

AN APPROACH TO THE PECULIARITIES OF LESBIAN, GAY, BISEXUAL, AND TRANSGENDER AGING

Abordagem das particularidades da velhice de lésbicas, gays, bissexuais e transgêneros

Milton Roberto Furst Crenitte^{ab} , Diego Felix Miguel^{bc} , Wilson Jacob Filho^a 

ABSTRACT

The invisibility of lesbian, gay, bisexual, and transgender people (LGBT) aging is a reality. These individuals suffer from ageism, from various forms of discrimination, and from the assumption that all are heterosexual and cisgender. They are also at higher risk of living alone, being childless, and having no one to call in an emergency. Few studies have addressed the subject, especially in the Brazilian medical literature. Additionally, geriatricians and gerontologists may encounter challenging situations when caring for LGBT older adults who are healthy, or have dementia, or are even at the end of life. Thus, this review article aimed to investigate the aging process of the LGBT population; to reinforce appropriate terminology; and to discuss the discrimination that they face in health care services, measures for health promotion, and the specific care of the LGBT older person with dementia, at the end of life, or living in a long-term care facility.

KEYWORDS: sexual and gender minorities; aging; dementia; palliative care.

RESUMO

A invisibilidade do envelhecimento de lésbicas, *gays*, bissexuais e pessoas transgêneras (LGBT) é uma realidade. Sofrem com os etarismos da sociedade, por diversas formas de discriminação e pela presunção de que todos são heterossexuais e cisgêneros. Ademais, eles expressam maiores riscos de estarem morando sozinhos, de não terem filhos e de não apresentarem alguém para chamar em caso de uma emergência. Poucos são os estudos que abordam esse tema, principalmente na literatura médica brasileira. Além disso, o geriatra e o gerontólogo podem se deparar com situações desafiadoras em suas práticas ao cuidarem de uma pessoa idosa LGBT saudável, com demência ou até mesmo em fase final de vida. Assim, este artigo de revisão bibliográfica teve como objetivos: abordar o envelhecimento dessa população, reforçar as definições apropriadas e discutir sobre as discriminações que sofrem nos serviços de saúde, sobre as medidas para a promoção de sua saúde e sobre as especificidades no cuidado da pessoa idosa LGBT com demência, em fase final de vida ou residente de uma instituição de longa permanência.

PALAVRAS-CHAVE: minorias sexuais e de gênero; envelhecimento; demência; cuidados paliativos.

^aGeriatrics Service, Hospital das Clínicas, Faculdade de Medicina, Universidade de São Paulo – São Paulo (SP), Brazil.

^bNon-governmental organization EternamenteSOU – São Paulo (SP), Brazil.

^cCentro de Referência do Idoso da Zona Norte – São Paulo (SP), Brazil.

Correspondence data

Milton Roberto Furst Crenitte – Rua Cerro Corá, 585, Sala 305, Torre 1 – Alto da Lapa – CEP: 05061-150 – São Paulo (SP), Brazil – E-mail: milton.crenitte@gmail.com

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SEXUALITY, GENDER, AND AGING

Currently, sexuality and gender norms have been challenged by social groups fighting against chauvinism, for racial equality, and for visibility and rights of lesbian, gay, bisexual, and transgender people, seeking thus to demystify taboos, stereotypes, and prejudice.¹ Such perceptions often derive from religious and moral fundamentalism, contributing to marginalize those who fail to meet socially established standards.¹ According to Louro, since birth we are conditioned to meet a social demand permeated by constructs of the culture we live in, which disregard people's subjectivity and freedom of expression, limiting them to preset standards.¹

The concept of gender, as a sociocultural construct, was first discussed in the 1970s by the feminist movement, with the purpose of differentiating biological from cultural aspects, thus expanding the reflection on sociocultural constructs that condition and limit a person's possibilities of being.² Since then, studies are advancing towards terminologies to better identify the existing diversity in sexual orientation and gender identity, in order to contribute to a rupture in traditionalism and a better representativeness in definitions.²

