RESEARCH

Being Lesbian, Gay, Bisexual, and 60 or Older in North America

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SUMMARY. This study examined mental and physical health, perceived social support, and experiences with HIV/AIDS of 416 lesbian, gay, and bisexual adults aged 60 to 91. Most participants reported fairly high levels of self-esteem; however, many experienced loneliness. Most

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also reported low levels of internalized homophobia, but men reported significantly higher levels than women did. Ten percent of respondents sometimes or often considered suicide, with men reporting significantly more suicidal thoughts related to their sexual orientation. Men also had significantly higher drinking scores than women, and more men could be classified as problem drinkers. Only 11% of the respondents said that their health status interfered with the things they wanted to do. Although 93% of the participants knew people diagnosed with HIV/AIDS, 90% said that they were unlikely to be HIV-infected. Participants averaged six people in their support networks, most of whom were close friends. Most support network members knew about the participants' sexual orientation, and the respondents were more satisfied with support from those who knew. Those living with domestic partners were less lonely and rated their physical and mental health more positively than those living alone. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <getinfo@haworthpressinc.com> Website: <http://www.HaworthPress.com> © 2001 by The Haworth Press, Inc. All rights reserved.]

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Most people have opinions about aging, and many people have thoughts about homosexuality. But few individuals have considered them simultaneously. In fact, many scholars, advocates for older adults, and other individuals consider the terms gay and aging to be incompatible. Consequently, there have been comparatively few studies about the lives of older lesbian, gay, and bisexual people. As a result, not only have the members of this segment of the aging population remained invisible, but myths and stereotypes have been created about them and have persisted. We decided to ask older lesbian, gay, and bisexual individuals across the country about their lives and to learn from their telling. Specifically, we designed this study to meet the following needs: (a) to give visibility to the experiences of older lesbians, gay men, and bisexual people in the gay and lesbian, aging, and academic communities; (b) to combat the myths and stereotypes about older lesbians and gay men; and (c) to expand our knowledge about older lesbians, gay men and bisexual people so as to enhance resources and programs to meet their needs.

The linking of ages to the stages of human life has been valuable in studying and learning about the experiences of various groups of people (i.e., children, adolescents, adults, and older adults). At the same time, it is important to acknowledge that there are many individual variations in developmental pathways, and the linkage of life stage and chronological age may be imprecise.

While all stages of development present challenges for all people, those individuals who are not part of society's mainstream tend to face additional hurdles. We have a growing body of knowledge proving that gay and lesbian adolescents and adults must confront additional life challenges, yet we have comparatively limited information about the lives of older lesbian, gay, and bisexual adults (see D'Augelli & Patterson, 1995; Duberman, 1997; Garnets & Kimmel, 1993; Patterson & D'Augelli, 1998; Savin-Williams & Cohen, 1996).

The study had these purposes: (a) to describe the psychosocial and health characteristics of a national sample of older lesbians, gay men, and bisexual women and men; (b) to describe the nature of the perceived support networks of older lesbians, gay men, and bisexuals; and (c) to investigate whether or not older lesbians, gay men, and bisexuals were more satisfied with the support they received from people who are aware of their sexual orientation and from people who are similar to them in terms of sexual orientation, gender, and age.

METHOD

A survey research design using a self-administered questionnaire was employed. Participants evaluated their mental emotional health, physical health, overall loneliness, responsibility for their loneliness, alcohol use, drug abuse, self-esteem, and perceived social support.

Procedures

In order to obtain a national sample for the study, we identified agencies and groups providing social, recreational, and support services to older lesbians, gay men, and bisexuals through agency networks and by community leaders. We identified a contact person for the study at each of the 19 sites (18 in the United States and one in Canada) which agreed to recruit participants. The contact person distributed and collected the study's questionnaires from those lesbians, gay men, and bisexual people 60 years and older who volunteered for the study. Each volunteer

was asked to complete the questionnaire anonymously. The questionnaire was subsequently returned to the contact person in a sealed envelope. In an effort to increase the diversity of the sample, a snowball sampling approach was used. Members of the sites who agreed to participate were asked to recruit other older people who were not affiliated with their group and who were not their partners or roommates. Data collection occurred in 1997-98. Each person who completed the questionnaire was given $10.00. We report results for a final sample of 416 older lesbian, gay, and bisexual adults. A response rate cannot be calculated because the number of older adults available at each site to complete the questionnaire could not be determined.

