



Social Support in the Lives of Lesbians and Gay Men at Midlife and Later

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Abstract: A large body of medical and academic literature has established the connection between strong social support and vigorous physical and mental health in aging populations. Largely unexamined to date, however, are the meanings and processes through which lesbians and gay men come to perceive, develop, maintain, and mobilize social support in midlife and later. The midlife cohort currently in this population stands to be the first group of homosexuals who will openly disclose their sexual orientation and their social support needs when they reach later life. Focusing on social support and informal caregiving for aging lesbians and gay men, we look at how the lifelong impact of the social, political, and economic stigma and discrimination, and related historical events, created significant cohort differences. This approach offers insight into similar processes occurring in other groups, such as ethnic minorities, and has implications for gerontological theory, policy, and research in general.

Key words: aging; cohort; caregiving; sexual minority; stigma; discrimination; LGBTQQ

A large body of medical and academic literature has established the connection between strong social support and vigorous health, particularly mental health. Social support has been credited with ameliorating the otherwise deleterious effects of psychosocial stress in people's lives, including anxieties associated with aging (Baltes & Baltes, 1990; Berkman, 1984, 1985; Bisconti & Bergeman, 1999; Cohen & Syme, 1985; Litwak, 1985; Peters & Kaiser, 1985). Those who are part of a social support network—typically spouses, family and relatives, confidantes, and close friends—provide assistance when needed and solicit care when it is required. Yet, for a variety of reasons, lesbians and gay men frequently have lacked access to many of these primary sources of support. Moreover, this sexual minority has experienced, over their life course, a variety of historical events and social changes that have profoundly affected access to the usual means of social and psychological support (Barker, 2004). Thus, cultural changes concomitantly influence distinct cohorts, in terms

of their self-identity, political activism, social networks, social visibility, and acceptance (Herdt & Boxer, 1993). Little is known, however, about the impact of these events on lesbians' and gay men's perceptions at either midlife or late life and about the availability or mobilization of support and informal caregiving for this group.

More research is needed on the lives, circumstances, and social support of midlife and older lesbians and gay men, who comprise an estimated 10% of the general urban adult population (Cahill, South, & Spade, 2000). Accurate knowledge would foster appropriate supplemental or complementary social services when necessary, services that would be both culturally sensitive and psychologically appropriate for this population. Learning more about gay men and lesbians and the ways in which they compensate for frequent lack of kin-based social support would also provide insight into how social support for other childless or family-less elderly could be accomplished. Moreover, filling the gap would legitimize nonkin caregivers, who

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through naturally occurring arrangements provide assistance to approximately 10% of dependent community-living elderly (Barker, 2002).

Study of social support for lesbians and gay men also carries the promise of theoretically enlarging our understanding of social support as a general phenomenon. Heteronormative assumptions have dominated the study and analysis of aging in North America, leaving either unasked or unanswered questions about the experiences of sexual minorities, including the social context of their aging, their need for care, and the delivery of the same (Herdt & de Vries, 2004). Social support remains problematic for this group because historically homophobia has disrupted gay men's and lesbians' connections to their natal families and discouraged biological reproduction resulting in families. Charting distinct age cohorts of lesbian and gay men and their life experiences would be fruitful for investigating and understanding similar cohort differences in other minority groups that have experienced discrimination and stigma (Teunis & Herdt, in press). In short, further detailed examination of midlife and older sexual minority populations would benefit sexuality theory, as well as gerontological and aging policy in general.

This is a large and complex undertaking, so let us first provide a brief road map to the article. We begin by examining the existence of distinct cohorts that are signaled in several ways: the terms used by gay men and lesbians in self-description and those resulting from the historical context of formation of gay and lesbian community, as well as those due to large-scale demographic (age) shifts in society. Implications of cohort differences for various aspects of informal social support are noted. We then move on to provide a brief overview of the literature on support needs in midlife and later, both generally and in the particular context of gay men and lesbians. A brief synopsis of central ideas in the literature on social support comes next, linked to an analysis of social support, aging, and lesbians and gay men, with particular reference to current and ongoing research conducted by the authors of this article. We conclude with a presentation of some of the major implications of the findings for understanding and investigating social support and policy for an aging lesbian and gay community.

In this article, we highlight the key points most germane to our argument in several large and complex literatures. We focus more on salient central concepts than on providing a detailed or comprehensive summary of all relevant work or empirical findings. We also review background material that may seem well-known but might not be for people coming to this article from different

disciplinary perspectives. We attempt to ensure that all readers are equipped with the minimum background necessary to understand our line of reasoning.

Defining Lesbian and Gay

Typically, *lesbian* and *gay* are presented and used as unproblematic terms, easily and meaningfully contrasted with other sexual identities.¹ However, across the course of life, lesbian and gay identities are contested, divergent, gendered, and far more nuanced than these simple categories imply (Cohler & Galatzer-Levy, 2000). Moreover, such labels have changed over time, as have the communities that adopted these labels (Herdt, 1997; Murray, 1995). Defining who is or might be a lesbian or gay man or a member of the lesbian-gay-bisexual-transgender-queer-questioning (LGBTQQ)² community is not at all straightforward. At least three quite distinct but frequently conflated concepts are centrally involved—biological sex, gender self-identity, and sexual behavior. The fusion of these ideas is compounded by increasingly malleable senses of basic anatomical/biological orientation; how, when, and to whom to disclose self-identification as a sexual minority; sexual behaviors; and participation in sexual minority communities, organizations, and events (Laumann, Ellingson, Mahay, & Paik, 2004; Laumann, Gagnon, Michael, & Michaels, 1994).

It is often assumed that apart from transgender individuals undergoing (biological) sex reassignment, sexual orientation or identity and sexual behavior are linked, fixed, stable, and enduring characteristics (Laumann et al., 1994). In fact, many men and women do not come to fully understand that they are not heterosexual in their sexual desires, attachments, and behaviors until well after adolescence, the expected and accepted period of developmental plasticity and sexual experimentation (Cohler & Galatzer-Levy, 2000). Thus, many lesbians and gay men often do not come out to themselves, let alone to others, until they are mature adults, sometimes not even until after being married and having children. Self-identity as a member of a sexual minority depends as much on experiencing strong emotional and psychological commitments to same-sex individuals as on desiring, having,

¹These same terms will be adopted here for ease of use and reference to the existing literature, notwithstanding their problematic nature as discussed in this section.

²For the purposes of this article, we focus on the majority segments of the LGBTQQ population—on lesbians and gay men. Many of the points raised herein will also or even especially apply to bisexual, transgender, or other sexual minority people; however, we leave the complications wrought by their different identities and behaviors to exploration at another time.

or claiming sexual behavior with a person of the same sex. Openness as a gay or lesbian person is fraught with social conflict, potential discrimination, and stigma, making many people circumspect in coming or being out. Some eschew active or obvious participation in LGBTQQ community events to keep their sexuality secret.

Many people, lesbians in particular (e.g., Adelman, 1987, 2000), are able to pass as heterosexual, usually because of gendered societal assumptions—about women's sexuality and lives and about gay men and their sexual behaviors and everyday lives. Some people in the sexual minority communities choose to pass as heterosexual, either occasionally in selected environments or all the time. Not all who are open about their alternate sexual identity and partnerships participate in the voluntary associations, sports clubs, churches, or other organizations created by sexual minority groups. As such, a segment of the LGBTQQ population participates marginally or not at all in the sexual minority community. The lifeways of these people remain hidden from their own kind and yet, sometimes paradoxically, these marginal individuals often adopt or accept meaningful and central parts of the minority self, though conditional and context dependent (Herdt, 1997).

Expression of self-identity as a member of a sexual minority group has altered over time, too, both within the LGBTQQ community and to outsiders. For example, whereas most older gay men, those in their 70s or older, are comfortable calling themselves homosexual, men in midlife often prefer the term *gay*, while younger men in their 20s and 30s frequently choose *queer* or *gay* as self-descriptors (e.g., Adelman, Gurevitch, de Vries, & Blando, 2006; Rawls, 2004). Currently within the sexual minority community, a host of labels and words are used to identify lesbians, gay men, and other subgroups within the LGBTQQ community. These terms—such as *dyke*, *femme*, *butch*, *queen*, *boi*, *bougy babe*, and *tranny*, to note just a few—reveal different degrees of visibility and pride in alternate sexualities. They also refer to divergent sexual cultures of which the heteronormative world is often completely unaware and reflect various degrees of differentiation and participation in the LGBTQQ community, its organizations, and events.

