

Same-Sex Partnerships and the Health of Lesbian, Gay and Bisexual Older Adults

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Abstract

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While extensive research has examined associations between marriage, cohabitation and the health of heterosexual adults, it remains unclear whether similar patterns of health are associated with the same-sex partnerships for older adults. The following papers examine how having a same-sex partner may be related to general self-reported health, mental health, and satisfaction with life for older adults. Analyzing survey data collected from lesbian, gay, and bisexual (LGB) adults 50 years of age and older, the first paper reports findings that those with same-sex partners have significantly better self-reported health, fewer depressive symptoms, less perceived stress, and greater life satisfaction, controlling for gender, age, education, income, sexuality, and relationship duration. Relationship duration did not significantly impact the association between partnership status and health, nor did gender. The importance of culturally sensitive clinical practice and policies

that recognize the role that same-sex partnerships may play in older adult health are discussed along with implications for future research. The second paper further examines how identifying as married is associated with significantly fewer depressive symptoms and greater life satisfaction compared to those identifying as unmarried partners, but not significantly less perceived stress. Social integration, as reflected in increasing access to and identification with marriage by LGB older adults, is an important area for future research to examine in order to study how changing social acceptance of sexual minorities may impact older adult health. The final paper reviews the theoretical frameworks that have been employed to study lesbian, gay, and bisexual older adult health. Social determinants of health models are contrasted with social constructionist and post-structural critiques of gender, sexuality, age and health. Future research needs to envision both structural sources of health disparities as well as account for individual agency and the resilient subject as important elements for theorizing the source and meaning of health disparities for lesbian, gay and bisexual older adults.

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Introduction

The study of lesbian, gay, and bisexual (LGB) older adults has emerged over the past 40 years, coinciding with the rise of contemporary public discourse about the existence, nature, and social standing of sexual minorities. In that time, popular and academic language about sexual minorities has evolved, and the focus of scholarly research on LGB older adults has moved from documenting their existence (Kimmell, 1977; Kelly, 1977; Berger 1982) to investigating topics such as their identity development (Ricards & Wuest, 2006; Quam & Whitford, 1992, Rosenfeld, 1999), their networks of social support (Jacobs, et al., 1999; Barker, et al., 2006), and their health (Hash & Netting, 2007; Fredricksen-Goldsen, et al., 2011). The base of knowledge about LGB older adults has grown rapidly as public discourse and the focus of research concerning this population has shifted dramatically over time.

The demographics of American society have also changed dramatically in the past 40 years, and older adults now comprise a larger portion of the population than they ever have (Hooyman & Kiyak, 2011). With the growing ranks of older adults in society and the growing visibility and public discourse concerning LGB communities, the need to understand more about LGB older adults has recently come into sharp focus. The Institute of Medicine summary of research on LGB and transgender communities (Institute on Medicine, 2011) identified older adults as one of the least researched sexual minority subpopulations, along with numerous gaps in empirical knowledge about LGB older adult health. Scholarly attention paid

to seeking greater understanding of the factors impacting health and health disparities for LGB older adults has never been greater.

The role of intimate partnerships has long been studied as a significant factor affecting the health of heterosexuals, including heterosexual older adults (Pienta, et al., 2000; Manzoli, et al., 2007; Scafato, et al., 2008). Married and cohabiting partners have been consistently shown to enjoy better physical and psychological health across the life course and to live longer. Recent research has begun to extend these findings to examine whether there are similar patterns of health among LGB individuals (Weinke & Hill, 2009; Grossman, et al., 2001; Wight, et al., 2012; Riggle, et al., 2009). This dissertation addresses whether partnership status is significantly associated with multiple measures of self-reported health and satisfaction with life. Further, this work explores the implications of existing theoretical frameworks and their capacity to recognize both social determinants and individual agency as important factors in shaping LGB older adult health.

The first paper, *Partnership Status and the Health of LGB Older Adults*, addresses whether two prominent theories used to explain the association between marital status and health for heterosexuals may also help in understanding patterns of health among LGB older adults. The Partnership Resource Model and the Gender Role Theory are used as frameworks for studying how partnership status, relationship duration, and gender may impact the health of LGB older adults. Data from a national sample of LGB older adults are examined, and findings are discussed regarding the role that partnership status plays in understanding self-reported health, depressive symptoms, perceived stress, and satisfaction with life.

Implications for practice are identified, as well as future directions for additional research to understand further how partnership status and health are related for LGB older adults.

The second paper, *Marriage, Health and the Social Integration of LGB Older Adults*, examines whether identifying as married is associated with better mental health outcomes above and beyond those observed for LGB older adults with unmarried partners and those without partners. Increasing access and identification with marriage may reflect growing social integration of LGB individuals within society, and based on Social Integration theory (Durkheim, 1951), it may be reasonable to expect better health outcomes for those identifying as married. Examining a national sample of LGB older adults, patterns of depressive symptoms, perceived stress, and satisfaction with life are identified and discussed. Needs for future research are identified in order to address how the rapidly changing public policy context regarding same-sex marriage may have ongoing implications for LGB older adult health.

The final paper, *Alternative Conceptual Frameworks of LGB Older Adult Health*, reviews dominant theoretical frameworks for the study of LGB older adult health disparities and suggests how alternative frameworks may provide additional focus on LGB older adults as resilient subjects with the capacity to shape their own health. Contrasting social determinants of health models with social constructionist and post-structural theories of gender, sexuality, age and health, the paper concludes with a call for more intentionally incorporating the role of individual agency in future research on LGB older adult health.

With the expansion of the LGB older adult population, the need to understand better the factors that impact their health is growing. This dissertation presents new findings and a call for ongoing development of research theory to keep pace with the dynamic discursive and public policy context in which LGB older adults live today.

Paper 1: Partnership Status and the Health of LGB Older Adults

An extensive body of scholarship has documented associations between being married or cohabitating and health (see Waite, 1995; Waite & Gallagher, 2000). Most of the research concerning health outcomes associated with marriage and cohabitation assume that respondents are heterosexual and that couples are always comprised of opposite sex partners. Less attention has been paid to possible associations between partnership status and health among lesbian, gay and bisexual (LGB) adults.

Many LGB older adults have been forming long-lasting, intimate same-sex partnerships for all of their adult lives. Although not legally recognized in the United States prior to the last 10 years (Human Rights Campaign, 2012), same-sex partnerships have long provided LGB older adults opportunities to share material and emotional resources as well as direct social support and shared social networks. Within the context of ongoing stigma and public debates, same-sex partnerships enjoy far less universal social sanction than heterosexual marriage (Saad, 2012). While the option to cohabit without marrying is generally available to all heterosexual partners, identifying as part of an unmarried same-sex partnership may reflect different individual preferences or differential access to state recognized same-sex partnerships for LGB individuals. Same-sex partnerships may provide similar health benefits as those observed in research on married and cohabiting heterosexuals, or they may demonstrate unique patterns of health.

Currently, it remains unclear whether older adults in same-sex partnerships experience benefits to physical and mental health and life satisfaction relative to their unpartnered LGB peers. This paper reviews the literature regarding health for partnered heterosexuals, and then examines these associations in a national sample of LGB older adults. The paper then considers the implications of these findings for practice and future research to address the role that same-sex partnerships may play in supporting the health of older adults.

Literature Review and Theoretical Frameworks

The Literature on Same-Sex Partnerships and Health. Researchers have documented a large body of evidence that heterosexual adults experience positive health outcomes associated with being married and cohabiting (Waite, 1995; Gallagher & Waite, 2000; Ross, et al, 1990; Manzoli, et al., 2007). Mortality is lower for married and cohabiting adults when compared with single, divorced and widowed peers (Hu & Goldman, 1990; Coombs, 1991; King & Reis, 2012; Idler, et al., 2012; Blomgren, et al., 2012). Married and cohabiting adults report being in better physical health (Prior & Hayes, 2003; Waldron, et al., 1996; Pienta, et al., 2000; Coombs, 1991) and mental health (Williams, 2003; Simon, 2002; Frech & Williams, 2007; Sherbourne & Hayes, 1990; Coombs, 1991) in comparison with unmarried adults living alone. Many researchers have repeatedly shown that having an intimate partner, whether married or unmarried, is consistently accompanied by better health outcomes.

When looking specifically at older adults, researchers have similarly found better health associated with having a partner. Married and cohabiting older adults

live longer than unmarried peers who live alone (Manzoli, et al., 2007; Scafato, et al., 2008; Tower, et al., 2002; Goldman, et al., 1995). Marriage and cohabitation are associated with better physical health and functional ability among older adults (Goldman, et al., 1995; Schoenborn, et al., 2009). Henderson, et al. (1986) found that cohabiting older adults reported lower frequency of depressive symptoms. In contrast, Wu, et al., (2012) reported that married and cohabiting older adults were significantly more likely to meet criteria for major depressive disorder than were single older adults. Most research, however, has consistently found that married and cohabiting older adults fare better on multiple measures of physical and mental health than their single peers.

In contrast to the extensive literature on heterosexuals, the scholarship concerning the associations between health and same-sex partnerships is much more limited. There have been relatively few sources of data on same-sex partnerships, and research examining associations between partnership status and health among LGB older adults has had to rely on smaller samples than the extensive scholarship on heterosexuals, thus limiting their power to detect significant differences. A few studies have found that having a same-sex partner is associated with measures of general health, depression, stress and happiness when compared with unpartnered peers (Wienke & Hill, 2009; Riggle, et al., 2010; Wight, et al., 2012; Grossman, et al., 2001). Specifically among LGB older adults, partnered individuals report fewer depressive symptoms (Wight, et al., 2012), less loneliness and better general mental health than LGB older adults living alone (Grossman, et al., 2001). The development of scholarship on same-sex partnerships and the health

of LGB older adults is in an early stage, but initial evidence suggests that, like heterosexual older adults, they may experience health benefits from having an intimate partner.

Theoretical Frameworks. There are several theoretical frameworks that attempt to explain the positive associations found between health and being partnered, two of which are considered in this paper: the Partnership Resource Model and Gender Role Theory. These two theoretical perspectives are particularly salient to the topic of same-sex partnership status and health. The Partnership Resource model draws attention to the perspective that shared resources in a partnership may buffer individuals, particularly those from oppressed communities, from some of the stresses and challenges that can accompany coping with growing old. Gender Role Theory highlights the unique role of gender and gender socialization in the composition of same-sex partnerships.

Partnership Resource Model. The Partnership Resource Model (referred to elsewhere as the Marital Resource Model) proposes that having an intimate partner provides social, emotional, and financial resources that promote positive health outcomes, which are reflected in health disparities between partnered and unpartnered heterosexuals (Ross, et al., 1990; Lui & Umberson, 2008). Both married partners and unmarried cohabiters benefit from shared resources and shared costs of maintaining a household, as well as from the emotional and social support they receive from their partners. These shared resources are theorized to buffer the health effects of stress across the life course. Further, health benefits from shared resources accumulate over time, reflecting cumulative resource advantages

for partnered individuals. This may explain why partnered heterosexuals report better health than unpartnered individuals, and why, in some studies, longer-lasting partnerships are associated with more health benefits than shorter ones (Meadows, 2009; DuPre & Meadows, 2007; Lillard & Waite, 1995; Gibb, et al., 2011).

The Partnership Resource Model has almost entirely been applied to heterosexuals, most often specifically addressing the benefits of marriage. Similar benefits, however, may result from shared social, emotional, and financial resources for same-sex partners. For LGB older adults, health benefits associated with being partnered may also accrue over the duration of a relationship, resulting in better health outcomes for longer-lasting partnerships. Thus far, the Partnership Resource Model has not been examined in the context of LGB older adults.

Gender Role Theory. A second conceptual model that frames much of the research on heterosexual relationships and health is Gender Role Theory, also referred to as Sex Role Theory or Marital Role Theory (Gove, 1972; King & Reis, 2012; Tower, et al., 2002). According to this theory, gender roles into which males and females are socialized make marriage a more beneficial arrangement for men than women. The division of responsibilities within intimate relationships and different role expectations based on gender (e.g., caregiver, homemaker, wage earner) place greater burdens on the physical and mental health of women who are typically socialized to provide emotional and caregiving support more readily than they are expected to receive them. These gendered expectations for the roles people play in intimate partnerships result in fewer benefits in health outcomes for married and cohabiting women than men (Aneshensel, et al., 1991; Scafato, et al.,

2008). However, changing gender norms and family structures within the past 50 years may account for conflicting findings as to whether Gender Role Theory continues to result in differences in the health benefits of partnership for heterosexual women and men (Simon, 2002; Williams, 2003).

By definition, the gender composition of same-sex partnerships differs from heterosexual partnerships. It remains unclear whether the impact of gender role socialization previously found for married and cohabiting heterosexuals results in differences in the way that same-sex partnerships impact the health of LGB older men and women.

The current study examines whether partnered LGB older adults experience better health associated with being partnered and whether health outcomes associated with partnership status are moderated by relationship duration, as the Partnership Resource Model would suggest. Further, the study examines the role of gender in explaining associations between health and partnership status for LGB older adults, testing how Gender Role Theory may impact same-sex partnerships. Accordingly, the following analysis examines three hypotheses.

1. Same-sex partnerships (both among those with access to legal marriage and those without) will be associated with better self-reported general health, fewer depressive symptoms, less perceived stress, and greater satisfaction with life than occurs among single LGB older adults.
2. Same-sex partnerships will afford greater health and satisfaction the longer they last.

3. LGB older women will enjoy less benefit from being partnered than gay and bisexual older men.

Methods

Data for this study came from the Caring and Aging with Pride Project (Fredriksen-Goldsen, et al., 2011), which conducted a cross-sectional survey in collaboration with eleven community agencies that provide services to LGBT older adults. The agencies were located in the Northeast, Upper Midwest and West Coast of the United States. Surveys were distributed to LGBT adults 50 years of age and older on the agencies' mailing lists. Some of the agencies maintain only electronic mailing lists, and therefore a web-based version of the survey was also provided as an option for respondents. Respondents answered questions pertaining to physical and mental health, life satisfaction, health behaviors, victimization, discrimination and caregiving relationships. Sixty-three percent of all the hardcopy surveys distributed (2,201) were completed. Through the web-based option, an additional 359 electronic surveys were submitted. The Caring and Aging with Pride Project was unable to verify the number of potential respondents who could have completed the electronic version of the survey, and therefore the response rate for that portion of the project is unknown. Including both the hardcopy and electronic versions, a total of 2,560 respondents completed the survey. The University of Washington Institutional Review Board approved all of the study procedures.