Instrument

The questionnaire contained several standard measures and additional questions designed for this study. We assessed self-esteem using the ten-item scale developed by Rosenberg (1965); the coefficient alpha for this scale was .86 in this study. We measured internalized homophobia, or negative views of one's sexual orientation, with the Revised Homosexuality Attitude Inventory (Shidlo, 1994); the coefficient alpha was .82. We used three scales to assess dimensions of loneliness and its management. Overall loneliness was determined with an eight-item version of the UCLA Loneliness Scale (Hays & DiMatteo, 1987). The two other dimensions of loneliness–perceived responsibility for loneliness (or the attribution of the causes of loneliness to one's own efforts or to others) and the personal control over loneliness–were each assessed by four-item, four-point scales (Moore & Schultz, 1987). In this study, coefficient alphas for the three scales were .86, .86, and .57, respectively. We measured alcohol abuse with the ten-item Alcohol Use Disorders Identification Test (AUDIT), which was developed by the World Health Organization to identify people whose alcohol consumption could jeopardize their health (Bohn, Babor, & Kranzler, 1995). Coefficient alpha for the AUDIT in this study was .77. We assessed drug abuse with the ten-item version of the Drug Abuse Screening Test (DAST-10; Skinner, 1982). Coefficient alpha for the DAST-10 was .62. To measure mental and physical health, we used several questions from a survey instrument designed to assess health and mental health problems in the elderly (Ahern & Gold, 1991; Hancock Gold, Ahern, & Heller, 1991), which were answered on five-point scales. (A sample

question was, "How would you describe your mental and emotional health at the present time?" answered from "Excellent" to "Very Poor.")

We used a modified version of the Support Network Survey (Berger, 1992; Berger & Mallon, 1993) to measure perceived social support. The SNS instructs the respondent to: (a) list up to 10 members of his or her support network, (b) designate the gender, age, and sexual orientation of each person and his or her relationship to the participant, (c) indicate the types of support the person gives, (d) rate his or her level of satisfaction with person's support (on a five-point scale, "not at all satisfied" to "extremely satisfied"), and (e) indicate the extent to which the person is aware of the respondent's sexual orientation (a three-item scale: 1 = "definitely knows," 2 = "definitely or probably suspects," and 3 = "does not seem to know or suspect"). The instrument also included demographic questions and items designed to assess the participants' experiences related to HIV/AIDS.

Finally, several questions concerned participants' lifelong experiences of victimization based on their sexual orientation. They were asked how often the following types of victimization had occurred: verbal insults, threats of physical violence, assaults, objects thrown, assaults with weapons, threats to have one's sexual orientation exposed, discrimination at work, and discrimination in housing. Response choices were in four categories: "never," "once," "twice," or "three or more." A total victimization score was computed by adding the scores of all types of victimization.

Participants

The sample consisted of 416 older lesbian, gay, and bisexual adults, 297 or 71% males, and 119 or 29% females. They ranged in age from 60 to 91 years, with an average age of 68.5. Most (92%) identified as lesbian or gay, and 8% identified as bisexual. More than three-fourths (79% or 327) were members of the gay-identified agencies or groups; and the remaining 21% or 89 were social contacts of those who were affiliated with the groups. About half (51%) of the respondents said they belonged to one or two gay or lesbian organizations; some reported belonging to no groups, while others reported belonging to up to 20 groups. Additionally, most participants (66%) said they regularly attended one or two groups on a regular basis. Some indicated attending no groups regularly, while others attended up to eight groups on a regular basis.