Not all who self-identify as LGBTQQ engage in sexual behavior with same-sex partners. During the second-wave feminist era in the 1970s, for example, there were many *political lesbians*, women who eschewed the patriarchal power and company of men but did not actually engage in sex with other women (Faderman, 1999). And not all who engage in sex with same-sex partners identify as a sexual minority. This fact was reinforced during the early years of the HIV/AIDS epidemic when ethnographic

research hammered home the message that for biological males who were sexually active with other biological males, the label *men-who-have-sex-with-men* (MSM) was a better epidemiological descriptor for understanding behaviors and infection prevalence rates than was wholesale assignment of the label *gay man* (Myers, Allman, Jackson, & Orr, 1995; Parker, Herdt & Carballo, 1991).

A key point to keep in mind with respect to social support is that identifying as lesbian or gay does not of necessity reorient people exclusively or even necessarily primarily away from the heteronormative world or displace the majority of connections to it. Precisely because of their alternate experiences and emotional/psychological orientations and attachments, however, lesbians and gay men experience particular differences and difficulties compared to their heterosexual peers, divergences and discrepancies that heretofore have been under-investigated in gerontology. Hiding from wider society the actual nature of one's sexual identity and sexual relationships, concealing the depth of one's emotional partnerships to particular people or gender groups, masking one's participation in the activities associated with a sexual minority community, and obscuring the true nature of one's identity and feelings in the mainstream world of family, school, and work all have lifelong and serious consequences. This article discusses one such consequence, the absence of adequate social support and informal caregiving available to aging lesbians and gay men, especially to the most senior cohorts who have hidden much of their lives from the view of others.

Distinct cohorts of midlife and older lesbians and gay men arose not just because of the ways in which they self-identified but also because of the extent to which they were able to form and sustain a visible community. As Adelman (2000) noted: "Lesbian was previously a sexual identity with an outlaw sensibility," whereas now lesbians see themselves as "an oppressed sexual minority" (p. xvi)—a clear indication of a major change in self and social identity and another marker of distinct cohorts. Gays and lesbians at midlife and later form a compelling case for microscopic psychosocial study because they came of age during dramatic shifts in the social acceptance of homosexuality. That is, during the formative adolescent or young adult years of these cohort members, social and cultural attitudes toward homosexuality transformed from individual pathology and stigma to positive group identity (Kimmel & Sang, 1995). This midlife cohort is the first group of homosexuals who will reach later life as out individuals, acknowledging their social support needs (including caregiving needs and arrangements), unlike the current cohort of seniors, many of whom remain

largely hidden, as previous studies have shown (Berger, 1982; Herdt, Beeler, & Rawls, 1997). The meaning of social support and the barriers to mobilizing such support in the lesbian and gay community have been impacted by several historic milestones that shaped the various cohorts across time (Elder, 1974; Herdt & Boxer, 1993).

Milestones in the Formation of Gay and Lesbian Community

Over the past two decades, social scientists and historians documented the roots of the gay and lesbian social movement in the United States (D'Emilio, 1983; Epstein, 2003; Herdt, 1997; Kimmel & Sang, 1995; Levine, Gagnon, & Nardi, 1997) that resulted both in enhanced public awareness of LGBTQ issues and in distinct cohorts by age within the sexual minority community. Deep-seated sexual prejudice (Herek, 2004) was the foundation for the challenges gay men and lesbians faced in forming a healthy self, normalizing their sexual orientation, and maintaining an accepted social life. The challenges were comprised of institutional forces of discrimination, homophobia, and anti-gay/lesbian violence in the 1960s, which provided the context for police brutality and harassment, blackmail, hate crimes, and religious persecution directed against homosexuals (Herek, 1995; Herrell, 1992). Resistance to prejudice and structural violence was initiated in San Francisco with the development of gay and lesbian voluntary organizations; by the mid-1960s, activists emerged, particularly in metropolitan areas, and, supported by heterosexual allies, fought back against police harassment (Boyd, 2003; Stryker & van Buskirk, 1996). Several years later in 1969, the Stonewall tavern riots erupted in New York City, giving added impetus to a nascent gay and lesbian civil rights movement, prominent in both San Francisco and New York City and eventually in large urban areas throughout the United States.

The American Psychiatric Association's declassification of homosexuality as a disease in December 1973 boosted gay and lesbian organizing, which led to bars, clubs, and social venues becoming more openly gay friendly and for many gay men and lesbians to an important source of informal social support. Now, some 30 years later, annual gay pride parades occur in cities across the country openly celebrating diverse sexualities and demonstrating the strengths and achievements of this social movement (Herrell, 1992).

While gay and lesbian organizing was taking place, the women's health movement was also under way. San Francisco served as one of the prime sites for activity and consciousness-raising related to lesbians' health and well-being, as evidenced by the development of the

Lyon/Martin clinic for women (The LGBT Religious Archives Network, 2005). This clinic provided a model for successful ventures into the provision of social and welfare support for lesbians as well as other women. The women's movement provided a necessary model for social support and care during the subsequent HIV/AIDS epidemic, as well as in innumerable other instances in which lesbians and gay men banded together (sometimes with sympathetic heterosexual friends) to provide care (Pearlin, Mullan, Aneshensel, Wardlaw, & Harrington, 1994; Turner, Catania, & Gagnon, 1994; Schneider, 1997). The epidemic decimated personal friendship and support networks while simultaneously creating a strong community-based model of care that crossed gender, age, ethnic, and cohort divisions within the LGBTQ community (Epstein, 2003). This greatly expanded the bridge between the lesbian and gay communities (Rubin, 1997) and assisted in the formation of a common understanding of the roots and responses to their sexual oppression.

By late 1981 the HIV epidemic was recognized within the sexual minority community and by health professionals and service providers; by 1984 people living with AIDS (PWA) became a distinctly visible group (Farmer, 1999). A controversy over whether to close gay bathhouses and the impact this action would have on the collective identity and support within the sexual minority community further increased gay and lesbian mobilization in response to the government's and medical professions' overwhelmingly lackluster response to PWA (Gagnon, 1992; Shilts, 1997). Activist groups, such as ACT UP, formed in New York and San Francisco particularly, pushed the government and health and welfare professions to include and respect the perspective of sexual minorities (Brown, 1997; Mamo & Mueller, 2003; Mueller, 1998, 2004).

The focus in HIV/AIDS research during the 1980s was on youth and young adults—on understanding risk behaviors and preventing the spread of infection and death among this group (Herdt & Boxer, 1993). The deaths of primarily young adult (20- to 40-year-old) gay men due to HIV/AIDS during the 1980s robbed surviving gay men of crucial support options then and in the future (Ryan & Fulterman, 1998). It was not uncommon for gay men to speak of losing 20 or more close friends or acquaintances to AIDS within a period of 5 or 10 years (Lennon, Martin, & Dean, 1990; Levine et al., 1997; Schmitz & Crystal, 2000). The massive scale of loss and the burden of grief that ensued for sexual minorities had both immediate and longer-term consequences and made both timely and crucial these questions about social support and informal caregiving.

By the 1990s, the previous emphasis on youth and risk began to give way to an increasing recognition of and attention to seniors (Herdt et al., 1997). For example, New York City witnessed the creation of a gay and lesbian seniors group (SAGE), followed by GLOE (later New Leaf Outreach to Elders) in San Francisco, to address issues of aging and care for older members of the gay and lesbian community (de Vries & Blando, 2004). Midlife and older lesbians and gay men, however, live in a society where youth and vigor are generally prized, and where social, legal, civic, economic, and welfare responses are built around influential images of youth. Ageism and marginalization within the lesbian and gay community, while widely acknowledged anecdotally, have thus far gone relatively unstudied (reviewed in Rawls, 2004).