The Caring and Aging with Pride Project successfully collected an unprecedented large sample of LGB and transgender older adults from across the United States, making this dataset particularly useful for studying within group

differences among this small minority of the overall population. The sample included a diverse cross-section based on key demographic characteristics, including sufficient subsamples of bisexual older adults to examine both the effects of gender and sexual orientation (same-sex oriented and bisexual). By including measures on a range of demographic and health variables, this data set presents a unique opportunity to study associations between partnership status and health among LGB older adults.

Consistent with the majority of research on LGB populations (Fredriksen-Goldsen & Muraco, 2010), “older adults” were defined as those 50 years of age and older. In order not to conflate the effects of gender identity and sexual orientation, this analysis excludes respondents who identified as transgender. Respondents who indicated their partnership status, relationship duration, race/ethnicity, education, annual household income, chronic illnesses, age and gender were included, resulting in a sample of size of 2,150 (Table 1.1).

Dependent variables. A single question from the Medical Outcomes Health Survey (Ware, et al., 1994) assessed self-reported general health, with 6 response options ranging from “excellent” to “very poor.” Single-item measures of general self-reported health are used extensively in population research and have been found to provide reliable and comparable results across studies (Kempen, 1992; Thombs, et al., 2008). The 10-item Center for Epidemiological Studies Depression Scale – Short Form (CES-D-S; Andersen, et al., 1994; Radloff, 1977) measured the estimated number of days respondents experienced depressive symptoms in the past week (<1 day, 1-2 days, 3-4 days, 5-7 days). Scores were summed across the 10

symptoms (summed range: 0-30) with higher scores indicating more frequently experienced depressive symptoms. Alpha reliability for the CES-D-S for this sample was 0.87. The 4-item Perceived Stress Scale – short form (PSS4) was used to measure perceived stress (Cohen, et al., 1983). The scale assessed how often within the past month respondents experienced stress, with respondents rating each item on a 5-point scale ranging from “never” to “very often.” Scores on the 4 items were averaged (averaged range: 0-4) with higher scores indicating more perceived stress. Alpha reliability for the PSS4 within this sample was 0.78. The Satisfaction with Life Scale (Diener, et al., 1985) asked respondents to rate their level of agreement with five statements, such as “In most ways, my life is close to my ideal.” Respondents selected from four options (“Strongly Disagree” to “Strongly Agree”), and an average was calculated across the five questions (average range: 1-4). Higher scores indicate greater satisfaction with life, with an alpha reliability of 0.89.

Independent variables. Respondents selected their current partnership status from six options (Single, Partnered, Married, Divorced, Widowed, Separated). Responses were dichotomized to compare respondents currently in a same-sex partnership (married or partnered) with those not currently in a relationship (single, divorced, widowed or separated). For those indicating their current status as partnered or married, they also indicated how long they have been in the relationship. The variable “gender” included the option to identify as female or male. Additional covariates assessed in this analysis included race (dichotomized as either white or not white) and sexual orientation (dichotomized as lesbian/gay or bisexual). Education was measured using a 6-category variable, which was collapsed

into three categories for the purpose of this analysis (high school or less, less than 4 years of college, or 4 or more years of college). Similarly, income was measured using a 6-category variable which was collapsed into three categories for this analysis (<\$35,000, \$35,000 - \$75,000, >\$75,000). Chronic physical illnesses were assessed by asking respondents to indicate if they had ever been told by a doctor that they had any of 21 chronic health conditions (e.g., asthma), with responses dichotomized for this analysis (less than five physical illnesses, or five or more). Chronic mental health was assessed by asking respondents if they had ever been told by a doctor that they had depression or anxiety, with responses dichotomized (yes/no to depression and/or anxiety).

Analysis. Analyses were conducted using Stata version 12. Descriptive statistics examined relationships between partnership status and the other independent variables. Preliminary tests for multi-collinearity were used to determine that the independent variables were not collinear to any concerning degree. Dependent variables were analyzed for optimal model choice. General health, depressive symptoms, perceived stress, and life satisfaction were modeled separately using regression analyses. Ordinal logistic regression was used to examine the 6-category general health outcome. Based on the unit of measure and distribution of CES-D-S scores, negative binomial regression was used to model depressive symptoms. Perceived stress and life satisfaction were analyzed using linear regression. In models where partnership status and gender were both significant, a subsequent regression examined whether there was a significant

interaction between partnership status and gender. For all analyses, a 0.05 confidence level was chosen a priori to indicate a significant statistical association.

Results

Table 1.1 describes the sample. The average age of respondents was 66.8 years (range: 50 – 95). Within the sample, 44.2% identified as married or partnered, and married and partnered respondents reported being in their current relationship on average 8.9 years (range: 0 – 65). The majority of respondents were male (64.8%), white (87.4%), and same-sex oriented (94.9%). Most respondents had completed at least 4 years of college (74.3%), reported five or more chronic physical conditions (60.0%), and had not been diagnosed with either depression or anxiety (62.3%).

TABLE 1.1 – Characteristics of Lesbian, Gay and Bisexual Adults, Ages 50-95
(N=2,173): Caring and Aging with Pride Project National Study

	Total N=2,150	Unpartnere d N=1,200	Partnered/Marri ed N= 950	p-value ^a
		<u>Mean (SD)</u>		
Age (years)	66.8 (9.0)	67.8 (9.0)	65.5 (8.8)	< 0.001
Relationship Duration (years)	8.9 (13.2)	-- ^b	20.1 (13.0)	--
		<u>Percent</u>		
Female	35.2	29.7	42.2	< 0.001
White	87.4	85.8	89.3	0.023
Bisexual	5.1	6.3	3.5	0.003
Education				< 0.001
High school or less	7.7	9.7	5.2	
<4 years college	18.0	21.4	13.7	
≥4 years college	74.3	68.9	81.2	
Income				< 0.001
<\$35,000	36.7	51.3	18.1	
\$35,000 - \$75,000	31.7	33.3	29.7	
>\$75,000	31.7	15.4	52.2	
≥5 Physical Illnesses	60.0	63.3	55.8	< 0.001
Dep. and/or Anxiety	36.7	40.8	31.5	< 0.001

^aBased on t-tests for difference of means and Pearson's χ^2 for proportions

^b Respondents who reported not being in a current relationship but indicated a duration of their current relationship were recoded as 0 years.

Partnered LGB older adults were significantly younger than those without partners (Table 1.1). Partnered respondents were more likely to be female and white, and they were more often in the highest categories of education and income. LGB older adults without partners were more frequently bisexual in comparison to partnered LGB older adults. Respondents without partners more frequently reported having 5 or more chronic physical illnesses and depression and/or anxiety.

Ordinal regression results (Table 1.2) indicate that partnership status was significantly associated with general health when controlling for the other variables.

Being partnered was associated with better general health in comparison with not being partnered (Table 1.3). Relationship duration was associated with poorer general health, as was having a household income less than \$35,000, having 5 or more physical illnesses, and having depression and/or anxiety. Being white was associated with better general health, as was having 4 or more years of college education relative to having a high school education or less. Age, gender, and sexuality were unrelated to general health when controlling for the other variables.

TABLE 1.2 – Ordinal Regression for General Health) Among Lesbian, Gay and Bisexual Adults, Ages 50-95: Caring and Aging with Pride Project. Range: Excellent to Very Poor.

Independent Variables	Model 1 b(SE)	Model 2 b(SE)
Partnered/Married Relationship	-0.35** (0.13)	-0.40** (0.15)
Duration	0.02*** (0.01)	0.02*** (0.010)
Age	0.01 (0.01)	0.01 (0.01)
Female	0.12 (0.08)	0.06 (0.12)
White	-0.34** (0.12)	-0.34** (0.12)
Bisexual	0.08 (0.17)	0.09 (0.17)
Education ^b		
1-3 years college	-0.20 (0.17)	-0.20 (0.17)
≥4 years college	-0.53** (0.16)	-0.53** (0.16)
Household Income ^c		
\$35k-\$75k	-0.41*** (0.10)	-0.41*** (0.10)
>\$75k	-0.82*** (0.12)	-0.82*** (0.12)
>5 Phys. Illnesses	0.86*** (0.09)	0.86*** (0.09)
Dep and/or Anxiety	0.56*** (0.08)	0.56*** (0.08)
Female*Partner	--	0.12 (0.17)
Cut 1	-1.63 (0.37)	-1.65 (0.37)
Cut 2	0.02 (0.37)	-0.01 (0.37)
Cut 3	1.36 (0.37)	1.33 (0.37)
Cut 4	2.89 (0.38)	2.87 (0.38)
Cut 5	4.7 (0.42)	4.66 (0.42)
	N=2,144	2,144
	LR = 347.67***	LR = 348.18***

^aReference group = Unpartnered (single, divorced, widowed)

^bReference group = high school education or less

^cReference group = <\$35,000

TALBE 1.3: Predicted marginal distribution of self-reported general health for LGB adults of average age (50-95), and average duration of current relationship

	Excellent	Very Good	Good	Fair	Poor	Very Poor
Overall Sample ^a	0.20	0.32	0.26	0.16	0.05	0.01
<i>For a white lesbian, <4 yrs college, med. income, ≥5 illnesses, no depression or anxiety:</i>						
Unpartnered	0.11	0.28	0.32	0.21	0.07	0.02
Partnered/Married	0.15	0.33	0.30	0.17	0.05	0.01
<i>For a white, lesbian, ≥4 yrs college, high income, <5 illnesses, no depression/anxiety:</i>						
Unpartnered	0.38	0.38	0.16	0.06	0.02	<0.01
Partnered	0.46	0.35	0.13	0.04	0.01	<0.01
<i>Non-white, gay male, high school, low income, >5 illnesses, with depression/anxiety:</i>						
Unpartnered	0.04	0.11	0.24	0.36	0.21	0.06
Partnered	0.04	0.14	0.28	0.33	0.16	0.04

^aObserved proportions

Negative binomial regression results (Table 1.4) illustrate that being partnered, as well as being older, were both significantly associated with a lower count of depressive symptoms in comparison with LGB older adults without partners, controlling for the other variables (Figure 1.1). Being partnered decreased the expected count of depressive symptoms by 20.8%, holding the other variables constant. Each additional year of age corresponded with a 1.1% decrease in depressive symptoms, controlling for other covariates. Having an annual household income less than \$35,000 and being diagnosed with 5 or more chronic physical illnesses were also significantly associated with more depressive symptoms. Gender, race, relationship duration and sexuality were not associated with depressive symptoms when controlling for the other variables.

TABLE 1.4: Results of Regressions of Depressive Symptoms (Negative Binomial), Perceived Stress (Linear) and Life Satisfaction (Linear) for LGB Adults, age 50-95: Caring and Aging with Pride Project National Study

Independent Variables	Depressive Symptoms b(SE)	Perceived Stress b(SE)	Life Satisfaction, b(SE)	Life Sat. Interaction Model, b(SE)
Partnered/Married	-0.31*** (0.06)	-0.17** (0.05)	0.28*** (0.04)	0.26*** (0.06)
Relationship Duration	0.01 (0.01)	0.01* (0.01)	0.01 (0.01)	0.01 (0.01)
Age	-0.01*** (0.01)	-0.01*** (0.01)	0.01*** (0.01)	0.01*** (0.01)
Female	0.01 (0.04)	-0.06 (0.03)	0.08** (0.03)	0.06 (0.04)
White	-0.07 (0.06)	-0.14** (0.05)	-0.01 (0.04)	-0.01 (0.04)
Bisexual	0.02 (0.09)	0.15* (0.07)	-0.07 (0.06)	-0.07 (0.06)
Education ^b				
1-3 years college	0.02 (0.08)	-0.14 (0.07)	0.09 (0.05)	0.09 (0.05)
≥4 years college	-0.12 (0.07)	-0.15* (0.06)	0.15** (0.05)	0.15** (0.05)
Household Income ^c				
\$35k-\$75k	-0.28*** (0.05)	-0.35*** (0.04)	0.23*** (0.03)	0.23*** (0.03)
>\$75k	-0.41*** (0.05)	-0.49*** (0.05)	0.32*** (0.04)	0.32*** (0.04)
>5 Phys. Illnesses	0.28*** (0.04)	0.15*** (0.03)	-0.07** (0.03)	-0.07** (0.03)
Dep and/or Anxiety	--	--	-0.25*** (0.03)	-0.25*** (0.03)
Female*Partner	--	--	--	0.03 (0.05)
Constant	2.98*** (0.17)	2.27*** (0.15)	2.00*** (0.12)	2.01*** (0.12)
	N=2,088	N=2,146	N=2,132	N=2,132
	LR = 249.38***	R ² =0.12	R ² =0.21	R ² =0.21
		F=26.37***	F=47.69***	F=44.03***

^aReference group = Unpartnered (single, divorced, widowed)

^bReference group = high school or less

^cReference group = <\$35,000

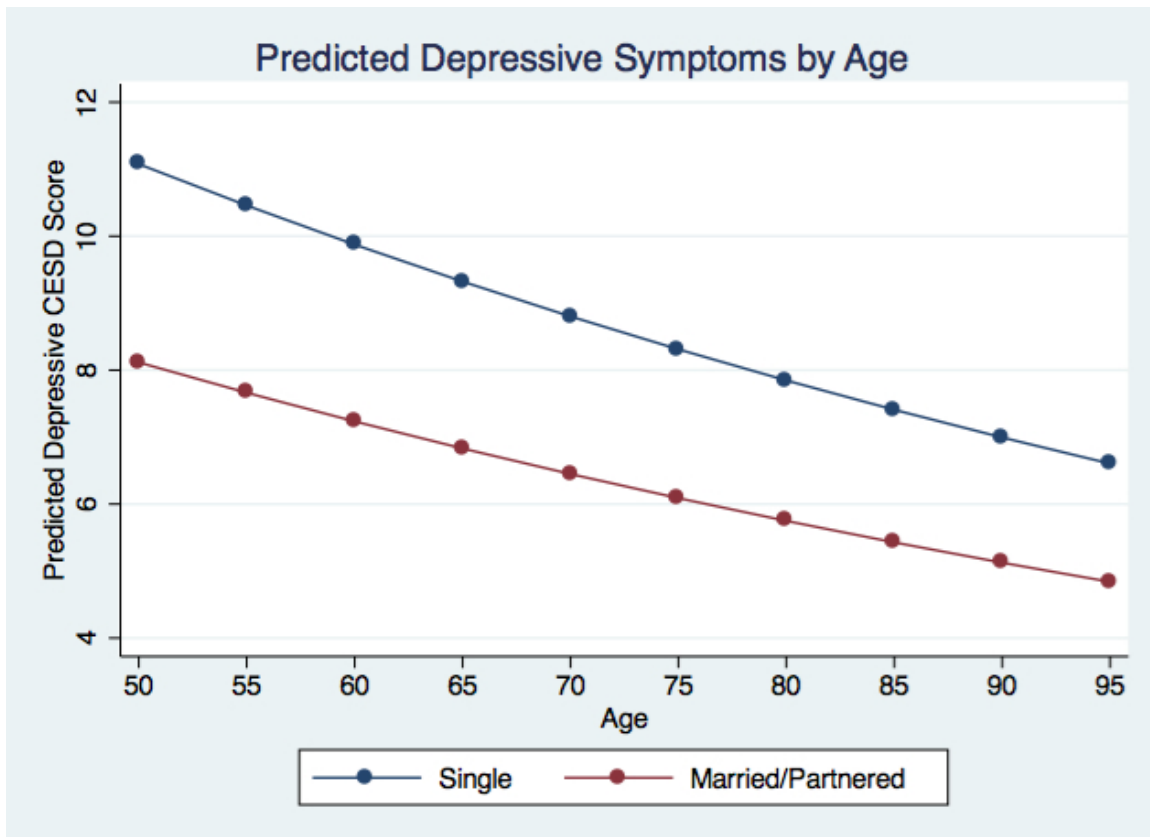


FIGURE 1.1: Predicted CES-D-S score by age for a white lesbian with <4 years college education, \$35,000-\$75,000 annual household income, and ≥ 5 physical illnesses, of average duration of current relationship: Caring and Aging with Pride Project National Study.

