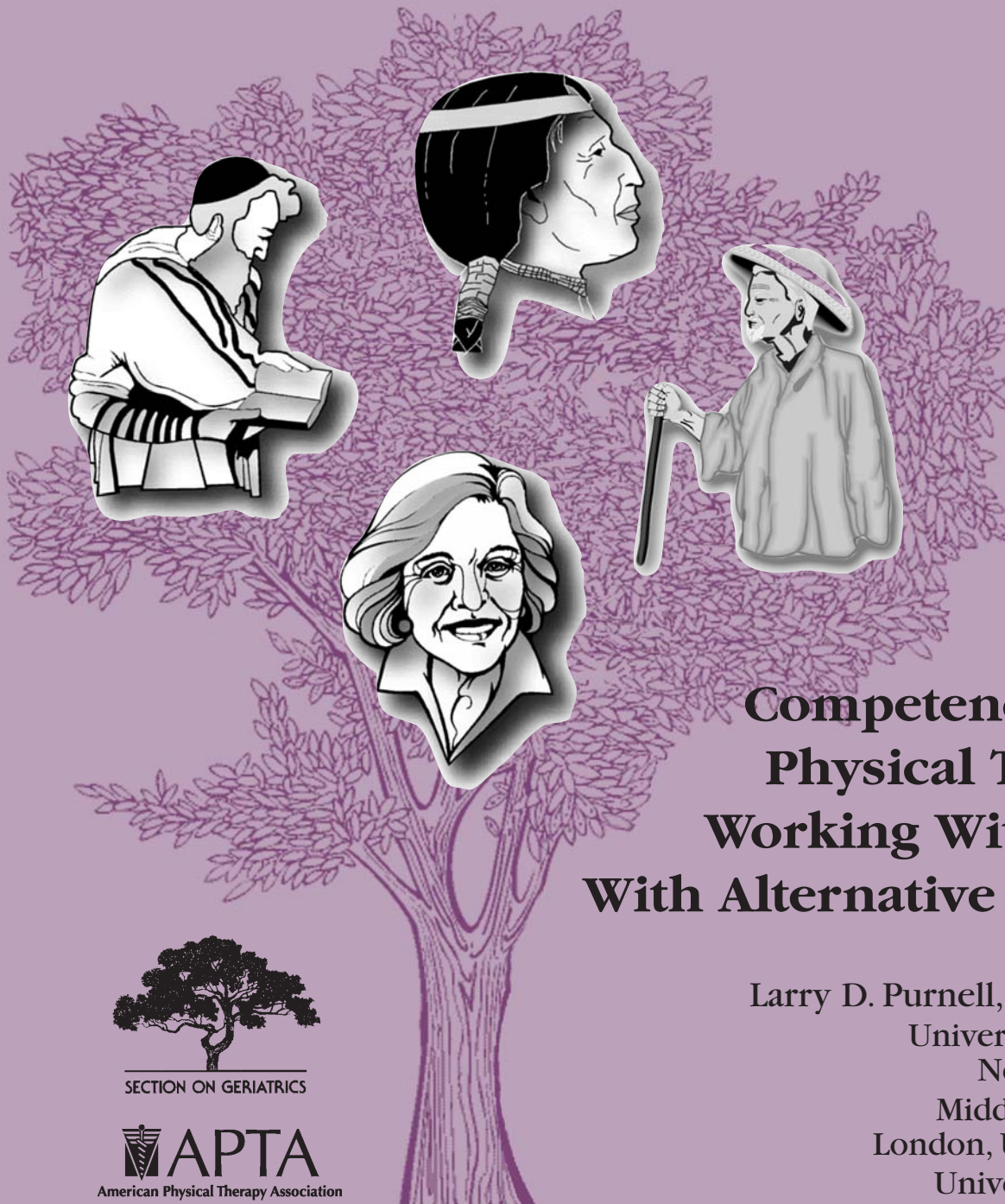


# Cultural Diversity of Older Americans

*An Independent Home Study Course for Individual Continuing Education*

**March–August 2003**



## **Cultural Competence for the Physical Therapist: Working With Clients With Alternative Lifestyles**

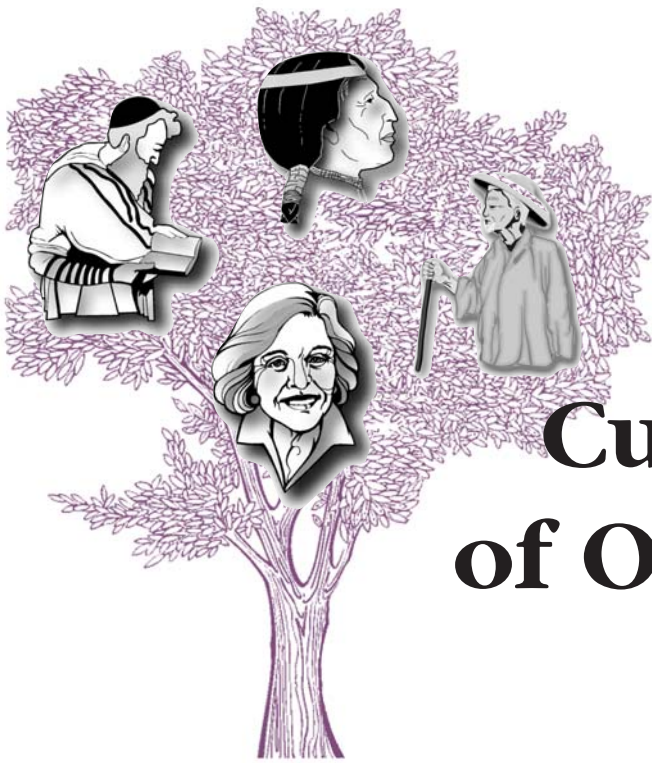
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Mary Thompson, PT, PhD, GCS—Editor  
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# Cultural Diversity of Older Americans

## Editor's Note

August 2003

Dear Home Study Course Participant,

As we conclude this monograph series on Cultural Diversity of Older Americans, it is an honor for me to introduce to you Larry D. Purnell, PhD, RN, FAAN. As a teacher, speaker, and award-winning writer with worldwide experience, he is uniquely qualified to author this monograph on working with clients with alternative lifestyles.

Dr Purnell teaches cross-cultural health care in several departments at the University of Delaware and holds appointments in England and the Republic of Panama. He has presented on cultural diversity throughout the United States, Australia, England, Scotland, Spain, Australia, Korea, China, Hong Kong, Panama, Finland, and Sweden.

His publications include *Transcultural Health Care: A Culturally Competent Approach*, edited with Dr Paulanka. The first edition has been translated into Spanish, French, Flemish, and Korean. It was also awarded the Best of the Branden Hill Books Award in 1999 and 2000. The second edition was released earlier this year and has been adopted by numerous colleges and universities.

With his wealth of experience and a full understanding of the literature, I know that Dr Purnell will help you provide culturally sensitive and culturally competent care to lesbian, gay, bisexual, and transgender older adults.

*Mary Thompson*

Mary Thompson, PT, PhD, GCS



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## Cultural Competence for the Physical Therapist: Working With Clients With Alternative Lifestyles

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### LEARNING OBJECTIVES

Upon completion of this monograph, the course participant will be able to:

1. Provide culturally sensitive and culturally competent care to lesbian, gay, bisexual, and transgender (LGBT) clients.
2. Discuss salient issues from the publication *Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Health*.
3. Identify health needs specific to LGBT clients.
4. Decrease barriers for LGBT clients accessing health care.
5. Identify resources for LGBT clients and health care providers working with LGBT clients.

### INTRODUCTION

The last 2 decades have seen an increased interest and emphasis on older adults and on LGBT people, without a corresponding increase in articles and research-based literature on older LGBT adults. What research literature is available is either in the form of ethnographic qualitative studies or descriptive in nature and frequently examines myths and stereotypes of these populations. The overall number of research-based studies is surprisingly small.

Most research studies and reports are convenience samples taken from urban communities where LGBT populations are more organized, but do not represent the populations as a whole. The sampling, for the most part, includes the more active, higher socioeconomic, and more educated LGBTs in the community, with little representation from minority groups, blue-collar groups, rural and widely dispersed groups, or lower socioeconomic groups. Additionally, sexual minorities experience discrimination; their sexual activities are illegal in some states, which makes it difficult for people to disclose their sexual orientation or identity to health care providers and researchers. Additionally, the over age 85 LGBT popula-

tion, except for a few anecdotal reports, are an invisible group.