Morale and adjustment have changed over time, leading to significant cohort differences within the sexual minority community (Adelman, 1987, 2000; Berger, 1982; Cohler, Hostetler, & Boxer, 1998; Sang, Warshaw, & Smith, 1991; Vacha, 1985). What has not changed over time for any LGBTQ cohort, however, are the legal and political barriers that keep gay men and lesbians from securely forming key types of social support. Historically, they have been prevented from formal recognition of partnership, marriage, family formation, adoption, inheritance, caretaking, and a variety of other forms of legal relationship, normative development, and support in society (Chauncey, 1994). Currently, marriage rights are being intensely debated. Religions have often stigmatized or excluded homosexuals from their congregations, and some churches continue to bar homosexual ministers as well as religious ceremonies or functions, such as weddings, for their lesbian and gay parishioners (Lewin, 1996).

Ethnographic studies have shown significant correlations between marginalization, lack of social support, and negative outcomes such as enhanced alcohol abuse (Newton, 1993), increased sexual risk-taking (Rubin, 1997), and loss of self-esteem with aging (Frable, Platt, & Hooley, 1998; Herdt et al., 1997). Some authors have contended that being without a partner seems to enhance the feeling of loneliness and increase substance use as a coping device (Grossman, D'Augelli, & Hershberger, 2000), although Hostetler (2004) provocatively questioned this interpretation. Hostetler reminded readers about the distinction between loneliness and being alone and suggested as well that singlehood should be considered along a voluntary-involuntary dimension. The life-long experience of prejudice and discrimination in response to their constructions of alternate sexualities (Herek, 1995) has also plagued the social development of sexual minority people, much as exposure to racism across

the life course has afflicted African Americans (Peterson, 1997). The resulting large disparities in the health and well-being of all LGBTQ people, including Latinos and other people of color (Diaz, Ayala, Bein, Henne, & Marin, 2001), in relation to the general U.S. population, have gained increasing attention (Gay and Lesbian Medical Association, 2001; Solarz, 1999). Only sketchily known for lesbians and gay men, however, are the connections among disparities in health and welfare and associated needs for greater care and social support at midlife and older ages and diminished access to certain types of social support central to the well-being of the majority aging population.

As a consequence of these historical and social factors, lesbians and gay men from the baby boom generation and from older generations have been forced to conceptualize, develop, mobilize, and sustain social support in a variety of alternative ways compared with their heterosexual counterparts. Precisely how this has been accomplished is largely unknown. However, it is clear that numerous individuals continue to remain hidden or closeted because of the reproduction of social inequalities (Parker & Aggleton, 2003). The current national debate on gay and lesbian marriage is further proof of the continuing crisis in the lives of sexual minorities as they struggle to normalize social support systems (Herdt & Kertzner, 2006; Yep, Lovaas, & Elia, 2003). It is unclear how, or if, current supportive ties and practices are effective and whether they can be sustained as each sexual minority cohort continues to age and experiences need for informal caregiving.

Midlife and Older: Demography and Need for Care

Surprisingly, midlife has remained a relatively unexplored time of the aging continuum (Neugarten, 1967; Willis & Reid, 1999). Glossing over what Dante refers to as the *dark wood* of the middle years (Huyck, 1989), developmentalists and gerontologists have tended to focus their work respectively on earlier and later periods in the life course, notwithstanding the physiological (e.g., Huyck), interpersonal (e.g., Katchadourian, 1987), familial (e.g., Cohen & Eisdorfer, 1995; Szinovacz, 1998; White, 1991), and political (e.g., Binstock, 2000) changes that have been alleged to dominate the landscape of the midlife adult (Willis & Reid, 1999). The impact of these changes on middle age and older sexual minorities, who already stand on the fringe of this understudied cohort, is of particular interest.

Demography and Change

Currently, nearly 36 million Americans—about 13% of the country's population—are age 65 years and older.

The older population grew from only 3 million at the beginning of the twentieth century, and their numbers are expected to more than double from 2010 to 2030. Within this population are a disproportionate number of women: 58% of the population age 65 years and older and almost 70% of the population aged 85 years and older are female (Federal Interagency Forum on Aging-Related Statistics, 2004).

To note that older women significantly outnumber older men is also to acknowledge implicitly that the majority of older members of the sexual minority population are most likely lesbians rather than gay men (Barker, 2004), and with the decimation wrought by HIV/AIDS, this imbalance will increase in the coming decades. To date, however, most research on midlife and older sexual minority populations has been on men, leading to recent calls not just for more research in general into this aging population (Herdt & de Vries, 2004) but for more research on older lesbians especially (Barker).

Globally, as well as in the United States, the period 1945 to 1965 ushered in one of the largest demographic shifts in modern times. The austere and uncertain times during World War II gave way to political stability, a booming economy, and a huge and rapid rise in the number of children being born. The appellation *baby boom* was applied to this enduring phenomenon. By 1996 the first boomers turned 50 years old, not only signaling a dramatic demographic change in the proportion of middle-aged Americans (Morgan, 1998) but also extending the pervasive and profound influences of this generation beyond that of smaller, more traditional generations that came before (e.g., American Association of Retired People, 2004; Marigny Research Group, 2002; Thornhill & Martin, 2005; Valliant, 2002). Within the boomer generation, however, there are distinct cohorts with divergent sensibilities and different sociopolitical causes: One cohort comprises those born before 1955; the other cohort includes those born between 1955 and 1965. Most of the widespread and general societal and political changes attributed to boomer optimism and activism were more the product of the first cohort than the later one. For gay and lesbian boomers, however, cohort differences in political and social activism are muted because visible and effective advocacy on behalf of sexual minority populations persisted longer than did the strident calls for political changes (e.g., Free Speech movement) and institutional responses ushered in by the boomers in general during their youth.

In education, career choices, political beliefs, and consumer behavior, boomers have dominated American culture for a half-century (Marigny Research Group,

2002). This generation challenged and changed the political structures and organizations in society through its vocal antipathy to them—to the Vietnam War, for example. Opposition to many forms of discrimination, including LGBTQ inequities, spawned a series of civil rights and social movements that ushered in an era of identity politics (D'Emilio, 1983). Studies of social movements in relation to sexual practices showed that boomers led the second sexual revolution of this century in the 1960s, following the invention of the Pill, the influence of feminism, and related activities driven by the then college-age boomers (D'Emilio & Freedman, 1988). For example, college boomers openly resisted the taboo on premarital sexual intercourse in the early 1960s (Irvine, 2002), challenged traditional sex segregation in college dorms, and delayed marriage (Moran, 2000). It was out of this context that gay and lesbian boomers, in the late 1960s and early 1970s, built upon the prior Black Power and Women's Movements, to challenge stigma, homophobia, and police harassment (Epstein, 2003; Herdt, 1992; Herrell, 1992; Stein, 1997). As these gay and lesbian boomers created a new social and political movement, they provided a new cultural context in which, approximately 10 years later, the first self-identified gay and lesbian adolescents began to emerge and declare their homosexuality while still adolescent. This gave rise not just to a new developmental cohort (Herdt & Boxer, 1993) but also to a new openness and visibility for this previously invisible minority population, with a new and often defiant political stance, and a new demand for respect, services, and acceptability (Herdt, 2000).

Within the LGBTQ community, the acceptability of this new openness varied dramatically by cohort. At the beginning of this new era of visibility, lesbians and gay men in midlife or older frequently felt discomfort and preferred to remain (at least partially) closeted, with relationships kept secret from the outside world (Kristiansen, 2004). In contrast, youth and young adults enthusiastically committed to an open, vibrant community and worked visibly and vocally to establish their real identities and legitimate, not hide, their life choices. Some of these pioneering *out and proud* youth are now themselves reaching midlife and continue to proclaim their sexual identity and affiliations, whereas some older lesbians and gay men still prefer to live in the quieter back rooms and interstices of the social and political order.

Health and Caregiving

From about age 45 years, the prevalence of chronic conditions and functional deficits increases markedly (Institute of Medicine, 1990; Merrill & Verbrugge, 1999;

National Academy on an Aging Society, 1999; Verbrugge, 1989; Verbrugge, Gruber-Baldini, & Fozard, 1996). Midlife sees the onset or exacerbation of the following kinds of chronic conditions, either as single disorders or in combination: arthritis and orthopedic impairments; cardiovascular disorders, including hypertension and heart disease; various cancers; diabetes; sinusitis; hay fever and other allergies; and sensory deficits, especially cataracts and hearing loss (National Academy on an Aging Society). Most of these conditions have deleterious impacts on emotional as well as overall physical health. Many of these common conditions result in significant functional impairment (Trupin & Rice, 1995), and hence, in midlife more temporary or permanent caregiving is needed. An array of community-based long-term care services, such as physical therapy, home health-care nurses, and medical social workers, are used to supplement day-to-day care provided by informal caregivers. Access to such services varies greatly and is dependent on a command of a wide assortment of resources, financial, regulatory, and personal. Midlife and older people, be they heterosexual or homosexual, tend to exhibit a broad range of abilities to access such services, depending on their geographic location, lifetime accumulation of requisite resources (governed largely by education, occupation, and major life decisions), and willingness to seek or accept help.

