s also known as Multiple Myeloma. And, when I was first diagnosed back in 2002, I thought I was going to be dead in 2 years.

Instead of two years, Jack continues to survive. However, within 5 years of his diagnosis, he had a bone marrow transplant, then remained in remission for another 4 years. However, as a result of his cancer recurrence last year, he has returned to oral chemotherapy. Jack has maintained a positive attitude about his cancer reality. He stated:

I'm fortunate that this particular kind of cancer can sometimes be dealt with by just taking pills. Now, they're pretty strong pills, and they have some side effects, but it's better than having to go into the doctor's office and be infused with chemo [chuckles] for three hours, three times a week. So, I've had to put up with that for this last year, but the side effects are not terrible. And, the oral chemo has gotten the numbers under control again, and I don't know how long that will remain effective, but I can imagine that it could be effective for years. That's the main, the big thing that I'm dealing with.

In addition to the oral chemotherapy, Jack also receives infusions of Zometa every three months to protect his bones. Aside from managing his Multiple Myeloma, Jack has also had cataract surgery to improve his vision in one eye.

Mike (67) also has a story of resilience. In the face of crippling health events, just like Jack, he maintains optimism about his ability to deal with his health status. Below, he describes his health journey and subsequent shift in abilities.

Okay, so I am HIV positive. I have been for sixteen to eighteen years. I know the exact date. I know exactly where I was standing when the doctor said, "There's, you know, there's something wrong with the blood." And, I'm in great health. I take one pill a night. So it's really just managing now, just going to the doctor. I'm non-detectable.



Mike has been successfully managing HIV. He regularly takes care of his health and is compliant with his medication regimen. As a result, his T-cells remain high. However, Mike knows what it is like to be on the brink of death, as a result of a very painful shingles outbreak. He described:

About six years ago I got shingles, and it hit my spine. So, that's why I have a nerve damage in my legs. I almost died in the hospital. I was there two weeks and I got below 90 pounds. It just shut down my whole lower body... and the nerve damage. I just had gotten sick and felt like this was going to pass. And, it just was not gonna pass. And, I couldn't stand up. I couldn't eat. I was, I literally was crawling.

Although Mike describes himself as being in a “peaceful place,” there have been long-term health consequences that limit his daily abilities and affect his quality of life, such as having chronic pain, leg fatigue, and reduced mobility. As a result of his documented disability, he is unable to travel and fully engage in activities that he enjoys.

I can walk really good faking it, but it does not mean that I'm not in a lot of pain. I'm in pain all the time. It's not a pain that's not manageable. My legs are burning. I take Lyrica for that. Maybe one a day in the evenings, always before bed. Sometimes a half in the afternoon, just to, you know, zone out or say, “I think I'm just going to lay in bed and enjoy the morning.” So, I do a little bit of that, but not much.

Social support is essential for Mike; he recognizes his need for continued assistance. For leisure activities, he states, “I really need somebody to go with me, to help me when my legs get tired. I need a shoulder to hold on to. I can do it, but I need that.”

These stories of resilience are true for many of the respondents who were fighting with various ailments, such as Tony (65), who struggled with substance abuse brought on by self-medicated grief at the loss of friends and family. His despair was so profound that he has

contemplated suicide. Erin (75) has polymyalgia rheumatica, a widespread inflammatory condition that causes aching and stiffness that she manages with corticosteroids. Mark (74) takes medication for depression, and Isabel lives with bipolar disorder and memory deficits.

Across the individuals with chronic conditions, a general pattern is that medical conditions may appear gradually over time or suddenly, but they have long-lasting effects. Participants sometimes felt ambiguity about whether the health issue they were facing was permanent and whether to label it as “chronic,” and they sometimes experienced anxiety about whether things would get worse. Three of the participants noted that conditions that people often assume are terminal – such as cancer or HIV/AIDS – may be manageable with treatment or surgery and have few side effects; in other instances, the side effects of a condition or a secondary diagnosis may have more of a daily impact than the condition itself. Sometimes a diagnosis of a chronic condition prompted changes in one’s behavior to lessen side effects or to try to stop further deterioration. Some individuals discussed how their chronic health concerns brought up fears of death/how one will die, whether they can tolerate their condition at the end of life, and whether they will be too much of a “burden” to caregivers/family.