A search of the literature found no studies of LGBT populations in the physical therapy literature. However, the American Physical Therapy Association Web site does include a link to the Organization of Gay and Lesbian Physical Therapy Professionals, whose Web site states:

Alternative Modalities, a nonprofit organization, came into being in June of 1993 at the American Physical Therapy Association conference in Cincinnati. Thanks to the efforts of some of our founding members, this was also the year the APTA added the words "sexual orientation" to its policy on nondiscrimination. Initially the group served mainly as a networking tool to put gay and lesbian therapists in touch with each other. Gradually our numbers have increased to well over 150 active voting members and more than 200 contacts and mailing list recipients. We look forward to showing a stronger voice in the APTA and our profession.<sup>1</sup>

A comprehensive survey on older adults or older LGBT populations has never been completed in the United States. However, an estimated 35 million people are age 65 years or older, with estimates of the LGBT population exceeding 3 million.<sup>2</sup> Yet this older group is almost invisible according to Urvashi Vaid, Director, Policy Institute, National Gay and Lesbian Task Force.<sup>3</sup> The popular estimate that 10% of the male population<sup>4</sup> and 5% to 6% of the female population<sup>5</sup> are exclusively or predominantly gay or lesbian is based on data from the Kinsey Institute from the 1940s and 1950s. A more recent compilation of data estimates that in the United States 9.8% of men and 5% of women report same-gender behavior since puberty, and 2.8% of men and 1.4% of women report homosexual or bisexual identity.<sup>6</sup>

About 52% of gays and lesbian seniors (age 50+) live alone,<sup>7</sup> which is more than twice the rate of all the people aged 55 years and older.<sup>8</sup> While 28.9% of the general over age 65 population were married and living with a spouse in 2000,<sup>8</sup> only 20% of gay men and lesbian women live with life partners.<sup>9</sup> No data could be found in the literature regarding the transgender population, who may be lesbian, gay, bisexual, or heterosexual.<sup>10</sup> Although there is little research concerning ethnic minority gay and lesbian seniors, one can posit that these groups exist in similar numbers with significant diversity among them.<sup>9</sup>

The LGBT individuals who are also from other disenfranchised groups, such as minorities and low socioeconomic status, may face additional stigmatization—being a member of a minority group, such as black or Hispanic, and being LGBT carries a double stigma. No reliable data exist on LGBT populations among African Americans, Hispanics, Asian/Pacific Islanders, Native Americans, Middle Easterners, or any other ethnic or cultural group. Additionally, there are no data available on the number of LGBT individuals by religious group, even though there are Web sites available for many of these subgroups (Table 1).

**Table 1. Internet Spirituality Resources**

Baptist – <a href="http://www.washingtonplazachurch.com">www.washingtonplazachurch.com</a>
Catholic – <a href="http://www.cacina.org">www.cacina.org</a>
Catholic – <a href="http://www.stbernadette.org">www.stbernadette.org</a>
Catholic – <a href="http://www.dignityusa.org">www.dignityusa.org</a>
Disciples of Christ – <a href="http://www.nationalcitycc.org">http://www.nationalcitycc.org</a>
Episcopal – <a href="http://www.allsoulsdc.org">www.allsoulsdc.org</a>
Episcopal – <a href="http://www.memorialepiscopal.org">www.memorialepiscopal.org</a>
Jewish – <a href="http://www.jrf.org">www.jrf.org</a>
Jewish – <a href="http://www.glbtejews.org">www.glbtejews.org</a>
Hinduism – <a href="http://members.aol.com/gendervariant/faith/hindu/index.htm">http://members.aol.com/gendervariant/faith/hindu/index.htm</a>
Islam – <a href="http://www.religioustolerance.org/hom_isla.htm">www.religioustolerance.org/hom_isla.htm</a>
Lutheran – <a href="http://www.cts-lutheran.org">www.cts-lutheran.org</a>
Lutheran – <a href="http://www.trinityelca.org">www.trinityelca.org</a>
Methodist – <a href="http://www.gbgbm-umc.org">www.gbgbm-umc.org</a>
Metropolitan Community Church (MCC) – <a href="http://www.newlightmcc.com">www.newlightmcc.com</a>
Metropolitan Community Church (MCC) – <a href="http://www.opendoormcc.com">www.opendoormcc.com</a>
Presbyterian – <a href="http://www.nyapc.org">www.nyapc.org</a>
Quaker – <a href="http://www.quaker.org">www.quaker.org</a>
Unitarian Universalist – <a href="http://www.uucss.org">www.uucss.org</a>
United Church of Christ – <a href="http://www.hopeucc.org">www.hopeucc.org</a>
Unity – <a href="http://unitycenteroflight.org">http://unitycenteroflight.org</a>
Christian Other – <a href="http://www.forministry.com">www.forministry.com</a>
Christian Other – <a href="http://www.newbeginningchristianchurch.org">www.newbeginningchristianchurch.org</a>
Center for Lesbian and Gay Studies – <a href="http://www.clgs.org">www.clgs.org</a>

Role changes associated with aging may be less severe for the LGBT population than for heterosexuals because of flexible gender roles throughout their lifespan. Research by Quam and Whitford<sup>7</sup> supports this belief and the authors conclude that self-disclosure of being gay and lesbian has the potential for supporting the aging process. In surveying a group of self-identified lesbian women and gay men over the age of 50 living in a Midwestern metropolitan area (N = 80), the authors found there is a security in aging with others with whom one can be genuine and honest. However, the inverse is also true. A strong fear of the absence of a relationship or the lack of understanding friends was prevalent for most respondents as they age. This fear may be a barrier to health care for older LGBT populations.

### **CULTURAL COMPETENCE FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER POPULATIONS** **Cultural Awareness, Cultural Sensitivity, and Cultural Competence**

The terms cultural awareness, cultural sensitivity, and cultural competence are a cause of concern for many health care professionals. There is no authoritative definition for these terms; sometimes, these terms are used interchangeably. This monograph uses the Purnell definitions<sup>11</sup> to distinguish among these terms.

Cultural awareness has more to do with the external signs of diversity—the objective culture such as the arts, clothing, and food choices. Cultural sensitivity has more to do with personal attitudes and not saying things that might be offensive to someone from a cultural or ethnic background different from the health care provider's. An example would be the therapist using gender-neutral language and language that demonstrates respect when referring to these populations.

Cultural competence is a conscious process that is not necessarily linear and includes knowledge, attitudes, and behaviors.<sup>12</sup> Moving toward cultural competence includes developing an awareness of one's own existence, sensations, thoughts, and environment without letting it have an undue influence on those from other backgrounds. Culturally competent health care providers demonstrate knowledge and understanding of the client's culture, health-related needs, and meanings of health and illness. With that knowledge and understanding, these health care providers do not assume that their beliefs and values are the same as the patient's or client's beliefs and values. This means accepting and respecting cultural differences and resisting judgmental attitudes such as different is not as good. Cultural competence is not an intellectual abstraction. Rather, it is honed with experience and, therefore, begins with being open to cultural encounters with LGBT populations and then adapting care to be congruent with the client's culture.

### **Assumptions**

The Purnell model for cultural competence<sup>12</sup> lists assumptions the health care provider needs to make to become culturally competent. These assumptions are adapted in Table 2 for the LGBT populations and are central to the remaining sections of this monograph.

### **AGING AND SEXUALITY AMONG OLDER LESBIAN, GAY, BISEXUAL, AND TRANSGENDER POPULATIONS**

Unfortunately, family members, caregivers, medical professionals, and society in general often ignore the sexual needs of older adults.<sup>14</sup> The prevailing myth is that older people are not interested in sex. Even though a sexual history is part of a health assessment, many health care providers do not ask about sexual orientation because of their own discomfort and lack of knowledge about alternative lifestyles or sexuality among the elderly. Moreover, some older adults are unwilling to discuss their sexuality, regardless of their sexual orientation. Many older lesbians, gays, and bisexuals have never revealed their sexual orientation to family, friends, or their health care provider, even when specifically asked, for fear of rejection or discrimination.<sup>7</sup>

The best predictor of sexual behavior in old age is the pattern of sexuality in earlier years.<sup>15</sup> This is based upon the stability of personality characteristics that predispose an individual toward desire for sexual expression. In a large (N = 1216), more recent study of older adults (mean age 77 years), researchers found the best predictors of sexual satisfaction were being sexually active and a positive mental health.<sup>16</sup> Sex is a powerful expression of intimacy, and its continuation into later life is important for the vast majority of older people. The few studies on sexuality in the elderly that have been completed conclude that sexuality is important and means much the same thing to many older people as it does to others. These studies report that most elderly view sexuality in older age as a sense of contributing to the other, the comfort of

**Table 2. Assumptions Underlying Cultural Competence<sup>12</sup> for Lesbian, Gay, Bisexual, and Transgender Populations**

- All health care professions need similar information about cultural diversity and lesbian, gay, bisexual, and transgender (LGBT) populations.
- One culture is not better than another culture; they are just different.
- There are core similarities shared by all cultures and subcultures.
- There are differences within, between, and among cultures and subcultures.
- LGBT cultures and subcultures change over time.
- The primary and secondary characteristics of culture determine the degree to which one varies from the dominant culture. Primary and secondary cultural considerations are discussed in detail by Dr Jill Black in the monograph, *Cultural Competency: Considerations for Older Adults*, which is part of this monograph series.
- If LGBT clients are coparticipants in their care and have choices in health-related goals, plans, and interventions, their compliance and health outcomes will be improved.
- Culture of the LGBT populations has a powerful influence on one's interpretation of and responses to health care.
- LGBT people belong to several cultural groups.
- Each individual has the right to be respected for his or her uniqueness and cultural heritage.
- Health care providers need both general and specific cultural information to know what questions to ask in order to provide culturally sensitive and culturally competent care.
- Therapists who can examine, evaluate, plan, intervene, and determine outcomes in a culturally competent manner will improve the care of LGBT clients for whom they care.
- Learning about culture is an ongoing process that develops in a variety of ways, but primarily through cultural encounters.<sup>13</sup>
- Prejudices and biases related to LGBT people can be minimized with education, training, and cultural understanding.
- To be effective, health care must reflect the unique understanding of the values, beliefs, attitudes, lifeways, and worldview of LGBT populations as well as individual acculturation patterns.
- Differences in race, culture, age, and sexual orientation often require adaptations to standard interventions.
- Cultural awareness of LGBT clients improves the caregiver's self-awareness.
- Professions, organizations, and associations have their own culture, which should be inclusive of all people of diversity.

