INTERVIEW

ENTREVISTA

Interview with Brian de Vries[1]

Entrevista con Brian de Bries[2]

Ricardo Iacub

Iacub: *There is an emerging area of LGBT aging research, practice and policy, yet we have all heard people question if aging is really different for LGBT people than it is for heterosexual persons. How do you respond to such comments?*

Vries: I think there's much in common between LGBT and heterosexual people in the way in which they age — aging is a great leveler in many ways. Still, we do find several significant differences in the physical and mental health of older LGBT persons as compared with comparably aged heterosexual persons. I think the factor that differentiates the two groups most prominentlyisstigma; that is, I think most, though not all, of the differences we find can ultimately be attributed to discrimination and a lifetime stigma.

[1] Aging expert and currently working very hard on Aging GLBTTI (gay, lesbian, bisexual, transgender, transvestite, intersex).

[2] *Experto en envejecimiento y que actualmente trabaja muy fuertemente sobre Envejecimiento GLBTTI (gay, lesbiano, bisexual, transgénero, travesti, intersexual).*

I: *What then are some of the differences?*

BdV: In terms of physical health, we find that older gay men, for example, have a much higher rate of anal cancer, probably related to HPV (Human Papillomavirus) to which they are exposed at a much higher rate than heterosexual men. Older gay and bisexual men also have higher rates of HIV/AIDS than do older heterosexual men. Amongst older lesbians, research has noted higher rates of reproductive cancers--breast and cervical cancers, in particular. These higher rates are probably related to nulliparity, that is the reduced likelihood of an older lesbian or bisexual woman having given birth to a child. Interestingly and for reasons not yet fully understood, older gay men and lesbians are much more likely to have or more likely to have asthma as well as diabetes. Very little is known about the experiences of aging transgender persons; what little is known suggests an exacerbation of some of the conditions already listed, in addition to the relatively unknown consequences of long-term hormone use.

I: *You've previously mentioned that there were also psychological differences; what might be these differences?*

BdV: A substantial amount of research has now found that older gay men and lesbians are more likely to suffer from depression. Older gay men report depression at over two times the rate of older heterosexual men and older lesbians at one of the half times the rate of heterosexual women. Related to these higher rates of depression are also higher rates of suicide beliefs, thoughts and behaviors. A couple of studies have also reported on the higher rates of stress and distress in the lives of older gay men and lesbians.

I: *So how does stigma, as you've described above, fit into this pattern of results?*

BdV: Older LGBT people live in a stigmatizing world — experiencing stigma based on their sexual orientation, gender identity, and age. Ilan Meyer has written significantly about the minority stress that characterizes the experiences of LGBT people. Minority stress theory suggests that living a life as an LGBT person involves additional daily life stressors in a heteronormative environment. These stressors might include, for example, decisions that LGBT people have to make on a frequent basis, such as whether or not to come out to their service provider, their healthcare provider, or any other person with whom they're coming into contact. There is a heightened vigilance involved in such engagement with the world. This necessarily involves a level of stress that exacerbates those of everyday life. It's not unlike carrying around a weight with you everywhere you go; there are health and other costs and consequences with this additional burden.

I: You described some of the physical and psychological conditions that are related to this burden or stress; what other ways might it manifest?

BdV: Older LGBT people have been found to have higher rates of smoking and higher rates of alcohol use, for example, than comparably aged heterosexual people. This higher usage of tobacco and alcohol was found even more so amongst older lesbians than amongst older gay men. There are also higher rates of obesity found amongst older lesbians in particular. Together these factors represent ways of (unhealthy) coping with the ongoing and significant stressors in a life. These patterns also are clearly related to some of the physical conditions about which we've talked. That is asthma and diabetes both can be seen to be associated with alcohol use and obesity. It's such a way, minority stress — that is prejudice and discrimination — serves as the foundation of many of these of many of these effects.

Minority stress can also be seen clearly in some of the laws and practices that exclude LGBT people. In the United States, exclusion from marriage has significant health consequences. In some of our research with gay men in the

middle to later years, those who were legally married had more positive health profiles than did those gay men who were in domestic partnerships—and both of these groups had more positive health features than gay men who were not in relationships. In our national study of LGBT baby boomers, we found that those boomers who lived in states where in same-sex relationships were not recognized tended to fear death and fear discrimination in later life much more so then did those who lived in the states wherein same-sex relationships were recognized. Clearly, laws, policies, practices have an impact on the lives of LGBT persons of all ages.

