Clinical Social Work Journal
https://doi.org/10.1007/s10615-019-00738-8

ORIGINAL PAPER

Social Isolation Loneliness Among LGBT Older Adults: Lessons Learned from a Pilot Friendly Caller Program

Angela K. Perone[1] · Berit Ingersoll-Dayton[1] · Keisha Watkins-Dukhie[2]

© Springer Science+Business Media, LLC, part of Springer Nature 2019

Abstract

Lesbian, gay, bisexual, and transgender (LGBTQ+) older adults face heightened risks of social isolation, given decades of discrimination. Research on telephone buddy programs with non-LGBTQ+ participants has proved predominantly unsuccessful at addressing social isolation. However, evidence suggests that LGBTQ+ adults may actually benefit from telephone buddy programs and in ways uniquely different from other groups. This article shares lessons learned from 35 participants across a 12-month pilot program that matched LGBTQ+ older adults to mostly LGBTQ+ volunteer callers of various ages. Over one-third of participants identified as people of color and over 20% as transgender or gender nonbinary. This project employed community-based participatory action research to identify, implement, and evaluate the program. Data includes information from questionnaires and telephone interviews prior to and during the program. Nearly all participants identified the importance of LGBTQ+ community in addressing social isolation and loneliness. Intergenerational matches also provided promising findings for making connections. While the project aimed to capture two groups (LGBTQ+ older adults experiencing isolation and volunteer callers providing support), the project revealed a third group: LGBTQ+ older adults at risk of social isolation. This third group usually emerged among the "Volunteer" callers who identified concerns about their own social isolation. The persistence of structural barriers also required the program to adapt to best meet participant needs. This article concludes with lessons learned and clinical implications for social workers who are addressing social isolation and loneliness among LGBTQ+ older adults.

Keywords Social isolation · Loneliness · LGBTQ+ · Older adults · Intergenerational · African Americans

Introduction

By 2030, an estimated 5 million adults over the age of 50 will identify as lesbian, gay, bisexual, and/or transgender (LGBTQ+) in the United States (Choi and Meyer 2016). Clinical social workers must be prepared to meet the needs of this growing population. Given the nature of clinical social work, concerns about social isolation could emerge during client assessments, diagnoses, therapy, or interventions and treatment. Scholars have identified a variety of programs and interventions to address social isolation for older adults (e.g., Cattan et al. 2011; Nicholson 2012; Poscia et al. 2018) but little research has focused on the needs of LGBTQ+ older adults. Results from this pilot program provide some of the first research that specifically examines the unique challenges and opportunities associated with a telephone buddy program for LGBTQ+ older adults and the clinical implications for the LGBTQ+ older adults and volunteers who participate.

Social Isolation and Loneliness Among Older Adults

Social isolation and loneliness are separate but related concepts that negatively impact the health and well-being of older adults (Nicholson 2012; Poscia et al. 2018). Social isolation generally refers to the objective absence of meaningful and sustained connections with other people, whereas loneliness usually refers to perceived lack of connection (Poscia et al. 2018). One cardiovascular health study found

✉ Angela K. Perone
peronea@umich.edu

Berit Ingersoll-Dayton
bid@umich.edu

[1] School of Social Work, University of Michigan, 1080 S University Avenue, Ann Arbor, MI 48109, USA

[2] SAGE Metro Detroit, 290 W. Nine Mile Road, Ferndale, MI 48220, USA

Published online: 12 December 2019

that higher levels of social isolation and certain life events (e.g. death of a friend) are associated with higher odds of loneliness (Petersen et al. 2016). Social support, including from friends, can alleviate loneliness, which can serve as an important pathway for well-being (Chen and Feeley 2013) and can provide meaningful connections (Annear et al. 2017).

Social isolation and loneliness can produce particular effects for various subgroups of older adults. Social isolation and loneliness are associated with poorer physical and mental health for older adult men (Taylor 2019) and white older adults and poorer mental health for Hispanic older adults (Miyawaki 2015). For African Americans, social disconnectedness is negatively associated with physical health whereas perceived isolation (or loneliness) is negatively associated with mental health (Miyawaki 2015).

Social Isolation and Loneliness Among LGBTQ + Older Adults

LGBTQ + older adults often have unique experiences and needs that create additional considerations regarding social support and loneliness. Many LGBTQ + older adults came of age during a time of significant victimization and discrimination toward LGBTQ + people (Fredriksen Goldsen 2018), which may make them more vulnerable to social isolation or loneliness as they age. The National LGBT Health and Aging Center's Aging and Health Report (2011) reports that LGBTQ + older adults have higher rates of mental distress, chronic disease, and disability (Fredriksen Goldsen et al. 2011). LGBTQ + older adults are twice as likely to live alone and four times less likely to have children as their non-LGBTQ + peers (Espinoza 2011), which further puts this population at a higher risk of loneliness and social isolation (Fredriksen Goldsen 2018). Moreover, many gay men have lost critical social networks due to AIDS (Butler 2019). Given decades of structural discrimination in family creation and rejection from biological families (families of origin), many LGBTQ + older adults have created social networks based on families of choice (non-biological friends, partners, ex-partners, neighbors, and co-workers) that act as surrogate families (Kim et al. 2017; Orel and Coon 2016). While families of choice offer important social support, they can present challenges because they often comprise peers of the same age (Butler 2019). As families of choice age together, social networks and connections can dwindle as health issues arise that preclude providing support and care to one another (Fredriksen Goldsen 2018).

It is important to consider the impact of heightened levels of social isolation and loneliness among LGBTQ + older adults. A study of 2560 LGBTQ + older adults found that nearly 60% reported lacking companionship and over half reported feeling isolated and/or left out (Fredriksen Goldsen et al. 2011). While transgender older adults have identified larger and more diverse social networks, they have also reported limited social support (Witten 2017). A heightened level of distrust from healthcare and social service professionals, given repeated experiences of discrimination, may also produce more social isolation among transgender older adults (SAGE and NCTE 2012). In a 2014 Harris Poll, nearly twice as many LGBTQ + older adults (30%) were very or extremely concerned about not having someone to care for them as they aged compared to only 16% of non-LGBTQ + older adults (SAGE 2014). An AARP report found that 76% of LGBTQ + older adults who participated in the survey were concerned about having adequate family and/or social supports to rely on as they age (AARP 2018). Thus, LGBTQ + older adults are experiencing social isolation and loneliness at elevated levels and are deeply concerned about experiencing these challenges as they age.