touching, passion, admiration, loyalty, renewal of romance, and an affirmation of physical functioning and pleasure.<sup>17,18</sup>

For the most part, researchers studying sexuality in old age did not ask subjects about their sexual orientation and assumed they were heterosexual. Thus, it is impossible to be certain about any similarities or difference based on sexual orientation from these studies. However, one can posit that these findings are the same for LGBT populations. There is some tentative evidence supporting this conclusion. There are a few studies focusing on older gay men and lesbian women. While sample sizes are usually small and often include people in middle age, most gay men and lesbian women report that sexual activity continues into old age, though perhaps less frequently, and sexual interest does not wane.<sup>19-21</sup>

#### **HEALTH ISSUES AFFECTING OLDER LESBIAN, GAY, BISEXUAL, AND TRANSGENDER POPULATIONS**

Older LGBT persons have many of the same general health conditions as the general population, although at varying degrees and according to the primary and secondary characteristics of culture, which are described in *Overview of Cultural Competency: Considerations for Older Adults* by Dr Jill Black in this monograph series. For both genders, advancing age requires more time for arousal and longer to achieve orgasm. Women are no longer fertile after menopause; however, men remain fertile through their lives, although erectile dysfunction is more common in older men because of other physiological problems, not age.<sup>22,23</sup> The most common concern of postmenopausal women is pain with any vaginal penetration secondary to thinning vaginal walls and decreased lubrication as estrogen levels fall.<sup>24</sup>

Common medical disorders that affect the sexual performance of the elderly include heart failure, cardiac

arrhythmias, myocardial infarction, hypertension, angina, stroke, chronic and acute respiratory disorders, arthritis, diabetes mellitus, hypothyroidism, prostatitis, cystitis and urethritis, renal disease, and neurological conditions such as Parkinson disease.<sup>25</sup> Physical therapists work with many older clients with these conditions, either as a primary or secondary referral. Once the therapist has established a trusting relationship with a client who has an alternative lifestyle, the client is more likely to ask advice about LGBT concerns. The therapist should provide sound, culturally sensitive, and culturally competent counseling within the therapist's scope of practice and knowledge, and make referrals when needed.

As people grow older, their need for health care services increases in order for them to live safely and independently. Access to health care, prescription drug coverage, and the need for services such as in home caregivers, nursing home care, and rehabilitation are some of the concerns people have in their later years. For LGBT elder populations, these challenges are complicated because of fear of homophobia from some health care providers.<sup>7</sup> Those LGBT seniors without children may be less likely to have informal caregivers. Additionally, when these populations are no longer able to live in their home environments, many find it necessary to *return to the closet* to decrease the potential for experiencing homophobia. Many older LGBT people express an interest in gay senior housing facilities, but few such facilities exist.<sup>7</sup>

Lesbian, gay, bisexual, and transgender adults may also be at a higher risk for certain health problems than their heterosexual cohort groups. For example, lesbian women are more likely than heterosexual women to smoke, be overweight, or abuse alcohol. Human immunodeficiency virus (HIV),<sup>26</sup> acquired immunodeficiency syndrome (AIDS),<sup>26</sup> and sexually transmitted diseases (STDs) continue to be a major health concern for older gay men.

Studies in psychoneuroimmunology suggest a direct association between psychological phenomena, reduced immunity, and tumor growth. Those LGBT people who do not disclose their sexual orientation may be at increased risk for melanoma and other cancers due to psychogenic suppression of the immune system.<sup>27</sup>

Despite these health concerns among older people with alternative lifestyles, the image of the older gay man or older lesbian woman as isolated and depressed does not hold up empirically—just as most older people in general are not isolated and depressed. Woolf<sup>28</sup> notes in a summary of the literature that the homosexual community is usually noted for its diversity, affording LGBT people the opportunity to meet new people and socialize, thus providing support for many in their old age. Additionally, work relations do not make up the majority of personal contacts outside the home for this population; thus, upon retirement, LGBT people have a network of friends who are already well established and unchanged, which makes the aging process easier. Grossman et al<sup>29</sup> confirmed this in their examination of the social support networks of 416 lesbian, gay, and bisexual adults aged 60 to 91. Participants averaged 6 people in their support networks, and most were friends. The sexual orientation, gender, and age of network members did not influence social support satisfaction. Rather, participants were more satisfied with support from those who knew their sexual orientation.

### **Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual, and Transgender Populations**

*Healthy People 2010: Understanding and Improving Health*<sup>30</sup> has served as a guide for all health professionals in reducing disparities in health care in the United States since the year 2000. However, some groups felt that the document did not adequately address LGBT health concerns. Thus, a collaborative effort among dozens of LGBT health experts and the National Coalition for LGBT Health, coordinated by the Gay and Lesbian Medical Association, a recognized authority and leader in LGBT health,<sup>31</sup> resulted in *The Healthy People 2010 Companion Document for LGBT Health*.<sup>32</sup> This 488-page book about the multicultural LGBT community is written by and for health care consumers, providers, researchers, educators, government agencies, schools, clinics, advocates, and health professionals in all settings.

The LGBT health document addresses model programs, resources, and recommendations. The document helps dispel myths and confusion surrounding LGBT people and focuses on approximately 110 objectives and 12 focus areas from the *Healthy People 2010* document,<sup>30</sup> the federal blueprint for public health for the remaining 7 years. Among the focus areas are access to quality health services, mental health, public health infrastructure, HIV, immunization and infectious diseases, tobacco, injury and violence prevention, and substance abuse. In areas where national data were unavailable, local sources, program evaluations, and small studies were used. The LGBT health document also contains 14 community

health standards for an LGBT access project. These standards speak to accessibility, confidentiality, patient and client nondiscrimination, comprehensiveness of services, and education of staff to diversity and LGBT populations, nondiscrimination among LGBT employees, and benefits for LGBT employees and their partners. The document also has an appendix with recommendations for access to quality services, education and training, research, and policy, as well as resources for LGBT populations listed by state.

### **Ten Things Lesbian Women Should Discuss With Their Health Care Provider**

The San Francisco Gay and Lesbian Medical Association has compiled a list of 10 things that lesbian women<sup>33</sup> and 10 things that gay men<sup>34</sup> should discuss with their health care providers. Whereas these health conditions can affect all women, lesbian women are less likely to volunteer this information if the health care provider does not specifically ask them about these health concerns, especially in terms of cultural ethnic behaviors and practices. The following are 10 things that lesbian women should discuss with their health care provider, and the health care provider should initiate a discussion about if the client does not.

#### **Breast cancer**

Several researchers have hypothesized that lesbian women are at higher risk for breast cancer than heterosexual women are because of higher rates of risk factors such as obesity, alcohol consumption, and nulliparity, and lower rates of breast cancer screening.<sup>35-37</sup> Diamant et al,<sup>38</sup> in their study of 6935 lesbians who received a Pap test or mammogram, only 60% had disclosed their sexual orientation to their health care provider. Additionally, many lesbians over the age of 40 do not get routine mammograms and do not do breast self-examinations or have a clinical breast examination.<sup>32</sup>

As with all older women at increased risk for breast cancer, therapists should inquire about preventive health behaviors such as monthly breast self-examinations and encourage a yearly clinical breast examination by a primary care provider. During upper-quarter examinations, observe for signs of potential breast disease such as enlarged regional lymph nodes, asymmetry, dimpling, or nipple discharge.

#### **Gynecological cancer**

Although all women share common risk factors for ovarian cancer, lesbian women have higher risks for some of the gynecological cancers because of not bearing children, not using oral contraceptives, and lower use of the health care system.<sup>39</sup> They may forgo a yearly exam that could significantly facilitate early diagnosis and treatment. A neuromusculoskeletal problem may bring older LGBT women that may otherwise avoid the health care system into the sphere of physical therapy. Encouraging regular health screenings may be an important aspect of the overall plan of care.

## **Osteoporosis**

The rates and risks of osteoporosis among lesbians have not been well characterized. Only 1 study was found that examined osteoporosis risk factors among lesbian and heterosexual women. Patton and associates<sup>40</sup> screened 71 lesbian women and 77 heterosexual women who were well educated, white, and between the ages of 29 and 51. In this sample, the 2 groups did not differ in age, body mass index, calcium intake, or alcohol use. However, lesbian women were more likely to have smoked and exercised regularly, and were currently using antidepressants, all mechanisms for coping with stress. They were less likely to have been pregnant or used oral contraceptives, both thought to be osteoporosis risk factors. Calcium consumption and weight-bearing exercise as well as avoiding tobacco and alcohol are mainstays of osteoporosis prevention. While lesbian women may be comparable to heterosexual women in the former, they often are at greater risk in the latter, as noted below.

## **Fitness**

Research supports that many lesbian women have higher body mass than do heterosexual women<sup>32,41</sup> and many are less concerned with weight and body image than are heterosexual women.<sup>41,42</sup> Such obesity is associated with higher rates of diabetes, heart disease, cancers, and premature death. Regular exercise can reduce obesity and may prevent disease and mitigate some of the harmful effects of these diseases. No studies were found on exercise programs targeted specifically toward lesbians or bisexual women, let alone older members of these groups. Research is needed to understand and address any barriers to beginning and sustaining a regular exercise program for older bisexual women and lesbians.

## **Heart health**

Smoking and obesity are the most prevalent risk factors for heart disease among lesbians.<sup>32</sup> As stated earlier, lesbian clients should be encouraged to become knowledgeable about exercise and healthy eating habits, and encouraged to decrease or stop smoking. Culturally competent physical therapists may have an important role in moving their patients and clients toward healthier living.

