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“I’m still raring to go”: Successful Aging Among Lesbian, Gay, Bisexual, and Transgender Older Adults

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Abstract

While we know that minority status differentiates the experience of aging, little research has been done to examine the ways in which patterns of successful aging may differ in diverse subgroups of older adults. In this exploratory study, we investigated and described experiences of successful aging in a sample of lesbian, gay, bisexual and transgender (LGBT) older adults. Directed by a community-based participatory research process, we conducted semi-structured in-depth interviews with 22 LGBT adults, age 60 and older. We took an inductive, grounded theory approach to analyze the taped and transcribed interviews. We coded respondent experiences in four domains: physical health, mental health, emotional state and social engagement. Four gradations of successful aging emerged. Very few in our sample met the bar for “traditional success” characterized by the absence of problems in all four domains of health. Most of the sample was coping to a degree with problems and were categorized in one of two gradations on a continuum of successful aging: “surviving and thriving” and “working at it.” A small number was “ailing”: not coping well with problems. Some of the experiences that respondents described were related to LGBT status; others were related to more general processes of aging. The research suggests that a successful aging framework that is modified to include coping can better describe the experiences of LGBT older adults. The modified conceptual model outlined here may be useful in future research on this population, as well as more broadly for diverse populations of adults, and may be adapted for use in practice to assess and improve health and well-being.

Keywords

minority groups; lesbian; gay; bisexual; transgender; successful aging; community-based participatory research

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Introduction

It has been well established that social structures of inequality along lines of race, gender, and class impact older adults and that minority subgroups experience aging differently (Anderson, Bulatao, & Cohen, 2004; Calasanti & Slevin, 2001; Dannefer, 1988). However, very few studies have examined possible variation in experiences of successful aging in minority subgroups. The purposes of this study were to investigate and describe successful aging in a sample of lesbian, gay, bisexual and transgender (LGBT) older adults. Because LGBT older adults are marginalized by virtue of sexual and gender minority status, they are believed to face unique challenges in achieving a happy, healthy older age. This study will present a conceptual model of successful aging in this minority population, developed from a grounded theory approach to analysis of 22 in-depth interviews with LGBT people age 60 and older.

Distinctiveness of the LGBT Experience of Aging

LGBT older adults share a unique historic location as witnesses to dramatic, rapid, and ongoing social changes in the construction of minority sexual and gender identity. The oldest among them have lived through the emergence of the modern construction of 'the homosexual,' the concomitant social exclusion and medicalization of homosexuality as a mental disorder, the rise of the gay liberation and lesbian feminist movements, the emergence and devastating impact of HIV/AIDS, the proliferation of sexual and gender minority identities (including bisexual, transgender, and queer), the 'normalization' of the movement and shift towards a politics of civil rights, and the increasing visibility and incorporation of LGBT issues into mainstream social and political discourse (see for example D'Emilio, 1998; Duberman, 1994; Faderman, 1992; Knauer, 2011; Rosenfeld, 2003; Vaid, 1996; Weeks, 2007). Despite important generational cohort and subgroup differences (Rosenfeld, 1999; Stein, 1997), LGBT older adults have a distinct experience of aging stemming from shared experiences in relation to LGBT community, the lifelong process of coming out, the experience of sexual and gender minority stress, marginalization inside and outside LGBT community, and LGBT pride and resilience.

While distinctiveness of the experience of LGBTs is the rationale for this study, many experiences of aging as an LGBT person may be unrelated to sexual or gender minority status. Challenges in achieving well-being and happiness in older age, such as the experience of the body failing, the loss of friends and social networks, and adjustment to new social roles in retirement are common challenges experienced by people of all sexual orientations and gender identities. Put another way, the salience of LGBT identities differs across contexts (Stirratt, Meyer, Ouellette, & Gara, 2008). LGBT identity may be extremely salient in some contexts, structuring and defining some experiences of aging, and much less salient in other contexts. Further, LGBT identity and status intersects with other identities and statuses, and those intersections form distinct social locations that shape individual experiences (Collins, 2000).

In this study, we treated LGBT adults holistically and explored their experiences of health and well-being as these experiences related to their sexual and gender minority status, as these experiences related to other statuses and identities (such as race/ethnicity), and as these experiences related to general processes of aging. Proceeding from a grounded theory approach to analysis of the data, we developed a conceptual model of successful aging that we believe well captures the experiences of the respondents in our sample as they described them. The resulting model is general enough to encompass both LGBT-specific experiences of aging and more general experiences of aging. As an exploratory study, the conceptual model presented must be viewed as preliminary and suggestive of potential patterns in the

experiences of LGBT older adults. It may also be a useful framework to describe the experiences of other diverse groups of older adults, particularly those groups who have experienced social marginalization, stigma, and exclusion.

Research Literature on the Health of LGBT Older Adults

The literature has established that LGBT people face significant adversities throughout their lives, resulting in health disparities across a number of domains. At the request of the National Institutes of Health (NIH), the Institute of Medicine (IOM) recently convened a consensus committee to review the state of knowledge in LGBT health and identify research gaps and opportunities. The committee concluded that a long history of stigmatization of LGBT people reflected in social structures and institutions has resulted in disparities in mental health, physical health, risk and protective factors, and access to health services among LGBT populations across the life course (2011).

While only a small number of studies have directed attention to the health of LGBT older adults in particular, the literature points to several areas of increased concern. Older lesbian, gay, and bisexual adults seem to be at a disadvantage in accessing informal caregiving from loved ones; they are less likely to have children than their heterosexual counterparts (MetLife, 2006), less likely to have partners (MetLife, 2010) and more likely to live alone (Wallace, Cochran, Durazo, & Ford, 2011). Formal services may not be prepared to meet the needs of LGBT older adults (Bell, Bern-Klug, Kramer, & Saunders, 2010; Knochel, Croghan, Moone, & Quam, 2011) and LGBT older adults may be reluctant to make use of services designed for the general population because they fear discrimination (Johnson, Jackson, Arnette, & Koffman, 2005). Several community-based research studies have found elevated levels of depression (Bradford, Ryan, & Rothblum, 1994; Fredricksen-Goldsen et al., 2011; Grossman, 2006; Shippy, Cantor, & Brennan, 2004) and high reported rates of victimization and discrimination over the life course among older LGBTs (Bradford et al., 1994; D'Augelli & Grossman, 2001; Fredricksen-Goldsen et al., 2011). Some studies have shown higher rates of alcohol and tobacco use among lesbian, gay, and bisexual older adults compared to older heterosexuals (Gruskin, Greenwood, Matevia, Pollack, & Bye, 2007; Valanis et al., 2000). Population-based data from California revealed higher odds of psychological distress, physical disability and fair or poor self-rated health in older LGBs compared to older heterosexuals (Wallace et al., 2011). Finally, older gay and bisexual men experience a high burden of HIV/AIDS (Dolcini, Catania, Stall, & Pollack, 2003).