Twenty-one percent of the participants were high school graduates, 14% had obtained associate degrees or various types of certificates, and 65% received a bachelor's or higher degrees. Most participants were European/Caucasian/White, with 3% describing themselves as African-American/Black, and 2% as Hispanic/Latino or Latina. One-third (34%) lived in a major metropolitan area, while approximately another third (35%) lived in a small city; with the remainder living in a suburb (10%), a small town or rural area (13%), or another type of community (7%).

Approximately half (47% of the males and 50% of the females) stated that they had a current partner. Couples averaged 15.25 years together, with no difference between males and females in the longevity of their relationships. Almost two-thirds (63%) of the participants lived alone, 29% lived with their partners, 2% lived with friends, 2% with relatives, and 3% said they were homeless. Three-quarters (74%) were retired, 18% were working, 3% were receiving disability payments, and 5% continued to work despite retirement from other work. Participants reported being retired for an average of at least nine years (M = 9.32), with some participants having recently retired (three months) and others having retired over 45 years ago. With regard to personal yearly income, 15% earned less than $15,000, 44% earned from $15,000 to $35,000, and 41% earned more than $35,000.

Limitations of the Study

This study did not utilize a representative sample of older lesbian, gay, and bisexual adults. This points to the difficulty in recruiting a representative sample of older lesbian, gay, and bisexual people for health-related research. Although the sample is geographically diverse, it is biased in favor of those who participated in a gay-identified group or knew people who did. The study also used self-identification in terms of sexual identity; therefore, older adults who have had same-sex experiences but do not identify as gay, lesbian, or bisexual were not included. Consequently, the findings cannot be generalized to all older lesbian, gay, and bisexual individuals.

FINDINGS

The results of the study will be presented in five sections: mental health characteristics, selected physical health characteristics, substance use and abuse, support networks, victimization and experiences with

HIV/AIDS. Gender differences are reported as appropriate. Results for group differences on major study variables are shown in Table 1.

Mental Health Characteristics

Data were collected for six areas including overall mental health, self-esteem, loneliness, responsibility for loneliness, internalized homophobia, and suicidality.

Mental health. Eighty-four percent of the participants reported that their mental health was good to excellent, 14% said fair, and 2% poor ($M = 4.18$, $SD = .77$). Regarding changes in mental health status over the past five years, 33% said that their mental health was better currently than it was five years ago, 54% reported that it stayed the same, and 13% said it became worse ($M = 3.35$, $SD = .91$). Additionally, current mental health was significantly positively related ($r = .22$, $p < .001$) to household income, indicating those participants reporting better mental health had higher income. There was a significant negative relationship between victimization and mental health ($r = -.14$, $p < .01$), indicating those participants reporting more victimization had lower levels of mental health. There was no relationship between reported mental health and the amount of time spent with other gay men or lesbians, or with the number of gay/lesbian organizations to which participants belonged. We used analyses of variance to examine differences in reported mental health between men and women, gay men/lesbians and bisexuals, and whether or not a participant lived with a domestic partner. No differences were found between men and women, $F(1, 406) = .52$, ns, or between gay men/lesbians and bisexuals, $F(1, 405) = .001$, ns. However, those participants living with a domestic partner rated their mental health significantly more positively than whose who lived alone, $F(1, 405) = 9.13$, $p < .01$.