This study is undergirded by two related theoretical frameworks: minority stress theory and the Health Equity Promotion Model. Minority stress theory posits that cumulative experiences of discrimination and marginalization, ranging from subtle disapproval to more extreme violence, can serve as stressors that negatively impact the health of LGBTQ + persons (Meyer 2003). Scholars have pointed to minority stress theory to explain the existence of health disparities for LGBTQ + persons (Hoy-Ellis and Fredriksen-Goldsen 2016). The Health Equity Promotion Model is a framework for understanding how both structural issues (i.e. discrimination) as well as community support and resilience can shape mental and physical health of LGBTQ + people across the life course (Fredriksen Goldsen et al. 2014). This model underscores the heterogeneity and intersectionality within LGBTQ + communities, the influence of structural and environmental context, and both health-promoting and adverse pathways that capture behavioral, social, psychological, and biological processes (Fredriksen Goldsen et al. 2014). This model emphasizes the importance of agency and resilience in promoting health as well as the negative impacts of structural barriers (Fredriksen Goldsen et al. 2014). Subsequent research employing this model has found that multiple experiences of marginalization over the life course were associated with poorer mental health and that social resources (i.e. social support, social participation, community engagement, and relationship status) were associated with better mental health (Fredriksen Goldsen et al. 2017). Both minority stress theory and the Health Equity Promotion Model provide important theoretical grounding for conducting research within the LGBTQ + community and for this particular pilot project.

Telephone Buddy Programs

As concerns about social isolation and loneliness have exploded in both scholarly and popular press, social service providers and community organizations have developed a variety of programs to address these social issues. One such effort has focused on different ways in which to reach out to isolated individuals via the telephone (Carroll et al. 2019). Telephone buddy programs have become particularly popular, given their lower risk and cost compared to other interventions (Cattan et al. 2011).

While earlier research based on quantitative data found that telephone buddy programs failed to address (or minimally addressed) loneliness and social isolation among older adults (Bogat and Jason 1983; Cattan et al. 2005; Heller et al. 1991), newer research using qualitative data suggests these programs provide important supports that may reduce loneliness and social isolation (Cattan et al. 2011; Preston and Moore 2019). Reporting findings from a study of 40 semi-structured interviews and survey data, Cattan et al. (2011) found that telephone buddy programs helped older adults gain confidence, re-engage in the community, and become socially active again. Older adult participants also reported a sense of belonging and alleviation of loneliness and anxiety (Cattan et al. 2011). In another study using focus group and interview data, telephone buddy participants reported that they could discuss sensitive issues over the phone that would be more difficult to discuss face-to-face (Preston and Moore 2019). It is possible that this newer research incorporating more qualitative data is providing a more in-depth picture of how these programs can benefit socially isolated older adults.

To date, there has been little research that focuses on social isolation and loneliness among LGBTQ + older adults. Further, previous intervention research has not examined the impact of telephone buddy or support programs for LGBTQ + populations, including LGBTQ + older adults, or with samples that are racially diverse. This article addresses this gap by examining a telephone buddy support program for LGBTQ + older adults from racially diverse backgrounds. Using qualitative data, we identify several salient themes that point to clinical social work implications for this overlooked population.

Methods

The present study involves a community-based program evaluation of a pilot telephone-buddy program that included 35 LGBTQ + older adults and volunteers over a 12-month period. This project began with an advanced convergent mixed methods design (Fetters et al. 2013) by simultaneously using qualitative and quantitative data collection and analysis through questionnaires and semi-structured interviews with a trained program coordinator. This design was advanced because it included community-based participatory research (CBPR) at multiple stages of the research (recruitment, data collection, analysis, and writing) (Fetters et al. 2013). However, the mixed methods design evolved into a CBPR qualitative study after we dropped the quantitative questions when some of the participants expressed discomfort with these questions (see below).

Community-based participatory research (CBPR) is a framework that centers social, structural, and physical environmental inequities while engaging community members, organizational representatives, and researchers throughout the research process (Fetters et al. 2013) and focuses on a shared partnership between academia and the community (Hacker 2013). CBPR centers on collaboration between researchers and nonacademic stakeholders throughout much of the research process, including problem identification, conceptualization and planning, data collection and interpretation, and representation and dissemination of the research findings (Leavy 2017). Here, this project incorporated principles of CBPR because of the immense role that community stakeholders played and the collaboration between community partners and academia. LGBTQ + community members, including older adults, were involved in this project from its inception. LGBTQ + older adults identified a problem (social isolation and loneliness among LGBTQ + older adults) to the community host organization through community conversations and events. The community host organization focuses on services and advocacy for LGBTQ + older adults and includes LGBTQ + older adults within its Board of Directors, staff, volunteers, and programming committee. LGBTQ + older adults and staff and volunteers associated with the community host organization collectively identified a gap in services to LGBTQ + older adults who are socially isolated or at risk for social isolation and developed a telephone buddy program to specifically serve this population.

This project also illustrates CBPR principles through the collaboration between the community host organization and academia. After identifying the need for a telephone buddy program, the community host organization then reached out to a university partner to collaboratively design the research framework, including standardized quantitative measures about perceived loneliness, depression, wellness, and sense of community (Broekman et al. 2011; Cramer et al. 2000; Harari et al. 2005; Hughes et al. 2004; Proescholdbell et al. 2006). While the community host organization collected the data (see more details below), the research partner and community host organization collaboratively interpreted the results and drafted this article to disseminate the research findings.

Program and Participant Description

This Friendly Caller Program was developed in a large Midwestern city that involved participants from four surrounding counties, including both rural and urban communities. The program aimed to reduce social isolation and loneliness among LGBTQ + older adults by connecting them with volunteer callers. The only requirements for LGBTQ + older adult participants were that they reside in one of the four counties that the Friendly Caller Program serves, identify as LGBTQ + , and be at least 45-years-old, the minimum age for most of the host organization's programs. We incorporated a lower minimum age than most programs for older adults because many people of color and LGBTQ + people experience age-related health issues earlier (Fredriksen Goldsen 2018; Goosby et al. 2018; Levine and Crimmins 2014) that could facilitate social isolation sooner than white, heterosexual, cisgender peers. Volunteer callers could be LGBTQ + or allies aged 18 and above. Volunteer callers were expected to conduct at least 45 min of calls per week to their matched LGBTQ + older adult. These 45 min could include one call or several calls throughout the week. The organization hired and trained a part-time program coordinator to oversee this program.