The research literature clearly indicates that health varies greatly across diverse sexual communities and sexual minorities (Diaz et al., 2001; Gay and Lesbian Medical Association, 2001; Johnson et al., 2002; Krieger, 2000). Lesbians and gay men are as prone to the acute and chronic conditions that generally afflict an aging population as they are to HIV/AIDS, breast cancer, and other disorders that might be associated with their specific status as sexual minorities. A study undertaken in San Francisco (Adelman et al., 2006) found that 24% of midlife lesbians and gay men reported at least one chronic condition similar in kind to one afflicting the general midlife population. Several such disorders were related to lifestyle factors, such as smoking or ingesting alcohol or taking illicit drugs, factors known to be major ways lesbians and gay men, especially at younger ages, cope with psychosocial stress. Prevailing rates of substance use (smoking, alcohol, illicit drugs), as well as obesity, suicide, depression, and interpersonal violence, were some 3 to 10 times higher among LGBTQ populations than in the general U.S. population (Gay and Lesbian Medical Association; Skinner & Otis, 1996; Solarz, 1999).

The degree to which over their lifetimes individuals in each cohort, midlife or older, have been able to

accumulate abilities or resources adequate to access long-term health care resources is dependent on historical contingencies (e.g., service in Vietnam War) as well as on educational and occupational opportunities. These are particularly fraught with difficulties for lesbians and gay men because of sexual prejudice and discrimination. Midlife and older women generally have less economic wealth than their male counterparts; single women—including lesbians—tend to be worse off than married or even many divorced women, especially in middle and old age (Barker, 2004). The extent to which an individual is open and out to family, friends, and others potentially has a huge impact on social support and formal and informal caregiving (Herdt & de Vries, 2004). Despite living now in an era of openness about minority sexualities, many lesbians and gay men, especially those in the older cohort, still fear the consequences of disclosing sexual minority status to health care providers or service agencies (Van Damme, 2002). Ponticelli (1998), for example, documented the fears that older lesbian women had about disclosure and the pitfalls and problems that resulted for some from disclosure. The prejudices and misinformation that health care staff had about sexual minorities and the distrust lesbians and gay men and their companions evinced toward health care providers created hostile and unsupportive environments (Eliason, 1996; Petersen, 1996; Ponticelli; Scarce, 1999). Very little research has documented the range or extent of the problems encountered, however. More investigation urgently needs to be done in this domain, especially as sexual minority groups are experiencing exactly the same demographic shifts as the rest of the population. In the future, as growing numbers of elderly lesbians and gay men will need long-term community-based care services or enter nursing homes, the need for greater sensitivity toward this population and for greater training of staff and administrators about this group's distinct circumstances will also increase.

At any one point in time, only 5% of the elderly population is confined in a residential skilled nursing facility. These people are significantly impaired, needing professional assistance with the basic activities of daily life or experiencing moderate to profound cognitive deficits. The vast majority of the older population aged 65 years or older is either healthy or in need of some less intense level of care, often on an intermittent basis and of a nontechnical, nonprofessional nature. Close kin, spouses, or children especially feel a responsibility to provide care to family members, out of a sense of love or respect, a feeling of moral obligation, a long history of association, and gratitude for past favors and mutual aid.

Kin—particularly close kin—are supposed to provide help for as long as necessary, often without tangible or immediate rewards, and to be willing to take on emotional and instrumental care including, if need be, intimate or personal care such as bathing or toileting (Croog, Lipson, & Levine, 1972; Litwak, 1985; Litwak & Szelenyi, 1969; Qureshi & Walker, 1989). When based on feelings of moral obligation and responsibility, informal care is expected to endure as long as necessary, for years even, until the kin's capacity to provide technically competent care is far exceeded. Several authors (e.g., Qureshi & Walker; Shanas, 1980) have pointed to the existence of a hierarchy of normative obligation or priorities that have been established largely by custom. There is a socially accepted order to the types of people from whom one can expect or command assistance before turning completely to professional or formal institutional care. These expectations are solidified and supported not just through common (caregiving) practices in society but also by official policies, legal statutes, and institutional regulations. For example, resources are often provided to spouse caregivers but not necessarily to other family or nonkin caregivers. This hierarchy comprises the following: first, family of marriage and procreation (e.g., spouse, children); second, family of birth or natal family (e.g., parents, siblings); third, affinal family (e.g., in-laws, spouse's natal family); fourth, fictive kin and other informal caregivers; and fifth, formal institutional services (e.g., home health agencies, nursing homes).

The principle of substitution implies that before turning to the formal (professional) system of long-term or institutional care services, people in need of ordinary level care look first to the informal care system, that is, to their family, partners, close friends, or others in their social support system. Only in the absence of informal caregivers of any type or when the level of need or the technical requirements of care exceed nonprofessional capabilities should institutional services be used. Thus, informal caregiving is a major task that comes to occupy much time and energy for the midlife and older population as they provide assistance to partners, parents, children, and others in need of care and assistance.

Caregiving in people's homes is a thoroughly gendered activity (e.g., Brody, 1986; Cancian & Olicker, 2000; Meyer, 2000), as wives, daughters, and daughters-in-law provide the vast bulk, over 85%, of informal care to dependent, older, community-living adults. Wives and daughters more than husbands and sons also provide hands-on direct care, assistance with personal care such as bathing, dressing, and toileting, as well as meal preparation and housekeeping tasks. Husbands and sons are more inclined

to provide less intimate but key instrumental care, such as financial assistance, household repairs, maintenance, and transportation.

In a heteronormative world, this principle of substitution and the predominance of female caregivers work reasonably and consistently well. The salient question, however, is: Can it work as well for lesbians and gay men? Even a cursory glance at this hierarchy of normative obligation throws its relevance and easy mobilization into question. Many (not all) lesbians and gay men are estranged from natal kin, whether temporarily or permanently. Lesbians and gay men are prohibited from establishing the protections and support afforded by legal spouses. Many (not all) lesbians and gay men do not have children or grandchildren. Many (not all) lesbians and gay men have little or only distant, even hostile, contact with a partner's kin. Thus, instead of being able to invoke easily the principle of substitution, lesbians and gay men are often forced to rely much more heavily on the affection and kindnesses of partners, friends, neighbors, and strangers or, in the absence of these classes of individuals, to forgo receiving any informal assistance until dire need arises or to submit themselves earlier than their heterosexual peers to formal institutional-level care.

What these conditions reveal is that along with the distinct cohorts structured around chronological age, self-identity, and connection to the LGBTQQ community discussed above, other cohorts exist, structured by other forms of stratification that exist among midlife and older lesbians and gay men. These significant stratifications, which are due to various experiences throughout the life course, influence access to and mobilization of social support. Thus, for example, the cohort comprised of lesbians and gay men who have maintained connections to natal kin have different social support resources to call on than do the cohort who are estranged, as do those with and without partners, children, or strong friendships. In LGBTQQ circles, friendships in particular become crucial social connections, forming the contexts within which informal social support is conceived, maintained, and mobilized.

Social Support

Social support as a concept has captured a great deal of popular and scientific attention, although it remains an elusive construct. In part, this derives from the fact that social support most frequently has been inferred while social networks have been measured, and even though the former is offered, in part, through the latter, social support is a functional and affective aspect of supportive behavior, whereas social networks are structural aspects

of social interaction (Lubben, 1998). Social support typically is seen as the resources that individuals (or groups or organizations) provide each other (Cohen & Syme, 1985)—resources that include affection, aid, and affirmation (Kahn & Antonucci, 1980).