Self-esteem. Most of the participants reported fairly high levels of self-esteem ($M = 34.85$, $SD = 4.52$, range = 17.5-40). Those living with domestic partners ($M = 35.8$, $SD = 3.84$) reported significantly higher levels of self-esteem, $F(1, 411) = 7.78$, $p < .01$, than those living alone ($M = 34.45$, $SD = 4.74$). However, an ANOVA showed self-esteem did not differ by gender, $F(1, 413) = 1.29$, ns, or by sexual orientation (i.e., gay/lesbian vs. bisexual), $F(1, 409) = .25$, ns. Those participants with higher levels of self-esteem had greater household income ($r = .22$, $p < .001$) and more people in their support networks ($r = .15$, $p < .01$). There was also a positive relationship between self-esteem and victimization, with those with fewer instances of victimization reporting higher self-

TABLE 1. Group Differences on Major Study Variables

	Gender					Sexual Orientation					Living Arrangements					Total	
	Male		Female			Gay/Lesbian		Bisexual			Alone		Domestic Partner				
Variable	*M*	*SD*	*M*	*SD*	*F*	*M*	*SD*	*M*	*SD*	*F*	*M*	*SD*	*M*	*SD*	*F*	*M*	*SD*
Mental Health	4.14	.83	4.20	.75	.52	4.18	.78	4.18	.68	<.001	4.10	.83	4.36	.58	9.13**	4.18	.77
Self-Esteem	34.69	4.50	35.25	4.56	1.29	34.80	4.60	35.21	3.74	.25	34.45	4.74	35.80	3.84	7.78**	34.85	4.52
Loneliness	14.15	4.14	13.83	4.71	.46	14.07	4.35	13.84	3.92	.09	14.65	4.47	12.65	3.56	19.19***	14.06	4.31
Responsibility for Loneliness	10.47	2.63	9.79	2.73	5.58*	10.33	2.73	9.59	1.92	2.42	10.15	2.65	10.56	2.71	1.99	10.28	2.67
Internalized Homophobia	24.27	6.50	22.13	5.06	10.31**	23.40	6.23	25.98	5.46	2.42	24.29	6.49	22.14	5.21	10.44**	23.66	6.21
Suicidality	3.95	1.96	3.44	1.28	6.77**	3.80	1.84	3.79	1.41	<.001	3.84	1.81	3.71	1.82	.42	3.80	1.81
Physical Health	3.92	.79	4.00	.81	.76	3.93	.80	4.12	.74	1.75	3.88	.82	4.11	.70	7.21**	3.95	.79
Alcohol Use (AUDIT)	3.36	3.46	2.32	2.47	8.89**	3.05	3.21	3.47	3.74	.53	2.98	3.10	3.29	3.57	.78	3.71	4.37
Drug Use (DAST)	10.24	.66	10.19	.57	.52	10.24	.65	10.18	.46	.29	10.23	.64	10.24	.65	.03	10.23	.64
Victimization	4.12	4.58	2.68	3.60	8.91**	3.69	4.36	3.94	4.48	.09	3.91	4.56	3.25	3.87	1.87	3.71	4.37

*p < .05; **p < .01; ***p < .001.

esteem (r = −.15, p < .01). However, self-esteem was lower among older participants (r = −>+″< p < .05). As with mental health, self-esteem was not affected by spending time with other gay men or lesbians, or by involvement with gay or lesbian organizations.

Loneliness. Many participants experienced loneliness. Over one-quarter (27%) said they lacked companionship, and 13% reported feeling isolated. There was no relationship between age and loneliness, r = .05, ns. Also, the amount of time spent with other gays or lesbians and involvement in gay or lesbian organizations were not related to loneliness. There was a significant positive correlation between loneliness and household income; those reporting more income were less lonely (r = −.18, p < .001). As would be expected, participants were less lonely when they had more people in their support network (r = −.23, p < .001). There was also a significant relationship between loneliness and victimization; those who were more lonely experienced more victimization (r = .18, p < .001). An ANOVA was used to examine differences in loneliness between those living with domestic partners and those living alone; participants living with domestic partners were significantly less lonely, F (1, 410) = 19.19, p < .0001. However, the ANOVA yielded no significant differences in reported loneliness between gay men/lesbians and bisexuals, or between men and women.