To the LGBTI+ Communication Handbook, the use of terminologies that address specificities and support sexual and gender diversity may reduce the impact of prejudice and discrimination.² It may also influence behaviors, attitudes, and practices that favor the empowerment of individuals that are still marginalized and socially vulnerable.²

We briefly describe below the terminologies used in this article, as defined by Reis:²

- **Biological sex:** refers to a person's biological characteristics at birth, including chromosomes, genitalia, hormone composition, etc. Defined as male, female, or intersexual. The intersexual person is born with a reproductive or sexual anatomy and/or a pattern of chromosomes that cannot be classified as being typically male or female;
- **Sexual orientation:** refers to a person's emotional, affective, or sexual attraction to other individuals. Thus, people are considered homosexual if they are attracted to the same gender; heterosexual if they are attracted to the opposite gender; bisexual if they are attracted to both genders; and asexual if they are not attracted to any gender or sex;
- **Gender:** issues regarding gender are divided into gender identity and gender expression. Gender identity refers to a person's self-perception and can be divided into man, woman, or non-binary; however, it may

not be apparent to other people. Gender expression refers to a person's self-expression in a public context, including both body characteristics and interaction to other people.

Lanz emphasizes that transgender people are those who break or deviate from gender norms, while cisgender people are those who conform to such norms, i.e., whose gender matches the biological sex they are assigned at birth.³

In this context, understanding these terminologies and their everyday applicability will reinforce the existing diversity in sexuality and gender issues, generating a key process of sociocultural reframing.² Ruptures in traditional social structures may then be created by encouraging society to be more sensitive and welcoming to differences.^{2,3} Those factors have a direct influence on the aging process of LGBT people, so that the appropriate use of the terms favors a plural setting² included in different realities, thus defining and raising the visibility of the specific demands of LGBT aging.

LONELINESS, SOCIAL ISOLATION, AND HEALTH RISKS

In our sociocultural reality, we are conditioned since childhood to appreciate and praise youth with stereotypical characteristics related to beauty, strength, liveliness, and exacerbated capacity to produce.⁴ Thus, the aging process tends to be a challenge in our society, especially because of its social nature and depreciation of old age. An example is when derogatory expressions are used to reinforce myths and negative stereotypes surrounding old age, causing individuals not to recognize their place of belonging in society during this important stage of life.⁴

Such feeling may be even more intense among LGBT people, as for them the body has a social and symbolic dimension that is both strong and mutable, e.g., gay men are socially required to have a "muscular" and "masculine" body.⁵ They are forced to meet this social need in order to be accepted, generating a visual distinction and identification both inside and outside the gay group, achieving then a standard which is also related to power. They face the need to conform to the mythical social standard of beauty and joviality expected by society, which is one of the main stereotypes linked to LGBT people.⁵

Overall, old age is assumed to be hetero-cis-normative, i.e., supposedly consisting of people who meet social norms established by heterosexual and cisgender models, which further hinders the visibility of diversity and complexity

found in the different realities of the older population, with a strong tendency towards generalization and shallow arguments regarding the subject.⁶ The problem is also increased by the generation of older people who have had their sexual orientation or gender identity repressed by prejudice, fear, or guilt. The process is known as internalized homophobia,⁷ a form of prejudice expressed by the LGBT person towards the self and driven by different factors such as religious beliefs, body and gender norms, mental health, among others. Such context favors the self-denial of sexual orientation or gender identity, in an attempt to conform to norms to be socially integrated.

For a person to accept and fully experience his or her sexual orientation and gender identity, not only is needed a process of self-knowledge but also of transgression and overcoming, in order to break imposed and socially expected standards.⁷ “Gay, lesbian, and bisexual individuals account for a sexual minority. As such, they face so much discrimination, stigmatization, and violence that is absolutely natural that, as a result, they experience high levels of stress and anxiety. So much so that our heterosexist society only tolerates them if they do not come out and remain forever ‘in the closet’.”⁷

Internalized homophobia, together with structural violence of LGBTphobic nature, are aspects that favor the invisibility of LGBT aging and the social isolation of this population.^{6,7} Thus, overcoming and reframing those stigmas during the lifespan is essential to ensure a successful aging and old age, with affective and social relationships that warrant the necessary support at this stage.^{6,7}

Usually, the major social support network of older adults includes their family, friends, neighbors, and community services, “the latter being represented by services that care for their needs to keep them socially active”.⁸ However, for many LGBT individuals those relationships are fragile or nonexistent because of broken socioaffective bonds due to LGBTphobia-related intolerance.