## **Depression or anxiety**

Lesbians may experience chronic stress from homophobic discrimination, which fuels the need for some to hide their orientation from others. Additionally, many lesbians have lost the important emotional support others get from their families due to alienation stemming from their sexual orientation. In their study of discrimination, Mays and Cochran<sup>43</sup> found that higher levels of discrimination might increase psychiatric morbidity risk among lesbians, gays, and bisexual men aged 25 to 74 (2.5% of the national representative sample self-identified as homosexual or bisexual; 73 out of 2844 individuals). Competent clinicians should be aware of the signs and symptoms of depression, anxiety, and panic disorders, and refer appropriately. Interestingly, lesbians and bisexual women reported more

experiences of discrimination in the form of denial or inferior medical treatment than any other group.<sup>43</sup>

## **Substance use**

Illicit drugs may be used more often among lesbian women than among heterosexual women. Because of stressors in the lives of lesbians due to homophobic discrimination, lesbians need support from each other and from health care providers. Eliason<sup>44</sup> found in a study of 242 substance abuse counselors that they lacked knowledge about the legal issues of LGBT clients and the concepts of domestic partnerships, internalized homophobia, and family issues. Substance abuse counselors require more education about LGBT clients to become more effective.

It is unknown if substance abuse is problematic among older lesbians and bisexual women. Nevertheless, substance abuse does interfere with the rehabilitative process and cannot be ignored by health care providers.

## **Tobacco**

Smoking and tobacco products may be used more often by lesbians than by heterosexual women.<sup>45</sup> Tobacco advertising campaigns often target the LGBT population, and tobacco companies contribute funds to AIDS campaigns and to the Gay and Lesbian Alliance.<sup>46</sup> Whether smoking is used as a tension reducer or for social interactions, addiction usually follows and is associated with higher rates of cancers, heart disease, stroke, and emphysema—the 4 major causes of death among all women age 65 and older.<sup>47</sup>

In the August 2000 report of the US Surgeon General<sup>48</sup> on reducing tobacco use, it was noted that the health care system and its providers needed to change to encourage widespread use of state-of-the-art treatment of nicotine addiction. The report shows that brief physician advice to quit smoking can double or quadruple normal quit rates, while a combination of behavioral counseling and pharmacological treatment can boost success up to 10 times. All health care providers should be aware of cutting-edge, evidence-based tools designed to help people quit smoking and remain smoke-free, and provide these resources to their clients or patients. Targeting specific audiences helps ensure success. While there are no tools directed to lesbians, tools are available for some minority groups and for smokers over age 50.<sup>49</sup>

## **Alcohol**

According to a review by Gomberg,<sup>50</sup> the literature suggests that although alcohol consumption tends to decrease as age increases, drinking and alcohol problems vary more among older women than within other age groups, and that women may be more likely than men to begin drinking after age 40. The research on drinking patterns among lesbians is scarce. The studies that do exist use small samples, which makes generalization difficult, but it appears that alcohol use and abuse are 2 to 3 times higher among lesbian women than among heterosexual women.<sup>51,52</sup> According to a literature review by Hughes and Wilsnack,<sup>53</sup> the existing literature suggests that les-

bians may drink more and, accordingly, lesbian women may encounter disproportionately more alcohol-related problems than heterosexual women. In addition, alcohol consumption and related problems may not decrease as much with age among lesbian women as among heterosexual women. As with substance abuse, alcohol abuse does interfere with the rehabilitative process and cannot be ignored by health care providers.

### **Domestic violence**

It is generally concluded that domestic violence occurs in about 11% of lesbian homes, about half the rate reported by heterosexual women.<sup>33</sup> However, Tjaden et al,<sup>54</sup> in their study on violence, found prevalence rates of domestic partner abuse to be comparable to or somewhat higher than those observed among heterosexual couples. A study in Texas of 283 subjects reported that 47.5% of lesbian women and 29.7% of gay men have been victimized by a same-sex partner.<sup>55</sup> No explanation has been given for these conflicting reports, although this author believes that it might be due to snowball sampling techniques. Still, several questions remain. Are health care providers alert for the signs of domestic violence among older women? Do they falsely assume that only men are batterers? Where do lesbians (and gays, bisexuals, and transgender individuals for that matter) go when they are battered? Cook-Daniels,<sup>56</sup> in writing about elder abuse and neglect among LGBT older adults, observed that clients are likely to be more resistant than other clients to accepting services. The author urged greater awareness of the existence and circumstances of older LGBT people to help build rapport, so these individuals can obtain needed services. More shelters need to welcome and include battered lesbians, and offer counseling to the offending partners to address this problem.

### **Ten Things Gay Men Should Discuss With Their Health Care Provider**

The 10 things gay men should discuss with their health care provider<sup>34</sup> are similar for heterosexual men but vary in the order of importance. Again, the primary and secondary characteristics of culture should be taken into consideration. If the gay client does not initiate these topics, the health care provider should initiate the discussion.

### **Prostate, testicular, colon, and other cancers**

As with all men, gay men are at risk for prostate, testicular, and colon cancers. Prostate and colon cancer incident rates increase with age, and age alone may be a barrier to some cancer treatment.<sup>57</sup> Rates for Kaposi sarcoma are many times higher for gay and bisexual men than for heterosexual men because of the incidence of HIV, which weakens the immune system. Now that anti-retroviral drugs are available, this rate is dropping.<sup>58</sup> Non-Hodgkin lymphoma is also higher among gay and bisexual men who test HIV positive.<sup>59</sup> Shorter survival time among gay and bisexual men with lymphoma and Kaposi sarcoma may be related to HIV and AIDS comorbidity.<sup>59</sup> All gay men should undergo screenings for these

risks as routinely as recommended for the general population. When neuromusculoskeletal problems bring older gay, bisexual, or transgender men into the sphere of physical therapy, encourage regular health screenings.

### **Anal papilloma**

Gay men are at increased risk for human papilloma virus, which causes anal and genital warts and results in increased rates of anal and penile cancers. Additional risk factors include smoking, lowered immunity, and age.<sup>60</sup> Current smokers are 8 times more likely than nonsmokers to get anal cancer, but that risk is lower for former smokers. People with lowered immunity, such as in those with HIV, also have higher rates. Cancer of the penis is typically diagnosed at age 66, and the average age of diagnosis for anal cancer is 63 years.<sup>61</sup> The highest rate for anal cancer is in those over age 85.<sup>60</sup> Some health professionals now recommend routine screening with an anal Pap smear. The American Cancer Society recommends a yearly digital rectal exam for men over 50 to check for prostate and anal cancers.<sup>60</sup> As with the other cancers, when neuromusculoskeletal problems bring older gay, bisexual, or transgender men into the sphere of physical therapy, encourage regular health screenings.

### **Fitness**

Problems with body image are more common among gay men than their straight counterparts. Gay men are more likely to experience bulimia or anorexia nervosa.<sup>62-65</sup> Exercise, while usually considered a successful coping mechanism, can be an obsession that can have harmful effects.<sup>66</sup> Excessive exercise is more typical of younger people, whereas obesity is associated with aging as metabolic rates slow. At the opposite end of the spectrum, overweight and obesity also affect the gay community, increasing the risk for diabetes, high blood pressure, and heart disease. As with most things, moderation in exercise and diet are beneficial to overall health and well-being. In the case of eating disorders, physical therapy may be a useful application in the management of distorted body image, to control excessive exercise, and reduce anxiety.<sup>67</sup> A physical therapist may be the best health care professional to advise older gay men on the most appropriate exercise program, especially in the presence of chronic diseases common with aging.

### **Depression or anxiety**

The evidence on depression and anxiety among gay men is mixed. Dorfman and associates,<sup>68</sup> in their survey of 108 older adults, found no differences between older gay men and heterosexual men. Yet in a review of the literature by Taylor and Robertson,<sup>69</sup> the effects of homophobia in everyday society appear to cause high levels of emotional distress in some gay men, which is associated with higher incidence of substance abuse, attempted suicide, and depression. Results from a qualitative study by Robertson<sup>70</sup> of 37 predominantly middle-aged gay men concur. These respondents faced profound social difficulties when coming to terms with their sexuality

throughout their life time. This was especially true for those gay men who were married and, thus, faced the strain of living 2 lives and cited alcohol abuse and depression amongst the effects of this stressful lifestyle. The Gay and Lesbian Medical Association<sup>34</sup> has concluded that gay men appear to be at a higher risk for depression and anxiety than the general population, and their affliction of the maladies may be more severe. Culturally competent mental health services targeted specifically at gay men are more effective in the prevention, early detection, and treatment of these conditions. Clinicians need to be aware of the increased risk of depression in this population and be alert for any signs and symptoms so that early referral and treatment can occur.

### **Human immunodeficiency virus and acquired immunodeficiency syndrome**

The Centers for Disease Control and Prevention (CDC) does not break down its HIV and AIDS data by age and exposure category. Nevertheless, gay and bisexual men are at an increased risk for STDs and HIV infection. By contrast, lesbians are at a significantly lower risk level. Gay and bisexual men also are at greater risk than are heterosexual men for prostatitis, urethritis, pharyngitis, hepatitis A virus, hepatitis B virus, syphilis, herpes, and genital warts.<sup>58</sup> Of the total AIDS cases reported through December 2001,<sup>71</sup> the primary cause was men who have sex with men (46% of all adolescent and adult cases, 55% of all men's cases). During that same time period, 11.1% of those newly diagnosed with AIDS were ages 50 or older, and this percentage has been rising for the past 6 years. According to the CDC, the incidence of AIDS has been growing twice as fast among people 50 and older as among those under 50. This trend may be related to research indicating that as people age they are at higher risk for progression to AIDS.<sup>72</sup> Regardless of the cause, researchers speculate that incident rates for older adults are probably conservative because of a lack of AIDS testing in this population.