While the literature points to many health disparities among older LGBTs, it also points to areas of strength and resilience among this population. For example, many studies of older LGBTs have found robust social networks and high degrees of involvement with LGBT community among the population (Grossman, D'Augelli, & Hershberger, 2000; Orel, 2006) and an association between such support and physical health (Grossman, 2006; Masini & Barrett, 2008). Studies have also revealed that while older LGBTs may be at a deficit in accessing support from spouses and children, they are able to call upon support from friends and "chosen family" – people considered family even though not biologically related (MetLife, 2010; Shippy et al., 2004). Further, the literature suggests that openly identifying as lesbian, gay, or bisexual may result in higher levels of self-esteem and life satisfaction (Fredricksen-Goldsen & Muraco, 2010).

Several studies of HIV in older adults paint a picture of resiliency and successful coping with disease. For example, HIV+ older adults express strengths related to living with HIV/AIDS in areas including self-acceptance, optimism, will to live, self-management, relational living, and independence (Charles A. Emlet, Tozay, & Raveis, 2011). Many HIV+ older adults have resources that enable access to medical and social services sufficient for coping, including positive attitude, HIV/AIDS knowledge and available social support -- especially

from gay communities (Fritsch, 2005). HIV+ older adults make use of social support networks of other HIV+ people that buffer against stigma (Poindexter & Shippy, 2008) and improve mental health and well-being (Chesney, Chambers, Taylor, & Johnson, 2003). They commonly undertake self-care activities (e.g., diet, vitamins, adequate rest, exercise) to improve overall health and self-manage HIV symptoms such as fatigue (Siegel, Brown-Bradley, & Lekas, 2004). However, HIV+ older adults are a diverse group with varied experiences (Crystal et al., 2003) and many HIV+ older adults are at risk of social isolation due to factors such as living alone (C. A. Emlet, 2006), loss of social networks due to death from HIV disease (Poindexter & Shippy, 2008), and for gay and bisexual men, the multiple stigmas of sexual minority status, aging and HIV (Robinson, Petty, Patton, & Kang, 2008). Experiences of loneliness and HIV stigma can result in poor mental health (Groves, Golub, Parsons, Brennan, & Karpiak, 2010).

This study contributes to the small, but growing research literature on the health of older LGBT adults by elaborating an empirically-derived conceptual model to assess health and well-being in this population. Recent developments such as the devotion of a chapter to later adulthood in the IOM report on LGBT health (2011) and an award from NIH for a national study of older LGBTs (Fredriksen-Goldsen et al., 2011) suggest that more attention will be paid to the needs of LGBT older adults in coming years. As momentum grows to examine older age in LGBTs, scientists will require conceptual tools to assess and ultimately intervene to improve health and well-being of LGBT older adults. Several early studies of LGBT older adults used the language of successful aging to broadly describe the state of health in LGBT older adults (Friend, 1990; Quam & Whitford, 1992). Our analysis suggests that a modification of the successful aging framework may be a useful conceptual tool.

Research Literature in Successful Aging

While there is no consensus on a definition of successful aging, this term has been used frequently in the gerontological literature. At the most general level, successful aging refers to the capacity for elderly people to thrive (Depp & Jeste, 2006) or to live a happier, healthier, satisfying old age (Holstein & Minkler, 2003). Other terms for successful aging in the literature include “healthy aging,” (Guralnik & Kaplan, 1989) “productive aging,” (Butler & Gleason, 1985) “optimal aging,” (Aldwin & Gilmer, 2004) and “aging well” (George & Clipp, 1991). In the prevailing conceptualization of successful aging, Rowe and Kahn (1987) distinguish successful aging from the usual or modal process of aging and argue that three characteristics are necessary for successful aging: a) the avoidance of disease and disability; b) high physical and cognitive functional capacity; and c) active engagement in life. Rowe and Kahn’s model has spurred empirical investigation of the prevalence of successful aging (Andrews, Clark, & Luszcz, 2002; Berkman et al., 1993), its determinants (Andrews et al., 2002; Montross et al., 2006; Pruchno, Wilson-Genderson, Rose, & Cartwright, 2010; Roos & Havens, 1991; W. J. Strawbridge, Cohen, Shema, & Kaplan, 1996), critiques of the model (Austin, 1991; Dillaway & Byrnes, 2009; Holstein & Minkler, 2003; Riley, 1998), and several efforts at reformulation (M. M. Baltes & Carstensen, 1996; P. B. Baltes & Baltes, 1990; Schulz & Heckhausen, 1996).

Several researchers have argued that elders’ own subjective view of their success at aging should be an important component of any definition (Bowling & Iliffe, 2006; George & Clipp, 1991; Holstein & Minkler, 2003; Knight & Ricciardelli, 2003; E. A. Phelan, Anderson, LaCroix, & Larson, 2004; E.A. Phelan & Larson, 2002; W. J. Strawbridge, Wallhagen, & Cohen, 2002). Researchers have pointed to a lack of convergence between subjective and objective definitions of successful aging in which many more older adults rate themselves as successfully aging than meet objective criteria (Montross et al., 2006; W.J. Strawbridge & Wallhagen, 2003; W. J. Strawbridge et al., 2002; von Faber et al., 2001). While objective definitions tend to emphasize physical functioning (Depp & Jeste,

2006), subjective definitions which rely on older persons' perspectives often include other major aspects of life such as coping, mental health, social relationships, attitudes, emotional well-being, community engagement and continued learning (Bowling & Iliffe, 2006; Fisher, 1995; Laditka et al., 2009; Reichstadt, Depp, Palinkas, Folsom, & Jeste, 2007; W.J. Strawbridge & Wallhagen, 2003; von Faber et al., 2001). Pruchno, Wilson-Genderson and Cartwright (2010) argue for a two-factor model of successful aging that includes objective and subjective success as two independent, but related dimensions.

Other researchers have argued that coping with physical health problems is an important component of successful aging (W.J. Strawbridge & Wallhagen, 2003; von Faber et al., 2001; Young, Frick, & Phelan, 2009). In Rowe and Kahn's conceptualization, success is defined by the absence of disease and disability; those who cope with health problems are excluded from the category of success. Because chronic illness often accompanies aging, defining successful aging by the absence of disease can seem to equate success with similarity to youthfulness. Indeed, in a review of large quantitative studies of successful aging, Depp and Jeste (2006) found that younger age was the strongest predictor of membership in the successful aging category. Critics have argued that this aspect of the concept is ageist (Dillaway & Byrnes, 2009; Holstein & Minkler, 2003). Other critics have noted that the absence of coping in the definition of success has led to a focus on a small, elite segment of the aging population, while disregarding paths to well-being and improvement in functioning for the majority of older adults (W.J. Strawbridge & Wallhagen, 2003; von Faber et al., 2001).