Linear regression was used to analyze perceived stress (Table 1.4). Being partnered and being older were both associated with lower perceived stress when controlling for the other variables in the model (Figure 1.2). Being white was also associated with lower stress. Relationship duration, being bisexual, having an annual household income less than \$35,000, having 5 or more chronic physical illnesses, and having depression and/or anxiety were associated with higher stress. Having 4 or more years of college education was associated with lower stress when compared with those with a high school education or less. Gender was not associated with perceived stress when controlling for the other variables.

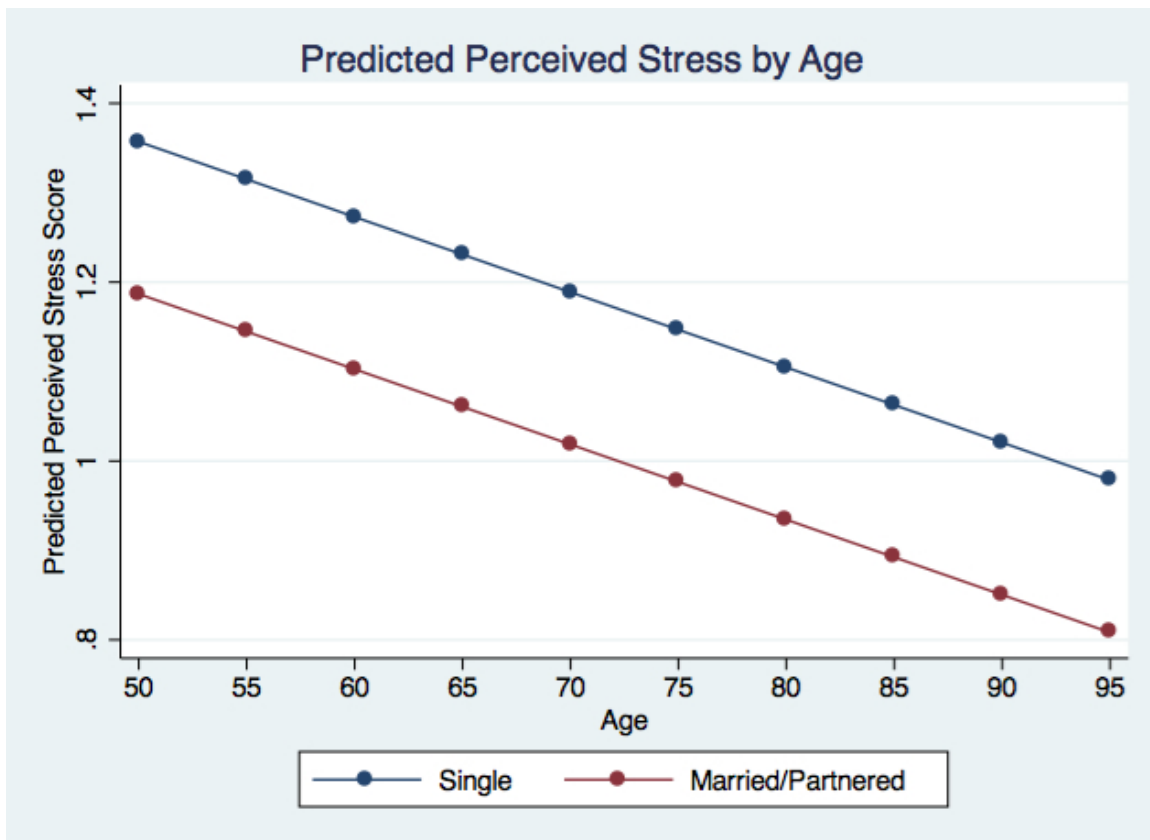


FIGURE 1.2: Predicted Perceived Stress score by age for a white lesbian with <4 years college education, \$35,000-\$75,000 annual household income, and ≥ 5 physical illnesses, of average duration of current relationship: Caring and Aging with Pride Project National Study.

Life satisfaction was also modeled using a linear regression (Table 1.4). Both being partnered and growing older were associated with greater life satisfaction, controlling for the other covariates (Figure 1.3). Higher satisfaction with life was also associated with being female and having 4 or more years of college education when compared with those with a high school education or less. Having an annual household income less than \$35,000, having 5 or more physical illnesses, and having depression and/or anxiety were significantly associated with lower life satisfaction.

When examining the potential interaction of gender and partnership, gender did not significantly moderate the effect of partnership status on life satisfaction.

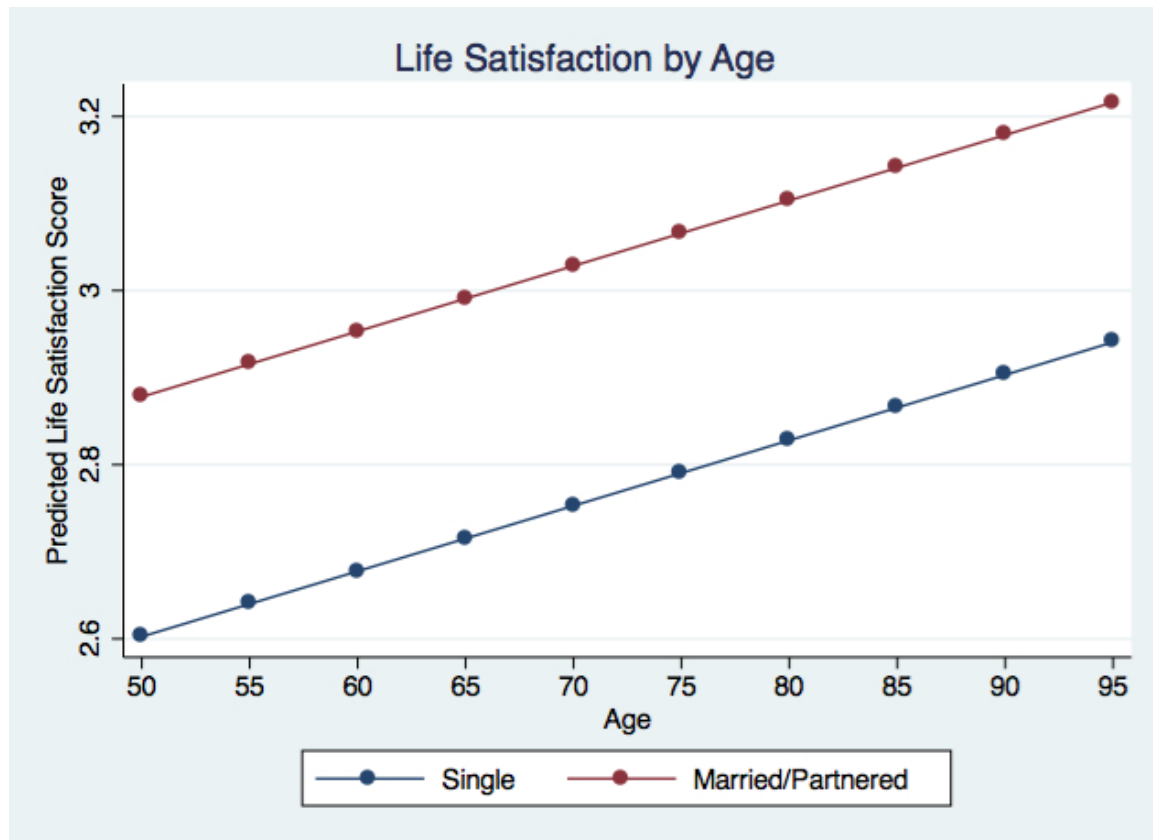


FIGURE 1.3: Predicted Life Satisfaction score by age for a white lesbian with <4 years college education, \$35,000-\$75,000 annual household income, and ≥ 5 physical illnesses, of average duration of current relationship: Caring and Aging with Pride Project National Study.

Discussion

The results of this analysis appear consistent with the Partnership Resource Model (Ross, et al., 1990; Liu & Umberson, 2008), insofar as older adults in same-sex partnerships enjoy greater health and life satisfaction than single LGB older adults. Shared social, emotional and financial resources in same-sex partnerships may serve to promote health and buffer the negative health effects of stress over the life

course for LGB older adults. However, contrary to findings from some heterosexual samples (Meadows, 2009; DuPre & Meadows, 2007; Lillard & Waite, 1995; Gibb, et al., 2011), there is no evidence of a cumulative advantage to being partnered for LGB older adults. When controlling for age, partnership duration is not significantly associated with better health or life satisfaction. Although the current relationships reported by respondents ranged from 0 to 65 years in duration, within this sample the health and life satisfaction benefits associated with being in a same-sex partnership did not appear to significantly increase the longer the relationship lasted, and in fact, duration was associated with more perceived stress and lower self-reported general health. While this finding contradicts the cumulative advantage proposed by the Partnership Resource Model, it is consistent with some of the research on heterosexuals that also found relationship duration not significantly associated with better health outcomes for older heterosexuals (Pienta, et al., 2000).

Contrary to Gender Role Theory (Gove, 1972), LGB older women do not experience significantly less benefit from being partnered than gay and bisexual older men. Overall, however, women in the sample reported significantly greater satisfaction with life than men, when controlling for demographic characteristics including partnership status. Recent findings among heterosexuals suggest that changing gender role expectations are eliminating the disparities observed previously in the health benefits of marriage (Simon, 2002; Williams, 2003). Gender appears unrelated to differences in health outcomes between partnered LGB older

men and women, perhaps as a result of similar cultural changes and sub-cultural adaptations in gender expectations for LGB individuals.

Limitations. Although the Caring and Aging with Pride Project national survey offers an unprecedented large sample of LGB older adults to study, the non-random sampling design limits the ability to generalize findings. LGB older adults who are not connected to service agencies were not sampled. It is not known whether there were systematic differences between those that responded and those that did not respond to the survey. Moreover, the unknown response rate for the portion of respondents who completed the survey online further limits the ability to conclude whether the sample is biased relative to the general population of LGB older adults. The cross-sectional design of the study limits the ability to draw causal inferences between partnership status and health. Some literature on heterosexual marriage (Pienta, et al., 2000; Waldron, et al., 2004; Hu & Goldman, 1990) has found a selection effect for the association of health and marriage, whereby healthier adults are more likely to get married and remain longer in marriages than unhealthy adults. Whether the Caring and Aging with Pride Project respondents were healthier before they were partnered, or whether being partnered promoted their health consistent with the Partnership Resource Model, is unknown. Relatively small sub-samples of racial and ethnic minority respondents may also make these results underpowered to detect whether important differences between racial and ethnic groups of LGB older adults exist compared to the sample as a whole.

Implications for Practice and Research. An estimated 1.5 million adults in the United States are 65 years and older and identify as lesbian, gay, or bisexual (Gerace, 2012). That number is expected to double by the year 2030. The findings from this study suggest the importance of clinicians accounting for the role that same-sex partnerships play in health and satisfaction with life when working with the growing population of LGB older adults. Since partnerships appear to be a health asset for heterosexual and LGB older adults, clinical assessments, interventions, and discharge plans for older adults receiving services and health care should carefully incorporate the value that partners may play in promoting health and well-being.

Older adults may also benefit from institutional policies and governmental legislation that recognizes both same-sex and heterosexual partnerships as health assets. Policy advocates need to translate these findings regarding health and partnership status into policy-level changes that promote LGB partners' well-being. For example, some LGB older adults report feeling unsafe to identify themselves and their same-sex partners as a couple in their senior living communities (Stein, et al., 2010). Further, unlike married heterosexuals, LGB residents in nursing homes are frequently denied the right to share a room with their partner (LGBT Movement Advancement Project & SAGE, 2010). Institutional policies in senior housing and health care facilities that restrict unmarried older adults from cohabiting may not only separate long-term same-sex partners from sharing social, emotional, and financial resources, but they may also have deleterious effects on their general health, depressive symptoms, and perceived stress.

Popular recognition and support for same-sex partnerships is quickly growing in the United States (Saad, 2012), as is the access that same-sex partners have to state-recognized legal statuses (Human Rights Campaign, 2012). Further research is needed to examine how the dynamic policy environment with regard to the legal standing of same-sex partnerships may have long-term consequences on the health of current and future generations of LGB older adults. Additional research should examine further what other factors may explain the unexpected negative associations in this sample between relationship duration and the outcomes of general health and perceived stress, controlling for age. Longitudinal studies may better isolate causal relationships linking partnership status and health among LGB older adults, as well as document how dramatic shifts in social policy and public opinion impact their well-being. Additional study of the mechanisms linking partnership status and health may also help identify important areas in which both clinical practice and programmatic changes can promote the health and life satisfaction of unpartnered older adults.