Working with older gay and bisexual men presents some challenges to health care providers. Many symptoms of HIV may resemble other diseases associated with aging such as congestive heart failure and dementia.<sup>72</sup> All health care professionals need to know that symptoms like fatigue, shortness of breath, chronic pain, weight loss, and rashes are associated with HIV. In addition, they need to know how to counsel and support maintenance of safer sex practices and how to encourage high-risk people to obtain hepatitis vaccinations. Positive changes can be made, according to the CDC; in recent years, older gay and bisexual men appear to demonstrate positive attitudinal and behavioral changes that lessen their risk for HIV infection and other STDs.<sup>73</sup>

### **Hepatitis immunization**

Hepatitis prevention and detection programs are primarily focused toward young adults, especially those at high risk.<sup>74,75</sup> In fact, older adults may be at increased risk

because the immune system declines with age. Regardless of age, men who have sex with men are at an increased risk of sexually transmitted hepatitis. Viral hepatitis can be potentially fatal. Universal immunization for hepatitis A virus and hepatitis B virus is recommended for all men who have sex with men. Sexual practices such as abstinence, monogamy, and condom use are effective at reducing the risk of viral hepatitis and other STDs, and are currently the only means of prevention for the very serious hepatitis C virus.<sup>76</sup> Health care providers need to educate their older patients and clients about adult immunizations, including those for hepatitis.

### **Sexually transmitted diseases**

Syphilis, gonorrhea, chlamydia, pubic lice, and other STDs occur among gay men at a high rate.<sup>34</sup> Sexual behaviors can increase or decrease one's risk for STDs. In a study presented at the 1994 Scientific Meeting of the Gerontological Society of America, Slusher et al<sup>77</sup> reported sexual behaviors among 432 self-identified gay men aged 25 to 77. Subjects older than 60 reported multiple partners (an STD risk factor) at nearly the same percentage as those aged 30 to 39, but were less likely to engage in receptive anal intercourse (another STD risk factor). Fewer of the older men were in long-term, monogamous relationships that would decrease their STD risk. Safer sexual practices, as discussed above, reduce the risk of STDs. Clinicians need to educate clients that advanced age is not protective against STDs and also need to be aware of STD symptoms and refer promptly.

### **Substance use**

According to the Gay and Lesbian Medical Association,<sup>34</sup> the substance use rates for gay men are higher than for the general population; substances include amyl nitrate (*poppers*), marijuana, ecstasy, amphetamines, as well as other drugs. While illicit drug use may decline with age, abuse of prescription drugs may increase with age. Again, substance abuse in whatever form interferes with the rehabilitative process and cannot be ignored by health care providers.

### **Tobacco**

Studies support the notion that gay men use tobacco at higher rates than do heterosexual men.<sup>46</sup> Health problems related to tobacco use include lung disease and lung cancer, heart disease, and high blood pressure. Interestingly, certain specific brand names are preferred by gay men that differ from those preferred by heterosexuals. As stated earlier about lesbians, all health care providers should be aware of cutting-edge, evidence-based tools designed to help people quit smoking and remain smoke-free, and provide these resources to their clients or patients. While there are not tools targeted to older gay men, there are tools designed for the older smoker.<sup>49</sup>

### **Alcohol**

Gay men have higher rates of alcohol dependence and abuse at 2 to 3 times that of their heterosexual cohort

group.<sup>45,51,52</sup> In the Robertson<sup>70</sup> study of mostly middle-aged gay men, participants used alcohol either to control their feelings (to drown them out) or to give them courage to go and meet people. Culturally competent services targeted to gay men are important in successful prevention and treatment programs. The physical therapist may play a role in providing another mode of stress reduction—exercise.

## **BARRIERS FOR OLDER LESBIAN, GAY, BISEXUAL, AND TRANSGENDER HEALTH CARE**

This author has the firm conviction that individual health is strongly linked to the overall health of the community. The community must be culturally responsive in its actions, beliefs, attitudes, and behaviors to all people to improve the general health of the community itself. The barriers discussed here are adapted to LGBT clients from the general barriers to health care described by Purnell.<sup>12</sup>

### **Myths, Stereotypes, and Realities**

Myths and stereotypes about aging in general and LGBT people specifically can serve as a barrier to health care. There are many mistaken beliefs about older people. For example: (1) the assumption that they are unusual if they are active and in good health; (2) that they are substantially different from the rest of the population, mentally incompetent, inefficient, or should not be in the work force; (3) that they are socially isolated from their families; and (4) that they are physically, socially, and economically disadvantaged. These stereotypes are frequently accepted by older people and influence their self view, causing some people to deny that they are aging or to behave in the way they think old people should behave.<sup>78</sup>

Myths about people who identify as bisexual include: they are confused about their sexual identity; if the right opposite-gendered person came along, they would be heterosexual; they are emotionally and psychologically immature; or they are oversexed. According to Friend,<sup>79</sup> older LGBT people are divided into 3 groups: stereotypic, passing, and affirmative. *Stereotypic* older LGBT people are those who conform to many heterosexist assumptions of what it means to be older and gay (ie, lonely, depressed, and isolated). *Passing* older LGBT people fall within the midrange of the continuum, suffer some internalized homophobia, do not challenge the heterosexist belief system, and expend intense energy trying to behave as heterosexual. *Affirmative* older LGBT people are psychologically well-adjusted, aging well, and active in social organizations, have great acceptance of their homosexuality, and are more likely to participate in research studies.

Concerning the mental health of older lesbian, gay, and bisexual adults, D'Augelli et al,<sup>80</sup> in their study of 416 adults aged 60 to 91, found that more people knowing about their gender identity decreased their loneliness, and they had less internalized homophobia. Grossman et al<sup>29</sup> also found that people who lived openly with lesbian and gay domestic partners were less lonely and rated their physical and mental health more positively than those who lived alone.

### **Availability**

Are needed services available and at a time when needed? For example, are services available after 6PM for someone who needs physical rehabilitation after joint surgery? Clinic hours coinciding with clients' work hours makes it difficult to schedule appointments for fear of work reprisals. Assuming that all older adults are retired can be a barrier to optimal care. If services are not available, can local services be expanded to meet any unmet needs?

### **Awareness**

Is the client and health care provider aware that needed services exist in the community? While health care services may be available in a community, if clients and providers are not aware of them, the services will not be used. Therefore, health care providers in all disciplines need to be aware of programs available in their community and communicate them to their LGBT clients. This includes posting notices of the services in community newspapers, on community radio stations, and in churches, grocery stores, beauty salons, barber shops, bars, and other places where LGBT people live, work, and shop, as well as in the languages used by the LGBT communities.

### **Accessibility**

Accessibility includes transportation issues when no health care provider is available in the immediate region of the person seeking health care. Older adults, or any person with a physical or mental handicap, may not have an automobile or may not be able to use public transportation. Transportation may also be difficult for an older adult who is the caregiver for another person who cannot be left alone in the home for too long. Given the numerous reports of homophobia and either overt or covert discrimination against LGBT people, it is understandable that many may not want to disclose their sexual orientation to health care providers.<sup>70,81,82</sup> Health care providers can help reduce some of these barriers by calling an area ethnic agency or church for assistance, establishing an advocacy role, involving professionals and lay people from the LGBT community and same ethnic group as the client (if possible), and using cultural brokers. If all of these elements are in place and used appropriately, they have the potential of generating culturally responsive care and assuring that LGBT individuals seek out the help they need.

### **Affordability**

When the service is available, but the client does not have financial resources, then affordability is an issue. While most LGBT people over age 65 are covered by Medicare, many younger LGBT people, like many in the general public, have no health insurance or are underinsured. No national data exist for the number of LGBT people who have insurance. The few local studies report that lesbians, gays, and bisexuals were less likely to have health insurance or more likely to be underinsured than the heterosexual population.<sup>83</sup> Studies from Chicago, Los

Angeles, New York, San Francisco, and Washington, DC all report that uninsured levels are highest among transgender people.<sup>84-87</sup>

Some LGBT people who do have health insurance are afraid to submit claims to their insurance companies for fear of reprisal in their employment, especially if their illnesses are associated with their lifestyle. Many are afraid to change employment because the new insurance company may not cover their health problems because of the preexisting conditions clause of some insurers. It may be that many LGBT people in their 50s and early 60s delay care because they are waiting for the relative anonymity of Medicare coverage.

### **Appropriateness**

Older LGBT people may have access to general medical care, but what might be needed are specific geriatric and psychiatric services targeted for LGBT populations. Typically the various health care professions may not value these services; they are not as glamorous or exciting as orthopaedic sports medicine and pediatric services, for example. If specific services are needed but older LGBT people must make do with general services, then the services provided are not appropriate.

### **Accountability**

Health care providers should be held accountable for their own learning in regard to the cultures of the people they serve. Health care providers must take the initiative to seek out ethnocultural information about the populations they serve. Everyone should have the expectation that health care providers can intelligently address their specific needs.