### **Coping Strategies**

Given the variety of health challenges faced by this sample of LGB older adults, participants discussed a number of strategies for coping with these challenges. They began engaging in health-promoting activities, shifting their perspectives about health and body, trusting in spiritual comfort, and accepting rather than resisting the end of life.

**Engaging in health-promoting behaviors.** Chronic diseases, such as addiction, mental health diagnoses, injuries from falls, and acute conditions are just some of the health challenges that made participants more aware of the need to be proactive with health-promoting behaviors.

Faced with increasing functional challenges, many discontinued harmful behaviors and began engaging in activities they believed would maximize their quality of life before death. Tony (age 65) started addressing a substance abuse addiction, for example, in midlife by reframing his understanding of life stressors and prioritizing his own well-being. He said, “I have to make sure that Tony is okay.” Additionally, he commented:

Well, I think the fact is, when I got clean, then I could think clearly. I could see things a lot clearer, ‘cause when you’re in a cloud of drugs, you don’t think clearly. You think irrationally, continually, destructively. But the fact is, when you get clean, you finally are able to deal with issues, ‘cause it’s not only about getting clean—it’s about dealing with those issues that made you use in the first place. ‘Course, when I first started using drugs, it was for the fun of it, you know what I’m sayin? But subconsciously, there’s things up under there that makes you use and you bury a lot of things, along life, that you don’t want to deal with. Once you get clean, you still have to deal with those issues! They don’t go anywhere. They were just buried. So, when it comes up, you have to deal with it on a daily basis. That changes your whole perspective, I think, of how you want to live because if you don’t deal with them, then you go back to doin’ what you were doin’. So, I think, that is what kinda changed me in life, in a sense. Because that’s how life is—you have to deal with each issue as it comes up, whether it’s good, bad or indifferent—that’s life! It’s life!

In Tony’s reflection, he came to understand the deleterious effects of using drugs as an escape mechanism. As a result, he made a decision to address life challenges as they come. Now, instead of trying to escape problems, he plans to seek support, check in with himself daily, and commit to avoiding relapse.

Isabel (age 65) has witnessed her mother-in-law's struggle with Alzheimer's disease. This experience has prompted Isabel to take steps to promote her own health and try to halt the memory loss that has impacted her in recent years. In her narrative, she describes how her mother-in-law's challenges affect her current motivation for engaging in health-promoting behaviors. She said,

I think [what] probably concerns me more [than emotional health] is the problem I'm having with my memory. My wife's mother has Alzheimer's, and so I'm like, "Oh my God! I have Alzheimers!" But it really is a concern that I'm forgetful... more than I usually am. I mean, we're both forgetful, but I'm just like, "Man, I can't remember anything anymore."

To counter her memory concerns, Isabel has begun exercising her cognitive skills by practicing memory and problem solving games found on the Internet. In this way, she feels as though she is taking productive steps to slow down the progress of cognitive decline. Isabel is not sure whether her memory deficits are a sign of an onset of dementia or if they are caused by the side effects of medications she is taking. In either case, she is very troubled by the very idea of losing her cognitive faculties. She exclaimed, "I mean you can tell from the way I talk that I have some aphasia. And that bothers me. So it's mainly my thinking that bothers me... 'Cause I don't want to lose my thinking, since I'm healthy physically."

Isabel's fears are further supported by the fact that her mother was physically healthy, yet faced Parkinson's disease. The fear of losing the ability to remember and process information caused her to consult with a psychiatrist. Although she does not categorize her anxiety about the situation as overpowering, she declares, "Oh my God, I don't want to die that way. I don't want to die either way - by dementia or Parkinson's or something like that, but I'm going to have to

die... I'm going to have to die." Isabel constructs her own story of taking proactive steps to promote her own health based on her witnessing two relatives deal with health issues and putting herself in their shoes—reflecting on what she wants her process of aging to look like. Such reflexivity can be helpful in practice with older LGB adults—encouraging them to reflect on older friends' and family members' experiences with aging, or perhaps sharing “sample stories” of aging LGB individuals and changing health needs, desires for aging care, and end-of-life plans.