Paper 2: Marriage, Health and the Social Integration of LGB Older Adults

A large body of literature has found multiple measures of health are positively associated with marital status (for reviews of the literature, see Ross, et al., 1990; Waite, 1995; Waite & Gallagher, 2000; Manzoli, et al., 2007). Researchers have relied on the ability to distinguish clearly between individuals who marry, those who choose to cohabit without marrying, and those living singly as a result of never marrying or surviving the dissolution of a marriage due to divorce or death. The vast majority of these studies have presumed that their samples are heterosexual, with legal access to state recognized marriage and the opportunity to choose among all available relationship status options.

For lesbian, gay and bisexual (LGB) individuals, however, options for a socially sanctioned relationship status have been much more limited. The term “partner” is used to denote same-sex couples in long-term, committed relationships, regardless of legal status. More recently, the quickly changing patchwork political landscape with regard to state recognition of same-sex partnerships has provided some LGB couples access to marriage, either because they reside in a state that has recently recognized same-sex marriage or because they travel to a jurisdiction that recognizes same-sex marriage. State-recognized same-sex marriage is currently only available in relatively few U.S. states and other nations (Human Rights Campaign, 2012; Friedman, 2012). It remains to be seen whether the category of marriage provides LGB individuals unique health benefits in comparison with unmarried partnered LGB individuals.

There is little consensus in society at-large or among LGB communities concerning the value or importance of same-sex marriage. Many LGB individuals report feeling conflicted about participating in legally recognized marriages for philosophical, political, and family reasons (Lanutte, 2008; Jeffreys, 2004). Approximately 20% of LGB adults report not wanting to get married, even if it were legally recognized where they live (Kaiser Family Foundation, 2001; Rothblum, 2005). The desire to avail themselves of the option of marriage where available varies by religiosity and parental marital status for same-sex couples (Oswald, et al., 2008). At a time when popular opinion in United States appears evenly split concerning endorsement of or opposition to same-sex marriage (Saad, 2012), even among LGB individuals its importance and potential impact on their lives remains unclear.

This paper examines how identifying as married, partnered, or single is associated with the health of LGB older adults. It reviews findings from scholarship on health benefits of marriage and cohabitation among heterosexuals, as well as recent research on LGB older adults. Conceptualizing same-sex marriage as an evolving status representing greater social integration than unmarried partnerships or those without partners, the paper reports findings from a national survey with regard to how health is associated with marital status for LGB older adults.

Background and Theoretical Framework

Both marriage and unmarried cohabitation have been consistently found to be associated with better health outcomes among heterosexual adults when compared with single adults (Waite, 1995; Manzoli, et al., 2007). Assuming that

everyone has access to marriage, researchers have tested whether health benefits are associated uniquely with the status of marriage, or whether cohabitation is associated with similar benefits.

Marriage has most frequently been found to be associated with better health outcomes when compared with unmarried cohabitation (Waite, 1995; Waite & Gallagher, 2000). Many researchers have observed a hierarchy of relationship statuses among heterosexuals, with health outcomes being worst for single adults, better for cohabiting adults, and best for married adults. Researchers have found that married adults enjoy better physical health (Pienta, et al, 2000) and mental health (Marcussen, 2005; Brown, 2000) than adults who cohabit without being married, and cohabiters enjoy better outcomes than single adults. Married adults report higher quality and more stable relationships than cohabiting couples (Skinner, et al., 2002; Brown, 2000; Brown & Booth, 1996). Self-reported general well-being and happiness are better for married couples than unmarried cohabiters, while these outcomes are better for unmarried cohabiters than for singles (Dush & Amato, 2005).

However, some studies have found that cohabiting is as beneficial or more beneficial than marriage. Scafato, et al., (2008) found that older women's mortality was unrelated to either marital status or cohabitation, but cohabitation was a stronger predictor of mortality than marriage for older men. Others have concluded that both marriage and cohabitation are equally valid predictors of mortality risk (Lund, et al., 2002). Gibb, et al, (2011) found that long-lasting relationships were associated with lower depression, suicidal behavior, and

substance abuse, but the legal status of the relationship as married was not significant. Both cohabiting and married fathers of young children reported better general health and mental health than single fathers, but the differences between health outcomes of married and cohabiting fathers were not significant (Meadows, 2009). In sum, although some research points to marriage as providing unique health benefits beyond those afforded to unmarried cohabiters, other studies have found cohabiting as beneficial as marriage.

Much of the research addressing associations between marital status and health does not consider unmarried, committed relationships as conceptually different from adults who identify as having never married or are currently single (Blomgren, et al, 2012; Hu & Goldman, 1990; Idler, et al., 2012; King & Reis, 2012; Lillard & Waite, 1995; Manzoli, et al., 2007; Prior & Hayes, 2003). In such studies, currently cohabiting, unmarried couples are identified as never married, divorced, widowed or single, based on their marital history. Other researchers acknowledge that there are unmarried cohabiters in their samples, but they drop them from analysis when considering marital status and health outcomes (DuPre & Meadows, 2007; Lui & Umberson, 2008). In research on marital status among heterosexuals, the status of unmarried cohabiters is often unclear.

Same-sex partnerships also have not fit well within the typology of marital status examined in most prior research. Same-sex partners would either be combined with lifelong unmarried peers or dropped from analysis in many studies. Conceptually, distinguishing being unmarried cohabiters and married couples among same-sex partners is quite different than distinguishing between married

and cohabiting heterosexuals. Whereas cohabitation reflects a decision on the part of heterosexual couples not to avail themselves of legal marriage status, unmarried same-sex partners typically do not have access to marriage. Among those same-sex partners who identify as married, it cannot be assumed that their marriage is legally recognized in the state where they reside, or that identifying as married reflects a legal status anywhere. The meaning and impact of identifying as married or cohabiting may present much more complex implications for the health of same-sex partners.

To date, only a few studies have examined how partnership status is associated with health among same-sex partners. Analyzing relatively small samples, researchers have found that same sex partnerships with some sort of legal status (e.g., civil unions, domestic partnerships, or marriage) appear to be associated with better health and life satisfaction (Riggle, et al., 2010; Wight, et al., 2012). Apart from the question of legal status, LGB older adults that have lived with a same-sex partner report less loneliness and better general mental health single LGB older adults (Grossman, et al., 2001). Although the difference in depressive symptoms for older gay men was not significant between those who were legally married and those who were unmarried partners, older gay men who were married reported significantly fewer depressive symptoms than single older gay men (Wight, et al., 2012). Thus far, studies have not found significant differences between identifying as an unmarried partner and identifying as married among LGB older adults.

Conceptual Framework. Social Integration Theory proposes that identification with and participation in stable social structures reduce isolation, protect health, and regulate the health behaviors of individuals (Durkheim, 1951). Socially recognized roles, such as being married, provide purpose and meaning to life, which promote overall health and psychological well-being (Thoits, 1983; Kobrin & Hendershot, 1977). Socially endorsed family forms such as marriage incorporate individuals into systems of support and mutual obligation that lead to conformity with priorities and behaviors that reduce health risks (Gove, 1972). Transitioning into social roles with greater symbolic commitment (e.g., from dating to cohabiting, or from cohabiting to married) reflects more socially integrated relational ties along a hierarchy of statuses that increase psychological health and well-being for individuals (Dush & Amato, 2005).

Natale & Miller-Cribbs (2012) argue that there are hierarchies of relationships statuses for LGB adults today. Levels of social stigma and acceptance differentiate LGB relationship statuses. Marriages reflect the most socially integrated relationship status, followed by civil unions, domestic partnerships, designated beneficiaries, cohabiters, and singles. Both social provision of these hierarchical statuses and individual endorsement of available statuses reflect levels of social integration for LGB individuals. Consistent with Social Integration Theory, LGB adults identifying their relationship status with higher levels of social integration are expected to enjoy better psychological health and satisfaction with life.

This study examines two hypotheses:

1. Relationship roles associated with greater commitment and social integration (single < partnered < married) will be associated with fewer depressive symptoms, less perceived stress, and greater satisfaction with life for LGB older adults.
2. Further, identifying as married in a state that recognizes same-sex marriage represents greater social integration and will be associated with greater psychological health and satisfaction for LGB older adults than identifying as married while residing in a state that does not recognize same-sex marriage.

Methods

Sampling. This paper examines data from the Caring and Aging with Pride Project, which surveyed LGB adults age 50 years and older in 2010 and 2011 (Fredriksen-Goldsen, et al., 2011). The project collaborated with eleven agencies that serve LGB and transgender older adults, located in the Northeast, upper Midwest and West Coast of the United States. Agencies with postal addresses for their clients mailed hardcopy surveys on behalf of the project. Agencies that maintain only electronic mailing lists sent an email notification describing the survey and inviting respondents to participate by requesting a hardcopy or completing the survey online. 2,201 hardcopy surveys were completed, resulting in a 63% response rate. An additional 359 respondents completed the online version of the survey. The project was not able to document how many potential respondents had access to the online version, so an overall response rate for both

survey formats cannot be calculated. In total, 2,560 respondents completed either a hardcopy or online version of the survey.

The unprecedented large sample of LGB older adults successfully surveyed by the Caring and Aging with Pride Project provides a unique data set to study responses from individuals across the country, including those residing in states that recognize same-sex marriage and those that do not. Where population-based surveys have successfully identified only a few hundred LGB respondents (e.g., Wienke & Hill, 2009) and fewer LGB older adults (e.g., Wight, et al., 2012), the size and diversity of the Caring and Aging with Pride Project sample provide an opportunity to do within group comparisons for this relatively small population.

For the current analysis, transgender respondents were excluded in order to not confound findings regarding sexual orientation with gender identity. Respondents who completed data on all relevant demographics (partnership status, age, gender, race, education, income, and chronic illnesses) were included in the following analysis, resulting in a sample of 2,173 respondents (see Table 2.1 for the sample description). The Caring and Aging with Pride Project methods and materials were approved by the University of Washington Institutional Review Board.

Measures. Respondents identified their partnership status from a list of options (partnered, married, single, divorced, widowed). For the current analysis, respondents were identified as married, partnered but not married, or single (including divorced and widowed). For respondents who selected more than one partnership status, if they selected married, they were coded married. If they

identified as partnered but not married, they were coded partnered. If they selected neither married nor partnered, they were coded as single. Control variables were included for race (white or non-white), gender (male or female), education (high school or less, less than 4 years of college, 4 or more years of college), and annual household income (less than \$35,000, \$35,000 - \$75,000, more than \$75,000). Consistent with the majority of LGB aging research, being 50 years of age or older is defined here as being an older adult (Fredriksen-Goldsen & Muraco, 2010). Chronic health covariates were assessed as having 5 or more chronic physical illnesses (yes/no) and whether they had been diagnosed with depression and/or anxiety (yes/no).

To examine how social policies may reflect social integration, a variable was included to indicate whether respondents resided in states that legally recognized same-sex marriages. At the time of the survey, 7 states legally recognized same-sex married couples (CA, IA, VT, NH, CT, DC, and MA). California was in the midst of judicial review of a voter approved ballot initiative that terminated the opportunity for same-sex couples to legally marry in that state; this meant that categorizing the legal standing of same-sex marriages at that time was complicated. The status of same-sex couples who had already married prior to the citizen's initiative remained legally recognized by the state of California at the time of the survey; for that reason, respondents who lived in the state of California were coded as living in a state that recognizes same-sex marriages. New York began recognizing same-sex marriages just after completion of data collection.

Outcomes measured were depressive symptoms, perceived stress and life satisfaction. Depressive symptoms were assessed using the 10-item CES-D (Andersen, et al., 1994; Radloff, 1977). For the CES-D, respondents reported an estimated count of how many days in the past week (< 1, 1-2, 3-4, 5-7) they experienced 10 depressive symptoms (e.g., “I could not get going”). The estimated frequency for the 10 symptoms was summed, producing a count from 0 to 30. In the current sample, alpha reliability for the CES-D was 0.87. Perceived stress (Cohen, et al., 1983) was measured using 4 questions indicating how frequently respondents experienced symptoms of stress in the last month (e.g., “how often have you felt you were unable to control the important things in your life?”). Responses were coded from 0 to 4 (never, almost never, sometimes, fairly often, very often), and a summary score was computed by taking the mean of the 4 responses. Alpha reliability for the perceived stress scale was 0.78. Life satisfaction (Diener, et al., 1985) was assessed from responses to 5 questions asking each respondent’s level of agreement with statements about their life (e.g., “In most ways, my life is close to my ideal”). Scores were coded from 1-4 (Strongly Agree, Agree, Disagree, Strongly Disagree), and a summary score was computed as the mean of the five questions, reverse coded for a score from 1-4, higher scores indicating more satisfaction. Alpha reliability for the life satisfaction scale in this sample was 0.89.

Analysis. Data were analyzed using Stata version 12. Initial descriptive statistics were conducted on the sample, and diagnostic tests suggested that collinearity was not a concern among the independent variables. Preliminary analysis of outcome variables was conducted for optimal statistical modeling.

Depressive symptoms were modeled using a negative binomial regression. The negative binomial was selected to best reflect the nature of the data as counts of days experiencing symptoms, and based on the distribution of the data. Perceived stress and life satisfaction were modeled using linear regressions. For initial models that showed a significant effect of identifying as married, an interaction term was examined to determine whether living in a state that recognizes same-sex marriage moderates the effect of identifying as married for LGB older adults.

Results

Table 2.1 describes the sample of LGB adults. The average age of respondents was 66.7 years of age. The majority of respondents were white (87.3%), male (64.9%), and with at least 4 years of college education (74.5%). Respondents who identified as married comprised 7.8% of the sample; 37.0% identified as unmarried partnered, and the rest (55.2%) identified as single (including single, widowed, and divorced). Single respondents were older and had higher probability of being male, less educated, having lower household income, having more than 5 chronic physical illnesses and having been diagnosed with depression and/or anxiety. Married LGB adults age 50 and older were more likely to be female, more likely to have a household income over \$75,000, less likely to have 5 or more chronic physical illnesses, and more likely to live in a state that legally recognizes same-sex marriages than their single or partnered peers. Unmarried partnered respondents were generally in the middle of the extremes of single and married peers on most measures; however they were the least likely to have been diagnosed with depression and/or anxiety.