In this context, quantitative studies are needed to investigate the issue. Existing data derive from the Anglo-Saxon literature and assume larger numbers of LGBT older people living alone, being single, childless, and having no family member to call in an emergency, when compared to their non-LGBT peers.⁹⁻¹¹ Thus, loneliness and social isolation may, on the one hand, have a direct impact on their health with increased risk of cardiovascular diseases and poorer control of depression and anxiety.^{12,13} On the other hand, they may also have a negative effect on the follow-up of patients with dementia syndromes¹⁴ and even those undergoing palliative treatment.^{15,16}

LGBT INVISIBILITY IN HEALTH CARE SERVICES

Gerontology has advanced substantially in recent years in fighting the myth of “asexual old age,”⁶ but Debert and Brigeiro argue that this emerging field, which deems sexuality to be crucial and beneficial to active aging, does so from a “heteronormative” perspective.¹⁷ Additionally, many health care professionals, with the purpose of avoiding discrimination, try to treat everyone equally.¹⁸ Others take on a neutral stance,^{19,20} but a magical state of neutrality does not exist. By assuming that everyone is equal, people continue to be treated as if they are heterosexual and cisgender, and thus their differences remain unexplored.^{10,21}

In this respect, many people question whether knowing the gender identity and sexual orientation of patients is relevant. Baker and Beagan²⁰ showed that the answer is yes, by revealing that those who come out to their physicians have higher levels of satisfaction, improved access to health care services, better control of chronic diseases, and greater adherence to measures of health promotion.

Furthermore, Sharek et al.²² reported the findings of a cross-sectional cohort study of 144 LGBT older people in Ireland. It was an important and pioneer study in LGBT gerontology, especially because researchers sought to understand LGBT people’s experiences, concerns, and possible barriers with accessing health care services. Some participants refused to complete the entire questionnaire. Whereas 43% of the sample (n = 51) felt respected as an LGBT person by their health care professionals, 23% (n = 31) reported low quality of treatment, and 54% of those (n = 16) attributed their negative experience to the fact of being LGBT. Also, 22% of the sample (n = 28) agreed with the idea of not revealing their LGBT identity to health care professionals for fear of a negative reaction, while 59% (n = 75) strongly disagreed and 19% (n = 24) neither agreed nor disagreed.

Such findings may be associated with early fear of discrimination and lack of confidence in the health care system, and could explain why older lesbian women undergo less preventive tests such as mammography or cervicovaginal cytology than their heterosexual peers.^{23,24} Even in Canada, where universal health care is provided, investigations show higher rates of LGBT older people with no support from a family physician compared to their non-LGBT peers.^{25,26}

HOW TO SHAPE LGBT-FRIENDLY ENVIRONMENTS AND PROFESSIONALS?

Some previously mentioned issues, such as fear of discrimination, LGBT invisibility, and lack of trained professionals

to deal with such issues, are possible barriers to accessing health care services.^{10,20} This is why fighting for the creation of spaces, practices, languages, and symbols indicating a non-discriminatory and inclusive place is so important. In this context, a simple mark such as a rainbow flag in the waiting room, in the hallway, or even on the apron of the care provider can help. In New York (US), the Mount Sinai Health System is a good example, as in some rooms there are posters featuring homosexual couples and sentences such as “We are proud of your health.”²⁷

Those messages are also important to make the environment safe and comfortable for patients with cognitive impairment. In initial stages, this may help the person “come out of the closet” or stay out of it. In more advanced stages, in turn, an indication that the environment and the professional are not discriminatory shows to caregivers and families (biological or of choice) that the history of that individual will be respected.^{14,28}

In all those contexts, an “active listening” approach demonstrating interest and empathy may be an initial step. The interlocutor may also use the same words as the client to refer to identities, partners, and relationships. In addition, the suggested approach is to ask questions instead of making assumptions. If there is any mistake in the approach of the LGBT patient, the professional should apologize and continue the treatment.²⁰