### **Adaptability**

Specialization has increased the barriers to accessing health care by fragmenting the system. For example, an elderly lesbian needs rehabilitative exercises for an injured shoulder; can she get a mammogram at the same time or must she make another appointment? Can a bisexual man needing gait training and strengthening exercises get an HIV blood test in the same building? If not, the services are not adaptable, which is not uncommon in today's health care system where specialization is the norm. In recent years, an increased interest in women's health has resulted in women's health buildings with clustered services, thus increasing convenience. Similar interest in men's health is lagging in most regions.

### **Acceptability and Attitudes**

Ageism, which is discrimination against people because of their age, has been recognized in American society in general and in the LGBT community specifically. Popular LGBT culture reinforces the value that what is old is less attractive and less worthy of attention than what is young. Ageism encourages isolation, which is already reinforced by heterosexism. Lesbian, gay, bisexual, and transgender seniors live in a heterosexist society that may stigmatize nonconformist behavior or identity.

While sexual orientation nondiscrimination laws have been adopted, LGBT people continue to face discrimination in housing, employment, health care, social services, law enforcement, and other aspects of life. As LGBT seniors age and are more dependent on services for care and assistance, they may be forced to have more contact with heterosexist institutions. For some, the fear of experiencing discrimination can prevent them from seeking needed assistance, thus placing them at risk for decreased quality of life, self neglect, and increased mortality risk.

Homophobia on the part of some members of the population at large, as well as from some health care professionals, is viewed as family value prejudice,<sup>88</sup> and it results in many LGBT individuals secreting themselves in the larger heterosexual society. As many as 40% of health care providers report they are sometimes uncomfortable giving care to LGBT patients.<sup>89</sup> In another survey,<sup>90</sup> 67% of respondents indicated that they had seen gay and lesbian patients receive substandard care because of their sexual orientation.

Anecdotal reports indicate that discrimination against older gay and lesbian adults also exists in long-term care facilities by forced separation from long-term partners, discriminatory comments from staff or other residents of retirement communities, and failure of senior centers to provide information or support gay or lesbian issues.<sup>28,91</sup> One would hope that with proper education and training about the LGBT community, discrimination would decrease.

A 1998 Canadian survey on discrimination by Druzin et al<sup>92</sup> surveyed 500 physician colleagues. Of those, 11% stated they would not see a gay or lesbian physician because of questions of competence or lack of comfort with such a physician. To improve the health status of older LGBT people, health care providers must become knowledgeable about the impact of homophobia, retirement and leisure issues, and the hidden abuse and neglect of LGBT populations.<sup>93</sup>

Although many studies report that alternative lifestyles are more accepted in large urban areas, few studies have addressed the quality of life for LGBT populations in the rural areas or in small cities.<sup>94</sup> However, current data report that the top 5 cities for gay couples are San Francisco, Washington, DC, Austin, San Diego, and Seattle. The top 5 cities for lesbian couples are San Francisco, Austin, Sacramento, Seattle, and Minneapolis-St. Paul.<sup>94</sup>

### **Additional Services**

Are additional services available? For example, are adult day care services available if a LGBT person must bring an aging partner along to rehabilitation at the hospital? Are services and client education offered in a language preferred by the client? Do health care providers have negative attitudes about patients' home-based traditional practices? Do biomedical providers incorporate clients' nonharmful alternative or complementary practices into treatment plans? Adverse subjective beliefs and attitudes from health care providers about alternative

practices and practitioners mean that the client will not reveal this information on return visits and may not return for the needed services until the condition is more compromised.

### **Approachability**

Do clients feel welcomed? Do health care providers and receptionists greet patients in the manner in which they prefer? Approachability includes greeting patients with their preferred names and treating all with respect.

### **Legal Issues**

Stein and Bonuck<sup>95</sup> surveyed the LGBT community (63% men, 36% women) in New York to obtain their preferences regarding advance care planning. The majority of both men and women supported legalization of physician-assisted suicide and preferred a palliative approach to end-of-life care. The researchers posited that the HIV epidemic was a major influence behind these results because of the significant impact of the epidemic on most gay men and lesbians. Other special issues to older LGBT people include the need for a durable power of attorney for health care, priority for visitation, a living will, or a last will and testament.

### **RECOMMENDATIONS**

Given the evidence available concerning issues related to older LGBT people, several recommendations seem appropriate as one moves toward cultural competence. Recommendations in general and those specific to clinical practice, education, policy and administration, and research appear in Table 3.

### **RESOURCES FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER POPULATIONS**

All health care providers need resources for their LGBT populations. An Internet search through Google, Yahoo, and PubMed reveals numerous sites, many of them just getting organized. A select few of the more informative sites are briefly described in the following paragraphs. As with all Web sites, the Web master or organization may not update information on a regular basis, and the site may lack adequate documentation or contain biased statements. The health care profession should view the site with discernment before recommending it to a patient or client. Some sites are for specific ethnic groups, some are primarily for clinical practitioners, others are for specific subcultures such as aging or retiring individuals, and some cover all these areas. Some Web sites provide examples of successful communities providing services to the LGBT community. Health care providers may use these sites for their own information. Other sites are excellent resources for patients or clients for on-line support and information, including policy formulation and activism.

#### **Asian and Pacific Islander Wellness Center**

The Asian and Pacific Islander Wellness Center ([www.apiwellness.org](http://www.apiwellness.org)) is the oldest and most compre-

hensive nonprofit HIV and AIDS service organization in North America targeting Asian and Pacific Islander communities. To meet the needs of clients who are often immigrants or refugees, the center's staff speaks 18 languages. The organization, based in California, provides free and confidential case management for HIV treatment, mental health and substance abuse counseling, on-site primary medical and psychiatric care, client and treatment advocacy, and group and individual support to Asian and Pacific Islanders living with HIV and AIDS. The organization also offers HIV and STD testing, social marketing and health promotion campaigns, community events, internships, and volunteer opportunities. The wellness center's research and technical assistance program builds HIV prevention capacity in Asian and Pacific Islander organizations and communities throughout the United States and its Pacific Territories; conducts community-based research; and trains nonmedical service providers in HIV treatment throughout California.

#### **The Gay and Lesbian Association of Retiring Persons**

In 1996, the Gay and Lesbian Association of Retiring Persons, Inc ([www.gaylesbianretiring.org](http://www.gaylesbianretiring.org)) was created to enhance the aging experience of gays and lesbians. It fills a void in the gay and lesbian community for retirement-related information and services, and provides an ideal environment to further research, study, and provide for its membership's unique needs.

This nonprofit organization exists to be a niche market provider of benefits and services specific to its members. These benefits and services include, but are not limited to, discounts or preferences on long-term care insurance, priority of members as residents in upcoming association senior housing development, health and body, and legal services. The association's offices serve as an information center where current data about member-friendly benefits and services—including those provided by other organizations—can be collected, organized, and made available to its members through publications and other forms of communication. Long-term plans call for development of special events for members and retirement communities (eg, independent living, assisted living, and skilled nursing including dementia care) that are sensitive topics to gays and lesbians.

#### **Gay, Lesbian, Bisexual, Transgender Health Web**

The Gay, Lesbian, Bisexual, Transgender Health Web ([www.metrokc.gov/health/glb/studies.htm](http://www.metrokc.gov/health/glb/studies.htm)), sponsored by the public health departments of Seattle and King counties in Washington State, is an example of culturally and linguistically appropriate health services for the LGBT community.

#### **Gay and Lesbian Medical Association**

The Gay and Lesbian Medical Association ([www.glma.org](http://www.glma.org)) works to maximize the quality of health services for LGBT people and strives to foster a professional climate in which diverse members can reach their full potential.

**Table 3. Recommendations for Culturally Competent Health Care for Older Lesbian, Gay, Bisexual, and Transgender People**