**Shifting perspectives about health and body.** Another coping strategy among these older adults is related to how they adapted their perspectives on health and body as they aged. Some spoke of beginning to recognize the “frailty” of their health after falls or sudden illnesses took them by surprise, and how they took action to tend to their health needs or put plans in place for aging-related care. Others embraced optimistic perspectives on health, particularly for chronic conditions, as a way to still “enjoy every day” and let go what is outside of one's control. For example, Jack (age 70), seems to view the proverbial glass as three-quarters full; he shared the following:

... being diagnosed with the cancer has had many positive aspects. There's nothing like being confronted with one's own mortality that does as much for making you really enjoy every day as it goes by and giving you a sense of being able to cope. You know, you think, “Okay, I'm getting through this, and it wasn't as bad as I thought, and I can face it,” whatever, you really get the feeling that whatever the future holds, you can face it because of all the things you have faced, and that you just enjoy life.

Jack's partner had remarked earlier on what a positive perspective Jack has; his narrative here suggests that he frames facing cancer as something that allows him to find enjoyment with the

present, recognize his own strength, and put cancer in perspective (“I can face it”). Such cognitive reframing can be helpful practice in working with older LGB adults to promote thoughts that assist with coping with changes to one’s health.

Mia (age 72) is quite aware of the subjective experience of reframing one’s perspective of body image and associated effects on healthy relationships. She commented on how negative perceptions can emerge as a result of being immersed in a youth-oriented society:

... specifically, as the body ages, we live in a youth-oriented society, so it’s not a pretty picture. The acceptance and acknowledgement and the awareness of the consciousness [of aging] has a strong psychological impact on aging and health care. I think that for Maggie and I, the physical aspect of our relationship has a lot to do with changes that she feels that her body has experienced that I don’t see. I am more accepting, but that’s an issue.

While Mia recognizes that society overemphasizes youth in connection to beauty, she frames her perspective as being about “acceptance” and “awareness” of her body as she ages. Yet, she hints at how her physical relationship with her partner is still impacted by how each of them view their own bodies changing with age, and that this has become an “issue.”

Several participants discussed how they struggled with feelings of anxiety and fears about aging. Tony noted how turning 40 brought about depression for him because he felt *old*, but later he started to reframe his mindset that aging is “part of life”:

I’m now 65, but when I turned 40, I have to say I was depressed for about six months of my life. People asked me, “Well, why was that--?” I said, “Because I’ve got out of my thirties, and I felt that I was old.” And I said, “Plus, I looked at my life. I felt like I had not accomplished anything at forty.” Didn’t own a home, nothing, nothing had gone

right. And I said, “People around me that were forty or whatever had bloomed out, done what they wanted to do in their professions.” And I said, “I just felt totally lost at forty.” So, for about six months there, I was like really depressed about that. And then I finally got out of the funk and went on with life, you know what I’m sayin, because I had to.

Tony’s narrative touches upon a common theme, particularly among the gay men in the sample, who spoke to anxiety and denial related to reaching middle age and beyond. Tony’s reframing – that aging is “part of life”—is a strategy of normalizing an experience, emphasizing the common journey we all have as we go through life. Reframing in this way and talking about coping strategies for coming to terms with changing health, body, and age can help LGB older adults face later life with confidence.

**Trusting in spirituality for comfort.** Another strategy participants used for coping with health challenges was trusting in spiritual beliefs. To be clear, not every participant was religious or spiritual, and a few were not affiliated with any particular religion. This is not uncommon among sexual minority adults (Herek et al., 2010), many of whom have had to overcome anti-LGB hostility from the religion of their childhood. However, a few participants, including all of the African American respondents, regularly attended religious services at least once per week and spoke to how their spiritual belief system guides them during moments when they feel vulnerable. Tony (age 65), in particular, had a very strong connection to God and spoke of how he was guided “full circle” in life – both geographically (preparing to move back to a West Coast city where he used to live as part of his intended journey) and coming to a place as a gay man where he can now accept himself fully again:

I guess God just wanted me to move around. And in each place that I went, I learned different things that I needed to know in my life, spiritually, physically, mentally... I

realized, in each place that I went, there was a spiritual need. And, that there was something important to me, spiritually, in churches and in pastors. So that motivated me a lot, to do the things that I did. And coming here to this city, everything finalized for me. I finally was able to accept who I was, spiritually speaking, because the church that I'm in gave me real clarity that it's okay to be who you are. And, God still loves you, no matter what, because he wouldn't have made you the way you are. He knew all about you even while you were still in your mother's womb. He knew exactly who you were and what you were going to be. So why would He hate me? Why would it be a sin for me to be gay and still know God? Why?