Before the program started, the program coordinator engaged in 5 months of focused outreach (email, phone, and in-person) to local organizations and agencies that serve older adults and/or LGBTQ + populations to identify the first ten program participants. The coordinator conducted outreach to Area Agencies on Aging, the local AARP, Alzheimer's Associations, senior centers, LGBTQ + centers, libraries, senior housing organizations, healthcare organizations and individual providers, and other social service providers for older adults. She continued to engage in outreach throughout the 12-month pilot program to increase the program participant number from 10 to 35. She also contacted local media and organizations to place articles in news and agency/organization newsletters.

During the initial outreach period, the program coordinator developed a program application and screening process and training manual. The program application included questions that asked about basic contact information, demographics, whether participants lived alone, emergency contact information, interests/hobbies, availability, personal reference, and expectations about the program. The application also asked participants to identify how they learned about the program and why they wanted to participate. The application was completed through an online link or over the phone with the program coordinator. One person had a proxy complete the application.

The program application asked participants if they identified as a "Volunteer" or "Member" and defined Member as someone who wants to receive calls to connect with other people. The Member category aimed to include LGBTQ + older adults who were experiencing social isolation or loneliness. We used the word "Member" because initial outreach efforts and reviews of other telephone buddy programs suggested that this word was less stigmatizing than asking participants to identify feelings of loneliness or experiences of isolation. When developing the program, we conceptualized Members as care recipients and Volunteers as caregivers.

The program coordinator subsequently called all applicants to determine whether they had the time and commitment to participate in the program. Another purpose of these initial calls was to ensure that applicants were not aiming to use the program for another purpose (e.g. dating service). She subsequently delivered an in-person training orientation to program volunteers in groups or individually. All program participants received a 13-page written orientation manual that included information about the organization, program goals, program scope (e.g. telephone-based program that cannot provide legal, medical, or spiritual advice or transportation), program expectations (e.g. 45 min of calls/week and volunteer commitment of 4 month minimum), program procedures, role of program coordinator, program evaluation, confidentiality, nondiscrimination, a glossary of key terms, and additional resources regarding terminology. The program coordinator matched participants based on responses from their application and initial telephone calls with her (e.g. shared hobbies, personalities, desired qualities of the caller).

Initially, 35 participants completed the application. However, before being matched, 11 participants dropped out of the program for various reasons: competing time commitments (n = 5), misunderstanding the LGBTQ + focus (n = 1); health problems (n = 1); and lack of response to the program coordinator's follow-up (n = 4). Subsequently, 24 participants attended orientation and were matched as either a Volunteer or a Member. Three additional Volunteers dropped out after being matched and before they began making phone calls to their Member. We were able to follow-up with 11 of the 14 Volunteers who dropped out of the program at this early point and learned that while most of them expressed a passion for helping LGBTQ + older adults, most of them did not realize the time commitment this program would entail. Before and immediately after matching participants, the program coordinator called the volunteers to reiterate the minimum 45-min per week calling requirement, which may have prompted the large number of volunteers to drop from the program at this point. This time commitment was not advertised on many of the initial outreach materials and thus may have been a surprise for many of the Volunteers. While we see the strong interest as a positive sign for program development, the sharp decline at this initial point may underscore a need for more clarity about the requirements

early on—perhaps on the program application itself. Moreover, it is important to note that none of the Members dropped out of the program at this point and had strong interest in engaging in the program. All 21 of the remaining program participants engaged in regular phone calls for a minimum of 5 months. Sixteen of the 21 participants (76.2%) continue to remain in the program after 12 months.

These 21 participants represent a diverse group—mostly within the LGBTQ + community. Only one participant (a Volunteer) identified as heterosexual. Nine participants (45%) identified as lesbian, five (25%) as gay, four (20%) as bisexual, and one (5%) as queer.[1] Of the eight participants (38.1%) who identified as people of color, five (23.8%) specifically identified as African American or Black. Five participants (23.8%) identified as transgender or gender nonbinary. Participants ranged in age from 19 to 78, with the average age of 52.

Data Collection and Analysis

We collected several types of data from all participants to evaluate the program. First, all participants provided baseline information through the program application. Second, after reviewing the applications, the program coordinator conducted semi-structured phone calls with all participants. This additional baseline included both open-ended qualitative questions and standardized quantitative measures. The quantitative measures included: the Social and Emotional Loneliness Scale for Adults (abbreviated form) (e.g. "I can depend on my friends for help.") (Cramer et al. 2000); the Revised UCLA Loneliness Scale (e.g. "How often do you feel that you lack companionship?" (Hughes et al. 2004); the Geriatric Depression Scale (e.g. "Do you feel that your life is empty?" (Broekman et al. 2011); the Perceived Wellness Survey (shortened) (e.g. "My friends know that they can always confide in me and ask for my advice.") (Harari et al. 2005); and sense of community (modified) (e.g. "How much do you feel like you belong in the LGBTQ + community?") (Proescholdbell et al. 2006). After the program coordinator collected data on these quantitative measures with the first ten participants, she observed that several expressed reservations about answering these questions (especially around loneliness and depression) and found answering the scales over the phone confusing. The program coordinator asked these questions again at least 6 weeks later for half of the participants. Ultimately, we decided to eliminate the standardized measures from this evaluation and focused on the participants' responses to our open-ended questions about the pilot program and its impact (see below for more detail). It is possible the process of collecting standardized measures about loneliness and isolation should be modified for LGBTQ + older adults to encourage participation, particularly given that this population has experienced repeated examples of discrimination and marginalization across time that may make them less trusting and less willing to answer questions about loneliness or isolation. It is possible that trust takes more time to develop, particularly when talking to LGBTQ + older adults with multiple axes of marginalization (e.g. HIV-status, race), which may make these questions especially difficult to answer so early in the program over the phone or in-person. It may be that participants from marginalized populations need greater anonymity at the beginning of a program when answering questions about loneliness and isolation. To enhance participants anonymity, the use of individual computers could be helpful. Unfortunately, many of our program participants lacked access to a computer or Internet to complete these questions online. Limited resources of the host organization also precluded alternative means of acquiring responses to these questions that would have better ensured anonymity (e.g. providing hard copies in-person, providing individual e-tablets for each participant to periodically respond to questions). However, other social service providers and organizations seeking to use validated measures may have more success by employing better means of ensuring anonymity among their participants.