<p><u>General</u></p> <ul style="list-style-type: none"><li>• Raise consciousness about ageism and the lesbian, gay, bisexual, and transgender (LGBT) communities in society that keeps both old people and people with alternative lifestyles invisible and disempowered.</li><li>• Do not be afraid of cultural encounters; learn from your LGBT clients. Be sincere and ask questions about beliefs and practices.</li><li>• Become aware of LGBT services available in the community.</li><li>• Dispel myths and stereotypes about aging and LGBT people. Address them in the work environment, during casual conversations, and anywhere else you hear disinformation being discussed.</li><li>• Address your individual attitudes and beliefs about LGBT populations. Leave negative baggage and attitudes behind.</li></ul> <p><u>Clinical Practice</u></p> <ul style="list-style-type: none"><li>• Include LGBT clients as coparticipants in care.</li><li>• Provide information to lesbian clients about their risk for breast cancer, gynecological cancer, diet and exercise, substance use, smoking, alcohol abuse, domestic violence, osteoporosis, and heart health. Make referrals as necessary.</li><li>• Provide information to LGBT clients about their risk for human immunodeficiency virus and acquired immunodeficiency syndrome, substance use, depression and anxiety, hepatitis vaccinations, sexually transmitted diseases, tobacco and alcohol use and abuse, fitness, anal papilloma, and prostate, testicular, and colon cancer. Make referrals as necessary.</li><li>• Encourage clients to discuss issues related to depression and anxiety. Make referrals as necessary.</li></ul> <p><u>Education and Training</u></p> <ul style="list-style-type: none"><li>• Conduct, coordinate, and advocate workshops on the unique needs of LGBT elders at national conferences, within the LGBT and aging professional community, and in the workplace.</li><li>• Take steps to educate yourself about the process of cultural competence, and obtain knowledge about the specific LGBT populations for whom you provide care. Learn from your clients.</li></ul> <p><u>Policy and Administration</u></p> <ul style="list-style-type: none"><li>• Include LGBT elders in services and programs.</li><li>• Form partnerships with federal and state policy, legislation, and other national advocacy groups to include full inclusion of older LGBT Americans in legislation and policies.</li><li>• Support local, state, and federal initiatives to expand services and legal protections for LGBT elders.</li><li>• Collaborate with federal agencies, especially the Administration on Aging and others within the Department of Health and Human Services, to ensure the inclusion of LGBT elders in all programs and services.</li><li>• Include information in the language preferred by the client.</li><li>• Ensure that information specific to LGBT populations is prepared and distributed in areas where this population works, shops, and goes for leisure and recreation, which is everywhere the general population goes!</li><li>• Coordinate/collaborate with the Federation of Statewide LGBT Political Organizations across the country on the inclusion of LGBT elders in their local, state, and national advocacy.</li><li>• Offer clinical hours at times when people can access the services. Perhaps the clinic or service does not have to be open or available every day of the week from 7AM until 9PM, but a variety of times should be available during the week and on weekends.</li><li>• Work with social services and local, state, and governmental agencies to obtain funds for economically depressed LGBT clients.</li><li>• Ensure that policies are inclusive for visitation privileges and legal rights for all clients.</li><li>• Obtain volunteers to assist with taking care of older individuals when they must accompany their partners to health care facilities.</li></ul> <p><u>Research</u></p> <ul style="list-style-type: none"><li>• Conduct research on the care-giving practices of the elderly by LGBT people in partnership.</li><li>• Compile research currently available on LGBT elders.</li><li>• Conduct new research on the demographics and service needs of LGBT elders.</li><li>• Make existing government and academic research projects inclusive of LGBT elders.</li></ul>
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Founded in 1981 as the American Association of Physicians for Human Rights, the Gay and Lesbian Medical Association *came out* as an organization in 1994 with a name change as part of the broader expansion for visibility, leadership, education, and advocacy. Members provide expertise in policy advocacy efforts, especially those dedicated to expand LGBT access to high-quality health care. Members represent the interests of thousands of LGBT physicians, medical students, and increasingly other health care professionals, as well as millions of LGBT patients throughout North America who seek equality in health care access and delivery.

This association's focus is to increase the visibility of the specific health concerns of LGBT patients and offer programs and services that it is in a unique position to provide. It serves and advocates for several layers of the LGBT community. It holds a number of conferences and

seminars designed for LGBT physicians and medical students, as well as for a growing number of researchers, policy makers, and other health care professionals to learn about LGBT health. These conferences provide continuing medical education credit to physicians and other health care professionals on subjects that include HIV and AIDS, lesbian health, mental health, primary care, and many other LGBT health-related topics.

Misinformation, homophobia among health care providers, and a lack of scientific data on basic lesbian health needs result in dangerously inadequate medical care for many lesbians. To address these concerns, there is the Lesbian Health Fund—the only fund in the world solely dedicated to funding research on lesbian health. Since its inception in 1992, this fund has awarded more than \$300 000 to 45 research projects, and research is underway on a number of important health issues.

The Gay and Lesbian Medical Association organizes and mobilizes members of the LGBT medical community through its Providers' Advocacy Network. This network is an alert system that is used to activate physicians and other health care providers to advocate for administrative and legislative changes to promote LGBT health and civil rights. The network is currently comprised of roughly 500 members who are activated as needed to address a range of issues—from providing input into the Department of Health and Human Services' medical privacy regulations relating to LGBT concerns, to voicing support for laws and programs such as the Hate Crimes Prevention Act.

This Web-based site allows visitors to search an on-line database to locate a doctor near their home or work. Once Web site visitors register, they are free to access provider information based on several search criteria including by area code and city. Everyone listed in the referral program is a member of the Gay and Lesbian Medical Association who has indicated that he or she is a licensed health care professional who is willing to be listed for referral purposes. The referral system is free of charge to both patients and providers.

The organization also publishes the *Journal of the Gay and Lesbian Medical Association*, a quarterly multidisciplinary, peer-reviewed medical journal devoted to the study of the health of LGBT populations. The journal focuses on both clinical and research issues and serves as a resource on clinical information relevant to these populations. Physical, mental, and psychological health issues are covered from the perspectives of medicine, nursing, psychology, sociology, health policy, and health law.

### **Gay and Lesbian National Hotline**

The Gay and Lesbian National Hotline ([www.glnh.org](http://www.glnh.org)) is a nonprofit organization that provides a service to the community by providing nationwide toll-free peer counseling, information, and referrals.

### **Gay Men of African Descent**

Located in New York City, this organization serves Gay Men of African Descent ([www.gmad.org](http://www.gmad.org)). Its core mission is to empower gay men of African descent through education, advocacy, health and wellness promotion, and social support.

### **Lavender Collar**

The Lavender Collar Web site ([www.lavendercollar.com](http://www.lavendercollar.com)) discusses workplace issues related to LGBT people. Antidiscrimination laws and case examples are frequent discussion topics.

### **Mautner Project for Lesbians With Cancer**

Founded in 1990, The Mautner Project for Lesbians With Cancer ([www.mautnerproject.org](http://www.mautnerproject.org)) is the only national organization dedicated to lesbians with cancer, their partners, and caregivers. Their project's mission is to provide (1) direct services to lesbians with cancer, their partners, and caregivers; (2) education and information to the lesbian community about cancer; (3) education to the

health care community about the special concerns of lesbians with cancer and their families; and (4) advocacy on lesbian health issues in national and local arenas. This site is also accessible in Spanish.

### **National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization**

The National Latina/o Lesbian, Gay, Bisexual, and Transgender Organization ([www.lluego.org](http://www.lluego.org)) mission statement has 5 parts. First, it provides a national organization to address issues of concern to LGBT Latinas and Latinos at local, state, regional, national, and international levels. Second, it seeks to create a forum of awareness, understanding, and recognition of LGBT Latina and Latino identities, legal rights, relationships, and roles in our communities. Third, it seeks to formulate and sustain a national health agenda that includes the impact of HIV and AIDS, breast cancer, and other health-related issues. Fourth, it is interested in developing a supportive network to facilitate the sharing of information and resources. And lastly, the organization seeks to educate and sensitize Hispanic and non-Hispanic communities by actively working against internalized issues that divide and oppress them, such as sexism, racism, homophobia, and discrimination.

### **Parents, Families, and Friends of Lesbians and Gays**

Parents, Families, and Friends of Lesbians and Gays ([www.pflag.org](http://www.pflag.org)) is a national nonprofit organization with over 80 000 members and supporters and more than 460 affiliates in the United States. This vast grassroots network is cultivated, resourced, and serviced by its national office, located in Washington, DC, and 14 regional centers. The organization promotes the health and well-being of LGBT persons and their families and friends through support to cope with an adverse society. It provides opportunity for dialogue about sexual orientation and gender identity, and acts to create a society that is healthy and respectful of human diversity.

### **National Gay and Lesbian Task Force**

The National Gay and Lesbian Task Force ([www.nglftf.org](http://www.nglftf.org)): (1) raises consciousness in LGBT communities about ageism in communities and in society that keeps old people invisible and disempowered; (2) collaborates with national aging agencies as well as LGBT organizations to ensure the full inclusion of older LGBT Americans in their policies, programs, and advocacy; and (3) forms partnerships with other national advocacy groups to fight for the full inclusion of older LGBT Americans in federal and state legislation. This Web site is also accessible in Spanish.

### **Elderly Issues for Gay, Lesbian, and Bisexual People**

Elderly Issues for Gay, Lesbian, and Bisexual People ([www.virtualcity.com/youthsuicide/links9a.htm](http://www.virtualcity.com/youthsuicide/links9a.htm)) is a very inclusive Web site with multiple links on topics such as: elderly; bisexuality; religion and spirituality; LGBT history;

HIV and AIDS; male youth prostitution; biological and learned homosexuality; public school issues; transgender, transvestite, and transsexual populations; lesbian and bisexual women; homonegativity and homophobia; identity formation and coming out; counseling and therapy; professional education; gay and bisexual male suicide problems; drug and alcohol use, abuse, and addiction; community attributes and problems; couples, families, children, and adoption; spousal violence; and race and ethnic minority issues in the United States, Canada, Europe, New Zealand and Australia, Latin America, Africa, and the Middle East.

### **Senior Action in a Gay Environment**

Senior Action in a Gay Environment ([www.sageusa.org](http://www.sageusa.org)) is a community intergenerational social service agency dedicated to honoring, caring for, and celebrating the lesbian and gay community's senior members. The organization has a dual purpose of fighting ageism and antigay bigotry faced by senior gays and lesbians, as well as providing positive role models for younger gays and lesbians. It has affiliates in over a dozen cities in the United States and Canada. The organization also has an annual conference.

### **Spirituality Resources**

Many churches welcoming the LGBT community are on the Internet. The list in Table 1 contains only a few. Most of them are local in the Washington, DC and Baltimore communities, while others are national. Some of the local ones have links to other regional churches and spiritually based connections. These religious and spiritual sites are presented because most research shows that as people age, spirituality and religion become more important in their lives. Religious leaders are often sought after for assistance with relationship problems, emotional problems, and physical problems. The health care provider must also remember that there are a multitude of folk healers from whom people obtain spiritual support.

## **CASE STUDY**

### **History, Examination, and Treatment**

Deng Qing appears to be a slight, older Chinese American man who comes into a large orthopaedic outpatient clinic well dressed in a suit, tie, and dress shoes but also wearing a sling on his right arm. He awkwardly fills out the physical therapy history form with his left hand prior to the physical therapy examination.