Responsibility for loneliness. Slightly more than half (52%) of the respondents agreed or strongly agreed that loneliness is a person's own fault. Men (M = 10.47, SD = 2.63) were more likely to feel responsible for their loneliness, F (1, 408) = 5.58, p < .05, than women (M = 9.79, SD = 2.73). There were no differences in feeling responsible for loneliness between gay men/lesbians and bisexuals, F (1, 405) = 2.42, ns, or those living with a domestic partner and or living alone, F (1, 407) = 1.99, ns. Unlike feelings of loneliness, there was a significant positive relationship between age and responsibility for loneliness; older respondents felt more responsible for feeling lonely (r = .15, p < .01). Feeling responsible for loneliness was not related to household income, number of people in a person's support network, time spent with other gay men or lesbians, or involvement in gay and lesbian organizations.

Internalized homophobia. Most of the participants reported low levels of internalized homophobia (M = 23.66, SD = 6.21), with men (M = 24.27, SD = 6.50) reporting significantly more negative attitudes toward homosexuality than women (M = 22.13, SD = 5.06), F (1, 411) = 10.31, p < .01. Additionally, those respondents living alone reported more internalized homophobia than those living with a domestic partner, F = (1,409) = 10.44, p < .01. There was no difference in internalized homophobia between

gay men/lesbians and bisexuals. Internalized homophobia was related to age; older respondents reported more homophobia ($r = .13$, $p < .05$). Those respondents with more household income reported less internalized homophobia ($r = -.11$, $p < .05$). Contact with more people appears to be related to internalized homophobia. Respondents who were members of more gay or lesbian organizations and who had greater levels of involvement in these organizations had less internalized homophobia. Additionally, those with more people in their support networks reported less internalized homophobia. Victimization was not related to internalized homophobia ($r = .04$, p = ns).

Suicidality. Related to internalized homophobia, 8% of all participants reported being depressed about their sexual orientation, and 9% had been to counseling to stop their same-sex feelings; however, 17% of all participants stated that they would prefer being heterosexual. Of all the respondents, 10% sometimes or often considered suicide. Of these, 29% said that their suicidal thoughts related to their sexual orientation, with men reporting significantly more suicidality related to their sexual orientation than women, $F(1, 406) = 6.77$, $p < .01$. Thirteen percent (52 people) reported a suicide attempt at some point in their lives, with most doing so between the ages of 22 and 59. We found no differences in suicidal thoughts between those who lived with a domestic partner and those living alone, $F(1, 404) = .42$, ns, or between gay men/lesbians and bisexual people, $F(1, 402) < .001$, ns. Additionally, there were no significant relationships between suicidal thoughts and age, household income, network size, or involvement in gay or lesbian organizations.

Selected Physical Health Characteristics

Three-fourths of the participants (75%) reported that their physical health was good to excellent, 21% said fair, and 4% poor. Regarding changes in their physical health status over the past five years, 11% said that their health was better; 50% reported that it stayed the same; and, 30% said it became worse. Eleven percent described their health status as interfering with things they wanted to do. More than half (57%) indicated that they exercised regularly, 27% sometimes, 12% seldom, and only 4% never. There was no apparent difference in reported physical health between men and women, or between gay men/lesbians and bisexuals. Individuals living with a domestic partner ($M = 4.11$, $SD = .70$) reported significantly better physical health than those living alone ($M = 3.88$, $SD = .82$), $F(1,406) = 7.21$, $p < .01$. Physical health was related to household income; those reporting better physical health had higher incomes ($r = .24$,

$p < .001$). Additionally, individuals experiencing less lifetime victimization reported better physical health ($r = -.14$, $p < .01$). Although not significant, physical health status was related to the number of people in the respondents' support networks; participants who had more people in their networks reported better physical health.