Participants were also asked qualitative open-ended questions prior to being matched, immediately after being matched, approximately 2–3 weeks later, and again approximately every 2–3 months thereafter. Pre-match qualitative questions aimed to identify motivations for participating in the program, including the degree to which participants wanted to create or maintain connections and/or reduce isolation. These questions were framed broadly to eliminate a sense of judgment and stigma that some of the participants identified in association with words such as "loneliness" and "isolation" (e.g. "Why do you want to participate in the Friendly Caller Program?"; "What do you hope to gain from participating in the Friendly Caller Program?"; "What are you looking for in a caller?"). The program coordinator subsequently asked semi-structured open-ended qualitative questions in phone calls with the participants to assess the appropriateness of the program, the process of the match and subsequent calls, and gather initial pilot data on the relationship between the program and perceived sense of isolation and social connection (e.g. "What are the strengths/drawbacks of the program/process for you?"; "How is the program currently serving/or not serving you?"; "Do you feel more connected/supported since starting this program? If so, why or why not?";"Tell us about changes in your life since starting this program."; "How has your telephone buddy helped (or not) during this time?").

[1] One person did not identify their sexual orientation, so the percentages for sexual orientation are based on n=20.

The program coordinator entered the qualitative data from follow-up phone calls with participants into Excel spreadsheets. The university researcher entered the open-ended responses from the pre-matched application data into the Excel spreadsheets. The university researcher also coded all qualitative program data first through open coding (Padgett 2008), a process of reviewing data for larger/broader concepts and themes (e.g. loneliness, isolation, needing connection, providing connection). Next, the university researcher engaged in focused and thematic coding (Padgett 2008), which allowed us to separate the broader concepts into more nuanced concepts and identify patterns and themes among the codes (e.g. intergenerational connections, quasi-members, barriers to social connectedness and belonging among LGBTQ + participants, barriers to continued participation and program engagement). The university researcher and program coordinator regularly met (biweekly/monthly) to discuss the accuracy of the coding. The university researcher and program coordinator also produced periodic memos to identify emergent ideas, themes, and lessons learned (e.g. promising intergenerational and diverse matches, addressing social isolation and loneliness among LGBTQ + older adults requires addressing the LGBTQ + community, participants may include LGBTQ + older adults "at-risk" for social isolation and loneliness, structural barriers present numerous and persistent challenges for LGBTQ + older adults).

Findings

This analysis process revealed five key themes: (1) the importance of LGBTQ + community; (2) the promise of intergenerational and diverse matches; (3) the emergence of a third group of "quasi-members" and transitions among groups; (4) barriers to social connectedness and belonging among LGBTQ + participants; and (5) barriers to continued participation and program engagement. Findings below include case examples; names have been changed and identifying information deleted to protect confidentiality.

Importance of LGBTQ + Community

LGBTQ + community emerged as a central theme among nearly all of the participants as a desired source of support and connection. Younger Volunteers specifically reported that they wanted to show their gratitude to the LGBTQ + older adults who had often sacrificed so much to build an LGBTQ + community from which they benefitted. In contrast, older LGBTQ + Volunteers (45 +) acknowledged a desire to sustain existing connections and to build new connections within the LGBTQ + community. Some LGBTQ + Volunteers also expressed concern that their connections to the LGBTQ + community would dwindle as they aged and/or experienced health issues or had to relocate. Members often expressed concern that they lacked any or much connection to LGBTQ + community.

> Cora, a 63-year-old Black lesbian noted that she is "pretty much a loner" and [doesn't] have anyone to talk to." She reached out to the program because she believed the "LGBTQ + community might be able to understand what I am talking about, and I don't have friends in that community."

Other participants noted that while they were involved in LGBTQ + groups or organizations, they still felt socially isolated from the LGBTQ + community.

> JoAnne, a 69-year-old white transgender lesbian wanted to connect to transgender veterans who had shared experiences with "self imposed isolation" but noted that she lacked much significant contact with the LGBTQ + community overall, despite participating in a local LGBTQ + community organization. After 1 month in the program, she expressed concerns about planning for death as a single older transgender woman. While she remained single after 6 months in the program, she was less focused on death and looked forward to continuing to receive calls from another transgender participant.

JoAnne's experience highlights the salience of loneliness despite interacting with other LGBTQ + people or organizations and underscores the importance of making meaningful connections with the LGBTQ + community.

Promising Intergenerational and Diverse Matches

During the application process, many participants expressed a desire to connect with someone who had similar experiences. Several African American participants wanted to be matched with other African Americans. Some of our transgender participants also wanted to be matched with other transgender participants. However, no one noted a preferred age range for a buddy. Thus, the program coordinator created several intergenerational matches, sometimes spanning decades apart. Intergenerational matches often shared other experiences, hobbies, or personalities but did not share a common historical or cohort experience. However, these matches proved very promising both in duration and satisfaction with the program.

> Amanda and Barbara were part of the first group of ten matched participants who continue to participate over a year later. Barbara, who lived in an assisted living facility, was 30 years older than Amanda. She originally noted that she would prefer another lesbian. At the time, we did not have another lesbian available to match with her and matched her with Amanda

> who identifies as heterosexual. After 3 months, both responded very positively to their emerging relationship and looked forward to the calls. Six months later, they remained equally enthusiastic about their relationship. After a year, they both remain committed and eager to continue with their regular calls. This longevity has required some flexibility, given various life circumstances (e.g., work and family commitments) that sometimes precluded a rigid minimum amount of 45 min of calls every week. However, they have built a trusting relationship. At 6 months into the program, Amanda was also able to provide a critical sounding board for Barbara when she expressed concerns about being treated differently at her home care because of her sexual orientation.

It is possible that the large difference in age actually facilitated stronger social connections because of their different life stages or that other factors were more important than age in terms of making a connection. Because Barbara already experienced various life stages and experiences before Amanda, Barbara may have been able to provide advice and help in ways that benefited Amanda (a Volunteer) and that also gave Barbara (a Member) an intrinsic sense of value and contribution. Moreover, Amanda and Barbara's successful match reveals that it is not necessarily essential to match along requested backgrounds. While Amanda was not the preferred "lesbian" match that Barbara had initially identified, they have been able to maintain a sustained and meaningful connection.

Amanda also expressed a deep interest in connecting with LGBTQ+older adults through this program. This was a common theme among younger participants. Thirteen of the fourteen younger participants (in their 20 and 30 s) expressed a clear desire to support older LGBTQ+adults. Some of the LGBTQ+younger participants noted that they wanted to "hear stories" and "remember our history" and "learn[] from elders in the community" who "paved the way for us." Because younger participants did not share the same historical experiences, younger volunteer callers may be more interested in hearing about Members' life experiences.