Social support has been described as operating through both direct and indirect means (Crohan & Antonucci, 1989) and across multiple dimensions. Researchers distinguish between emotional support and one or more other functions, such as material support (Rapp, 1982), instrumental assistance (Berkman, 1985), and informational assistance (Miller et al., 2001). Martire and colleagues (Martire, Schulz, Mittelmark, & Newsom, 1999) defined instrumental support as “provision of material resources or physical assistance,” emotional support as “communications of affection and self-esteem,” and informational support as “advice or guidance” (p. 302). Differences in afforded support also have been noted between family and friends. Increased levels of emotional and informational support via the family have been linked both to increased needs for physical assistance and to adherence to social norms that dictate the importance of family support (Carstensen, 1995; Martire et al.). Friends function largely in the affective domain of support (de Vries, 1996), typically without formal recognition by the state.

In sociocultural terms the problem of inadequate support has to do not only with the types of support, or the lack thereof, but also with the meanings assigned to support and with the perceptions of and believed availability of support in a particular community (Valliant, 2002). For example, measures of support levels frequently take into account both the perception and amount of support received (Blazer, 1982; Cohen & Wills, 1985). A personal qualitative evaluation of social support, termed *support schemata*, has strong predictive value for personal life adjustment (Pierce, Sarason, Sarason, Joseph, & Henderson, 1996). Further, Lubben (1998) noted that particular support networks existed in reaction to particular assessed needs. Therefore, the type of support existing was likely to fluctuate as perceived needs changed. The notion “Be careful what you ask for, for you just might get it” is particularly relevant since a strong link has been established between expected and actual support received (Krause, 1999; Krause, Liang, & Keith, 1990). As Wortman and Silver (1989) noted, however, not all supportive attempts were successful, as reported by those for whom the attempts were intended.

Such perspectives address the dynamic and systematic character of support. That is, social support is part of culture and community. Social support in one relationship

may thus affect support derived in the context of other relationships (Depner & Ingersoll-Dayton, 1988), because relationships are embedded in a complex social world of characters, where one-on-one relationships have both direct and indirect effects on other social interactions. More globally, social support appears to vary by gender (Unger, McAvay, Bruce, Bergman, & Seeman, 1999), health status (Morgan, Neal, & Carder, 1996), marital status (e.g., Wu & Pollard, 1998), and presence of children (Zhang & Hayward, 2001), among a host of other factors. Noted inconsistent differences are attributable to ethnicity (Mendes de Leon, Gold, Glass, Kaplan, & George, 2001). We argue as well that social support varies by sexual minority status, a factor that to date has been largely overlooked and underresearched.

Similar to the case for friendship, the multidimensional and dynamic influences on social support undermine its simplistic interpretation as a commodity, a view wherein support can be treated as something individuals have rather than as something individuals offer or receive (e.g., Adams, Blieszner, & de Vries, 2000; Allan & Adams, 1989; Davis & Todd, 1985; Parker & de Vries, 1993). Support, as both idea and subjective feeling, is created and sustained through interaction. A complete interpretation of social support requires an understanding of these questions: What sort of support is offered? What sort of support is received and/or expected? How is support perceived?

A context within which such questions may be framed is the convoy model. Plath (1980) used the term *convoy* to describe the protective layer of family and friends who surrounded the individual and helped in the negotiation of life challenges (Antonucci & Akiyama, 1987). Convoy is an evocative metaphor, constructing the image of a group of ships traveling life’s sometimes turbulent waters, guiding and aiding each other. A strong and positive feature of the convoy model, as articulated by Kahn and Antonucci (1980), is its dynamic nature and life course emphasis. In contrast to the static or snapshot view of social networks typically found in gerontological literatures, this model characterized social support as social networks changing over time and circumstance. Thus, individuals passed through the life course embedded in a convoy—a group of people to which the individual was connected through the giving and/or receiving of social support. These people were arranged in a series of concentric circles of support relative to the individual. The people who made up an individual’s convoy changed over time as a function of the interacting properties of the individual such as age, sex, and health (e.g., Carstensen, 1995) and situational forces such as finances, residential mobility, role changes, and

role losses (e.g., Tesch, Nehrke, & Whitbourne, 1989). The same properties also jointly determined the individual's requirements for social support at any given time relative to the adequacy of support provided by the convoy. De Vries and Watt (1998) reported on the convoy maps of heterosexual individuals ranging in age from 18 to 92 years. They found that family members disproportionately occupied the circles closest to the focal individual, although key friends may have been nearby. Given the often ambivalent relationship gay men and lesbians have with their biological families—and the loss of friends through HIV/AIDS, friends who might have otherwise featured more prominently in the convoy—as well as a lifetime of prejudice and discrimination possibly affecting wealth accumulation, the particular form and function of social support networks for gay men and lesbians in midlife and later is of great interest.

Of course support may be conceptualized in several other ways as well. Ferraro and Ferraro (1995) proposed a model of *social compensation*. In this model, as relationships changed with age, loss, or other social circumstances, individuals attempted to replace those features or persons now missing as a compensatory mechanism to maintain continuity. For gay men and lesbians, this suggests that friends occupy positions that may have been abandoned or vacated by family members or that family are (re)turned to in order to fill spaces left by deceased friends or those rendered unavailable (due to failing health or death, for example). In yet another model addressing social support, Baumeister and Leary (1995) noted that people had a fundamental need to belong and a concomitant “pervasive drive to form and maintain a minimum quantity of lasting positive and significant interpersonal relationships” (p. 497). This need could be satisfied by particular types of relationships wherein particular aspects or dimensions of the self were supported, nurtured, or stimulated. Again, one's chosen family could be highlighted as a means and end by which this need was addressed.

Social Support, Aging, and Lesbians and Gay Men

Notwithstanding a burgeoning literature examining the lives of gay men and lesbians of many ages, including midlife and later (e.g., Herdt & de Vries, 2004; Kimmel & Martin, 2001; Quam, 1997), much remains to be learned about these individuals. The increasingly broad base of research on gay men and lesbians derives from past studies, work that was largely institution and clinic centered (Berger, 1982) rather than community based (Cohler, Hostetler, & Boxer, 1998). The narrowness of

epistemological and theoretical underpinnings and methodological approaches employed in extant work has also had an impact. Even within the qualitative paradigm, for quite sound social service and clinical reasons there has been a heavy emphasis on interviews about psychological well-being and development, but little work using narrative or phenomenological approaches, for example. Ethnographic and qualitative study of sexual minority people in their real-life settings has been virtually absent, as Cohler and Galatzer-Levy (2000) noted in their major review. This has severely limited our understanding of the interactive and intersubjective aspects of the perceptions, expectations, development, and maintenance of social support among midlife and older lesbians and gay men.

Furthermore, study samples have tended to be small and nonrandom, and the participants, most of whom were recruited through LGBTQQ-affiliated organizations, have tended to be not just young but also male (Barker, 2004; Berger, 1982). Indeed, much of what is known about sexual minorities was reported from the perspective of gay men. Studies have also tended to have a limited geographic focus, frequently focusing on central city or metropolitan locations on the East or West Coasts with less attention given to rural areas, smaller cities, or other regions. There is a familiar list, too, of other factors that stratify social groups in important ways—ethnic, economic, religious, political, occupational, to mention just a few—that in general have barely been mentioned let alone examined in literature on sexual minorities. Although not focused on aging, Diaz's (1998) book and Greene's (1997) edited volume on ethnic and cultural diversity among lesbians and gay men are welcome starts to addressing these kinds of stratifications within the sexual minority community and their impact on social support.

In general, then, knowledge about aging gay men and lesbians actually has come from work with younger adults (reviewed in Hostetler, 2004). Most studies that have purported to include older respondents in fact included few participants over 40 years of age—rare are the studies that included people at midlife let alone those who are older, 65 or more. Especially absent are studies of very old gay men and lesbians, those aged 85 plus, who are members of the general population segment that is not only increasing in numbers most rapidly but also most likely to be in need of formal and informal caregiving and social support (National Academy on an Aging Society, 1999). The literature on midlife or older lesbians in particular is inadequate (Barker, 2004; Berger, 1982; Kimmel, 1979; Kimmel & Martin, 2001). Notable

exceptions are works by Adelman (1987, 2000) and Kehoe (1988), which offered provocative insights into the lives and challenges facing midlife and older lesbians.