Tony's perspective is that there has been a purpose or lesson from each thing he's faced in life – and this understanding provides him with strength in getting through struggles, such as coming to terms with his gay identity. Spirituality, in this way, may be one intrapersonal coping resource for helping older adults “make sense” of the challenges they face in life – and social workers and other helping professionals can open conversations to such topics when working with older LGB adults. Specific spiritual practices may also bring comfort to this population, as was shared by Mia, who described what helped her thrive: “I meditate and have a strong spiritual base, which comforts me.” For some adults, practices like meditation may prove helpful as a spiritual coping strategy although they may not be tied to a particular religion for the individual.

**Accepting the end of life.** Some respondents discussed the importance of accepting that one's life will end as a means of coping with difficulties. Mike (age 67) was asked a question about how he would cope if he received a major health diagnosis, such as cancer, that had an impact on the appearance of his body:



So I wouldn't have a problem going at the end of life, if I had cancer. I've had a good run. I'm not a big star. I'm not a big city personality, I'm a whatever. And maybe I'm a hack. I don't know. Maybe I'm a wannabe. But, I did things. I had a good time. And sometimes you have to just let it go. This was enough. I need to pass on whatever nuts that I've cultivated and pass them on to somebody.

Mike asserts his appreciation of the life he's lived ("I've had a good run"), even though, as a performer, he's "not a big star." He accepts who he is, the decisions he has made, and deals with challenges as they arise. As he says, "sometimes you have to just let it go," meaning that the end of life is not something that anyone can avoid, and acceptance is one way of preparing for late life. He also speaks to the value of knowing that others can carry on something into the future ("...whatever nuts that I've cultivated"), a point which reflects Erikson's generativity vs. stagnation stage of adult development (Erikson & Erikson, 1981).

Another participant, Mark (age 74), engaged in acceptance of the end of life through a unique type of social engagement. He participated in a monthly discussion group that focused on end of life and death. Their conversations regularly turned to topics around end-of-life planning:

I have a view that my mortality is not frightening. We go to a group also every month. It's about getting together with a number of people at a local cemetery, and we sit out looking at the cemetery and talk about what have we done to prepare for [death], documents and otherwise. Also, what are we doing to enrich our lives as long as we're here. In essence, we're mortal. People sit around and talk openly about, "Yes, I do realize I'm gonna die." So, I really think that's valuable. One last thing that I'd like to say is that people that are struggling with aging—if you go one time and you don't like [our group], you can eat the sandwich and leave.

### **Discussion and Conclusion**

This study intended to provide insight into how a marginalized population – LGB seniors – cope with health challenges. The participants' narratives highlight many ways LGB older adults face and anticipate acute and/or chronic health conditions and cope with these challenges. Although health challenges can affect older adults of any sexual orientation, LGB adults may face unique challenges that complicate decision-making, such as family rejection, lower likelihood of having children to support them, and homophobia from health care providers and society-at-large.

Participants of this study experienced a number of health conditions that mirror disparities that have been documented with representative samples of LGB adults, such as risks for mental health conditions such as depression, substance abuse (though both participants impacted were in recovery), suicidal ideation, and HIV/AIDS (Conron et al., 2010; Fredriksen-Goldsen et al., 2011). Multiple participants were cancer survivors, and others discussed acute conditions that become more common with aging, such as an unexpected fall or bowel obstruction. Only one participant had no current health issues, and five of the nine participants noted more than one major health issue. This is particularly striking, given that all participants were in their 60s or 70s, as opposed to older cohorts. Social workers, gerontologists and others who work with older adults can benefit from anticipating such health disparities that can affect quality of life and functioning among LGB individuals as they age.