In contrast, older Members may be less interested in connecting with other older adults, particularly if their aging peers are thriving when they are struggling. Alternatively, they may be more interested in connecting with Volunteers (regardless of age) whose experiences make the obstacles in their own lives appear less challenging. This may be especially true within a community with significant historical trauma.

> Geena, a 66-year-old Black transgender woman captures this sentiment when she noted a desire to "hear about what other person[s] experience to let me know other people have it worse than me".

While Geena did not expound on specific obstacles in her life, her desire to speak to people who had it "worse than her" suggests that she is grappling with challenges in her own life. Research underscores the significant obstacles that exist for transgender women of color, including increased risk of violence, health disparities, and discrimination (SAGE and NCTE 2012). Here, Geena's comments suggest that she was uninterested in connecting with someone who was thriving while she experienced her own challenges.

Emergence of "At-Risk" Quasi-Members and Transitioning Between Groups

Only a little over a third of all participants in the program personally identified themselves as Members (care recipients) who were experiencing social isolation or loneliness—through the application and/or initial phone conversations with the program coordinator prior to being matched. During outreach efforts at the beginning of the program, several older adults told the program coordinator that the word "lonely" was stigmatizing. Even after modifying recruitment materials to emphasize social connections, more people felt comfortable identifying themselves as Volunteers (caregivers) who wanted to make calls to support others as opposed to Members who received calls for support. However, it became clear after only a month into the program, a third group of program participants existed who we called Quasi-Members. Quasi-Members represented LGBTQ+older adults who currently felt connected and a sense of belonging but were at risk for social isolation and loneliness in the future. They straddled both a care recipient and caregiver position. These Volunteers often expressed concern about the potential disappearance of their networks and support if they experienced a health issue or had to relocate to different housing. They often identified multiple goals for participating in the program that included helping LGBTQ+older adults who needed support and also maintaining or building their own LGBTQ+community connections. They also often transitioned between a Volunteer and Member role.

> Sherry, a 64-year-old transgender lesbian initially entered the program as a Volunteer wanting to provide support to other LGBTQ+older adults. She had lost family and friends after transitioning and divorcing her ex-wife and noted how helpful support would have been at that time in her life. However, several months into the program, she experienced housing instability and economic challenges that shifted her more to a Member (care recipient) role. After briefly dropping out of the program, she was re-matched with a Volunteer who could provide her more support.

While Sherry demonstrates how a Quasi-Member shifted from Volunteer to Member, other participants shifted from

being a Member (care recipient) to a Volunteer (caregiver) throughout the program.

> Calvin, a 53-year-old Black bisexual man was eager to participate so much so that he expressed interest in joining the program nearly 4 months before the program actually began with matched participants. Calvin experienced many compounding barriers in his life, including poverty, reliance on food pantries, lack of family support, reliance on public transportation, and multiple health issues that limited his ability to work. He lamented about losing touch with his friends and was "tired of being alone." After 3 months in the program, he noted that [r]eceiving calls made [him] really ready to get back up, to start looking for work again and just get outside." After a year in the program, Calvin was much more involved in local community events, including groups focused on LGBTQ + older adults and aging and had a much more positive outlook about his life position, even though many of the same structural limitations remained (e.g. health, low-income, lack of family support). He is now transitioning to providing support and "giving back" as a Volunteer caller.

Calvin represents one of the most successful Member experiences in the program. While the telephone buddy program was unable to address the myriad structural barriers in his life, it provided a sustained connection and source of support that appeared to have a positive impact on his personal wellbeing and provide support when he needed to tackle some of the structural barriers in his life (e.g. unemployment). Both the experiences of Sherry and Calvin also underscore that the care recipient and caregiver roles are quite fluid, perhaps even more so in the LGBTQ + aging community where social connections and a sense of belonging may be more fragile, given decades of systematic discrimination. Given these experiences, clinical social workers and other service providers designing LGBT programs may benefit from considering program evaluation and research designs that are inclusive and sophisticated enough to incorporate Quasi-Members who may need to switch roles from caregiver to care recipient (or occasionally play both roles), given various life circumstances.

Barriers to Social Connectedness and Belonging Among LGBTQ + Participants

LGBTQ + older adults discussed several barriers to maintaining social connections and feeling a sense of belonging. These challenges included transportation, housing, health, loss of friends and partners due to death or relocation, and isolation from senior centers. These findings add to the literature on LGBTQ + aging indicating that discrimination against LGBTQ + older adults presents significant challenges to obtaining social support as well as securing affordable and safe housing and healthcare (Boggs et al. 2017; Choi and Meyer 2016). It also underscores the connections to both minority stress theory (Hoy-Ellis and Fredriksen-Goldsen 2016) and the Health Equity Promotion Model (Fredriksen Goldsen et al. 2014) that address how cumulative experiences of discrimination and structural challenges may pose barriers to one's health. The present study highlights the connection between discrimination, social isolation, and mental health. Several Members (care recipients) identified how structural challenges create compounding obstacles for establishing relationships and connection. These challenges did not disappear once in the program but became a source of conversation and support from Volunteers.

> Early in the program, Rhonda noted that she felt isolated because she does not use computers or have her own transportation. She was formerly incarcerated and struggled with the challenges related to finding housing, income, and support with a criminal record. Six months later, these challenges remained along with health issues that prevented her from walking without having to take frequent breaks. After a year in the program, she continued to experience these obstacles and expressed concern that they precluded her from having an intimate companion.

These structural barriers were particularly heightened for the participants who identified as racial minorities and/or transgender. Many of these participants experienced decades of compounded forms of ostracism and discrimination related to race, gender, sexual orientation, health (including HIV status), and age. Weekly calls could not change their circumstances, but they provided an important outlet to talk about them. One of the difficult circumstances was the loss of a long-term partner.

> Robert and his partner had lived together as a couple for nearly 40 years in his partner's home. After Robert's partner died, his partner's family evicted Robert, and he had to relocate to a completely new home away from his friends. Robert reported "enjoying" his calls and noting a stronger connection with his match than his own biological family. However, during the holidays, he noted that he feels his partner's loss and feels lonelier during this time.

Robert's experience demonstrates how the need for social support may be heightened at particular times of the year. Even though Robert was openly gay and had a support network near his previous home, his forced relocation left him isolated from this network of friends. In contrast to Robert, Esther lived with her partner for nearly 45 years without ever telling anyone that they were a couple or that she was gay.