BARRIERS AT LONG-TERM CARE FACILITIES

If a heteronormative and cisnormative setting is a general rule at hospitals and health care centers, the situation may be even worse at long-term care facilities for older adults (LTCF), where respect for intimacy, objects, and LGBT lives is an exception.²⁹ A 2010 US study involving 217 institutionalized LGBT older adults showed that 23% had been verbally or physically harassed by other residents and that 14% had had the same experience but carried out by the health care staff.²⁹

Thus, the process of institutionalization of LGBT older adults is accompanied by a justified fear of having to hide their sexuality, and when they find a place that is sensitive to their needs, these individuals demonstrate a deep satisfaction.²⁹ To create spaces where those people are included, respected, and loved, LTCF administrators are responsible for providing their staff with proper training at all levels.²⁹ The preservation of each one’s identity and the intolerance towards other users’ offensive or negative attitudes may then become a rule, not an exception.²⁹

HEALTH SPECIFICITIES OF LGBT PEOPLE

In addition to the strategies studied for promoting health and active aging in the general population, some peculiarities should be addressed for each group in the acronym LGBT. Regarding gay men, an issue still little discussed but with potential to influence morbidity and mortality is anal cancer. While its incidence in heterosexual men is 0.6 cases per 100,000 person-years, in men who have sex with men (MSM) with HIV the number is 158 times higher.³⁰ Based on that some societies have already recommended screening for this cancer with yearly anal Pap smear in all men with HIV.³⁰ Even for those who are not infected with the virus there are some studies showing benefits of ordering the test.³¹ Additional measures are important, such as care related to alcohol, tobacco, and other drugs, prevention of other sexually transmitted infections (STIs), guidance on safer sex, and vaccination against hepatitis A and B.^{19,27}

In the case of older lesbians, in turn, observational data show higher rates of obesity and nulliparity compared to their heterosexual peers,³² and such findings may be related to an increased risk of breast cancer.³² Thus, health professionals are responsible for reinforcing the need of medical follow-up and mammography screening, as recommended in guidelines.^{19,23,28} An approach to STI prevention and screening is also needed.³³ It must include explanations regarding safe use of sexual objects, with instructions for covering them with condoms,³⁴ for the preferred use of latex or rubber vibrators,³⁵ and for the application of lubricant.

For transgender men, the transitioning process and the use of testosterone replacement therapy (TRT) may produce harmful effects such as polycythemia, weight gain, acne, tendon rupture, and obstructive sleep apnea syndrome.³⁶ Furthermore, even under the effect of TRT transgender men still have a greater risk of osteoporosis than cisgender men. Thus, bone density screening should be performed at least once after the age of 65 years.³⁶ Equally important are breast cancer screening, cervicovaginal cytology, and assessment of vaginal health for those who have not undergone gender reassignment surgery.²⁸

Regarding transgender women, estrogen replacement therapy may change the risk of developing some diseases, such as hypertension, diabetes mellitus, dyslipidemia, venous thromboembolism, and osteoporosis.³⁶ Therefore, bone density testing is important for them as well, and in some cases it may start before the recommended age for cisgender women.³⁶ Cancer screening is also imperative. Both breast cancer screening and discussion of the risks and benefits of prostate cancer screening are indicated.²⁸

DEMENTIA IN THE LGBT POPULATION

The lack of social support to the LGBT population²¹ is a cause for concern in the presence of dementia syndromes, whose prevalences increase with aging. On the one hand, heterosexual and cisgender individuals who have rejected their LGBT family members may be faced with the need of caring for someone who they had little or no previous contact. On the other hand, some LGBT people have constructed their “families of choice”³⁷ during their lifetime. In those cases, not only should health care professionals respect those relationships but also guide the preparation of documents that ensure patients’ choices even as the disease progresses, such as a living will or advance directive.^{14,21}