Several scholars have suggested modifying and broadening the category of successful agers to include people who cope well with living with disease and disability. For example, Depp and Jeste (2006) in their review of successful aging research propose a consideration of two types of successful agers: "escapers" who avoid illness and disability (and who would likely meet a Rowe and Kahn definition) and "survivors" who maintain cognitive functioning, life satisfaction and social engagement while living with illness or disability. Baltes and Baltes (1990) make a different modification to include coping in their "selective optimization with compensation" model. This model describes successful aging as a process of adjusting expectations, priorities and goals (selection), focusing on high priorities (optimization), and working around limitations (compensation) to do the best with the capacities that one has.

Research suggests that a formulation of successful aging which includes coping would reflect the subjective perceptions of older adults who tend not to view the absence of illness and disability as essential to aging well (Montross et al., 2006; Parslow, Lewis, & Nay, 2011) and who emphasize coping in their understandings of aging well (Fisher, 1995; Reichstadt et al., 2007; Tate, Lah, & Cuddy, 2003; von Faber et al., 2001). Coping with disease or disability enables older adults to retain mastery over their lives in the face of significant threats to function and independence, and is thus an important component of resilience (Janssen, 2012). Coping involves cognitive and behavioral efforts to master, tolerate, or reduce external and internal stresses. Such efforts either manage or alter the source of stress (problem-focused coping) or regulate stressful emotions (emotion-focused coping) (Folkman & Lazarus, 1980). Kathy Charmaz's (1993) work elucidates patterns of the latter type of coping undertaken by people with chronic illnesses, in for example, the strategy of making sense of illness and its toll on one's life through the division of time into "good" and "bad" days.

Another criticism of the concept is that the term "success" carries an implicit normative component or value judgment, which is particularly troubling given that many of the determinants of success are outside individual control (Holstein & Minkler, 2003). A related critique is that the concept is individualizing and does not attend to structural determinants

or social contexts of aging (Austin, 1991; Dillaway & Byrnes, 2009; Riley, 1998). Further, Dillaway and Byrnes argue that the successful aging paradigm should only be used if it can be shown to be “inclusionary to the various perspectives, structures, and social locations that older adults occupy” (2009, p. 717). They argue that it cannot be assumed a priori that successful aging will be a meaningful construct to describe the experience of aging in the range of diverse older adults by race, gender, class and other social locations and contexts. Liang (2012) recently argued that successful aging is an inherently Western—and specifically American—construction that does not adequately capture cross-cultural perspectives on what constitutes a good old age. Liang instead proposed an alternative in “harmonious aging” to recognize the challenges and opportunities of old age.

A few studies have examined successful aging in minority subgroups in the United States. Phelan and colleagues (2004) examined subjective endorsements of successful aging attributes among Japanese-American and whites living in the Pacific Northwest and found a great deal of similarity across the items endorsed, with some differences in the relative importance of components. Laditka and colleagues (2009) conducted focus groups with several racial/ethnic subgroups and found notable differences in perceptions of aging well between Chinese, Vietnamese, American Indian and white older adults; compared to other racial/ethnic groups Chinese-Americans emphasized mental outlook, Vietnamese-Americans deemphasized independent living, and American Indians did not include diet or physical activity in discussing the elements of aging well. A few studies have examined racial differences in experiences among participants in the MacArthur Studies of Successful Aging program; Kubzansky, Berkman and Seeman (2000) found racial group differences in distress scores and Whitfield and colleagues (2000) found differences in naming and memory. More empirical work is needed to document the ways in which minority status and social marginalization patterns differentiate experiences of successful aging. This study makes an important contribution by adapting the successful aging framework to describe the experiences of diverse older adults by sexual orientation and gender identity.

Design and Methods

Community-Based Participatory Research Process

This exploratory study reports on results from one qualitative research initiative developed in the context of a larger and ongoing community-based participatory research (CBPR) process that began in the Fall of 2008 and brought together researchers and community-based organizations with an interest in LGBT aging in the Boston, Massachusetts metropolitan area. The Massachusetts LGBT Aging Needs Assessment Coalition (M'LANA), is organized around collaborative CBPR principles including involving individuals and communities affected by the research in all aspects of the research process, reciprocal learning from the expertise of the members, shared decision-making, and mutual ownership of the processes and products of the research (Viswanathan et al., 2004). These principles have been adopted in other studies in gerontology (Glanz & Neikrug, 1997) and LGBT health (Northridge, McGrath, & Krueger, 2007). Adoption of the principles of CBPR in M'LANA ensures the involvement of sexual and gender minority older adults and communities in the coalition's work and increases its relevance and sustainability. M'LANA's major goals are to better understand and document the unique needs of LGBT older adults, including their vulnerabilities and sources of strength, and to develop programs and services to better meet these needs.

The original purpose of the research initiative from which this study was based was to collect pilot data and gather information to inform future M'LANA initiated research proposals. The primary aims of the research initiative were to learn how LGBT older adults feel about participating in research, to understand the nature and make-up of the social

networks of LGBT older adults, and to assess the willingness of LGBT older adults to participate in research that utilized social network recruitment. M'LANA included a broad secondary aim to explore the health and social life experiences of LGBT older adults. In M'LANA meetings, members suggested and drafted questions for the semi-structured interview guide. The final interview guide included questions about coming out as LGBT, partnership histories, health, community engagement, and concerns related to growing older. Table 2 includes a selection of several of the interview questions and follow up probes that most frequently elicited information relevant to this study.

The research initiative was not originally designed to measure or explore successful aging, and the interview guide was not constructed with successful aging in mind. Respondents were not specifically asked about how successfully they were aging. Successful aging emerged as an organizing structure from the authors' grounded approach to analyzing the data. In first reviewing the interview transcripts and notes, the authors began to uncover a storyline in the data about the capacity and the degree to which respondents in the sample were able to thrive and live happy, satisfying lives. This storyline and the themes we uncovered within it corresponded with major themes in the successful aging literature. The interview guide included questions and follow-up probes to explore the health and social life experiences of LGBT older adults which happened to overlap with some of the major elements of successful aging. The inclusion of such questions undoubtedly facilitated the authors' discovery of successful aging themes in the data. While this was not originally designed as a study of successful aging, modification of original study goals and discovery of new organizing frameworks based upon the themes that emerge from the data is typical in grounded theory approaches to qualitative research and analysis (Charmaz, 2003; Strauss & Corbin, 1998).

Procedures

Participants were recruited for the study using a combination of community-based outreach and snowball referrals. CBPR coalition members invited friends, colleagues, and clients to participate in the study; they also passed along study information to colleagues and encouraged colleagues to recruit participants. Research study coordinators visited several congregate nutrition program sites that serve LGBT older adults and their allies, described the study and invited participation. Study participants were also asked to inform their peers about the study and to pass along study flyers. Inclusion criteria were (a) 60 years of age or older, (b) lives in Boston metropolitan area, and (c) identifies as gay, bisexual, lesbian, or transgender or has been in a same sex relationship during their lifetime.

Interviews were conducted by the authors, each of whom has prior qualitative interviewing experience. The majority of interviews took place in private study consult rooms at a community health center. For convenience of participants, a small number of interviews were conducted in private rooms at the congregate nutrition site locations where research coordinators recruited for the study. To accommodate and include participants with mobility restrictions, a few interviews occurred in the participants' homes. All interviews were conducted between December of 2009 and November of 2010.