Substance Use and Abuse

Only 9% of the sample (38 people) could be classified as "problem drinkers" on the AUDIT. Eleven participants added comments indicating that they were "recovering alcoholics." Men ($M = 3.36$, $SD = 3.46$) reported significantly more alcohol use than women ($M = 2.32$, $SD = 2.47$), $F (1, 412) = 8.89$, $p < .01$, and significantly more men could be classified as "problem drinkers." For this sample, it appears contact with other people does not affect alcohol use. There was no difference between those living with a domestic partner and those living alone, $F (1,410) = .78$, ns. Further, there was no relationship between alcohol use and number of people in support networks or involvement with gay or lesbian organizations, nor was alcohol use related to age. There was no relationship between alcohol use and household income, or with victimization experiences.

Eighty-three percent reported no evidence of drug abuse in the past year on the DAST, with 36 participants emphasizing abstinence from drug use by writing unsolicited comments on their questionnaires such as, "I don't do drugs," and "No drugs ever!" There were no gender differences with regard to drug abuse.

Support Networks

The 416 participants listed a total of 2,612 people in their support networks, so the respondents' networks averaged 6.3 people. Participants' sexual orientation was not related to the size of their networks. Close friends was the most frequently reported category, listed by 90% of the participants. The second most frequently reported category was partners (listed by 44%), followed by other relatives (listed by 39%), siblings (listed by 33%), and social acquaintances (listed by 32%). Co-workers were listed only by 15% of the participants, parents by 4%, and husbands/wives by 3%. Half (49%) of the people in the networks were under 60 years of age, and half were 60 or older. The range of networks members' ages was from 15 to 94 (average age = 58). Respondents were significantly older than their network members, $t [387] =$

23.56, $p < .001$, on the average by about 10 years, a finding that held for women as well as men.

Women listed significantly more people in their networks, t [414] = 2.94, $p < .01$, than did men, and had more women (75%) in their networks (both lesbian and heterosexual) than did men (26%). Men's networks contained more gay/bisexual males (54%) than women's networks (10%). Heterosexual men were equally represented in men's and women's networks. Bisexual women and men reported having significantly more heterosexual people in their networks compared to lesbian and gay respondents, $F(2, 390) = 6.07$, $p < .01$. An average of six people in the networks "definitely knew" the participants' sexual orientation, an average of about two persons "definitely or probably suspected," and an average of 2.5 persons "did not know or suspect." Participants were more satisfied with the support they received from those who definitely knew of their sexual orientation than from those who suspected or were unaware of it. They were most satisfied with the support provided by their lovers/partners, and they were very satisfied with the support from close friends or co-workers. An ANOVA showed significant differences among the most frequently reported category of people offering support (i.e., partners/lovers, close friends, spouse, coworkers, other relatives, and social acquaintances), $F(8, 2819) = 22.51$, $p < .0001$. Post hoc tests (Tukey Honestly Significant Difference) revealed significant ($p < .05$) differences between (a) parents and: social acquaintances, close friends, and partners/lovers; (b) siblings and: social acquaintances, close friends, and partners/lovers; (c) coworkers and: social acquaintances, close friends, and partners/lovers; and (d) other relatives and: social acquaintances, close friends, and partners/lovers. Participants were not more satisfied with the support they received from people who were of the same sexual orientation, $F(3, 2689) = 1.2$, ns, or who were close to them in age, $F(2, 2827) = 1.91$, ns. The more satisfied participants felt with support received, the less lonely they felt, $r = -.32$, $p < .01$. Regarding the types of support received, 62% indicated that they received emotional support from their networks, 54% practical support, 13% financial support, 41% advice and guidance, and 72% reported general social support (Grossman, D'Augelli, & Hershberger, 2000).