Somewhat hidden beneath some of these statistics are findings that suggest that LGBT people and lesbians and especially older gay men are less likely to be partnered then are men and women in the heterosexual population. We found, for example, that almost 3/4 of gay men in our sample of LGBT people in the San Francisco Bay area were not in a partnership; almost half of older lesbians in the same sample were not in a partnership of any sort. These percentages, and especially those for gay men, are much higher than what you would find amongst a comparably age sample of heterosexual adults. In fact, in our national study of LGBT boomers we found that about 12% of gay male boomers had never been in a relationship of any sort. This percentage was four times higher than that of comparably aged heterosexual men. This is one of the ways in which I think minority stress forms the backdrop for many these findings and many of the experiences of LGBT persons as they age: Many older gay men moved through life never expecting to marry having always been excluded from marriage — even families; this message of exclusion is one LGBT people have long heard from religious institutions, their governments, and so many others.

I: *The strongly suggest the role of cohort; how important is cohort understanding the experiences of LGBT older persons?*

BdV: I think it's critical to understand the role of cohort in explaining and working with LGBT older adults. Think of it — this group of LGBT people grew up and were socialized in a time when there were no role models of LGBT people, when they were taught that it's wrong, illegal, immoral to be lesbian, gay, bisexual or transgender. They were socialized during a time when same-sex desires were seen as a psychiatric illness. These sorts of assaults have a legacy as may be seen in some of the exacerbated physical and psychological conditions experienced by older LGBT people.

I: You have identified ways in which LGBT older adults fare more poorly than heterosexual adults of the same ages; are there any ways in which LGBT adults fare more favorably?

BdV: Yes, I think there are some hidden strengths beneath these negative findings. Without diminishing in anyway the significant costs of a life of stress and stigma and all the assaults that LGBT people have endured, as well as the many LGBT people who never reached their later years, I think there are significant sources of strength to be witnessed and understood in the experiences of older LGBT people. In fact, many of those who are now in their later years represent the hardiness, competence and resilience of this cohort. We have heard such reports in our research; about two-thirds of our sample of LGBT boomers said that being LGBT has helped prepare them for aging. About half of the same sample said that being LGBT has made aging more difficult. How can we reconcile these apparent discrepancies? I think the answer lies in dealing with discrimination and stigma. Older LGBT adults have had to develop ways of being, ways of coping, ways of living over the course of their lives that serve them well now in their later years.

I think we may see evidence of this in many ways. Many studies, including within our own research, for example, found that older LGBT people are more highly educated than comparably aged heterosexual people. I think this may be seen as a positive coping strategy — it suggests an approach to life of questioning and

finding answers, of seeking or developing solutions and resources. In the United States, LGBT people have been associated with the term “chosen family:” the idea that notwithstanding distance and perhaps exclusion from biological kin, LGBT people have developed a network of unrelated others they may see, and interact with, as kin. These are people to whom we are not or may not be biologically related, but on whom we would call in times of need and with whom we might celebrate, commiserate, and for whom we might offer and receive care.

I think we see the resilience of this community most clearly in an examination of its response to HIV/AIDS. At a time when the government shamefully turned it’s back on those most immediately and dramatically affected at the first appearance of AIDS, the LGBT community rallied, found its voice, demanded and offered services of care and support. I think we see a similar movement in progress around issues of aging. I think the LGBT community has witnessed how its older members have been shunned by more traditional aging services and communities have organized or are organizing to provide the services that are needed. Resources to support LGBT older adults are being developed, supportive housing is being developed, education of traditional aging services is happening — and all of these are largely coming from (or originating in) the LGBT community itself.

This is the source of my hope. I have witnessed LGBT communities looking out increasingly for their aging members and providing or developing the services that are needed. We are once again “caring for our own” and, in so doing, creating services that are meaningful, relevant, inclusive. I think this action and these services ultimately challenge the traditional models of aging and the heteronormative ways in which aging services are provided. And I think the benefits of this effort extend beyond the LGBT communities: we begin to broaden the scope and make more inclusive the environment in which all older people age — and this includes LGBT persons. It’s a movement and it’s momentum that benefits all and I think it has its roots in the understanding of LGBT aging.

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