A semi structured interview guide including additional probing questions was used to elicit data from participants. Participants also completed a self-administered demographics questionnaire. The interviews lasted between 1 and 2 hours. Immediately following each interview, or as soon as possible, the interviewer wrote detailed notes of major elements of the participant's life history, including demographics, living situation, partnership history, health, sexual orientation and degree of "outness," social networks, community engagement, and attitudes toward growing older. All interviews were audio recorded and transcribed verbatim (striking out any unique identifiers) and reviewed for quality assurance purposes.

All participants went through a written informed consent process. All study procedures were reviewed and approved by the Institutional Review Board of Fenway Health.

Data analysis

We used the tools of grounded theory as an approach to analyzing the interview data (Padgett, 1998). Grounded theory allows for the “discovery” of meaning and the generation of theory through systematic analysis of qualitative data that begins with minimal a priori assumptions (Strauss & Corbin, 1998). In our first readings of the data, we endeavored to set aside a priori assumptions as we developed “sensitizing concepts” (Bowen, 2006; Charmaz, 2003) to guide and organize the coding process. Prior to implementing the full coding process, the first author read and analyzed the interview notes and transcripts to uncover broad abstract thematic concepts that ran through the set of interviews (Morse & Field, 1995). Second, the research team met and agreed to successful aging and health as two broad “sensitizing concepts.” Third, two individuals from the research team independently conducted open coding of the transcripts using the sensitizing concepts as a point of departure. This resulted in the initial specification of thematic codes in a preliminary codebook. Consultation among the coders occurred until there was an agreement on the final coding system and standardized code definitions. This iterative process allowed the study team to refine thematic code definitions and to begin theory-building conversations that identified and detected patterns and connections between the themes, experiences, and concepts relevant to the phenomenon under investigation. All transcripts were coded based on agreed upon definitions, which were continually modified as needed. QSR International’s NVIVO 9 software was used for data management, organization and coding purposes.

We analyzed the *manifest content* of the interview transcripts by coding the statements made by our participants at “face value.” We also analyzed *latent content* of the interview transcripts by interpreting the underlying meaning in participant statements in reference to the entirety of the participants’ interview and life story (Berg, 1998). We privileged our interpretation of the latent content to resolve contradictions within the manifest content. For example, several participants described their health in broad terms very positively (“My health is excellent”) but went on to describe serious health conditions and complications. In these cases, we interpreted their positive self-ratings of health as indicators of positive attitude rather than accurate depictions of their health states.

In the final, theory-building stage of analysis, the first author developed a draft conceptual model of gradations of successful aging in the sample that connected the domains of health uncovered through the coding process. The research team met several times to refine and finalize the conceptual model. Strategies for rigor, including analytic triangulation, peer debriefing, and auditing were implemented to ensure authenticity and accuracy of data interpretations (Padgett, 1998). Two coders applied the conceptual model by classifying each participant along the gradations specified in the model. The coders wrote independent case summaries, justifying classification of each participant. While the coders agreed upon the majority of classifications, they met to discuss 6 (27%) discrepancies in case classifications until agreement was reached.

Participants

The characteristics of the sample are summarized in Table 1. A total of 22 participants who ranged in age from 60 to 80 were recruited for the study. The majority of participants (87%) were between 60 and 69. Half the sample was male and half was female; 1 of the female participants identified herself as transgender (born male and transitioned to female). The vast majority (91%) of the sample identified as gay or lesbian, with 1 participant identifying as bisexual and 1 identifying as heterosexual. 18% of the sample was African-American and

the rest non-Hispanic white. The sample was highly educated; all had at least some college, and 59% had at least some graduate school. 55% of the sample was retired, 36% worked full or part time, and 9% were out of work or unable to work. Despite the high level of education among the sample, 27% had an annual household income of less than \$25,000.

In the following sections, all participant names and several small personal details not affecting the interpretation of participants' stories have been changed to protect confidentiality.

Results

Domains of Successful Aging

Using a grounded theory approach to analyzing data, we identified four major domains to organize what we learned about successful aging from our respondents' discussions of their life histories, health, social networks and community activities. Our approach to conceptualizing health in an expansive manner is consistent with the World Health Organization's broad and widely adopted definition of health as "the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1948, p. 100). Our identification of multiple dimensions of successful aging is consistent with previous research (Parslow et al., 2011; E. A. Phelan et al., 2004; Pruchno, Wilson-Genderson, & Cartwright, 2010; Rowe & Kahn, 1987). Table 2 lists dimensions of each of the four domains of physical health, mental health, emotional state, and social engagement and the semi-structured interview questions and follow-up probes that most frequently elicited information about each domain. While the social-psychological domains of mental health and emotional state have been less frequently included in previous literature, several scholars have found that these domains are important elements of elders' subjective perceptions of successful aging (E. A. Phelan et al., 2004; von Faber et al., 2001).

Physical Health includes respondents' self-assessments of their overall physical health, the presence and extent of physical health conditions, cognitive health or impairments, and functional health or limitations. Most respondents provided relatively detailed information about their physical health in response to a semi-structured question that asked "How is your health overall?" Respondents typically replied with an overall self-assessment, such as "My health is fine—for what it is—for a 60 year old man" or "I'm very, very healthy", and then went on to describe whatever physical ailments or conditions with which they lived. Common conditions described include high blood pressure, cardiovascular disease, diabetes, HIV, orthopedic conditions and overweight/obesity. Many also enumerated the medications they took on a regular basis. Several respondents provided information about their cognitive health. A commonly mentioned concern was memory loss and decline in ability to keep track of conversation; two respondents had neurological conditions as a result of stroke or traumatic brain injury and experienced more severe cognitive impairments. Several questions prompted respondents to discuss functional health capabilities. Some reported active participation in physical activity, others an inability to do all that they used to do, and others trouble getting around and accomplishing activities of daily living.

Mental Health includes the presence and extent of mental health conditions and involvement in mental health services. Mental health is an area that was not specifically probed for in the interview guide, but one that was often brought up by respondents. Many brought up a mental health condition in response to the question "How is your overall health?" For those with a more serious or recently acute mental health condition, the opening question "Will you start by telling me a little bit about yourself?" elicited information about this domain. For others – including several respondents who came out as lesbian or gay early in life and

faced stigma, pressure, or psychotherapy aimed at changing their sexual orientation – discussion of the process of coming out included information about mental health conditions or engagement in mental health counseling. Several respondents experienced depression, anxiety, and other mental health conditions as a result of the stigma of coming to terms with and disclosing non-normative sexuality.