TABLE 2.1 – Characteristics of Sample of Lesbian, Bisexual and Gay Adults, Ages 50-95 in 2010 or 2011 (N=2,198): Caring and Aging with Pride Project National Study

	Total N=2,173	Single N=1,200	Partnered N=803	Married N=170	p- value ^a
Age (years)	66.7 (9.0)	67.8 (9.0)	<u>Mean (SD)</u> 65.5 (8.8)	65.5 (8.8)	< 0.001
			<u>Percent</u>		
White	87.3	85.8	89.0	89.4	0.074
Female	35.1	29.7	40.0	50.6	< 0.001
Education					< 0.001
High school or less	7.6	9.7	5.2	4.7	
<4 years college	17.9	21.4	14.0	11.8	
≥4 years college	74.5	68.9	80.8	83.5	
Household Income					< 0.001
< \$35,000	36.3	51.3	19.2	11.2	
\$35,000-\$75,000	31.8	33.3	30.6	27.1	
> \$75,000	31.9	15.4	50.2	61.8	
>5 Chron. Phys. Illnesses	59.9	63.3	56.3	53.5	0.002
Dep. or Anxiety Diagnosis	36.7	40.8	30.6	35.9	< 0.001
Legal Access to Marriage	38.4	43.0	27.8	55.9	< 0.001

^aBased on t-tests for difference of means and Pearson's χ^2 for proportions

In the entire sample, 39% lived in jurisdictions that legally recognized same-sex marriages at the time the survey was collected. Of those either partnered or married, 30% of those residing in states with legal marriage reported being married. 11.2% of those living in states without legal marriage reported being married. Of those married, 55.9% lived in states with legal recognition of marriage.

Table 2.2 illustrates the findings of the negative binomial regression of depressive symptoms. LGB older adults who identified as married reported experiencing significantly fewer depressive symptoms than unmarried partnered peers, controlling for the other variables in the model (Figure 2.1). Single respondents experienced significantly more depressive symptoms than partnered and married individuals. Being older was associated with fewer depressive

symptoms, as was being in the top two categories of household income. Having more than 5 chronic physical illnesses and residing in a state in which same-sex marriage was legally recognized were associated with more depressive symptoms. Although identifying as married was significantly associated with depressive symptoms, there was no significant moderating effect of living in a state that legally recognizes same-sex marriage for respondents identifying as married.

TABLE 2.2 – Negative Binomial Regression Results for Depressive Symptoms among Lesbian, Gay and Bisexual Adults Ages 50-95: Caring and Aging with Pride Project National Study.

Independent Variables	Depressive Symptoms, b(SE)	
Partnership Status ^a		
Married	-0.16 * (0.08)	-0.12 (0.11)
Single	0.20*** (0.04)	0.20*** (0.04)
Age	-0.01*** (0.01)	-0.01*** (0.01)
Female	0.01 (0.04)	0.01 (0.04)
White	-0.05 (0.06)	-0.05 (0.06)
Bisexual	0.04 (0.09)	0.04 (0.09)
Education ^b		
1-3 years college	0.02 (0.08)	0.02 (0.08)
≥4 years college	-0.11 (0.07)	-0.11 (0.07)
Household Income ^c		
\$35k-\$75k	-0.27*** (0.05)	-0.27*** (0.05)
>\$75k	-0.39*** (0.06)	-0.39*** (0.05)
State recognition ^d	0.09* (0.04)	0.10* (0.04)
>5 Chron. Phys. Illnesses	0.28*** (0.04)	0.28*** (0.04)
Married*State Recognition	---	-0.07 (0.15)
Constant	2.66*** (0.17)	2.66*** (0.17)
	N = 2,111	N=2,111
	LR = 255.77***	LR = 255.97***

^aReference group = Partnered (unmarried)

^bReference group = high school or less

^cReference group = <\$35,000

^dReference group = resides in a state that does not legally recognize same-sex marriage

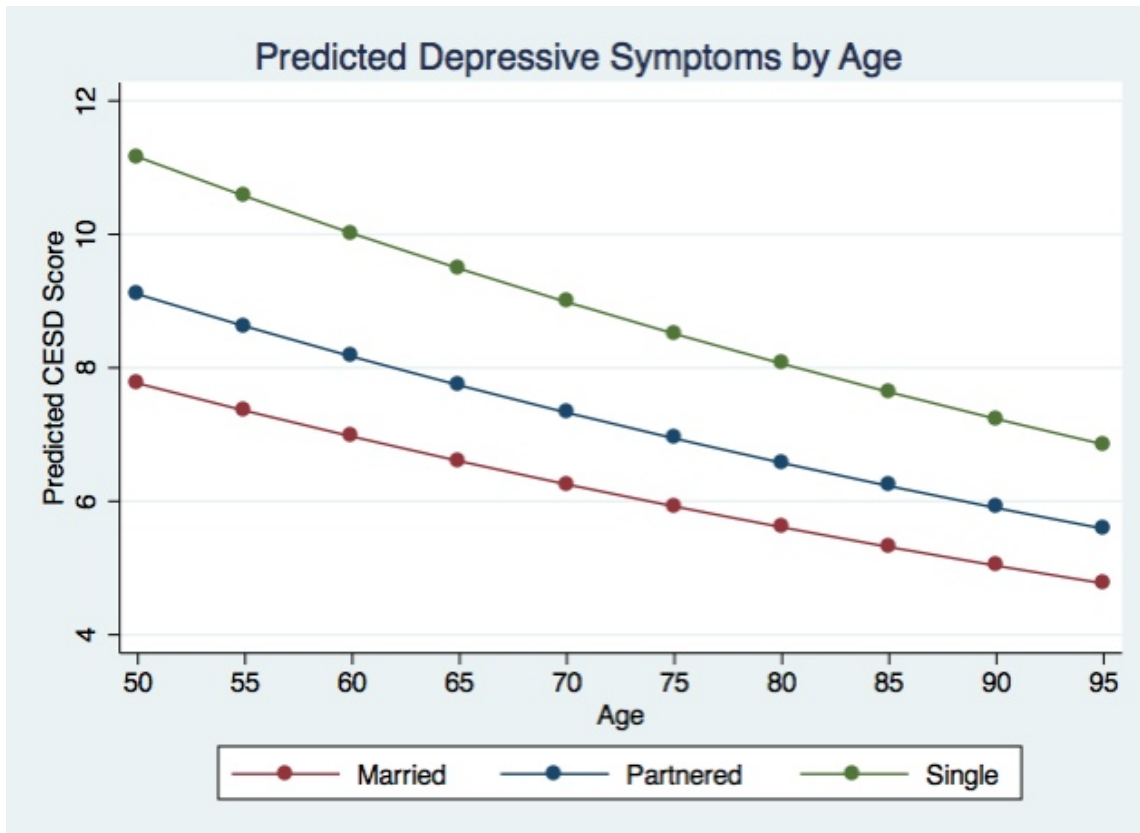


FIGURE 2.1: Predicted CES-D-S score by age for a white lesbian with <4 years college education, \$35,000-\$75,000 annual household income, and ≥ 5 physical illnesses: Caring and Aging with Pride Project National Study.

Table 2.3 represents findings from OLS regressions for perceived stress and life satisfaction. With regard to perceived stress, being single was associated with significantly greater perceived stress in comparison with both unmarried partnered and married peers, controlling for the other variables in the model. However, the difference between unmarried partnered and married LGB older adults was not statistically significant. Less perceived stress was associated with more years of age, being white, completing at least 4 years of college, and being in the top two categories of household income. More stress was associated with being bisexual in comparison with being gay or lesbian, and having 5 or more chronic physical health conditions. Because there was no significant association of marriage with perceived

stress, a test of a moderating effect of identifying as married and living in a state that recognizes same-sex marriage was not conducted.

TABLE 2.3 – OLS Regressions for Perceived Stress and Life Satisfaction among Lesbian, Gay and Bisexual Adults Ages 50-95: Caring and Aging with Pride Project National Study.

Independent Variables	Perceived Stress, b(SE)	Life Satisfaction, b(SE)	
Partnership Status ^a			
Married	-0.08 (0.06)	0.17** (0.05)	0.19** (0.07)
Single	0.08* (0.04)	-0.25*** (0.03)	-0.25*** (0.03)
Age	-0.01*** (0.01)	0.01*** (0.01)	0.01*** (0.01)
Female	-0.06 (0.04)	0.08** (0.03)	0.08** (0.03)
White	-0.12* (0.05)	-0.01 (0.04)	-0.01 (0.04)
Bisexual	0.16* (0.07)	-0.08 (0.06)	-0.08 (0.06)
Education ^b			
1-3 years college	-0.13 (0.07)	0.09 (0.05)	0.09 (0.05)
≥4 years college	-0.14* (0.06)	0.15** (0.05)	0.15** (0.05)
Household Income ^c			
\$35k-\$75k	-0.34*** (0.04)	0.22*** (0.03)	0.22*** (0.03)
>\$75k	-0.47*** (0.05)	0.31*** (0.04)	0.31*** (0.04)
State recognition ^d	0.06 (0.03)	-0.02 (0.03)	-0.02 (0.03)
>5 Chron. Phys. Illnesses	0.16*** (0.03)	-0.08** (0.03)	-0.07** (0.03)
Dep and/or Anxiety	--	-0.25*** (0.03)	-0.25*** (0.03)
Married*State Recognition			-0.04 (0.09)
Constant	2.09*** (0.15)	2.27*** (0.12)	2.27*** (0.12)
	N=2,169	N=2,155	N=2,155
	R ² =0.12	R ² =0.22	R ² =0.22
	F=24.53***	F=45.53 ***	F=42.28***

^aReference group = Partnered (unmarried)

^bReference group = high school or less

^cReference group = <\$35,000

^dReference group = resides in a state that does not legally recognize same-sex marriage

The linear regression of life satisfaction demonstrates that married LGB older adults are significantly more satisfied with life than unmarried partnered peers, who are significantly more satisfied with life than single peers, controlling for

the other variables in the model (Figure 2.2). Being older was associated with greater life satisfaction, and having 4 or more years of college education was accompanied by greater life satisfaction when compared with those with a high school education or less. Female respondents were more satisfied with life than male respondents. Lower life satisfaction was associated with household incomes less than \$35,000, having more than 5 chronic physical illnesses, and having been diagnosed with depression and/or anxiety. When adding an interaction term, there was no significant moderating effect on life satisfaction of living in a state that legally recognizes same-sex marriage for respondents identifying as married.

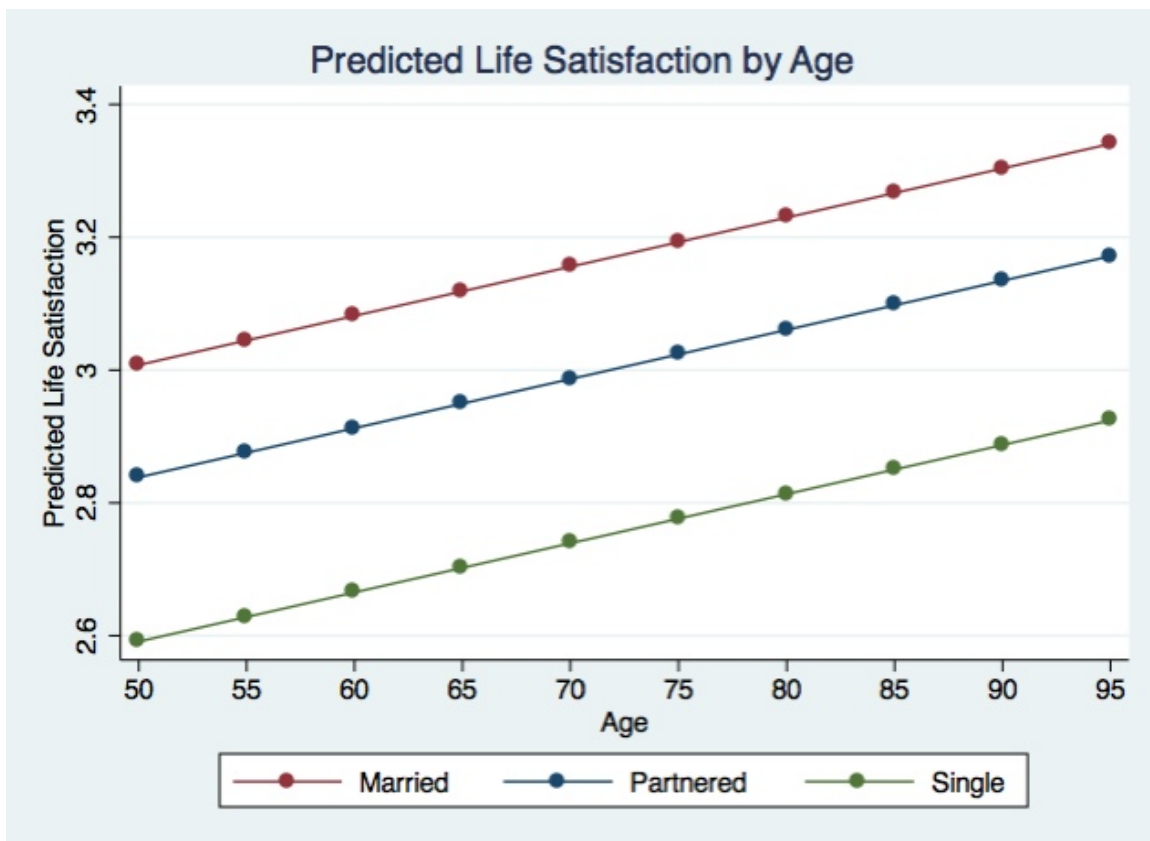


FIGURE 2.2: Predicted Life Satisfaction score by age for a white lesbian with <4 years college education, \$35,000-\$75,000 annual household income, and ≥ 5 physical illnesses: Caring and Aging with Pride Project National Study.

Discussion

Consistent with Social Integration Theory (Durkheim, 1951), a hierarchy of relationship statuses appears to be supported by evidence regarding mental health outcomes and life satisfaction for LGB older adults. Marriage is significantly associated with better outcomes with regard to depressive symptoms and life satisfaction than unmarried partnered and single LGB older adults. Both married and unmarried partnered LGB older adults have significantly better outcomes than singles with regard to depressive symptoms, perceived stress, and life satisfaction. With regard to perceived stress, however, the difference between LGB older adults who identify as married and those with unmarried partners was not significant. Although the difference in perceived stress was not significant between married and unmarried partnered LGB older adults, the remainder of the findings suggest an ordered association between the three relationships statuses and mental health and life satisfaction.