Social support has typically assumed a heteronormative paradigm, with age and life cycle norms appropriate to heterosexuals (e.g., White, 1991), a developmental and social dilemma critiqued long ago by Boxer and Cohler (1989), albeit in reference to gay and lesbian youth. Several recent studies that we have conducted attempted to redress this imbalance. The results of two studies, in particular, pointed to the complex and potentially unique roles played by friends and chosen families of gay men and lesbians in the middle and later years. One study, based in Chicago (Herdt et al., 1997), assessed attitudes toward and preparations for aging; it included 111 gay males and 49 lesbians, who ranged in age from 45 to 90 years (with a median age of 51 years). The subjects were predominantly White and college educated, and almost half (48%) lived alone. In thinking about old age, they were most concerned about their spouse or partner, their career or work, and their friendships. The average male respondent had come out to himself at age 22 years and was explicitly gay-identified and out to his family and friends; there was also a good chance he was closeted at work. Half of the participants in the sample were in a partnered relationship. Half of the women and one third of the men had been married to people of the opposite sex. The sample revealed a population that had a high frequency of long-lasting partnerships (romantic, sexual, and life partnerships) with same-sex lovers. Interestingly, men in this study felt marginalized from the gay community as they aged and they perceived their aging to diminish their social support dramatically, while women tended to have networks that were more resilient and showed less fluctuation in response to changes with aging (Herdt et al.; Cohler, Hostetler, & Boxer, 1998).

Another study (Adelman et al., 2006) examined aging, health, social support, and housing preferences among 1,301 self-identified LGBTQQ adults in San Francisco. It was conducted through Openhouse, a San Francisco not-for-profit organization that has plans to build housing for older gays and lesbians, one of only a handful of recent initiatives aimed at providing supportive housing for sexual minority elders. The respondents, 55% of whom were men and 45% of whom were women, ranged in age from 18 to 92 years. Sixteen of them (about 1%) identified as transgender. Just over one third of the respondents were between 50 and 59 years of age, just under one third were between 40 and 49 years of age, and the remaining one third were divided between those younger than 39 years and those older than 60 years. Three quarters of the

sample identified as White, and about 5% each as African American and Latino; fewer than 3% identified as Asian American; just over 1% viewed themselves as Native American; and almost 10% of the sample identified themselves using multiple racial categories. Only 2% had not completed high school and almost half of the sample had at least some college education. Younger (under 40 years) and older (60+ years) respondents described themselves as less out than did those in the middle years. Almost one third of the entire sample reported some disability or chronic illness. In descending order of frequency, these included HIV disease, psychological disorders, diabetes, heart disease, asthma, arthritis, back-related health concerns, hypertension, neurological disorders, cancer, colitis, and other disorders. Except for HIV, this disease profile was not different from that expected of a general population group of the same age. It is also a disease profile pointing to a great likelihood in the foreseeable future of declining health and functional ability and, therefore, of increased future need for social support and caregiving.

Roughly half of Adelman and colleagues' sample (2006) reported their relationship status as single (with men somewhat more likely than women to be single). Interestingly, men were more likely both to have been single and to have been coupled longer than women. Over one half of the women and one quarter of the men over the age of 60 years had children. For the sample as a whole, about one third of women and one seventh of men reported having children. When asked about their number of friends, individuals reported as many as 135. On average, though, the men and women of this sample reported 8 close friends. This number did not differ by age or gender, a dramatic departure from the pattern noted in large samples of heterosexuals (e.g., de Vries, 1991). Moreover, this mean number was larger than that found with comparably aged heterosexuals. More than half of the women and men of this sample said they would turn to their friends and/or their partners in a time of crisis; almost 10% would turn to their siblings; and almost 4% would turn to their children.

Traditional Role of Family

Shanas (1980) and Qureshi and Walker (1989) described a principle of substitution based on a hierarchy of normative obligations or social expectations of the order in which individuals are called upon (and/or present themselves) to be deliverers of support, and informal care in particular. Recall from our description above that spouses and then children (typically daughters and daughters-in-law more than sons) are first, followed thereafter

by other relatives and finally by friends. In general, the experiences of friends in this context have rarely been studied (e.g., Barker, 2002), although hints have long existed in the literature on gay men and lesbians of the greater role played by their friends in this context. The ordering of this principle of substitution, however, clearly reflected heteronormative patterns, which renders it significantly less applicable to the lives of aging lesbians and gay men.

While many gay men and lesbians maintain relationships with natal kin, the effects of estrangements that they experience from family at earlier periods in their adulthood can continue to strain caregiving relationships in later life. This lack of contact could cut off older lesbians and gay men from receiving care from family members, including their children, or work to prevent lesbians and gay men from being mobilized as a source of care for aging parents, siblings, or children in need. Alternatively, the need for aged parents or other family members to receive care could motivate natal kin groups to ameliorate or begin to heal breaches in relationships with lesbian or gay family members. At this time, however, very little is known about the sources, timing, duration, or negotiation of estrangement or reincorporation of sexual minorities into their natal families (Allen & Demo, 1995; Bernstein, 2001; see Herdt & Koff, 2000, for a cultural and developmental study of Chicago families). Collectively, lesbians and gay men tend to have fewer children and, because of alienation, fewer relationships with extended kin in midlife or later, although this varies considerably by individual circumstance. At least one third of lesbians and gay men have children (Barker, 2002; Kimmel and Martin, 2001). In a study of 1,466 lesbians and gay men aged 17 to 81 years, Fredriksen (1999) reported that one third of these people were actively providing care to at least one other person. Compared to gay men, lesbians were significantly more likely to be caring for children or elderly people, whereas gay men were more likely to be assisting similar-age working adults with an illness or a disability. Having a child meant the respondent was less likely to identify openly as lesbian or gay. Importantly, however, having child or adult care responsibilities was not predictive of the degree of support the individual received from natal kin or the degree of harassment he or she experienced in relationships with natal family.

Many lesbians and gay men have same-sex partners who play a prominent role in the provision of care to them. Some two thirds or more of older heterosexual women live as a marriage partner until the last 7 to 10 years of their lives when they become widows, on average, becoming widowed around age 70 (Federal Interagency

Forum on Aging-Related Statistics, 2004). At their deaths, no matter their age, older men are still most likely to be married. In contrast, suggestions are that from age 50 on, only around half of all older lesbians have partners, as possibly do the same or a smaller proportion of gay men (Adelman, 2000; Kimmel & Martin, 2001; Quam, 1997). Clearly, the absence of a partner at a time when health problems begin to develop in midlife or at older ages and when functional decrements begin to become evident means that a major avenue for sustained social support and a key resource for day-to-day assistance are absent.

Very little is known about the pattern over the life course of temporary or permanent partnerships among gay men or lesbians, and there is even a poor understanding of what the term *partner* encompasses for them. The literature has tended uncritically to assume that having a partner meant the same thing as having a spouse, including qualities such as being in an exclusive sexual relationship with a person who lives in the same house and shares legally in the financial and other benefits and burdens of that association. Some very exploratory work, however, has shown that a high proportion of gay men and lesbians negotiate, organize, and maintain partnerships in ways that are distinct from marriage relationships. Such differences include but are not limited to having fewer restrictions around other temporary sexual unions, living in geographically distant places, maintaining separate households even when resident in the same city, and not mingling personal, financial, or other resources. These important differences may allow people to remain closeted to family, workmates, and the general community but enable them to disclose to friends and others if they so wish. They may also represent a genuinely different construction of the emotional and social meanings of partnering and of expectations of support stemming from primary relationships (Barker, 2004). Also, various cohorts of lesbians and gay men, differentiated by their tolerance of broad public openness of their identity, will have distinct constructions of the meanings and behaviors they associate with and expect of partners and thus of the nature of social support due them and expected from them. These differences in the meaning of being partnered provide other reasons why the heteronormatively based principle of substitution is not easily applicable in a gay and lesbian context.