> After Esther's partner passed away, she publicly acknowledged their relationship at the funeral. She then moved to a senior living community where she told administration that she was a lesbian. In hopes of connecting more with the LGBTQ + community, she joined a small LGBTQ + support group for older adults. She left after 3 weeks when someone asked her on a date. She joined the Friendly Caller Program to find space where she could connect with the LGBTQ + community without having to worry about dating.

Building a relationship by phone provided Robert and Esther a safe and comfortable outlet to connect with the LGBTQ + community after losing a partner. Robert and Esther's experiences also align with the Health Equity Promotion Model, suggesting that social support like this may improve the health and wellbeing of LGBTQ + older adults, particularly those who are experiencing barriers to social connectedness and belonging.

Barriers to Continued Participation and Program Engagement

Structural barriers often created barriers for remaining in the program or regularly responding to calls.

> Two transgender participants, Chris and Sherry, experienced homelessness after several months into the program. Homelessness and housing instability is a particularly acute problem for many transgender older adults (Porter et al. 2009), and these participants were no exception. Chris left the program to find housing in another state, whereas Sherry left briefly and returned once she found local temporary housing. In contrast to Chris, Sherry had reached out to the program coordinator and other people affiliated with the Friendly Caller organization to find temporary housing before leaving the program.

While the Friendly Caller Program was not designed to provide referrals, necessity demanded it. The additional assistance from the program coordinator may have solidified a deeper trust and desire to rejoin the program for Sherry, whereas the structural burdens of finding housing out of state may have prompted Chris to determine that the program was too burdensome at this time.

Health issues also created barriers for some of the participants to stay involved.

> Gladys, left after 5 months in the program due to compounding health issues and concern that she "couldn't assist anyone until she resolved" her own health issues. Gladys joined the program to connect with others after losing her partner. While she noted that she felt alone and disconnected from the LGBTQ + community, she also identified herself as a Volunteer—and not a Member—and wanted to help others in the LGBTQ + community.

Receiving calls while navigating new health issues possibly could have helped Gladys but because she identified herself as a Volunteer caller who *made* calls to help someone else, she may have been unable to easily transition into a mindset of receiving help.

Other participants left the program (even if just temporarily) after experiencing a match that they felt was not the right fit.

> Edith (Quasi-Member) left the program after 5 months after she had been matched with Rhonda (Member), who experienced a bevy of structural challenges. Edith noted that she felt judged by Rhonda, that she could not provide enough support by the phone, and that she preferred to be re-matched before ultimately leaving the program altogether. Rhonda expressed concern that Edith did not understand Rhonda's experiences as someone who was poor and had served time in prison. As a Native American lesbian, Edith had experienced her own share of systematic discrimination and structural barriers. However, Edith currently experienced much more social, economic, housing, and health stability than Rhonda, which may have sparked some animosity or frustration from Rhonda, particularly if Rhonda expected to have conversations about shared experiences of structural challenges. Nonetheless, Rhonda stayed in the program and accepted another match, whereas Edith did not. Edith had entered the program both to help others and connect to the LGBTQ + community.

Perhaps, because she was also seeking support through the program, the negative experience with Rhonda left Edith feeling overwhelmed, unsupported, unconnected, and unwilling to continue in the program.

Lessons Learned and Clinical Implications

Overall, experiences from participants in this telephone buddy program suggests promising directions for clinical social workers who are addressing social isolation and loneliness among LGBTQ + older adults. While this 12-month pilot program was unable to capture data from validated measures, the open- and close-ended survey questions and qualitative data reveal how the participants found meaning and social connection through this program. For those who were matched with a buddy and began engaging in phone calls, all participants had sustained engagement for at least

5 months, with over 76% of participants still engaged after a year.

This program also underscores the benefit of a telephone buddy program for deeply marginalized community members struggling with structural barriers that cannot be resolved through the program. Sparse research exists on how telephone buddies may benefit diverse communities. This program contained a participant group representing individuals who experienced multiple levels of marginalization (e.g., based on their race, gender, age, sexual orientation, gender identity, income, health, and incarceration). In contrast to earlier research on presumably white, heterosexual older adults that found telephone buddy programs ineffective (Bogat and Jason 1983; Cattan et al. 2005; Heller et al. 1991), this project reveals how these kinds of programs and interventions may be effective for marginalized older adults, particularly those who experience (and have historically experienced) multiple forms of structural barriers across the life span. We identify lessons learned and clinical implications for social workers serving LGBTQ + older adults in the section below.

Addressing Social Isolation and Loneliness Among LGBTQ + Older Adults Requires Addressing LGBTQ + Community

First, clinical social workers should be aware of the need to address social isolation and loneliness among LGBTQ + older adults (AARP 2018*)* and recognize that LGBTQ + older adults may have unique needs that are different from other populations (Fredriksen Goldsen 2018, 2011*)*. One lesson learned here is the importance of LGBTQ + community and how that may be a critical factor to consider when addressing social isolation and loneliness among LGBTQ + older adults.

Older adults who exist within communities that have experienced unique historical trauma—and who may continue to experience discrimination based on their association with that group—might benefit from more focused attention to their connections within a particular community. We learned here that LGBTQ + older adults who experience social isolation and loneliness may benefit from resources that generate meaningful connections to the LGBTQ + community, including individuals who were not open about their sexual orientation and/or gender identity or previously active in the LGBTQ + community. The Health Equity Promotion Model helps explain how both structural issues (i.e. historical trauma) as well as LGBTQ + community support can shape mental health among participants. Connecting with LGBTQ + community may help promote agency and resilience that may buffer some of the negative impacts of the historical trauma and discrimination that many LGBTQ + older adults have experienced across their life course. The preliminary findings here suggest that further research is needed to examine these connections.

Because many LGBTQ + older adults do not share their sexual orientation or gender identity with service providers, clinical social workers should assume that any of their clients may be LGBTQ + and thus offer LGBTQ + community resources to all of their clients (SAGE Metro Detroit and ACLU 2019). Providing these resources will likely build trust with clinical social workers and, over time, LGBTQ + older adult clients may be more willing to share information about issues in their life for which they need help and support (similar to what happened for many program participants). Research suggests a growing trend in clinical practice with LGBTQ + persons that emphasizes treatments or interventions that focus on developing social connections, intimate relationships, and fostering generativity that goes beyond solely focusing on "coming out" (Bennett and Douglass 2013). Our experience with the Friendly Caller program points to the importance of helping to develop connections and relationships specifically within the LGBTQ + community. Clinical social workers can further foster support and trust among LGBTQ + clients by building relationships with LGBTQ + community organizations and by specifically displaying images that convey a commitment to serving this community (SAGE Metro Detroit and ACLU 2019). While the rainbow flag has many variations, it remains one of the most widely recognized symbols for the LGBTQ + community. Clinical social workers wearing a rainbow pin or who have a rainbow flag, decal, sticker, or sign on their door may engender more trust among LGBTQ + clients (SAGE Metro Detroit and ACLU 2019), which could help identify LGBTQ + older adults who need more supportive services, such as a telephone buddy program.