While identifying as married is associated with mental health outcomes, residing in a state that legally recognizes same-sex marriages does not significantly change the relationship between identifying as married and psychological health. This may reflect LGB older adult couples in states that provide legal sanction for same-sex marriage have not yet realized any further degree of social integration, beyond that associated with identifying as married, to result in further discernible mental health effects. In fact, consistent with research that has found negative health consequences of highly contentious legislative battles over LGB legal rights

(Maisel & Fingerhut, 2011), the overall effect of residing in a state that has recognized same-sex marriage (all within the past 8 years) is significantly more depressive symptoms among LGB older adults than for those residing in states that do not recognize same-sex marriage. The degree to which the recent legal recognition of same-sex marriage represents increasing social integration may require longer to detect or the level of social conflict around the debates may need to decline to see changes in the mental health outcomes of LGB older adults.

Limitations. The Caring and Aging with Pride Project gathered an unprecedented large sample of LGB adults aged 50 and older; however the cross-sectional design of the survey limits the ability to distinguish temporal ordering. Some studies have suggested health benefits associated with heterosexual marriage may be due in part to selection bias, whereby healthier individuals are more likely to be perceived as attractive partners and therefore more likely to marry and to stay married (Pienta, et al., 2000; Hu & Goldman, 1990; Waldron, et al., 1996). Whether the partnered and married individuals in this sample were healthier and more satisfied to begin with, or whether their partnership status preceded their better health and satisfaction, is impossible to distinguish from these data. Similarly, it remains unknown whether identifying as married reflects couples who are already more committed to one another and socially integrated, or whether identifying as married results in greater social integration, accounting for better mental health and life satisfaction.

The non-random sampling strategy for the project limits the generalizability of the findings. In particular, LGB adults age 50 and older who are not affiliated with

LGBT service agencies may respond differently than those recruited into the Caring and Aging with Pride Project. The potential impact of response bias is unknown as a result of not knowing whether non-responders were significantly different from those who chose to participate in the survey. Although 63% of the people who were mailed a hardcopy survey completed it, not knowing the response rate for those who completed the online version of the survey further limits the ability to generalize results.

The quickly changing landscape with regard to legal recognition of same-sex marriages suggests that these findings may be limited to the particular historical context in which the sample was collected. Whether observed associations, such as the relationship between frequent depressive symptoms for those residing in states with same-sex marriage, remain consistent over time will need to be reexamined as public policy continues to wrestle with the issue of the legal status of same-sex partnerships. The legal status of unmarried partnered respondents in this sample is unclear. Whether some of the partnered respondents enjoy an alternate legal standing where they reside (such as civil unions or domestic partnerships) is unknown. Similarly, it is unclear what specifically it may mean for individuals in this sample to identify as married, but not reside in a jurisdiction that recognizes same-sex marriages. Whether they have been legally married in another jurisdiction or simply identify as married as an indication of commitment apart from any legal standing is unclear.

Conclusions. More socially integrated relationships statuses are associated with better mental health outcomes among LGB older adults in this sample. Not only

is having an intimate partnership related to mental health for this population, but whether that relationship is identified as a marriage or not also matters when considering depressive symptoms and satisfaction with life. Insofar as marriage is a signifier of increased social integration (Durkheim, 1951), identifying as married may point to important mental health assets available to some LGB older adults.

The Caring and Aging with Pride Project offers a unique snapshot of LGB older adults nationwide at a time when social recognition for same-sex partnerships has been very visibly contested in public discourse and legislation. Since data collection was completed, more states have passed legislation recognizing same-sex marriage, and it seems likely that more LGB older adults will identify as married in the coming years as a result of expanded access to this and other legal statuses. It will remain important for researchers to examine whether associations between identifying as married and the mental health of LGB older adults continue to be observed. Capturing the complexity of legal statuses currently available nationwide for same-sex partnerships (e.g., civil unions, domestic partnerships, state recognized marriages) will also require that surveys include more questions about different types of partnerships. Future research should clarify both how respondents identify their partnership status and what jurisdictions (if any) legally recognize their self-identified partnership status. Studying the role of social integration will also benefit from longitudinal research that tracks the impact of social policy changes that provide same-sex partners access or, as in the case of California, withdraw access to more integrated socially recognized relationship statuses. Additional efforts to measure other indicators of social integration, such as whether family, friends,

coworkers or neighbors recognize and endorse the partnership status of LGB older adults, will provide further evidence of the role that social integration plays in understanding the association between partnership status and the health of LGB older adults.

Paper 3: Alternative Conceptual Frameworks of LGB Older Adult Health

The field of study of lesbian, gay and bisexual (LGB) older adults has grown rapidly in recent years. Pioneering research published more than 35 years ago began with documenting the existence of this population (Kimmel, 1977; Kelly, 1977; Kimmel, 1979, Berger, 1982, Berger, 1984). Since then, scholarship on LGB older adults has interrogated a range of issues, including identity development (Rickards & Wuest, 2006; Peacock, 2000; Charbonneau & Lander, 1991; Kertzner, 1999; Quam & Whitford, 1992, Rosenfeld, 1999), social networks and social support (Barker, et al., 2006; Grossman, et al., 2000; Jacobs, et al., 1999; Richards & Brown, 2006), the impact of social policies (Porche & Purvin, 2008; Cahill, et al., 2000; Grant, et al., 2010), health and access to care (Hash & Netting, 2007; Cantor, et al., 2004; Brotman, et al., 2003; Hughes, 2007; Johnson, et al., 2005), and coping with ageism and homophobia (David & Knight, 2008; Adelman, 1990; Balsam & D'Augelli, 2006; Emlet, 2006; Fox, 2008; Genke, 2004; Iwasaki & Ristock, 2007; Morrow, 2001). As scholarship has grown concerning the characteristics and challenges faced by LGB older adults, increasing attention now focuses on identifying health disparities among LGB older adult subgroups and between LGB older adults and their heterosexual peers (Institute On Medicine, 2011; Fredriksen-Goldsen, et al., 2011).

The development of the literature addressing LGB older adult health disparities has coincided with emerging theoretical critiques of essentialist assumptions regarding gender, sexual orientation, age, and health. Essentialism

proposes that there are unchanging and fixed properties that define a particular group (Fuss, 1989). Essentialist assumptions behind studies of LGB older adults have focused on identifying and comparing objective characteristics of this population. In contrast, theories of the social construction of gender, sexual orientation, age and health conceptualize these categories as malleable, changing across history in what they mean and how they function. A tension persists between the scholarly project of documenting health disparities among LGB older adults and theoretical critiques of essentialism. Both sides of this theoretical tension present opportunities to answer different types of questions regarding LGB older adult health.

This paper reviews some of the theoretical foundations of existing LGB older adult health research as well as alternative theoretical formulations posed by social constructionist and post-structuralist scholars. While research has successfully identified important disparities that likely reflect lifelong stresses associated with stigma and discrimination for LGB older adults, they frequently rely on deterministic arguments, theorizing causal mechanisms linking societal phenomena to community level conditions and ultimately to internal individual health. Revisiting the theoretical contributions of social constructionist and post-structuralist scholars of gender, sexuality, age and health suggests ways that LGB older adult health research can highlight individual agency and the resilient subject as not merely acted upon by social determinants of health, but actively embodying health as a form of resistance to oppression.

The study of same-sex partnerships offers one avenue to examine the role that individual agency may play in LGB older adult health. In light of contemporary political debates, same-sex partnerships represent a site at which existing social constructs of gender and sexuality are currently being publicly contested. Partnerships also reflect embodied practices and potential expressions of individual agency, whereby LGB older adults express gender, sexuality and age in ways that innovate on and diverge from heteronormative familial forms. Same-sex partnerships may also reflect practices of resistance to dominant discourses, with implications for embodied, co-constituted experiences of gender, sexuality, age and health for LGB older adults.

Existing Research and Theory

LGB Older Adult Health Disparities. While LGB older adults are generally underrepresented in health research, growing evidence confirms that disparities exist in both their mental and physical health outcomes as compared with heterosexual older adults (Institute on Medicine, 2011). Disparities have been documented between LGB and heterosexual older adults pertaining to mental distress and disability (Fredriksen-Goldsen, et al., 2011), cancer (Valanis, et al., 2000; Zartisky & Dibble, 2010), obesity (Clunis, et al., 2005; Roberts, et al., 2003; Valanis, et al. 2000; Fredriksen-Goldsen, et al., 2011), cardiovascular disease (Roberts, et al., 2003; Fredriksen-Goldsen, et al., 2011; Valanis, et al., 2000) and overall physical health (Fredriksen-Goldsen, et al., 2011). With the release of the Institute on Medicine report (2011) and its recommendations to the National Institutes on Health to reexamine their funding priorities to address gaps in LGB and

transgender population health research, the scope of knowledge about LGB older adult health seems likely to continue to grow. However, less is understood with regard to why these disparities exist.

Most studies of LGB older adult health do not explicitly identify a theoretical orientation or conceptual framework from which to approach the topic (Fredriksen-Goldsen & Muraco, 2010). Where studies identify specific social theories to understand health disparities among LGB populations, they primarily focus on the chronic and cumulative effects of social inequality across the life course. Theories of cumulative inequality propose that social systems expose disadvantaged groups to higher levels of health risks relative to other groups (Ferraro, et al., 2009; Dannefer, 2003; O’Rand, 1996; DiPrete & Eirich, 2006). The impact of social forces such as stigma and discrimination are theorized to obstruct access to material and social resources, leading to impaired health outcomes that accrue over time. From this perspective, older adults bear the cumulative burdens of disadvantage and inequality experienced across the life course, explaining why members of marginalized and oppressed communities frequently experience poorer health and higher rates of poverty in old age.

Social Causes and Pathways to Health. Ecosocial theory offers a broad explanation for how social conditions may be incorporated into embodied experiences of health and disease (Krieger, 1994; 1999; 2001). Researchers theorize that there are interlocking systems by which macro forces are transmitted vertically through levels of social organization until they are manifest inside individual bodies. Rather than focus primarily on proximate causes to account for the presence of

disease at the individual level, the fundamental causes of disease are located in social conditions, such as income disparity and stigma (Link & Phelan, 1995; Phelan, et al., 2010). Research from public health and sociology has sought to identify and document the pathways linking social conditions to specific health outcomes.

Gehlert, et al. (2008) describe a downward causal chain, whereby society-wide phenomena such as stigma, discrimination, poverty and racism influence community-level conditions, such as neighborhood crime, unemployment, and housing. For example, they identified how pervasive racism and poverty result in unsafe housing and crime in a specific neighborhood. In turn, the lack of personal security promotes social isolation and depression, which alters stress-hormone responses in individuals living in the neighborhood. Elevated stress hormones have been shown to cross cell membranes and alter cellular structures in ways that increase the survival of tumor cells. In this way, stigma, discrimination, poverty and racism are identified as upstream social determinants of differences in incidents of cancer. Sustained and heightened physiological arousal also reduces the body's ability to cope with other health-threatening processes such as infections and injuries. Individual bodies and psyches, therefore, show cumulative effects of larger social conditions that result from chronic experiences of inequality across the life course, partially explaining health disparities observed among older adults.

By charting pathways that link social causes to disease processes, researchers have identified connections between a variety of social conditions and specific health outcomes. Racism, as well as other forms of stigma and discrimination, has been causally linked to elevated levels of stress, wearing down

the body's ability to effectively cope with opportunistic infections (Geronimus, et al., 2006). Racism and discrimination have been shown to negatively affect employment and social support, and reduce health-promoting behaviors, resulting in worsening blood pressure, cholesterol, mental health and self-reported health (Johnston & Lordan, 2012; Williams, et al., 2003; Braveman, et al., 2011). Poverty and socioeconomic disparities have long been studied for their associations with adverse health outcomes (Kosa, et al., 1970; Luft, 1978; Braveman, et al., 2011). Causal mechanisms such as health behaviors, diet, health care utilization, neighborhood crime, and social isolation have been identified as mechanisms linking poverty to incidents and survival of cancers (Hellenthal & Bermejo, 2012), obesity (Scott & Wilson, 2011), diabetes and coronary heart disease (Braveman, et al., 2010), among many other health outcomes. By identifying upstream social causes of downstream health disparities, researchers have built a growing body of evidence to explain how social conditions impact individual health through a variety of intervening mechanisms.

Social Causes and LGB Health. Meyer's (2003) minority stress model describes how downward causal mechanisms may explain health disparities specifically for LGB communities. Expanding from traditional formulations of stress and coping (Lazarus & Folkman, 1984), Meyer suggests that both distal and proximal sources of disproportionate social stress afforded to members of a minority status create a chronic and overburdened stress load that results in symptoms of physical and mental illness. LGB individuals are exposed to society-wide sources of stigma and discrimination that negatively influence their access to

material and social resources. Stigma is defined as “an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from whole and usual person to a tainted, discounted one,” (Goffman, 1963, p. 11). Stigma based on LGB identities triggers physiological and psychological stress responses, both as a result of interpersonal experiences of discrimination as well as from chronic stress accompanying the anticipation of future discrimination (Stuber, et al., 2008; Meyer, 2003). The minority stress model proposes that discrimination against LGB individuals, such as being denied employment, housing, or health care, directly impacts their health. Further, discrimination indirectly impacts the health of LGB individuals through the experience of stress from disclosure management, whereby individuals are forced to continually calculate and cope with the consequences of disclosing their stigmatized sexual minority status.

In the past decade, Meyer’s minority stress model has been used often to study LGB health, including among older adults (Wight, et al., 2012). Although much of the literature studying health outcomes among LGB older adults does not explicitly identify a theoretical framework (Fredriksen-Goldsen & Muraco, 2010), many of these studies appear consistent with the underlying foundations of the minority stress model, proposing that both interpersonal discrimination and chronic stress from social stigma impair health (Grossman, et al., 2001; McFarland & Sanders, 2003; Masini & Barrett, 2008; Orel, 2004). Multi-level social stresses from sexuality-based stigma, as well as stigma related to other minority statuses of LGB individuals such as race and age, cascade downward into the bodies and psyches of individuals (David & Knight, 2008; Shippy, 2007).

Researchers seeking to identify how minority stress and other social determinants impact LGB older adult health understandably focus on deterministic models of the relationship between individuals and their environment. Gehlert, et al., (2008) identify a largely unidirectional causal stream of social conditions cascading downward until they “get under the skin” of individuals in the form of disease (p. 343). This scholarship has successfully identified statistical associations between statically conceptualized categories of sexual orientation and health outcomes. From the theoretical context of cumulative inequality and minority stress, these associations are seen as reflections of mechanistic processes whereby social inequality is translated downward into individual bodies and psyches.