As the physical therapist, Bob reviews the form prior to the physical examination. He notes that the patient neglected to fill out the form completely, including gender and marital status. The therapist attributes this to a possible language barrier or just difficulty writing with a nondominant hand. According to the form, Deng Qing is 70 years old and his primary complaint is right shoulder pain. The medical diagnosis is a rotator cuff tear, and the only comorbidity checked on the form was hypertension.

During the history, Deng Qing explains in perfect English that he was born in the United States shortly after

his parents emigrated from Taiwan, and has lived in New York City his entire life. Before retiring he worked in the garment district. His current problem began after he helped a friend redecorate a loft apartment, which involved a lot of overhead activities. Deng Qing describes the pain as intermittent and sharp when he moves his arm out to the side or forward. It then changes to a dull pain that lasts for hours. It has interrupted his sleep because he cannot lie on his right side. Ice, Tylenol, and the sling seem to relieve the pain somewhat.

Bob then asks Deng Qing to remove his jacket, shirt, and tie so he can examine the shoulder. Deng Qing seems reluctant to start undressing, so Bob leaves the examination room and returns a short time later to find Deng Qing still fully dressed. Bob then asks if Deng Qing needs any assistance to which Deng Qing replies no but does request a gown. Bob thinks this is odd, but attributes it to Chinese cultural differences and pulls a gown out of a cabinet. Bob returns a second time and finds Deng Qing seated, wearing the gown, and avoiding eye contact. When Bob exposes the right shoulder to conduct the physical examination he cannot help but notice that Deng Qing has female breasts. Bob is confused and embarrassed. He now recalls that Chinese sometimes give their family name first. He does not know how to address his patient—by what name or title (Mr or Ms). Therefore, Bob does not call Deng Qing anything and instead obtains eye contact before speaking. Bob does not ask about Deng Qing's breasts and does not inquire about the blank items on the intake form. Instead, Bob completes a thorough upper-quarter examination, ruling out cervical dysfunction. Findings are consistent with a degenerative partial rotator cuff tear.

Bob recommends, and Deng Qing agrees to, pulsed ultrasound for 2 weeks followed by 2 weeks of inferential current and progressive strengthening exercises, all at a frequency of 3 days per week over a period of 3 weeks. After the initial treatment, Deng Qing reports some relief of the right shoulder pain. Bob leaves the treatment room after he ensures that Deng Qing does not need help getting dressed but wonders if Deng Qing will return for the remaining sessions. Bob worries that he has ruined the patient and practitioner relationship.

### **Discussion**

While the physical therapist, Bob, was not homophobic, there were many missed opportunities to demonstrate cultural competence, beginning with the physical therapy history form. Intake forms are a patient's first impression of a health care provider's office and set the tone for how comfortable a patient feels being open about sexual or gender identity. The Gay and Lesbian Medical Association<sup>96</sup> published sample recommended questions for LGBT-sensitive intake forms. Specific items that would have been helpful in the case of Deng Qing include having a space that asks for one's legal name as well as the name the patient prefers to be called (if different). In not wanting to make a mistake, Bob chose to avoid the question entirely, which is considered rude in

most cultures. Deng is the family name, and as an acculturated Chinese American, Deng Qing prefers to be called Qing. Faced with circling a letter *M* or *F* on the intake form, Qing chose to leave the item on gender blank. An open-ended blank line or a *check all that apply* list might have been more helpful to both the patient and the clinician. Gender is important in that it is a risk factor for many diseases. Bob did not discuss any of the 10 health-related topics for lesbians that were suggested in this monograph. However, it is not too late, and perhaps on a later visit, Bob will at least ask about things such as osteoporosis knowledge, screening tests, and diet and exercise history, since Qing has several risk factors (ie, postmenopausal, Asian, and slight build) for osteoporosis. Questions regarding sexual identity and sexual practices are important for health promotion and disease prevention, and the Gay and Lesbian Medical Association gives several helpful examples for intake forms. These topics may be easier to answer on the intake form than in person with an unknown health care professional, and the clinician can discuss any areas of concern at subsequent visits after establishing rapport.

The next opportunity for culturally competent care centers on modesty. Throughout this monograph series, it is clear that different people have different levels of comfort with space and modesty based on a combination

of factors including gender, religion, age, ethnic and racial background, and numerous other factors. Rather than assuming all men patients would feel comfortable removing a shirt in the presence of another man, every patient, regardless of gender, should be afforded privacy and appropriate draping. To do otherwise risks placing a barrier between the patient and optimum health care. In this case, Qing could have chosen to leave the facility and forego care, rather than face the coming embarrassment.

During the examination and intervention, Bob provided competent physical therapy care but not culturally competent care. For fear of using heterocentric language, Bob ignored important issues for culturally competent LGBT care. Bob needs to listen to Qing. Listen to older LGBT patients and reflect the language they use to describe themselves and others in the community. Be sensitive to appropriate pronouns. When in doubt, ask.

Finally, Bob is afraid that Qing might not return to continue treatment. This is a very real possibility, as many older LGBT patients have experienced discrimination and inferior medical care, as discussed in this monograph. Ending the session with a frank disclosure by Bob of his fears and a sincere apology may have gone a long way toward creating an open, positive environment where real healing could begin.

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## NOTES

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# Cultural Diversity of Older Americans

## MONOGRAPH EVALUATION FORM

“Cultural Competence for the Physical Therapist: Working With Clients With Alternative Lifestyles”

by Larry D. Purnell, PhD, RN, FAAN

Directions: Please rate this monograph on the categories of “Organization, Clarity, and Presentation,” “Relevance of Material,” and “Fulfillment of Needs” by circling the number that best describes your opinion. Record your thoughts as you complete the monograph and while they are fresh. At the end of the series, you will receive a course evaluation form; you will have the option of transferring information from the monograph evaluation form to that form or returning the individual forms you completed for each of the 6 monographs.

### Organization, Clarity, and Presentation

5	4	3	2	1
Material well organized; clearly written, interesting		Satisfactory organization and presentation		Poorly organized, hard to follow, confusing

### Relevance of Material

5	4	3	2	1
Meaningful, accurate, comprehensible, contemporary		Satisfactory, but limited at times		Deficient, inaccurate, dated material

### Fulfillment of Needs

5	4	3	2	1
Needs fulfilled, goals achieved, stimulated by content		Satisfied with content		Needs unfulfilled, goals not met

**Author Rating** \_\_\_\_\_ (Scale of 1 to 5, with 5 being the highest rating)

Please Comment: \_\_\_\_\_  
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***Thank You!***



## Section on Geriatrics Home Study Course

### *Cultural Competence for the Physical Therapist: Working With Clients With Alternative Lifestyles*

#### REVIEW QUESTIONS

- The majority of studies on lesbian, gay, bisexual, and transgender (LGBT) populations in the United States are:
  - centered on Hispanic men.
  - centered on white women.
  - qualitative ethnographic studies.
  - quantitative studies on the size of LGBT populations.
- According to this monograph, cultural competence is:
  - an ongoing process for which to strive.
  - being aware of the objective signs of culture.
  - synonymous with cultural awareness.
  - synonymous with cultural sensitivity.
- Evidence suggests that gender role changes for older LGBT people as compared with heterosexual populations are:
  - less severe.
  - more ingrained with aging.
  - more severe.
  - the same as for the heterosexual populations.
- According to the *Healthy People 2010 Companion Document for LGBT Health*, gay men as compared with heterosexual men have:
  - a decreased risk for depression and anxiety.
  - a decreased risk for pancreatic cancer.
  - an increased risk for anorexia.
  - an increased risk for obesity.
- According to the *Healthy People 2010 Companion Document for LGBT Health*, lesbians as compared with heterosexual women have:
  - a decreased risk for obesity.
  - a decreased risk for ovarian cancer.
  - an increased risk for breast cancer.
  - an increased risk for sexually transmitted diseases.
- Research shows that lesbian, gay, and bisexual adults who are comfortable with letting people know about their sexual orientation are more likely to:
  - have less loneliness.
  - have more internalized homophobia.
  - live alone.
  - live with someone of the same sex.
- Among those without Medicare coverage, which of the following groups is least likely to have health insurance?
  - bisexual people.
  - gay men.
  - lesbians.
  - transgender people.
- Mr J, age 62 years, is receiving gait training and muscle strengthening exercises after a cerebrovascular accident. After your third visit, he confides in you that he is gay and is now interested in participating in the gay Catholic community. He asks you if you know how he might get in contact with the gay community. You refer him to:
  - Dignity.
  - social services.
  - the Gay and Lesbian Association of Retired People.
  - the Gay and Lesbian Medical Association.
- The primary responsibility for gaining or maintaining cultural competence with a LGBT client/patient rests with:
  - basic educational programs.
  - primary employers.
  - the community leaders.
  - the individual therapist.
- You are on your second visit to the home of Ms Toenges, age 72 years. You are teaching her exercises after her mastectomy. Today she is teary eyed and tells you her friend of 32 years, Melinda, is afraid to look at her incision. As the therapist, your best response is:
  - do you want me to talk with her?
  - perhaps she can help you with your exercises.
  - that's okay; she will come around in time.
  - why do you want her to look at it?

**ANSWERS**

- 1. c
- 2. a
- 3. a
- 4. c
- 5. c
- 6. a
- 7. d
- 8. a
- 9. d
- 10. b