Victimization Based on Sexual Orientation

Sixty-three percent of the participants reported experiencing verbal abuse based on their sexual orientation over their lifetimes, while 29%

were victims of threats of violence, 16% experienced assault, 11% had objects thrown at them, and 12% were assaulted with a weapon. Twenty percent reported employment discrimination based on their sexual orientation, and 7% experienced housing discrimination. Being victimized by someone who threatened to disclose their sexual orientation was reported by 29% of participants. Victimization was related to gender, $F(1, 398) = 8.91$, $p < .01$, with men ($M = 4.12$, $SD = 4.58$) reporting more victimization than women ($M = 2.68$, $SD = 3.60$). Additionally, increased victimization was related to visibility: those participants who had memberships in more lesbian, gay, or bisexual organizations, $r = .19$, $p < .001$, or attended them regularly, $r = .16$, $p < .01$, reported more victimization. However, the size of an individual's support network was not related to victimization, $r = .007$, $p =$ ns. Reported levels of victimization were related to household income; as income increased, levels of victimization decreased, $r = -.19$, $p < .001$. Although not significant, older individuals reported less victimization than their younger counterparts, $r = -.09$, $p < .10$. There was no difference in victimization reported by those individuals living with a domestic partner or those living alone, $F(1,397) = 1.87$, $p =$ ns. Further, there was no reported difference between gay men/lesbians and bisexuals, $F(1, 398) = .09$, $p =$ ns.

Experiences with HIV/AIDS

Ninety-three percent of the participants knew people diagnosed with HIV/AIDS, and 90% knew someone who died from HIV/AIDS. Additionally, 47% indicated they knew three or more people who had died from HIV/AIDS. Ninety percent said that are very unlikely or unlikely to be infected with HIV, 6% didn't know, 2% likely or very likely, and 2% reported being infected. Of the 2% who reported being HIV infected, eight were men and one was a woman. Participants were asked about whether or not they had been tested for HIV/AIDS, and if not, whether they planned to in the next year. Forty percent indicated they had two or more HIV/AIDS tests, 18% had only one test, and 2% expected to be tested in the next year. The remaining 40% said they did not expect to take an HIV/AIDS test.

DISCUSSION

Today's older lesbian, gay, and bisexual people grew up when heterosexism and homophobia remained largely unchallenged. Further-

more, the culture and institutions of the time reflected pathologizing models of homosexuality. Lesbians and gay men were classified as mentally ill, and they were thereby stigmatized and assigned to a low status. Therefore, in addition to the negative events related to society's homophobia, lesbians, gay men, and bisexuals experienced social stress and stigmatization as members of a sexual minority group in a dominant heterosexual society. At the center of this experience was (is) the incongruence between their culture, needs, and experiences and societal structures (DiPlacido, 1998; Meyer, 1995). This incompatibility has led lesbians, gay men, and bisexuals to experience negative life events (e.g., loss of custody of children, anti-gay violence), as well as more chronic daily hassles (e.g., hearing anti-gay jokes, always being on guard). Some studies and reports have linked minority stress to greater mental health problems, emotional distress, and depressive mood among gay men, and excessive cigarette smoking, heavy alcohol consumption, excessive weight, and high-risk sexual behaviors among lesbians and bisexual women. However, there is evidence to suggest that some gay men, lesbians, and bisexuals deal successfully with minority stress, so that it does not lead to negative health outcomes. Social support and certain personality characteristics, such as hardiness and self-esteem, have been found to moderate the negative effects of stress (DiPlacido, 1998).

The older lesbians, gays, and bisexuals in this study experienced much of their development at a time when many stress-buffering factors were not available. On the average, they were born in 1929 and were 40 years of age at the time of the 1969 Stonewall Riots in New York City, which marked the beginning of the modern lesbian, gay, bisexual, and transgender civil rights movement. They averaged 44 years of age when homosexuality was removed from the American Psychiatric Association's list of mental illnesses in 1973, 52 when the first cases of AIDS were reported in 1981, and 69 when the television character "Ellen" disclosed her sexual orientation to a national audience in 1997. Although older lesbians, gay men, and bisexuals constitute a diverse group, these life-course markers indicate that they experienced many years of stress before these sociopolitical events influenced their lives. In addition to altering the perceived status of lesbians, gay men, and bisexuals in American society, these events empowered many older people to disclose their sexual orientation for the fist time (Herdt & Beeler, 1998), and have encouraged others to attend support and social groups designed to meet their needs. As a result, the experiences resulting from these events have enabled many older lesbians and gays to construct positive identities (Friend, 1989, 1990).