Emotional State includes respondents' attitudes toward life's ups and downs and self-described persistent emotional states such as happy, worried or satisfied. As with mental health, state was not specifically probed for in the interview schedule. Emotional state came up throughout the interview and in response to many different questions. Discussion of current and prior relationships often included information about emotional state. For example, one respondent talked about living alone and never having a long-term partner as a major regret as he looks back over his life. Another said of her life shared with her partner of 30 years, "I am wild about her. I couldn't be more fortunate." Several questions asked about attitudes towards aging and these prompted discussions of positive attitude (for example, "I'm happy to be alive" or "in general, this is the happiest phase of my life") and worries and fears (for example, "I'm afraid of becoming incompetent, just unable to take care of things, depending on other people, and isolated").

Social Engagement includes respondents' social and family network characteristics—including size, strength of ties, frequency and quality of interactions—and engagement in community organizations and activities (both inside and outside of LGBT community). This dimension was extensively probed in the interview. Respondents were asked to think about the number of people they talk to about important things in their lives, to tell us about those people and how often they communicate with them. They were asked several questions about participation in both LGBT and non-LGBT community organizations and activities. In response to these questions, many discussed their satisfaction or dissatisfaction with their current social network relationships; several participants expressed a desire to enlarge their networks.

Gradations of Successful Aging

We coded each case according to the 4 domains of successful aging detailed above. We sought to identify both successful agers and those who were having less success, so that we could better understand the experiences of resilient LGBT elders and those LGBT elders who were faltering. It was immediately clear that to follow Rowe and Kahn's formulation by characterizing the sample in two simple categories—successful agers and unsuccessful agers—would not adequately describe the range in the domains of health that we observed. Only a small slice of our sample fit a traditional characterization of successful aging defined by a) the absence of disease or disability, b) high physical and cognitive functioning, and c) active engagement in life. Instead, we found that the range of our respondents' experiences could be better described through examination of the degree to which they were able to cope with the problems that growing older almost always brings. In our sample, the problems identified included: for physical health, disease or disability and limitations on functional and cognitive capacities; for mental health, presence of mental health conditions; for emotional state, frustrations, fears, sadness, regrets, dissatisfaction with life; and for social engagement, challenges to active engagement such as the loss of members of one's social network and a more limited range of LGBT community venues catering to older adults. By examining the degree to which older adults coped with these problems, four categories of successful aging emerged as outlined in Table 3.

Traditionally Successful: Avoidance of Problems—The first category retains Rowe & Kahn's prevailing formulation of successful aging. These respondents have managed to

avoid the problems and challenges that growing older typically brings. They described no current physical health conditions (other than high blood pressure and cholesterol), functional limitations, or cognitive impairments; had no mental health conditions; expressed a positive attitude and/or joy, happiness, and satisfaction with life; and were engaged with community organizations, with activities and/or with a strong social network. Only 2 (9%) of our participants fit this definition.

Maryanne—a 68 year-old woman, married with adult children with whom she is close—is an example of someone we characterized as “traditionally successful.” Maryanne described herself as heterosexual, and was included in our sample because she is transgender (that is, her sex assignment at birth was male and she has transitioned to female). Maryanne described no current physical or mental health conditions. She was retired with an active social life in which she volunteered, went dancing and gardened. She was content with her life and had no worries or fears about aging. In talking about her life, she said, “I’m so happy with where I am.” She went on: “I’m still active, you know, around the house—still can do most things...I feel like I’ve aged well.”

Maryanne’s case illustrates a temporal dimension of these categories; they are not fixed or permanent states of successful aging, but can change over time from better to worse or worse to better. Our analysis of Maryanne’s case suggested a movement in her life from a worse state to a better one that happened as she came to terms with and affirmed her female gender. For much of the interview, Maryanne described a struggle with intense anxiety and depression earlier in her life that resolved when she made the decision to transition as she neared retirement. While Maryanne had a difficult time coming out and faced negative reactions from many friends and colleagues, affirming the female gender that she had suppressed for so much of her life was ultimately a freeing experience that improved her mental health and emotional state tremendously.

Surviving and Thriving: Successfully Coping with Problems—Older adults in this category experience a concern or problem in one or more dimensions of their health and so do not fit Rowe and Kahn’s formulation of the successful ager. However, these older adults are still thriving and living a satisfying older age by coping with the problems they face. These older adults may experience disease, but any physical or mental health conditions they have are successfully treated with few or no side effects. They may experience functional limitations, but these are minor and age-appropriate modifications that allow for continued physical activity and mobility (for example, choosing to run on a treadmill for fitness, rather than competing in a grueling road race). Emotionally, these elders may experience frustrations, worries, or a conflicted attitude towards aging, but on the whole are satisfied with their lives. Socially, these elders may find engaging with community a challenge or may find maintaining or rebuilding their social networks somewhat difficult, but they persevere and are active and connected with others. We characterized 10 (46%) of our sample as “surviving and thriving.” This category constituted the largest proportion of our sample.

Lisa, a 69 year-old lesbian, is an example of someone we characterized as “surviving and thriving.” While Lisa was not currently partnered and lived alone, she was socially connected with many friends, was active in community organizations and volunteered a good deal of her time with LGBT organizations. She was close with her adult daughter and grandchild. Things weren’t perfect in the social dimension for Lisa; she had lost some friends to death in recent years and expressed some dissatisfaction at the relatively small gay and lesbian community of color in her city. In terms of her physical health, Lisa had arthritis and back problems that made her a bit slower, but she was still very active and enjoyed

playing tennis with friends. She had no mental health conditions. Of her overall health, Lisa said:

I think I'm relatively lucky. I don't have high blood pressure or heart disease...I have had arthritis and both knees replaced, things like that. I'm not carrying around yet the burden of serious illness, and I can still get around. But I'm walking slower—because I'm getting—I have arthritis in my hip. *But I'm still raring to go.* I still have the motivation to get going. Let's get going! But [with] my colleagues, [it's] "oh, I'm too tired. I can't stay up this late."

In terms of her emotional state, Lisa was reasonably satisfied with life, even though she had some fears of developing Alzheimer's and said she "hates aging." She also regretted that she had not been able to make a long term relationship work. Lisa's case illustrates the importance of attitude in surviving and thriving; she credited her positive attitude with keeping her active and engaged, despite aches and pains. It also appeared that her positive attitude kept her from dwelling too much on her fears about aging and her regrets in life.

Within the category of those we classified as "surviving and thriving," there was a considerable range of *severity of problems* faced and range of *degree of success in coping* with problems. In terms of range of *severity of problems*, some faced very minor challenges. For example, one respondent described Vitamin D deficiency that had recently caused her uncomfortable aches and pains, a somewhat minor problem in the physical domain that was now well controlled with supplements. Another described a full social life and yet expressed some difficulty feeling connected to LGBT community in the absence of spaces he perceived to be inviting to older LGBT adults. While such marginalization from LGBT community is conceptually important and reflects the uniqueness of challenges of growing older as an LGBT person, we interpreted this as a relatively minor challenge for the respondent in the social engagement domain. In contrast, others faced tremendous adversity. Two respondents described decades-long battles with HIV, clearly a major problem in the physical health domain. Several others had lifetime struggles with depression or anxiety, major challenges in the mental health domain. Lisa's moderate troubles in the physical and emotional domains put her in the middle of the group of "survivors and thrivers" in terms of the severity of problems faced. In terms of range of *degree of success in coping*, some described virtually no burden in coping with the problems they faced, while others described some side effects of treatment, the need to make some considerable age-related modifications in their activities, or significant effort undertaken to improve social engagement and emotional state. Lisa again falls towards the middle of the range of "survivors and thrivers" in terms of the degree to which she was successfully coping with her physical limitations and emotional struggles. Similar patterns of ranging in the *severity of problems* and *degree of success in coping* were observed within each of the other gradations of successful aging detailed below.