One key phenomenon with respect to social support differences between mainstream familial social relations and those of sexual minorities concerns the ties that bind people together (Beeler, Rawls, Herdt, & Cohler, 1999; de Vries, Blando, Southard, & Bubeck, 2001). Beeler and colleagues reported that two thirds of the midlife and

older gay men and lesbians they interviewed identified a family of choice. As Weston (1991) commented, chosen families resembled social networks in the sense that they permeate household lines and they “radiate outward from individuals like spokes on a wheel” (p. 109). Moreover, they resembled the same homosocial conditions that social networks revealed. Gay families differed from social networks, however, “to the extent they quite consciously incorporate symbolic demonstrations of love, shared history, material or emotional assistance, and other signs of enduring solidarity” (p. 109). Families of choice, like friendships, lack those legally sanctioned and organized rituals and acknowledgment by civil institutions that give rise to issues of mutuality and definition. Thus, many questions remain unanswered about the sources of support for older lesbians and gay men, such as: On whom can gay or lesbian individuals depend for support and what circumstances/conditions test this dependence? Can members of a family of choice be mobilized to provide informal care?

De Vries and Hoctel (in press) examined the chosen families of gay men and lesbians, who ranged in age from 55 to 86 years. All but 1 of their 20 respondents considered their friends to be their family in some manner. About one third of the sample, for example, said, “Our friends are like a family to us” or “This inner circle I call family.” Some participants felt that their friends were like family yet different, saying, “I consider them like an alternative family” or “I do consider my friends as family but not in the same way as my blood family; it’s like my second family.” Others viewed their friends as family by default. Representative statements in this category of response included “They’re all I have left” and “I see my friends as my family because I don’t have any connections with my birth family.” Finally, about one quarter of the respondents saw their friends as greater than, or superior to, their family. These respondents expressed such sentiments as “I feel closer to them than to my own family,” “To my family of choice, I am a whole person,” and “[Friends] provide the sustenance that you ordinarily would want a family to provide.” Implicit in many of their responses was a sense of mutual dependence. For example, one man said, “Gay people have to make their friends their family. If my brother and sister-in-law’s friends fell away, they’d still have their family. If my friends fell away, I would have nothing.” One woman mentioned, “We need each other in a way that heterosexuals don’t. We’ve led a life of nobody being there.”

Some lesbians and gay men aged 65 years or more have a style of anticipating caregiving needs in old age, distinct from styles used by heterosexual nonkin

partnerships (Barker, 2002). Reminiscent of arrangements associated with *tontines*, or investment groups, in the business world, these social network tontines comprise groups of friends who in earlier times pledged to provide care to everyone in the group until only one individual survived. Caregiving tontines among gay men and lesbians often comprise groups of five to six individuals who met, usually through their employer (e.g., the military), at their residence (e.g., single-room-occupancy hotels in the inner city), or at their voluntary organization (e.g., church). Although in theory a pathway to care available to any older person, this particular constellation of care was not found among the heterosexual older people who were studied (Barker). A lifetime of enforced silence, hassle, discrimination, persecution, and rejection by family, service agencies, and the wider society may have led these older lesbians and gay men to prefer tontines to other forms of care, particularly when they feel vulnerable and therefore reluctant or unwilling to request or accept help from outside the sexual minority community to which they belong.

Friends in the Lives of Gay Men and Lesbians

For gay men and lesbians, the enlarged role of friends is likely to be complex and broadly based, as kinship is for blended families. Many older gay men and lesbians fled or were expelled from their families and sought refuge in large urban centers, where they found both anonymity and similarity, where past behaviors and selves could be abandoned, and where they found others like themselves (reviewed in Herdt, 1989). Familial ties were not strengthened with the passing years (although rapprochements may have occurred). Instead, gay men and lesbians turned to each other for what their families could not or would not provide them (Nardi, 1999). Lesbian and gay friendships arose, as Nardi has written,

out of a need to find role models and identity in an oppressive society. The friendship group for heterosexuals may be close and important, but it occurs as an option in the context of a heterosexually dominant society. However, the gay person must create, out of necessity, a meaningful friendship group to cope with threats to identity and self-esteem in a world of heterosexual work situations, traditional family systems, and stereotyped media images. (1982, p. 86)

Grossman, D’Augelli, and Hershberger (2000) claimed that social support from friends was particularly important in the lives of older gay men and lesbians. Older gay men and lesbians were more likely to participate in gay and lesbian social groups than in senior recreation center

activities (Quam & Whitford, 1992). Dorfman and coauthors (1995) compared older gay men and lesbians with comparably aged heterosexuals. They found few differences in the important impact of social support; however, lesbians and gay men received significantly more support from friends, whereas heterosexuals received more support from family, a finding that supports the idea that friendship networks are a more important source of social support for older lesbians and gay men (Beeler et al., 1999).

Studies of social support in the lives of lesbians and gay men have focused heavily on the caretaking of younger gay men who are HIV positive or who are living with AIDS (Levine et al., 1997). The role played by lesbians and by heterosexual friends and families in providing care to those gay men with HIV has been well noted (Aneshensel et al., 1995; Lennon, Martin, & Dean, 1990; Schmitz & Crystal, 2000; Turner, Catania, & Gagnon, 1993). Despite frequent institutional obstacles to enactment of the caregiving role (Barker, 2002), friends not only figure prominently as caregivers in gay and lesbian circles but even parallel the frequency of partner caregiving among heterosexuals (Mullan, 1998; Pearlin et al., 1994; Richards & Folkman, 1997; Turner, Catania, & Gagnon, 1994). The prominence of friends in this context further underscores the inapplicability of the principle of substitution (Shanas, 1980) in a gay and lesbian framework, and the importance of friendships and chosen families of gay men and lesbians.

In much of the literature on social support among lesbians and gay men to date, the focus has been on understanding it as a generic activity rather than on how specific circumstances of sexual minority groups have constrained their access to caregiving or molded their responses to such needs. Essentially unexamined thus far is how cohort, regional, or other major social divisions within the sexual minority community (for example, ethnic, socioeconomic class, religious, or occupational differences) affect access to and delivery of social support and informal care. The exact impact of chronic illness on the lives of midlife lesbians and gay men, especially on their social relationships and informal caregiving needs and practices, is also unknown at this juncture. The gendered nature of caregiving has also been unexamined within the sexual minority community. Thus, it is unclear whether there are differences between gay men and lesbians in the ways they experience constraints on the type of persons or resource venues on which they rely for help. Equally unclear is whether they experience the same consequences for providing care to others. For example, the literature reports that in general, when compared to men, women undertake more caregiving and suffer greater consequent emotional, physical, and economic adversities and tolls on

their bodies and lives (National Academy on an Aging Society, 1999).

Discussion

Human societies around the world generally expect people to marry heterosexually, form families, and have children—milestones for entry into the community and into full personhood (Herdt, 1981, 1987, 1997; Herdt & Kertzner, 2006). In postindustrial societies, heteronormative marriage is fundamental to state policy formation, to social entitlements, and to the very concept of citizenship (Richardson, 1998). Discussion of gay and lesbian aging should not be divorced from critical policy changes inherent in recent debates on marriage rights—both in connection to mental health and to human rights (Kitzinger & Wilkinson, 2004; Herdt & Kertzner). Discussion on support in the lives of older Americans has typically focused on this marriage-centered set of norms and normative expectations for heterosexuals and for those presumed to be heterosexuals (Herdt & de Vries, 2004). We believe that this emphasis is too narrow to apply to diverse family formations and relevant social policies in the twenty-first century. Family support has historically been less available to lesbians and gay men. A recent study suggested that gender-atypical people experience marginalization early in life due to the social stigma attached to their deviation from gender role norms (Oswald, 2002). Such stigma may result in greater lifetime risk for suicide and other mental health impacts for some gay men as well (Paul et al., 2002). While most individuals perceive the nuclear and extended family as their primary source of support, this heterosexual norm is not always or as easily available to gay men and lesbians.

As society changes—for example, with an increased number of blended families and a growing diversity of family experiences—support systems will also undergo change (Coontz, 1992; Coontz, Parson, & Raley, 1999; Skolnick, 1979, 1991; Stacey, 1990). When the HIV/AIDS epidemic erupted in the 1980s, the gay and lesbian communities took ownership of the situation through new patterns of caregiving for people with AIDS (Schneider, 1997). Gay men provided care to their sick peers as did many lesbians, assisted in some instances by heterosexual family or friends. The notion of families of choice, originating from the lesbian and gay movement but now of increasing importance to the mainstream as well, remains largely unexamined as a mechanism of support (Weston, 1991). Likewise, the limitations imposed by the social construction of what state rights extend to intimate partners and of what can be discussed in public, within families, and in community settings are barriers to support

between same-sex couples (Burrington, 1998; Herdt, 1997; Wolfson, 2004). A recent study (Carrington, 1999) in San Francisco of longer-term gay and lesbian couples revealed the importance of how families of choice organized their household division of labor and informal care-taking, in part like heterosexual couples in activities such as cooking and cleaning, but innovative in other aspects of social life. Overall, the concept of social support and its link to health, especially mental/emotional well-being, is a major focus of study in gerontology that has importance for older people in general and for caregivers of frail or dependent individuals. More study is required to understand the needs of sexual minorities as they age (Kimmel, 2004).