However, there are limits to this approach in understanding health disparities. Deterministic social theories afford little room to the role of individual agency, the capacity to act on one’s own behalf. Krieger argues for more complex acknowledgment of social and individual sites of agency (2001), but ecosocial theory has advanced the notion of individual agency very little. Link and Phelan (1995) argue that focusing on upstream social causes of disease is a necessary counter-balance to individualistic Western values. Focusing on individual responsibility for health perpetuates cultural values that too frequently ignore systemic and structural reasons why patterns of health disparities are so pervasive. Although Meyer (2003) cautions against completely ignoring individual agency in considering the impact of minority stress on LGB individuals, he favors structural, objective explanations for poorer health outcomes in order to avoid inadvertently casting LGB subjects as responsible for their own disadvantages. In order not to

blame the outcomes of structural inequality on the individuals that suffer from them, health research has paid less attention to the role of individual agency in shaping health.

Essentialist assumptions underpin most LGB older adult health research. Meyer (2003) acknowledges that some experiences of discrimination and stigma may be contextualized as socially and privately interpreted phenomena; however, the effects of social conditions are seen as penetrating bodies and impacting the objectively observable physiology and psychology of individuals. Age is presumed to be a constant, which temporally contextualizes the accumulation of the effects of social inequality. Gender is most often treated as a control variable, dichotomous for all except the extremely few studies that include transgender older adults. Health is typically operationalized as an identifiable state of normative physical and/or psychological functioning, with illness reflecting functional deviance from the norm (Turner, 2004).

Alternative theoretical formulations may be more effective in centering LGB older adult agency in the context of social inequality. Social constructionist and post-structural theories of gender, sexuality, age and health suggest frameworks for considering how LGB older adults are not only acted upon by social forces, but are themselves actors in shaping their own well-being.

Alternative Theoretical Frameworks

Social Construction and Post-Structural Theories. Social constructionist and post-structural theorists have focused on how gender, sexual orientation, age and health are socially constructed and discursively embodied categories, rather

than static, objective characteristics. These frameworks suggest alternative ways to approach the study of LGB older adults and account for expressions of individual agency whereby LGB older adults shape their own well-being outside of strictly deterministic models of health.

There is considerable overlap in concepts and constituents of social constructionist and post-structuralist theories. The use of these terms in this paper is intended to associate scholars with the schools of thought with which they identify or have been identified by others, rather than to attempt to make definitive distinctions between them. In general, social constructionism is united by the theoretical proposition that meaning-making is bounded entirely by socio-cultural processes and contextualized by time and place (Witkin, 2012; Lock & Strong, 2010). There is no one, objective truth, but multiple possible truths among which dominant and subordinate interpretations of the world are imbued by social discourse with different levels of power. Social constructionism rejects essentialism and interrogates categories that are typically conceptualized as static and self-evident, such as gender and age. Theorists identified broadly as social constructionists tend to focus less on the level of the individual in enacting assumed meanings, and more on documenting broad social changes in assumed meanings across history.

Post-structuralism is typically characterized as a specific school of thought within social constructionism (Lock & Strong, 2010). Post-structuralism includes a variety of theorists that examine a diversity of subjects, including gender, sexuality and health (Belsey, 2002; Agger, 1991). In general, post-structural theorists argue

that there is no direct correspondence between language and the world around us. How we understand the world and ourselves is always mediated through the cultural values and beliefs inherent in the language with which we assign meaning. Therefore, what we understand to be true is unstable and always discursively contested. At no time can we step outside of the social discourses that shape our assumptions about ourselves and the world; therefore we participate in the discursive creation and contention of meaning with our actions and words. Post-structuralist theorists often focus on the concept of embodiment, whereby social discourses shape perceptions of the self, and through the actions of bodies, discourses are reified and reproduced at both the micro and macro levels of social interaction. Through our words and patterns of social practice, we embody both the world of assumed meanings as well as the potential to resist and contest them. Post-structuralism seeks to deconstruct assumed meanings, illuminating how taken-for-granted categories conceal alternative meanings and potential truths and the power that they hold.

Theorists of gender, sexuality, age and health include those identified as social constructionist as well as post-structuralist. Regardless of the label, they represent sharp critiques of essentialist notions about the meaning and the study of gender, sexuality, age and health. Rather than view these categories as objectively observable representations of truth, social constructionist and post-structural theorists examine how they are constructed concepts, whose meanings change over time. Recognizing them as constructs, rather than essences, these theorists suggest

ways to identify resistance to dominant discourses and recognize the potential for individual agency and the transformation of meaning and power.

Gender and Sexuality. Judith Butler (1990, 1993) proposed that gender and sexuality are culturally constructed and repetitively reconstituted in the ways individuals behave. Rather than encompassing an essential set of characteristics of what it is to *be* male or female, gender is at least as much defined by what we *do* as it is by anatomy or genetics. Proposing a post-structural understanding of meaning-making, Butler argues that we do gender and sexuality in stylized and ritual ways, conforming to or deviating from gender dichotomous social expectations. We perform gender on an ongoing basis through countless embodied acts such as eye contact, personal grooming, clothing, vocational choices and expressions of intimacy. The regulative discourses of gender and sexuality are dynamic, shaped and signaled by changing norms and the ways in which existing gender and sexuality expectations are conformed to or transgressed. The normative expression of what it means to be male today, for example, diverges from the normative expressions of being male fifty years ago with regard to household responsibilities, style of dress and wearing jewelry. Temporal changes in normative performance of gender and sexuality evolve through broad discursive changes in society as well as from the practice of individual transgressions from the norm, both inadvertent and intentional. The subject's capacity to rearticulate norms into deviant performative acts transforms socially constructed meanings of gender and sexuality into potential sites of resistance and agency.

Queer theory has expanded on Butler's notion of the performativity of gender and Michel Foucault's (1978) post-structural critiques of historical sexuality discourses. It highlights the historical evolution of queer subjects, gender deviant and sexually deviant identities, which fail to conform to socially constructed dichotomies of opposite-sex oriented gendered selves. The 19th and 20th century creation of sexually non-conforming categories (e.g., "homosexuals") by medicine, particularly psychiatry, not only created self-consciously sexual minority selves, but it also structured new systems of power and authority whereby sexualities could be classified and controlled. Queer theory deconstructs the notion of "common understandings" of binary, essentialist identities, critiquing normalizing impulses for even non-normative sexual identities (e.g., lesbian/not lesbian) as exercises in discursive power that privilege some at the expense of others. Individual expressions of gender and sexuality that blur (or "queer") socially accepted categories, such as an effeminate heterosexual man or an individual who self-consciously presents as gender-ambiguous, highlight how taken for granted essences of gender and sexuality rely on socially reinforced conformity. The performativity of queer identities that deviate from social norms can be an important site for the potential to resist dominant discourses and the powers that they reinforce.

Age. Theorists have also focused on the ways in which age is socially constructed. In particular, what constitutes old age has been strongly contested (Estes, 1979; Gullette, 1997, 2004; Laws, 1995; Cruikshank, 2009). Like gender and

sexuality, the social understanding of old age has been regulated primarily by biomedical authority, which equates old age with decline and social dependency, and helpfully offers interventions to permit bodies to defy or even reverse their age (Estes, 1979; 1993; Estes & Binney, 1989; Gullette, 1997; 2004). The meaning and description of old age are socially conscribed and increasingly contested. It has been equated with wrinkled skin (and the promise of age-defying skin cream). Old age may be signaled by retirement from full-time employment, with implications for how social class and the ability to survive without employment structure oldness differently for different groups. Popular home video games propose to calculate a player's "fitness age," equating age as a consciously alterable state, equivalent to calculable standards of normative performance on tests of balance, body control and body mass index (Millington, 2009). Appealing to Butler's (1990, 1993) proposition of the performativity of gender, theorists argue that old age is similarly a socially constructed category that is enacted within and between individual bodies. Individuals *do* old age across a broad spectrum of diverse and frequently contested performative acts (Jolanki, et al., 2000; Laws, 1995; Gullette, 2011).

Accelerated aging theory argues that what it means to be old has different references and norms for gay men than it does for heterosexuals, and as a result, gay men grow old faster than their heterosexual peers (Friend, 1980; David & Knight, 2008). Though little empirical support has been found for accelerated aging theory (Berger & Kelly, 2002), the concept challenges researchers to question the taken-for-granted nature of age as a constant measurement in research, particularly for LGB populations.

Dominant discourses regarding the meaning, characteristics and value of old age are being challenged as adults 65 years of age and older are projected to become a larger proportion of the population than ever before in the coming decades. How new cohorts of old “baby boomers” do old age is likely to be different from the norms of old age for prior generations, in light of how baby boomers have redefined social constructs across the life course (Turner, 2004).

Health. Medical sociology has begun to explore how health and illness are socially constructed and interpersonally embodied as well (Turner, 2004). Physical and mental symptoms not only shift over time in how they are categorized as illness or health, but the embodied experience of those symptoms is influenced by socially proscribed categories such as gender, age, race, ethnicity, class, and sexual orientation (Lorber, 2000). The human body is a social project (Shilling, 1993), and regulation of the body throughout the past century has been primarily in the purview of medical authority (Foucault, 1973). Symptoms experienced as non-pathological two generations ago have been reconstituted by medical discourses as deviations from normal embodiment and suitable for medical intervention. For example, menopause, historically experienced as a normative life stage, is now subject of medical intervention for almost half of post-menopausal women in the United States (Brett & Chong, 2001; Utz, 2011; Turner, 2004). Younger cohorts of post-menopausal women describe menopause in terms of symptoms for which they consult their physician to treat, whereas older cohorts are less likely to perceive it as a problem or a disease that needs to be treated. Other conditions such as premenstrual syndrome (Parlee, 1994) and erectile dysfunction (Tiefer, 2004) have

also been dramatically reconstructed over time by medical discourses that constitute both the problem and the interventions to solve it. Like gender, sexuality and age, health and illness are embodied discursively as well as social constructed. Although the biomedical paradigm places medical experts who are in possession of mechanical readings of bodily measurements as the final arbiters of the presence or absence of health, we *do* health as ongoing embodied practices and rituals that have both the capacity to reinforce normative standards as well as transgress and resist them (Foucault, 1971, 1973).

Calasanti (2009) advocates for theorizing the intersections of gender, sexuality and age as key to advancing an understanding of “multiple ‘old ages’ – discourses and practices that vary by gender, race, ethnicity, class, and sexual preference” (p. 482). Intersectionality emphasizes the diversity of experiences for LGB older adults (Cronin & King, 2010). Gender, sexuality, age and health interact, simultaneously shaping embodied practices and mutually constituting one another (Heaphy, 2007). Categories at the margins of normative discourse highlight the ways that these mutually constituting identities reconfigure and stretch the bounds of how each identity is socially imbued with assumed meaning. For example, cognitively disabled LGB older adults embody multiple identities that shed light not only on each minority status (disabled, LGB, older adult), but the intersection of these statuses also points to the ways that disability, sexuality, gender and age combined carry sets of socially constructed assumptions (e.g., the common assumption that cognitively disabled older adults are asexual). Health and illness are experienced through the expectations and practices of gender and sexuality

(Bar-Lev & Tillinger, 2010). Age, as well, influences how people assess their health. Self-perceived health appears to differ from clinical indicators that might imply that older adults are in poor health. Despite having multiple chronic illnesses and physical impairments, 75% of older adults report that their health is “good” or better (Federal Interagency Forum on Aging Related Statistics, 2010). The perception of health is shaped by age, just like gender and sexuality are frequently expressed with new meaning and practices for older adults (Russell, 2007). As individuals reach older adulthood, the relative salience of gender, sexuality, and health constructs change, and identities formerly considered core may cede to the primacy of old age and health discourses (Cruikshank, 2008). Gender, sexuality, age and health intersect and mutually shape what each of these categories means and how they are embodied.

In summary, the meaning of the words female, male, lesbian, gay, bisexual, queer, old, young, healthy and ill are part of larger discourses intimately linked to one another and to medical authority over bodies. The embodied experience of people, particularly people claiming identities such as lesbian, gay, bisexual and old, that transgress and visibly contest dominant discourses, can be an important site for the study of individual agency and resistance. Social constructionist and post-structuralist theories of gender, sexuality, age and health point toward an active role that individual agency plays in shaping the embodied experience of health that deterministic social theories have frequently not addressed.

Individual Agency, Transgression and Resistance

In many ways, theorizing the social determinants of health has been an intentional counter-argument to victim-blaming, whereby people are credited as solely responsible for their health as a result of their individual choices and behaviors (Krieger, 1999, Link & Phelan, 1995). By focusing on causal mechanisms from social factors downward into individual physiologies, social determinants of health research has effectively located structural sources of inequality that are complicit in observed health disparities of minority populations. Within this framework, individual health behaviors such as smoking or seeking preventative care are identified as outcomes of ecosocial factors such as racism and poverty instead of as isolated causes of individual health outcomes (Gehlert, et al., 2008). Social conditions are theorized to be fundamental causes for both differences in health behaviors and health outcomes for socially disadvantaged groups (Link & Phelan, 1995).

While focusing on social determinants of health appropriately locates structural causes of inequality and health disparities, in the extreme it can overlook individual agency as a source of resistance to the effects of social inequality. While avoiding blaming individuals for the effects of social inequality, deterministic models may inadvertently contribute to the picture of stigmatized individuals as defined solely as victims of their oppression. Alternatively, theories that propose that gender, sexuality, age and health are embodied discursively and performed through repetitive and ritual acts at micro and macro levels of social interaction

suggest ways in which individuals may exercise agency by deliberately choosing to transgress normative discourses.

Gender, sexuality, age and health are mutually constructed and discursively practiced in countless ways. Normally, the embodied practices that constitute them are automatic and unselfconscious (Butler, 1993). For example, people typically do not consciously choose to conform to or transgress normative expressions of gender or age. The more powerful the assumptions about an identity, the more taken for granted are the ways in which the identity is performed. Normative social discourses rise to the level of assumed truth at the point at which subjects automatically discipline themselves to conform to dominant meanings, unselfconsciously internalizing social constructs as embodied truth (Foucault, 1978). Judith Butler (1993) specifically took issue with the reading of her theoretical framework of the social construction and embodied reification of gender and sexuality to mean that performativity was equivalent to self-conscious performance. To the contrary, Butler argued that disciplining social discourses on such taken for granted topics as gender and sexuality are so integral and assumed that they constitute the conscious self, and apart from which we normally cannot conceive of ourselves. Deliberate transgressions of gender and sexuality norms (e.g., dressing in a manner typical of the opposite gender) are usually publicly disciplined and ultimately serve to recapitulate the dominant discourse rather than resist it.