Working at It: Some Coping, and with Effort—Like those who are "surviving and thriving," these older adults also experience challenges to their health. Unlike "survivors and thrivers," these older adults face persistent problems that are only partially managed. These folks are coping some of the time, but expend considerable effort to do so and are not always successful in coping. They may experience physical or mental health conditions that are only partially successfully treated and/or the treatment side effects may be bothersome. However, they do not experience these conditions as a constant burden; their conditions are managed some of the time. Those in this category may have functional limitations that somewhat restrict their mobility and interfere with participation in physical activities, even when age-appropriate modifications are made. They may rely on technology or services to sometimes assist in mobility, but are able to manage activities of daily living. Older adults who are "working at it" may confront persistent sadness, worries or fears that preclude a

sense of overall life satisfaction, even though they do not fully dominate their emotional state. In the social domain, people in this category may not be fully satisfied and may struggle to engage with community or to maintain or rebuild their social networks. However, these older adults have at least some deep connections with others and are at least somewhat actively engaged. We characterized 6 (27%) of our sample as “working at it.”

Phil, a 66 year-old gay man, is an example of someone who we characterized as “working at it.” His physical and mental health was good and he reported no problems or concerns. Emotionally, Phil was coping well with some concerns, including worries about money and regrets that he never has had a committed partner. Phil was “working at it” in the social domain. Phil lived alone, had no children, and while he had a few good friends, he felt he lacked a network of like-minded people with whom to do “ordinary little things” things like go to a movie. He explained:

One of the things I’m doing now, much more intensively than I could do when I was working, is I’ve tried to take some active steps towards expanding my social network: to go to events, talk to people. Usually—I shouldn’t say usually—but often, it’s sort of a waste of time. But, you need to continue that process and go to a variety of things. I spend a lot of time to add people to my life. But I’ve had a little bit of success with that in the last year. And I think that it’s possible to sort of enlarge my life, particularly in the gay community.

Phil went on to explain that he made choices to be cautious and guarded about his sexuality during his working years so as to protect himself from employment discrimination and stigma. His discussion of hiding his sexuality in his earlier days as a gay man recalled Rosenfeld’s (1999) exploration of the cohort of older gay men and lesbians who reject gay liberation discourse and instead rely upon hiding and passing to guard against stigma. Phil had come to recognize disadvantages and limitations of this approach. From Phil’s point of view, it was precisely his caution and reticence to be open about his sexuality that had made it difficult to meet other gays and lesbians and landed him with the social struggle he currently faced. However, Phil was working—and struggling—to improve his life in the social domain. He had been seeing at least “a little bit of success” that seemed to keep him at it.

The research team had some initial disagreement about how to categorize Phil along the gradations of successful aging. The team discussed Phil’s case in some detail and considered Phil as a candidate for characterization as “surviving and thriving.” For the most part, Phil was doing pretty well in his life. Ultimately, the research team came to agree that Phil’s struggles and dissatisfaction in the social domain were severe enough to warrant a designation as “working at it.” However, his case illustrates that the categories may not be discrete, but perhaps would be better understood as continuous. Further, in Phil’s case, his efforts of “working at it” may pay off and Phil may become more engaged with community and satisfied with his social life, moving him to categorization as a “survivor and thriver.” Like Maryanne’s case, Phil’s illustrates the likely temporal dimension of the categories, as well as the possibility to intervene to improve health along the continuum.

Mitch is an example of a participant who we could clearly categorize as “working at it.” Mitch was not completely successful in coping with physical health problems. As a 60 year-old gay man, Mitch reported that “my health is fine” but went on to describe a number of chronic problems: severe vision impairment, depression, sleep apnea, and obesity. Mitch’s vision impairment qualified him for disability insurance, which he reported relying on for living expenses. However, Mitch reported that maintaining the paperwork for disability every month was quite challenging. Given the complexity of these challenges he was able to cope to a degree. For example, Mitch was able to manage his depression by participating in

therapy but had given up on trying to manage his weight and sleep apnea. Although he considered himself an extrovert and had a large social network, his vision impairment impacted his ability to be as social as he would like and made it difficult (but not impossible) for him to stay connected with others by email. He reasonably expected his vision impairment to continue to worsen and his emotional state suffered: because he expected to outlive his partner, he often wondered who would care for him as he aged. It appeared that Mitch's ability to cope was limited by only being able to focus on a few health-related challenges at a time.

Ailing: Mostly struggling with Problems—While many older adults demonstrate resilience in the face of minor and major problems, not all are able to cope. We considered older adults in this state as ailing; they experience problems in one or more dimensions of health that are not managed successfully, resulting in poor health. Physical and mental health conditions that are present may not successfully be treated and treatment side effects may be severe; these conditions may represent a constant burden for older adults in this category. Functional limitations may severely restrict mobility and interfere with activities of daily living. Emotionally, these older adults may be unhappy, worried or fearful and generally dissatisfied with life. Socially, those who are “ailing” may be mostly disengaged with community and/or unable to maintain or rebuild social network ties. We characterized 4 (18%) of our sample as “ailing.”

Michael, a 69 year-old gay man, is an example of someone who we characterized as “ailing.” Michael had been successfully coping with a few physical health problems related to his back and prostate, but struggled in other domains. He suffered from severe depression his entire adult life which remained not well managed even though he was on medication. His mental health and emotional state have been deeply impacted by a long history of psychotherapy aimed at changing his sexual orientation. He had recently rejected the suggestion of his doctor to resume treatment with an affirming therapist. Michael had come to a point in his life where he intellectually accepted that he was gay, but nevertheless he continued to feel shame. He was in an open relationship with a male partner, but did not feel loved and wished he could get the nerve to leave. Socially, he described himself as withdrawn. He described having a good relationship with his ex-wife, children and grandchildren, but he lived alone and had only one gay friend aside from his partner. He went to some gay community events, but felt like an outsider.

Emotionally, Michael was angry and felt that because he spent decades trying to be heterosexual that he had been cheated out of a good life. He described the state of his mental health and general emotional state as he explained why he felt he couldn't get up the nerve to leave his boyfriend:

MICHAEL: ...I fear for my mental health sometimes. I still wonder when I am going to flip out and go out of my mind, because I came so close to it so many times. I was abusive with myself at times. I have arrived at a point in my life where things are better for me now than they probably ever have been. I'm reasonably satisfied with my life at this point. I wish that I could forget, to a degree, the past [referring to history with psychotherapy], but I can't. I live with it every single day, and I know I have a lot of anger, and I, but I realize that nobody ever meant to harm me in any way. It's just that it was very, very mishandled.