The older lesbians, gay men, and bisexuals who participated in this study experienced their early identity development at time when homosexuality was synonymous with abnormality, inferiority, and shame. As a result, many feared that identifying their sexual orientation would lead to humiliation, dishonor, and rejection, so they remained invisible. They tended to internalize society's negative stereotypes about them, developing feelings of unworthiness and self-hate (Friend, 1990; Grossman, 1997). However, it appears that most of study's participants have mastered their sexual identity challenges leading to identity acceptance, identity pride, or identity synthesis (Cass, 1979), which have led them to become members of social groups of older lesbians, gay men, and bisexuals.

Their overall mastery of sexual identity development is apparent in many of the findings of the study, which is consistent with the findings of Berger (1996) and Kehoe (1989). The large majority of the participants reported fairly high levels of self-esteem, low levels of internalized homophobia, and a good or excellent mental health status. The large majority of the participants also reported no evidence of drug use in the past year, and relatively few could be classified as "problem drinkers." The large majority of the participants described support networks that consisted mainly of close friends, thereby creating "families of choice"; however, almost half (44%) also listed partners among their network members. Although the participants were most satisfied with the support that they received from partners, they were very satisfied with the support received from close friends and co-workers. The most important factor in determining support satisfaction was the knowledge of their sexual orientation by the support group member, which is a prime example of their identity acceptance and pride.

Although a majority of the participants appear to have developed some resilience to the stress related to their minority status, evidence of distress remains. Most striking is the victimization based on sexual orientation, with almost two-thirds (63%) of the participants having experienced verbal abuse, and more than a quarter (29%) threats of physical violence. A similar percentage of people (29%) reported being victimized by someone who threatened to disclose their sexual orientation to others. As indicated by Herek, Gillis, and Cogan (1999), stigma-based personal attacks on lesbian, gay, and bisexual adults are more deleterious to their mental health than other types of attacks.

The participants in this study reported other evidence of ongoing distress. For example, more than one-quarter (27%) reported feeling lonely, and more than half (52%) reported that responsibility for loneliness was a person's own fault. Other indices of continuing distress were: 10% of the participants reported sometimes or often considering suicide, 17%

feeling that they wished they were heterosexual, and increased visibility led to greater victimization experiences. If Lee's (1987) conclusion, based on his four-year longitudinal study of older gay men in Canada, is correct–i.e., successful involves being fortunate and/or skilled enough to avoid stressors (including the stress of coming out)–then these participants are engaged in such a process. Lee found that health, wealth, and lack of loneliness were associated with high life satisfaction among the study's participants. Another distress related to their sexual orientation was knowing large numbers of people diagnosed with HIV/AIDS (93%) and who had died as a result of HIV/AIDS (93%). The impact of these experiences was not assessed, and it is recommended that future research include the implications of living as an older lesbian, gay, or bisexual person through the HIV/AIDS epidemic.

Using a snowball sampling approach, we asked older lesbian, gay, and bisexual people who belonged to social and recreational agencies and groups to tell us about themselves. There were 416 responses, producing a larger and more geographically diverse sample than has been gathered in other studies. They completed structured questionnaires to inform us about some of their experiences and current lives. We learned that our findings are consistent with a recent development in social gerontology: socioemotional selectivity theory, which posits that older adults engage in motivated processes to regulate their social interactions, with the primary purpose of controlling their emotionality (Carstensen, 1992; Carstensen, Gross, & Fung, 1998). Using this approach, the findings of the current study support the idea that older lesbian, gay, and bisexual people engage in processes to reduce the stress associated with their minority status, thereby reducing their internalized homophobia, enhancing their identity acceptance and pride, and creating supportive social networks. Future research is needed to understand these processes, not only for the implications of providing programs and services, but to help those older lesbian, gay, and bisexual people who are not able to engage in these programs and services on their own.

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