We identified a number of coping strategies used by this sample to address current or anticipated health challenges in later life. Some of these strategies reflected active coping, such as Isabel's problem-focused approach to memory concerns, Jack's cognitive ability to shift his perspective about cancer and mortality, and Mia's emotion-focused success in reframing

negative images of aging and beauty. Tony's narrative recounts a deliberate shift from passive coping (illicit drug use for escaping life's challenges) to active coping (engagement in recovery activities and personal reflection). Additionally, respondents described a number of coping resources used as prevention or intervention approaches to acute and chronic health challenges and aging-related concerns, including engagement in regular exercise, volunteering in the community, developing a spiritual sense of self, and seeking information from legal representatives, medical personnel, and LGBTQ community groups. These results have some patterns in common with the study by Putney et al. (2016) among older lesbians, despite differences in the gender and racial make-up of participants. Our study similarly identified spirituality as important for meaning-making and comfort in the face of health issues, as well as an acceptance of one's mortality (which was treated by Putney et al. as an example of development growth in late life, rather than a coping strategy).

Our finding regarding the importance of engaging in health-promoting behaviors as a coping strategy aligns with one of the factors of successful aging among LGBT older adults documented by Fredriksen-Goldsen et al. (2015). Their study particularly looked at physical activity, leisure activity, routine health check-ups, and not using substances. Our participants added further examples to this list, including engaging in physical therapy or medication as prescribed by a health provider, using meditation to promote well-being, improving one's diet, and engaging in technology-based memory exercises. We encourage researchers to incorporate such examples of preventative health behaviors in future studies of LGB older adults. There is also a need for research about methods for encouraging such healthful behaviors among this population.

The narratives related to coping with health challenges did not as clearly emphasize the role of social support, building connections with other LGB people, resisting cultural norms, or dealing with feelings about one's sexual orientation, which previous research has suggested may be important (Fredriksen-Goldsen et al., 2015; Putney et al., 2016; Van Wagenen et al., 2013). While there were certainly some narrative threads around these topics among a few participants, including the importance of spiritually coming to terms with sexual orientation (Tony) and some examples of resisting heterosexist, racist and ageist norms, these topics were not strong narratives across the sample in connection to coping with health problems. The absence of these topics may be related to the particulars of these nine individuals, our sampling and interview method, or other unknown factors. However, these topics are worth attention in future research, particularly among LGB adults who may experience variation in social support, live in rural areas that have more ingrained norms of heterosexism, and among LGB seniors of color.

This study demonstrated a number of methodological strengths. The use of qualitative interviews allowed for in-depth exploration of particular health conditions and coping strategies among LGB older adults. Such topics are underexplored among this population. The use of narrative analysis allowed for holistic exploration of the lives of sexual minority seniors and the connection to social services practice. Further, this study included both male and female participants, with notable diversity in terms of income, housing situation, and degree of being "out" about sexual orientation. We used a sampling approach that incorporated strategies for reaching single adults (about 45% of the sample) and African Americans (33% of sample). Each of these identity dimensions is likely to play a role in health disparities and coping for older adults (Conner et al., 2010; Fredriksen-Goldsen et al., 2011; Fredriksen-Goldsen, Kim, Bryan, Shiu, & Emler, 2017; Kim, Jen, & Fredriksen-Goldsen, 2017; Lam & Perales, 2017).

Nonetheless, there are notable limitations to the study. First, this was a geographically-limited sample: all participants were from one city in the Southeastern U.S. or its surrounding suburbs. There are likely to be different experiences among rural LGB adults that were not explored here. Everyone in this sample was either African American or white, and the experiences of these two groups likely vary beyond what is captured here and are different from other racial/ethnic groups of LGB seniors. The sample was also highly educated; future research could implement recruitment strategies to capture individuals with less than a college degree, such as through more extensive outreach with social services providers. The study's methodology involved one-time interviews; longitudinal research could better assess sexual minority adults' health and coping strategies over time. Readers should also keep in mind the limitations of qualitative research and how the results of this study are not generalizable to a broader population of LGB older adults. However, the patterns revealed in the data with regards to health challenges and coping could be further explored for transferability of findings to other population-based samples of LGB older adults in the future.

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