INTERVIEWER: So, is your anger--who is your anger directed at?

MICHAEL: Life. Life.

INTERVIEWER: Yeah.

MICHAEL: God. Who else can I blame, if I'm going to blame somebody?

While Michael manifestly said that he was “reasonably satisfied with his life,” we interpreted the latent content of this excerpt and the life story told in his interview differently. In our analysis, Michael was not satisfied, but was resigned to a status quo of persistent unhappiness and poor and potentially volatile mental health. Elsewhere in the interview, he explained that he expected to be transformed when he came out over ten years ago: able to finally live a good and happy life with fulfilling romantic and sexual relationships. Unfortunately, he continued to struggle with guilt and shame and did not find the sense of freedom, the happiness, or even the sexual pleasure that he sought.

Michael's case illustrates the interrelationship between the domains of successful aging, in which negative dynamics in his mental health, social engagement, and emotional state fed into each other. In each of these domains, Michael's condition could be described as poor, as he has had significant struggles that have not been well-managed. Ultimately, the impact of Michael's heart-breaking life story on these domains led us to designate him as “ailing.”

Overarching Themes

In building the conceptual model of gradations of successful aging in our sample, we observed several overarching themes. While four categories of successful aging emerged and we were able to categorize all the participants in the sample under one of the four categories, we found that our participants did not always neatly fit into categories and sometimes seemed to straddle the line between them, suggesting that the categories may be better thought of as continuous and not discrete. Further, we observed variation within each category in terms of the range of severity of problems that participants faced and range of degree of success participants had in coping. Attitude emerged as an important element that seemed to have a determining role in successful aging for several participants. For example, although some participants identified moderate to significant health related issues, their optimism, positive attitudes, and “can-do” spirit seemed to fuel a motivation to cope with the challenges of aging. We observed a temporal dimension in the categories of successful aging, as several of our participants described recent changes in their health status including movements from worse to better (for example, knee replacement surgery had significantly increased mobility and physical health for one participant) and from better to worse (for example, the death of friends had impacted social engagement for another participant). Finally, we observed an interrelationship in the domains of health in several participants in which experiences in one domain of health were connected to and fed into other domains.

Discussion

This study illustrates the ways in which the successful aging framework can be modified to describe experiences of aging in a sample of LGBT elders, a minority subgroup who share experiences of stigma related to their sexual orientation and/or gender identity. Many of the themes raised by our participants are broadly relevant and might likely be the same as themes raised by older adults in the general population; other themes raised were directly related to LGBT status. By incorporating the perspectives and experiences of minority individuals, by seeking to understand individuals' perceptions of positive and negative aging, by including coping in the definition of “success,” and by attending to the social contexts of our participant's lives, our approach responds to several of the major criticisms of the successful aging framework. Our modified conceptual model, which includes several gradations of success, may be useful in future research on LGBT older adults and may be adapted for use in practice to assess and intervene to improve health with LGBT elders.

Our semi-structured interview guide included several very general questions about health, social networks, community engagement and attitudes towards aging. This study design enabled older adults to speak in their own words and on their own terms about how they well they were aging. As we inductively analyzed this data, we uncovered several themes in successful aging not present in traditional Rowe and Kahn formulation, but that have been important in previous studies of successful aging that include subjective perceptions of older adults. Notably, our modified typology incorporated coping with and disease and incorporated multiple interrelated dimensions of health, including the social-psychological domains of mental health and emotional state.

Because coping with adversity and negative consequences in multiple dimensions of health are common experiences in the lives of stigmatized minorities, these modifications of the successful aging framework may be particularly relevant to describe the experiences of LGBT older adults. Many in our sample had accumulated experiences of social exclusion and marginalization across the life course. Such experiences may constitute added stress and result in a higher burden of physical and mental illness (2011). Only a few in our sample experienced traditional successful aging by avoiding health problems altogether. However, most demonstrated extraordinary resilience in coping with health problems in the physical health, mental health, emotional state and social engagement domains; they were surviving and thriving or working at improving their health despite challenges. A small number of others were ailing and not able to cope with problems. Future research is needed to identify determinants of successful aging in sexual and gender minority older adults, including potential determinants that are unique to LGBTs and the characteristics of those who demonstrate resilience.

Our study has several important limitations. Because we recruited a relatively small sample from a limited urban geographic area using community-based convenience sampling, our study must be viewed as exploratory in nature. The study is not generalizable to all LGBT older adults. Further, several potentially important demographic groups were not represented in the small sample that we did recruit. For example, LGBT elders who live in other parts of the country and in less urban areas may have different experiences that were not included in the study. The sample that we recruited was highly educated, mostly white, and mostly lesbian and gay with just one bisexually identified participant and one transgender participant. LGBT elders who are less educated, LGBT elders of color, bisexuals and transgender elders may also have different experiences that were not adequately captured in the study. We were also limited by our cross-sectional research design in what we could learn about changes in successful aging over time within individuals. Finally, a large majority of the participants were in their 60s and shared a similar generational cohort experience. This homogeneity limited our ability to analyze the data historically. Previous research has demonstrated profound effects of generational cohort variation in the experience of aging as LGBT (Rosenfeld, 1999). We are unable to determine if our findings reflect the experience of this cohort or LGBT aging more generally.

A major limitation of our research design is that we did not include a separately drawn sample of non-LGBT people from which to compare and contrast LGBT experiences with cisgender (that is, non-transgender) and heterosexual experiences. The lack of a comparison group makes it impossible for us to quantify the distinctiveness of the LGBT experience of aging or to specify those elements of the LGBT experience that are unique and those that are common to all. The conceptual model which we have specified is general enough that it may be useful to describe experiences of aging in any population. Future research could compare LGBT and cisgender heterosexual experiences using this model to further explore these questions.

The study was exploratory in nature and was not originally designed to measure successful aging. Instead, successful aging emerged as a particularly relevant framework to describe the experiences of our sample through a grounded theory approach to analysis. This approach has strengths and limitations. The approach maximizes the validity of our conceptual model, as the model emerged from responses to very general, conversational interview questions that elicited a broad range of information relevant to successful aging. However, we may have missed important elements of successful aging that were not specifically probed due to the exploratory nature of the research design. For example, while participants were asked to tell us about their health and were asked several questions about their attitudes toward aging, they were not asked in a straightforward manner how successful they felt they were aging. Such a question may have elicited further information relevant for analysis that would have helped us better define the categories of successful aging by more fully incorporating subjective, lay points of view on what constitutes success. Future research should address these limitations and be designed to further refine the conceptual model, standardize its measurement and address its reliability.