Intergenerational Support Can Provide Important Positive Connections for LGBTQ + Older Adults

While none of the Members expressed a desire for an intergenerational match, we found intergenerational matches to be particularly successful based on the qualitative comments from program participants and longevity of the matches throughout the program. Intergenerational support may be especially useful in communities with a shared sense of history, trauma, and resilience. Younger members of that community may benefit and desire to hear stories from community members that blazed a path of equal rights and progress for their generation. At the same time, older adults in the LGBTQ + community may appreciate sharing their stories and feeling valued for their experiences. Clinical social workers may find that intergenerational supports work well among LGBTQ + communities for fostering new connections and sources of support among this population. When

developing or supporting telephone buddy programs, clinical social workers should consider making telephone buddy matches that span one or more generations.

Participants May Include LGBTQ+Older Adults "At-Risk" for Social Isolation and Loneliness

We initially contemplated two groups (1): Members/care recipients who were experiencing social isolation or loneliness and needed support and (2) Volunteers/caregivers who were providing support. However, we quickly learned that many LGBTQ+Volunteers expressed concern about social isolation and loneliness in the future and expressly participated, in part, to maintain and build LGBTQ+community connections. We identified this group as "Quasi-Members" because they straddled the Member and Volunteer groups.

Clinical social workers serving LGBTQ+older adults should be mindful of the need for anticipatory support, even if LGBTQ+older adult clients do not immediately express this need. Given that LGBTQ+older adults are less likely to have informal caregiving support as they age (Butler 2019; Espinoza 2011; Fredriksen Goldsen 2018), clinical social workers should be aware that LGBTQ+clients may be at a higher risk of social isolation and loneliness than other clients (Fredriksen Goldsen 2018). While they may currently be well connected and have a strong sense of belonging, LGBTQ+older adults may be very aware and concerned about experiencing social isolation and loneliness in the future. Early access to resources and support programs may be particularly beneficial for LGBTQ+older adults who exist in this "Quasi-Member" category. Thus, clinical social workers should provide LGBTQ+resources and referrals that help maintain connections, like support groups or a telephone buddy program, even when LGBTQ+older adult clients express that they currently feel socially connected and supported.

Structural Barriers Present Numerous and Persistent Challenges for LGBTQ+Older Adults

Most of the Members detailed a variety of interconnected structural barriers that present significant challenges in their lives, including housing instability, job instability, poverty, access to reliable transportation, health issues, and lack of family support. In accordance with the minority stress theory (Hoy-Ellis and Fredriksen-Goldsen 2016), these challenges may have negatively impacted their ability to maintain social connections and a sense of belonging. While these structural barriers rarely changed for participants, some participants found their weekly calls helpful support, whereas others found them burdensome as life challenges continued to stack up. As a telephone buddy program, this program was not designed to tackle the myriad structural issues impacting many of our participants. Some of the Volunteers were left unsettled by their inability to do much more than listen when confronted with the harsh realities that their telephone buddy described, which underscores the important role that program coordinators or clinical social workers can provide to help Volunteers navigate these difficult realities. In particular, clinical social workers in the program can provide important resources, referrals, and professional support (e.g. counseling) that supplement the social and community connections from a telephone buddy program. Moreover, Volunteers' frustrations about structural barriers reflect much of the realities that many clinical social workers encounter. However, an important lesson that emerged from this program was that we can and should do more to connect the macro and micro experiences in ways that improve health and wellbeing of LGBTQ+older adults—even if through small steps. Clinical social workers who are less familiar with working with LGBTQ+older adults can take that first step by educating themselves about the historical experiences that have prompted elevated social isolation and loneliness among LGBTQ+older adults as well as intersecting challenges related to ageism, sexism, racism, heterosexism, transphobia, and other forms of oppression (Hash and Rogers 2013). A 2018 AARP report revealed that 88% of LGBTQ+respondents would feel more comfortable if service providers were specifically trained for LGBTQ+needs (AARP 2018). Clinical social workers should seek out trainings that provide important background about structural challenges facing LGBTQ+older adults. National organizations like SAGE USA offer in-person trainings and webinars. Additional organizations like SAGE Metro Detroit provide in-person and online trainings that also offer CE credit for social workers.

Building LGBTQ+-Welcoming Referrals Can be Incorporated Into the Program

The initial program scope included only matching participants for telephone calls. It did not incorporate a referral system due to a limited list of known LGBTQ+-welcoming providers and concerns about creating unmanageable capacity issues for the part-time program coordinator and overall program. However, as participants began to increasingly express needs for service referrals, the program had to evolve to meet those needs. Because the program coordinator had carved out 5 months of intensive outreach to community partners before the program began, she was better positioned to provide LGBTQ+-welcoming service referrals when needed. While this list of referrals continues to grow, this experience underscored the challenge in identifying LGBTQ+-welcoming resources for older adults. Many LGBTQ+resources focus on youth, and many aging resources focus on the needs of heterosexual, cisgender

older adults, which leaves LGBTQ + older adults in a quandary of where to find culturally appropriate services. To better address this concern, the program coordinator worked closely with the organization's training coordinator to engage in targeted outreach to service providers to increase awareness about this population and the need for targeted training that further grew our list of LGBTQ + -welcoming service providers. Clinical social workers developing telephone buddy programs for LGBTQ + older adults should feel empowered to grow a list of LGBTQ + -welcoming referrals through the program itself. While building an LGBTQ + -welcoming referral list takes time and persistence, there are three potential approaches that may help: (1) reviewing an existing list and reaching out to providers about LGBTQ + inclusion; (2) connecting with local LGBTQ + community partners about their referrals; and (3) reaching out to current referrals and asking them to adopt nondiscrimination policies and engage in culturally responsive training (SAGE Metro Detroit and ACLU 2019). Clinical social workers can implement any or all of these approaches to begin developing their own list of LGBTQ + -welcoming referrals.