In initial stages of dementia, LGBT individuals may feel frustrated or even distressed while trying to remember if they have revealed to the health care professional their sexual orientation or gender identity.^{14,38} In more advanced stages, in turn, sexual disinhibition may occur. To treat such behavior, health care professionals must overcome their own discomfort and be aware that non-pharmacological and drug strategies are similar to those employed in the heterosexual and cisgender population.³⁸

PECULIARITIES OF ENF-OF-LIFE CARE IN LGBT OLDER ADULTS

Sexuality should be understood as a core component of the life of all humans and should therefore be included in palliative care planning.³⁹ It is not just about the sexual act but also about intimate contact, physical closeness, and emotional connection, which become more important in later stages of life.¹⁶ However, many LGBT older people, for fear of discrimination and lack of confidence in health care services, deprive themselves of those manifestations and thus are not provided with a death with dignity.^{15,39} “Two additional questions are significant. First, this group of people, as previously said, may have a more precarious social support, and studies report their fear of being alone, of being discriminated, and of dying with pain.”¹⁶ Second, transgender people and those who refuse to reveal their sexual identities report greater difficulties and greater discomfort when discussing end-of-life issues with health care professionals.³⁹

Thus, palliative care curriculum should also include specialized training on the needs of that population. Reygan and D’Alton⁴⁰ have showed in a pilot educational program applied to oncologists and palliativists that most professionals would recommend the specific training to their colleagues and also felt confident when performing LGBT patient care.

IN BRAZIL: PERSPECTIVES AND CHALLENGES

There has been considerable progress in public policies targeting the LGBT population in Brazil in recent years, but much remains to be done. LGBTphobia is a reality that needs to be considered and confronted through laws that quantify, qualify, and monitor violence on grounds of hatred and intolerance, in order to ensure proper treatment for such situations. LGBT aging, in the context of great social achievements, remains invisible. Despite LGBT activism and the fight for older adults’ rights, the subject has been little debated in conferences and other spaces of social participation.

Thus, in 2017 the EternamenteSOU group was created in São Paulo, Brazil, and later became a non-governmental organization (NGO), with the purpose of raising the visibility of issues relevant to the LGBT population.⁴¹ The NGO pioneered then the organization of specific events for supporting the cause and training health professionals, such as LGBT Aging Seminar, Introduction Course to LGBT Aging, and Diversity Chat.⁴¹ The EternamenteSOU group also promotes events and socioeducational actions to favor self-knowledge, autonomy, independence, and empowerment of LGBT older adults through artistic languages and monthly thematic meetings, as well as other activities that reinforce affective and belonging bonds.⁴¹

Henning⁴² describes two approaches in the services targeting the LGBT population, the separate-but-equal model and the together-but-different model. The separate-but-equal model assumes that in order to act appropriately towards the LGBT population, services must be developed and implemented preferably or exclusively *by* and *for* community members. In turn, the together-but-different model suggests that existing services act towards sensitizing and qualifying health professionals in dealing with diversity and respecting the sexual orientation and gender identity of all older adults. Both approaches have interesting mechanisms of action and cover the different realities of LGBT older people. On the one hand, they consider the need of working with older adults who are out and invisible to public policies in terms of access and care. On the other hand, they also involve a greater proximity to older adults who have chosen or were conditioned to live their homosexuality or gender identity in a reserved or repressed way.

Those assumptions inspired the work of EternamenteSOU, as a way to demystify and expand the group’s intervention to all older people, focused on understanding the aspects that marginalize and oppress them, taking part in the history for visibility and ruptures with structural and LGBTphobic violence to which they are submitted.

FINAL CONSIDERATIONS

Although the LGBT population is not homogeneous, addressing lesbian, gay, bisexual, and transgender people in the same article has the purpose of creating a positive and person-centered approach considering the specificities and needs of each group. Sociocultural issues have a direct influence on the aging process. Thus, LGBT people who live within a context of structural violence, constrained by hetero-cis-normativity

during their lifetime, may experience aggravated situations in old age that contribute to social isolation and loneliness.

Furthermore, much of the information gathered in this article was drawn from Anglo-Saxon contexts. Therefore, new studies and discussions, especially in Brazil, are needed to create more inclusive health care environments and to fight the “invisibility” of LGBT people, thereby improving their geriatric and gerontological care continuously.

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