Despite the study limitations, the conceptual model presented makes an important contribution to the research literature that describes the health and well-being of LGBT older adults. The literature in this area is underdeveloped; a relatively small number of studies focusing on LGBT older adults have been conducted and most of these studies have lacked guiding theoretical or conceptual frameworks (Fredricksen-Goldsen & Muraco, 2010). Early work in the field in the 1970s and 80s primarily aimed to dispel negative stereotypes of older gay people as sad and lonely, worthy of pity at best and scorn at worst. In later decades, researchers have adopted a minority health disparities perspective and aimed to uncover the specific and unique challenges that older LGBT adults face. In contrast to the early literature, these works have often focused on areas of health and well-being in which LGBT elders have fared poorly (see review in Fredricksen-Goldsen & Muraco, 2010). In the next decade, the field may seek a more nuanced picture of LGBT health and well-being in older age. Because the conceptual model outlined here allows for simultaneous attention to experiences of resilience and adversity, and includes the experiences of adults doing well and those who are struggling, it may be a useful tool for such a nuanced understanding.

The ability to capture experiences along gradations of success may also make this conceptual model well-suited in practice settings as an assessment tool. The model could be used in work with LGBT clients to evaluate current health status across multiple domains, to identify areas where improvement might be made, and to set goals to improve health and well-being. Our findings suggest that individuals are not always static in successful aging, but that they can and do improve or regress with changes in their social contexts, networks and/or sources of social support, with changes in the treatment of their health conditions, and/or with changes in their health behaviors. Further, for many in our sample, optimism and having a positive attitude supported movement from a worse health state in the past to a better health state in the present. As found in the research literature, positive attitude supports resiliency and fosters overall good health (Coyne, Tennen, & Ranchor, 2010; Ellis & Ryan, 2005). Future research is needed to further explore the role of attitude in resilience among LGBT older adults, particularly to determine its potential as a buffer against the negative impact of minority stress.

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Abbreviations

CBPR	Community-based participatory research
LGBT	Lesbian, gay, bisexual and transgender
LGB	Lesbian, gay, and bisexual
M'LANA	Massachusetts LGBT Aging Needs Assessment

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Highlights

- Successful aging can be modified to describe the experiences of LGBT older adults.
- In our sample, we identified a continuum of successful aging along four gradations.
- Few in our sample met traditional criteria for successful aging.
- For most of our sample, success was characterized by coping with health problems.

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Table 1

Participant Characteristics

Total N = 22	N (%) ^a
Age (Range 60–80)	
60–64	10 (46)
65–69	9 (41)
70+	3 (14)
Gender	
Male	11 (50)
Female	11 (50) ^b
Sexual Orientation	
Gay or lesbian	20 (91)
Bisexual	1 (5)
Heterosexual	1 (5)
Race/Ethnicity	
White (Non-Hispanic)	18 (82)
African-American	4 (18)
Education	
Some college or college degree	9 (41)
Some graduate school or graduate degree	13 (59)
Employment Status	
Part- or full-time	8 (36)
Out of work or unable to work	2 (9)
Retired	12 (55)
Annual Household Income	
Less than \$25,000	6 (27)
\$25,000 – \$49,999	5 (23)
\$50,000 or greater	10 (46)

^aPercentages may not add up to 100 due to rounding or missing data

^bIncludes one transgender respondent who was born with male sex assignment and identifies as a woman.

Table 2**Four Domains of Successful Aging: Physical, Mental, Emotional, and Social Health**

Domains and Dimensions	Semi-Structured Interview Questions and Probes That Most Frequently Elicited Information^a
I. Physical Health	
Self-assessment of overall health	How is your health overall?
Presence and extent of physical health conditions	Do you have any ongoing health problems? Do you do anything special to try to stay healthy? Do you receive any care or health assistance at home?
Cognitive health or impairments	
Functional health or limitations	
II. Mental Health	
Presence and extent of mental health conditions	How is your health overall? Do you have any ongoing health problems? Can you tell me about how out you are about your sexual orientation?
Engagement in mental health counseling	
III. Emotional State	
Attitude towards life's ups and downs	Are you currently in a relationship? Can you tell me about your fears or concerns about aging?
Persistent emotional states (eg. happy, worried, satisfied)	What are the joys/positive aspects of aging?
IV. Social Engagement	
Social and family network characteristics including size, strength of ties, frequency and quality of interactions	Can you tell me about the people in your life whom you talk with about important things? People like your friends, family members, colleagues or neighbors? Will you tell me about the LGBT activities or organizations you participated in this past year?
Engagement in community organizations or activities	Aside from LGBT community, are you involved in other organizations, groups, clubs, or activities in your local community?

^aOpening questions "Tell me a little about yourself" frequently elicited information across all domains.

Table 3

Four Gradations of Successful Aging: Traditionally Successful, Surviving and Thriving, Working at It, and Ailing

I. Traditionally Successful: Avoidance of Problems. N=2 (9%)

All four dimensions of health can be described as excellent or very good

Physical: No current physical health conditions, functional limitations, or cognitive impairments.

Mental: No mental health conditions.

Emotional: Positive attitude and/or expresses life satisfaction, joy, happiness.

Social: Engaged with community organizations, with activities and/or with a strong social network.

II. Surviving and Thriving: Successfully Coping with Problems, N=10 (46%)

Concern(s) are present in 1+ dimensions of health, but are well-managed

Physical: Any present conditions are successfully treated with few adverse effects or complications. Any functional limitations are minor; age-appropriate modifications allow for physical activity and ability.

Mental: Any mental health conditions are successfully treated with few side effects.

Emotional: Frustrations, worries, or a conflicted attitude towards aging may be present, but on the whole is satisfied with life.

Social: Challenges engaging with community, or maintaining or rebuilding social network ties may be present, but is active and connected with others.

III. Working at It: Some Coping, and with Effort, N=6 (27%)

Concern(s) are present in 1+ dimensions of health that pose persistent challenges and are only partially managed

Physical: Conditions may be only partially successfully treated, but are not a constant burden; treatment side effects may be bothersome.

Functional limitations may somewhat restrict mobility and interfere with participation in physical activities, even when age-appropriate modifications are made.

Mental: Mental health conditions may be only partially successfully treated, but are not a constant burden; treatment side effects may be bothersome.

Emotional: May confront persistent sadness, worries or fears that do not fully dominate emotional state, but may preclude a sense of overall life satisfaction.

Social: May struggle to engage with community, or to maintain or rebuild social network ties; at least some deep connections with others are present, but may not be fully satisfied with social life.

IV. Ailing: Mostly Struggling with Problems, N=4 (18%)

Concern(s) in 1+ dimensions of health are not managed and result in poor health

Physical: Present conditions may not be successfully treated; treatment side effects may be severe; physical conditions may be a constant burden. Functional limitations may severely restrict mobility and interfere with ADLs.

Mental: Mental health conditions may not be successfully treated; mental health conditions may be a constant burden.

Emotional: May be generally unhappy, worried or fearful; may be generally dissatisfied with life.

Social: May be mostly disengaged with community and/or unable to maintain or rebuild social network ties.

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