With the baby boomers becoming middle-aged, with more people retiring before age 65 (along with an increase in active workforce participation by the healthy segment of the population older than 65 years), with recognition that people experience chronic disabling conditions starting at around age 45 years, and with many midlife adults providing care to family or friends, interest in understanding social support at midlife is burgeoning. To date, however, only a handful of studies have been done on midlife and older lesbians and gay men and their provision of and access to social support. The time has come for new policy thinking in this arena.

Evaluation and change of policy regarding this topic is necessary not just in relation to sexual minority populations but in relation to the general population as well if we are to address more completely the consequences of demographic shifts and changes in society over the past 50 years. Sexual minorities are just as affected by these changes as are other social groupings. Changes that have had a profound and continuing effect on the age structure of the U.S. population as well as on its political, economic, and legal institutions and civil society, in addition to the advent of the large boomer generation, make social support and formal and informal caregiving essential topics for further exploration and discussion. Now and increasingly in the future, there is a need for examination of specific policies with a view to changing them to enhance the social support needs of all citizens. Demographic, social, economic, and political changes affecting the availability of social support—and thereby spurring the need for policy changes—include the following:

1. The effects of increased aging of the population—increasing life expectancy, greater control of life-threatening conditions leading to lesser mortality at early ages but greater morbidity at older ages, and longer years of living at home with functional dependencies—have led to an increased and prolonged need for formal and informal caregiving. For the majority heterosexual population, the burden of caregiving will continue to fall predominantly on the shoulders of women. How this will affect gay men and lesbians in particular is unknown.
2. Internal migration within the United States by younger generations for education or occupation makes many traditional caregiving resources (e.g., family, community organizations) less immediately available, especially for rural elderly.
3. Changing family structures and life course trajectories, especially for women—with more women working outside home full-time, greater divorce rates and variety in family formation and re-formations, delayed initiation of childbearing, smaller completed family size, and an increased rate of grandparents and great-grandparents raising children—means that fewer traditional caregivers (i.e., wives, daughters, and daughters-in-law) will be available when needed to provide care to elderly dependents living at home. It is unknown how development of computer capability and the Internet, employer acceptance of telecommuting and flextime, and employer and government family leave policies will interface with these trends.
4. Caregiving is no longer an activity confined to private homes but is becoming a commodity—a formally taught, marketable, and professionalized skill that allows the traditional coterie of caregivers to sell their care labor outside the home rather than providing it for free in a domestic context. Health care policy, financing, and regulation as well as increased need for assisted-living facilities or nursing homes have created demand for a type of care worker known as Licensed Vocational Nurses or Certified Nursing Assistants, people who provide the bulk of hands-on care, or essential daily personal care, for frail elderly adults in institutional settings.
5. Women's persisting income inequalities compared to men and women's greater longevity despite generally having more health problems and greater functional deficits, when combined with the increased need for women to work outside the home and to sell their care labor (as described in points 3 and 4 above), will mean that the future availability of women to engage in informal (i.e., in unpaid, nonprofessional) care of family members or others in need of regular day-to-day assistance

within the domestic setting will become markedly constrained. When in midlife or as young elderly (under age 75), women will often be providing care to others, such as parents, children, or husbands. When women get to be more advanced in age and themselves need more informal daily assistance, circumstances will increasingly militate against their easily getting it, because, first, the availability of female care providers to assist in the home setting will be severely limited (points 2, 3, and 4 above) and, second, their lifetime legacy of access to and accumulation of fewer economic resources will limit women's ability to purchase alternative (institutional) care. Again, exactly how this will affect lesbians in particular, and gay men, is unknown.

6. The expense of and difficulty in obtaining alternative sources of long-term residential care such as assisted living, life care communities, and skilled nursing facilities will eliminate access to these facilities for people of modest or low incomes, including many sexual minority individuals and especially women. These institutions are expensive, often costing well over \$50,000 per year per individual, with costs tending to rise every year. How long-term care insurance, which is itself expensive, might affect access in the future is unknown.
7. Currently institutions providing care to the elderly are unable to keep up with demand for space (due to increased longevity, expansion of morbidity, and other factors; see 1 above). Admissions to nursing homes are now largely confined to those in severest need (i.e., have two or more deficits in the six fundamental activities of daily living or one such deficit plus moderate to severe cognitive decline). People with such poor functioning are, on the average, over 80 years of age. Because nursing home populations represent just 5% of all elderly persons, the most incapacitated, the care needs of the vast majority of the older population, those who are mildly to moderately impaired, will increasingly rest squarely on community-based services and domestic capabilities.

In much of this article, we have noted the assumption of heteronormativity as pervasive in the research literature on social support needs. Yet sexual minority individuals make up a sizable minority population—up to 10% of the adult population, especially in urban centers (Michaels, 1996). Despite a shared experience of stigma, discrimination, and prejudice, LGBTQ people comprise

a minority population divided internally by age cohorts and demographic stratifications (for example, by ethnicity and socioeconomic class) as well as by sexual self-identities. Nonetheless, it is a population able to forge a stable, enduring, and visible sense of community vis-à-vis the heteronormative world. Lesbians and gay men comprise a minority population for whom continuing connections to their natal family or families of procreation are often fraught with difficulties, tensions, and fragility. The assumption that the heteronormative frame that mobilizes action and concern in the majority population will work, or work as well, among lesbians and gay men is dubiously useful when it comes to understanding the social support needs, options, and preferences of this population. As we have seen from the foregoing review, there is a considerable paucity of studies on social support for gay men and lesbians.

Study of this issue is urgently needed in order to provide appropriate supplemental or complementary social and welfare services when applicable, services that are culturally sensitive for this population (Herdt et al., 1997; Beeler et al., 1999). Further study of social support for aging lesbians and gay men is essential not just for the development of equitable social policies and access to services but also because it is pertinent to understanding social support as a general phenomenon. Social support varies significantly within groups because of aspects of differentiation in society (such as gender, ethnicity, and socioeconomic class) and the impact these have on life course trajectory. Despite these variations, there has been little empirical demonstration or theoretical discussion in the literature about specific causes and consequences of life course variations in participation in society. These critical points suggest that lesbians and gay men could also be key groups for sexuality research because they could provide insight into variations in relation to social support across the life span.

Distinct cohorts within the gay and lesbian community make this a salient population for gerontological research also. Not only do distinct cohorts based on age and gender exist within this population but, in addition, major historical events that influenced their visibility and acceptance created additional cohorts. The effects of systematic discrimination, prejudice, stigma, and silencing are also well known and are reproduced in situations of social inequality (Irvine, 2005; Parker & Aggleton, 2003). Study of these factors served to produce a cultural logic and sentiment about social support and caregiving that are quite distinct from that applied to the dominant heteronormative population and problematize existing social policies affecting the elderly. We believe that

focusing more explicitly on the particularities in the lives and circumstances of middle age and older gay men and lesbians can enable identification of salient topics and issues that need further investigation in relation to all older populations and can provide an opportunity not just to answer questions and address issues regarding aging gay men and lesbians but also to advance the entire field of social gerontology and thereby to provide answers, spur new questions, and raise new knowledge important to all older people.

We believe that the current debate about the marriage rights of lesbian and gay couples in the United States is healthy and productive for creating new discourses and potential policy advances. We encourage these discussions and urge empirical research in the coming years to ground them in the real experiences of gay men and lesbians. However, we also caution about restricting the formation of new policy surrounding midlife and aging within the LGBTQQ population to this area alone, as a significant number of people in this community have social support needs that go beyond the reach of marriage rights alone. It is our hope that as this debate unfolds a diverse range of social support needs and services will be recognized and developed for this critical population in our society.

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