However the potential exists for individuals to deploy alternative discursive practices, deliberately choosing to defy social norms. Foucault repeatedly stressed the potential for resistance at both the level of social organization as well as

individual bodies (Picket, 1996). Transgressing normative boundaries becomes an expression of resistance when it brings to light otherwise hidden and oppressive systems of power that dominant discourses create. Practices that provoke the question, “*why* is this considered normal?” have the potential to disrupt the well-worn paths of discursive power. Butler (1997) revisited the debate about the potential for resistance and confirmed that it is a possibility. Because power requires embodied reiteration, it is vulnerable to disruptions of that reiteration. Acting contrary to discursive power as a means of disrupting the taken-for-granted nature of normative discourse is a real possibility at the level of the individual subject. However, Butler warns, such resistance is profoundly dangerous to the social existence of the resistor, since dominant discourses constitute both the social context and the self itself. Almost always, embodied practices that transgress social norms are punished. Sometimes those practices may also disrupt power and alter the perception of what is taken for granted (Mills, 2000).

Performativity and Same-Sex Partnerships. Same-sex “kiss-ins” over the past 5 years are an example of the deployment of alternative discursive practices exercised deliberately to transgress and transform long-standing heterosexist norms (Gabbatt, 2011; Fuchs, 2010; Associated Press, 2009). Across North America and Europe, groups of same-sex couples have assembled publicly and engaged simultaneously in kissing as a means of protesting the exclusion of same-sex intimacy from socially accepted discourse. Often targeting sites where LGB intimacy has been formally excluded or punished, kiss-ins have become a graphic example of the deliberate practice of alternative discursive acts to confront, challenge, and

redefine the taken for granted assumptions about acceptable expressions of gender and sexuality in public spaces and ways that they are disciplined.

Beyond protests, same-sex partnerships, long practiced in LGB communities, reflect transgressions of established social expectations that have regulated norms pertaining to gender, sexuality, and age. As the social discourse regarding the meaning and value of same-sex partnerships is increasingly contested in political debates about their legal standing, these relationships carry both personal and political implications. Identifying as a member of a same-sex partnership defies social conventions about acceptable expressions of gender and sexuality. Being an LGB older adult who claims a primary, intimate relationship with someone of the same gender requires a complex set of intentional decisions and deliberate practices that transgress gender, sexuality and age norms. These transgressions carry social costs, such as the potential rejection of family and friends and the lack of access to material benefits afforded to opposite-sex partnerships. They may also result in potential rewards, such as shared emotional and material support and greater perceived quality of life. While there are likely complex ways in which social forces flow downstream to influence the likelihood of an LGB older adult participating in a same-sex partnership, the relationships can also reflect individual agency and the deliberate deployment of alternative discursive practices that have implications for health and happiness.

Researchers have identified many ways that intimate partnerships shape the embodied experience of health and disease. Partners co-create the shared meaning and experience of an illness (McGovern, 2011). Having a partner can facilitate

improved cognitive functioning for older adults (Harris, et al., 2011). In partnered relationships, illness and health may be experienced from the perspective of a “communal body,” with both partners’ identities intricately tied to the shared experience of illness and recovery (Fergus, 2011, p. 100). The experience of illness in the context of a partnership can redefine how both the healthy and the ill partner estimate their quality of life and well-being, and illness in old age can actually increase an individual’s assessment of life and relationship satisfaction (McGovern, 2011). Illness experiences and partnerships co-constitute one another just as gender, sexuality and age co-constitute partnerships. Mutual identities are embodied simultaneously, and the embodied practices of being an intimate partner change the subjective experience of health and illness.

A great deal of empirical research has identified links between health and marriage for heterosexual older adults (Pienta, et al., 2000; Manzoli, et al, 2007; Scafato, et al., 2008). Married heterosexuals live longer than unmarried peers, and they enjoy better physical and psychological health across many measures (Prior & Hayes, 2003; Waldron, et al., 1996; Williams, 2003; Simon, 2002). Less research has focused on same-sex partnerships, but similar associations between partnership and health appear to exist. LGB individuals in same-sex partnerships report being generally healthier and happier than unpartnered LGB individuals (Weinke & Hill, 2009). LGB older adults living with a partner report being healthier and less lonely than those living alone (Grossman, et al., 2001). Although results of partnership status appear similar for LGB and heterosexual older adults, opposite-sex partnerships draw from a less contested and more universally sanctioned social

discourse than same-sex partnerships. The heteronormative life course makes long-term partnering for heterosexuals broadly taken for granted. Heterosexuals generally have access to extensive formal and informal sanctions to support their coupling, and their partnerships are typically uncontested and positively regarded by family and friends.

In contrast, while same-sex partnerships reflect some of the same discourses of the normative life course that heterosexual marriage represents, they also carry different social meanings and values and transgress long-held norms about gender and sexuality. Same-sex partnerships have historically been able to appeal to fewer structural social supports than heterosexual partnerships. The heteronormative life course, including the expectation that children will grow up, date members of the opposite sex in adolescence, get married in young adulthood, have children within the marriage and be cared for by subsequent generations in older adulthood, has had no socially sanctioned parallel for LGB individuals. Same-sex partnerships for LGB older adults inhabit an increasingly contested social discourse, and the social value and embodied practices of same-sex partnerships continue to enjoy much less consensus.

LGB older adults have been forming same-sex partnerships without access to legal recognition or society-wide acknowledgement for most of their lives. Within LGB communities, same-sex partnerships have been defined by a range of practices and language, many of which overlap with dominant discourses about marriage and many of which deviate from them (van Eeden-Moorefield, et al., 2011). While the evidence is sparse owing to the very early stages of scholarship on the topic, same-

sex partnerships are constituted in many different forms, including cohabiting dyads, stepfamilies with children and grandchildren, primary families with children and grandchildren, sexually open relationships, and relationships comprised of more than two partners. Age and gender also appear to interact, with younger LGB subjects appealing to different discourses and engaging in different coupling practices than LGB older adults (Adam, 2006). Same-sex partnering has reproduced some aspects of conventional heterosexual marriage norms while deviating from others, reflecting innovative expressions of the performativity of gender and sexuality.

As increasing public attention is paid to the social standing and value of same-sex partnerships, being partnered reflects complex practices and deliberate decisions on the part of many LGB older adults to transgress heteronormative expectations. In addition to structural determinants that likely shape their health and well being, same-sex partnerships are an increasingly and publically contested set of embodied practices that defy many social norms about gender, sexuality and age. These alternative discourses on gender, sexuality and age may also have implications for how older adults experience and assess their health status. From a perspective of the embodiment of gender, sexuality, age and health, partnership status represents an expression of individual agency whereby LGB older adults exercise agency in innovating familial forms that may impact their health.

Conclusion

Studying the associations between same-sex partnerships and the health of older adults highlights how the embodiment of sexuality, gender, and age are

mutually constituted alongside of the embodiment of health. Theories of the social construction of gender, sexuality, age and health explain how these demographic categories, frequently treated as essential in research, require socialization to establish and maintain them. Historically, these constructs change over time as social norms and values are contested and reconfigured. Post-structuralist theories describe how, within the socially constructed identities into which we are socialized, individuals embody gender, sexuality, age and health through performative, ongoing acts. Individual agency resides within the performativity of these multiple identities and the opportunities for resistance that embodiment provides.

Growing evidence documents how marginalized identities at the intersection of these categories, such as LGB older adults, are acted upon by social conditions in ways that impact their health. However, the embodied practices of LGB older adults also have the potential to stretch the bounds of social norms and even create ruptures within the fabric in which these identities are co-constructed. The practices that constitute same-sex partnerships for LGB older adults contest dominant discourses of gender, sexuality and age, impacting the quickly evolving social appraisal of the meaning and value of such relationships (Taylor, et al., 2009). Same-sex partnerships also impact the experience of embodiment itself, shaping how LGB older adults inhabit statuses of health and illness as outcomes of their own agency.

Research informed by social constructionist and post-structural theories of gender, sexuality, age and health should seek to conceptualize these categories as evolving across time. Studies of older adults must account for this evolution across

the life course of research subjects. Just as the boundaries and salience of these categories has changed in dramatic ways over the past century, embodied practices associated with them have evolved as well. Many LGB older adults report shock at seeing the rapid advance of political debates about legal recognition for same-sex partnerships in the past 10 years (Porche & Purvin, 2008). Just as they have witnessed dramatic change in the public discourse about same-sex partnerships, they have seen arguably more dramatic changes in the social norms and discursive power of the performativity of gender, age and health. Across the lifecourse, older adults have likely named and understood their sexual orientation and gender identities with a quickly changing vocabulary and set of dominant and alternative social expectations. Health research should focus on identifying practices of resistance to dominant discourses that have long marginalized and pathologized LGB and old age identities, incorporating measures of individual agency such as non-heteronormative familial forms as well as other transgressions of social norms engaged in deliberately as strategies for shaping one's own health and happiness.

Conclusion

The findings from this dissertation confirm that partnerships matter to the health and satisfaction with life of LGB older adults. Having a same-sex partner is associated with better self-reported health, fewer depressive symptoms, less perceived stress, and greater satisfaction with life. Further, identifying as married is associated with significantly fewer depressive symptoms and greater satisfaction with life when compared with unmarried partnered LGB older adults and unpartnered LGB older adults. Both having an intimate partner and identifying that partnership as a marriage have implications for the well-being of LGB older adults.

Additional research is needed, however, in order to better understand how partnerships and health are related for LGB older adults. Longitudinal data may be required to better examine how relationship duration and quality affect health outcomes over time. Collecting more information, such as the health status of one's partner or the impact of contentious political campaigns related to LGB rights, may shed more light on some of the surprising findings with regard to relationship duration and living in a state that recognizes same-sex marriage. Further, larger population-based samples will be essential in order to more confidently generalize research findings to the broader population of LGB older adults. Extending research findings to the realm of practice should focus on how policies that support the recognition of same-sex partnerships may have implications for LGB older adult health. Further, identifying the mechanisms by which partnership status is associated with health may focus clinical practice on interventions needed to support the health of unpartnered LGB older adults.

In addition to extending research on health disparities for LGB older adults, theoretical frameworks employed in this effort should reexamine how both social determinants and resilient LGB subjects shape health in old age. Entirely deterministic models of health may overlook innovations, adaptations, and resilient strategies employed by oppressed communities to cope with social exclusion and stigma. Theoretical frameworks that account for both social context and individual agency as factors in health may better capture the importance of strategies of resistance to dominant discourses that have historically marginalized and pathologized LGB and old age identities.

While findings from this dissertation echo similar results of studies of heterosexuals, same-sex relationships reflect not only a different gender composition from heterosexual partnerships, but also different and contested meanings and social standings of relationship statuses. As political changes in support of same sex marriage or civil unions are taking place in several states, many LGB older adults have evolving sets of options with regard to legally recognized partnership statuses. Both the social integration represented by those statuses and the instrumental benefits that may be afforded by access to legal rights and protections may account for some of the associations between health and partnership status in these papers. Same-sex partnerships across the life course may continue to have increasing access to more socially integrated statuses. The evolution of the political context and the subsequent impact that evolving policies and changing access to social recognition may have on the health of LGB older adults is only beginning to be studied.

However, social constructionist theoretical critiques should drive future research to also explore the complexities of how same-sex partners identify and embody their partnership statuses. The historical contexts in which older adults have formed partnerships prior to recent political changes have likely shaped the meaning and norms of long-lasting same-sex partnerships in unique ways. Simply asking if an LGB survey respondent is married not only fails to capture the precise legal standing of that partnership status, it also glosses over a lifetime of personal biography and social struggles that may make answering that question much more complex and nuanced for LGB older adults than for heterosexuals. Further, since legal standing describes only one indicator of social integration, exploratory research should be conducted to better inform how to construct survey questions to measure other possible indicators of social integration, including the degree to which a respondent's relationship status is recognized and accepted by family members, co-workers, neighbors and members of a faith community. What it means to identify as married, or as a member of an unmarried partnership, or as a single older adult will benefit from qualitative research to better understand what researchers are actually measuring when they ask LGB older adults their partnership status.

Clearly, intimate partnerships hold meaning and impact the lives of LGB older adults. Forming intimate partnerships has been a strategy of resistance in defiance of social norms for most of the lives of LGB older adults today. Just within the past decade, however, some states have extended formal recognition of same-sex partnerships. How directly state-recognized legal statuses correspond to the

embodied practices that LGB older adults have engaged in outside of social sanctions prior to these political developments has yet to be fully understood. LGB older adults have innovated new familial forms and patterns of partnership in the absence of legal recognition; because of this, it remains to be seen whether simply extending the legal rights afforded to heterosexual marriage, for example, will result in conformity between same-sex and opposite-sex partnership norms in the future.

The story of how same-sex partnerships impact the health of LGB older adults will require further study, including research on how self-identified partnership status is associated with mental and physical health outcomes, but also on what embodied practices are associated with self-identified partnership status and the subsequent health implications of those practices. Whether identifying as partnered or as married constitutes resistance to dominant discourses of gender, sexuality, and age, or whether it reflects the disciplining of non-normative identities into dominant social structures as a means of reifying existing patterns of power and privilege, remains to be seen. New forms of legal recognition for same-sex partnerships may serve to assimilate the counter-cultural familial forms that LGB older adults have innovated over the course of their lives, leading to more conformity between the benefits associated with socially sanctioned relationships for LGB and heterosexual older adults. However, legal recognition of same-sex partnerships may also unsettle dominant discourses about gender, sexuality, and age. Unsettling dominant discourses could result in changing patterns of health for both heterosexuals and sexual minorities. Increased social integration may serve to change the way that LGB older adults embody partnership status, but extending

partnership rights formerly restricted to heterosexuals could also alter the flow of privilege and power that has resulted in health disparities based not only on sexuality and partnership status, but also on gender and age as well. Ongoing research will be required to understand the outcomes of today's contested discourses about the meaning and value of same-sex partnerships, not only for the implications they have for LGB older adult health, but for heterosexual patterns of health as well.

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