Conclusion

LGBTQ + older adults represent an important and growing population that is becoming more visible as cultural and legal norms continue to improve. Yet decades of historical trauma and discrimination have left many LGBTQ + older adults more vulnerable to social isolation and loneliness. Program data from this pilot Friendly Caller Program reveals important findings and lessons learned for clinical social workers that can help support and build connections for this population moving forward.

While this study provides important insights for service providers working with LGBTQ + older adults, it also has limitations. This pilot project included a small sample and did not involve a randomized controlled study. Subsequent research could include a large-scale randomized controlled study that could better examine the efficacy of this approach and provide a model that could be adapted for other contexts beyond a telephone buddy program, including drop-in centers or clubs. Moreover, few participants had access to computers or Internet, and limited resources precluded offering participants options for responding to questions about their health and wellbeing apart from a telephone conversation with the program coordinator. Subsequent programs may benefit from using alternative methods of collecting data, including offering individual tablets and Internet access, or home visits with hard copies of the questions that can be answered independently from the interviewer. Despite these limitations, however, this pilot project shows promise for providing more inclusive and culturally responsive services for LGBTQ + older adults at risk for social isolation or loneliness. Clinical social workers can build on the lessons learned to enhance their own practice for better serving LGBTQ + older adults.

Acknowledgements This pilot program and research support was provided, in part, through grants from the Community Foundation for Southeast Michigan HOPE Fund and the University of Michigan School of Social Work Gerontology Learning Community. The authors would also like to thank the program participants for their involvement and candid responses to better evaluate the program, and volunteers and staff for their time and commitment to this project and to addressing social isolation and the needs of LGBT older adults. The authors would also like to thank our research assistant Katrine Weismantle for her invaluable assistance in gathering and synthesizing articles for review.

Funding This pilot program and research support was provided, in part, through grants from the Community Foundation for Southeast Michigan HOPE Fund and the University of Michigan School of Social Work Gerontology Learning Community.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures in studies involving human participants were in accordance with the ethical standards of the institutional and/or national committee with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. Because this research focused on community-based program evaluation and self-assessment, it was granted "not regulated" status by the University of Michigan Institutional Review Board (HUM00145365).

Informed Consent Even though the program did not fall under IRB regulations, we received informed consent from all participants to anonymously share data collected in reports and publications that support further development and improvement of this and other similar programs in the future.

References

AARP (2018). *Maintaining dignity: Understanding and responding to the challenges facing older LGBT Americans*. Washington, DC: AARP Research. https://doi.org/10.26419/res.00217.001.

Annear, M. J., Elliott, K.-E. J., Tierney, L. T., Lea, E. J., & Robinson, A. (2017). "Bringing the outside world in": Enriching social connection through health student placements in a teaching aged care facility. *Health Expectations, 20*(5), 1154–1162.

Bennett, J. L., & Douglass, K. E. (2013). Growing pains: An Eriksonian view of the arc of presenting concerns in an LGBT community mental health center. *Clinical Social Work Journal, 41*(3), 277–287.

Bogat, G. A., & Jason, L. A. (1983). An evaluation of two visiting programs for elderly community residents. *International Aging and Human Development, 17*(4), 267–280.

Boggs, J. M., Dickman Portz, J., King, D. K., Wright, L. A., Helander, K., Retrum, J. H., et al. (2017). Perspectives of LGBT older adults on aging in place: A qualitative investigation. *Journal of Homosexuality, 64*(11), 1539–1560.

Broekman, B. F. P., Niti, M., Nyunt, M. S. Z., Ko, S. M., Kumar, R., & Ng, T. P. (2011). Validation of a brief seven-item response bias-free Geriatric Depression Scale. *The American Journal of Geriatric Psychiatry, 19*(6), 589–596.

Butler, S. S. (2019). Social networks and social isolation among LGBT older adults. In L. W. Kaye (Ed.), *Social isolation of older adults: Strategies to bolster health and well-being* (pp. 181–196). New York: Springer Publishing.

Carroll, A., Feldman, M., & Hauss, J. (2019). *Community-based social isolation programs*. New Orleans: Presentation at the meeting of the American Society on Aging.

Cattan, M., Kime, N., & Bagnall, A.-M. (2011). The use of telephone befriending in low-level support for socially isolated older people—an evaluation. *Health and Social Care in the Community, 19*(2), 198–206.

Cattan, M., White, M., Bond, J., & Learmouth, A. (2005). Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Ageing & Society, 25,* 41–67.

Chen, Y., & Feeley, T. H. (2013). Social support, social strain, loneliness, and well-being among older adults: An analysis of the Health and Retirement Study. *Journal of Social and Personal Relationships, 31*(2), 141–161.

Choi, S. K., & Meyer, I. H. (2016). *LGBT aging: A review of research findings, needs, and policy implications*. Los Angeles: The Williams Institute UCLA School of Law.

Cramer, K. M., Ofosu, H. B., & Barry, J. E. (2000). An abbreviated form of the Social and Emotional Loneliness Scale for Adults (SELSA). *Personality and Individual Differences, 28*(6), 1125–1131.

Espinoza, R. (2011). The Diverse Elders Coalition and LGBT aging: Connecting communities, issues, and resources in a historic moment. *Public Policy & Aging Report, 21*(3), 8–12.

Fetters, M. D., Curry, L. A., & Creswell, J. W. (2013). Achieving integration in mixed methods designs—Principles and practices. *Health Services Research, 48*(6), 2134–2156.

Fredriksen Goldsen, K. I. (2018). Shifting social context in the lives of LGBT older adults. *Public Policy & Aging Report, 28*(1), 24–28.

Fredriksen Goldsen, K. I., Kim, H.-J., Bryan, A. E. B., Shiu, C., & Emlet, C. A. (2017). The cascading effects of marginalization and pathways of resilience in attaining good health among LGBT older adults. *The Gerontologist, 57*(Suppl. 1), S72–S83.

Fredriksen Goldsen, K. I., Kim, H. J., Emlet, C., Muraco, A., Erosheva, E. A., Hoy-Ellis, C. P., et al. (2011). *The Aging and health report: Disparities and resilience among lesbian, gay, bisexual, and transgender older adults*. Seattle: Institute for Multigenerational Health.

Fredriksen Goldsen, K. I., Lehavot, K., Walters, K. L., Yang, J., Hoy-Ellis, C. P., & Muraco, A. (2014). The Health Equity Promotion Model: Reconceptualization of lesbian, gay, bisexual, and transgender (LGBT) health disparities. *American Journal of Orthopsychiatry, 84*(6), 653–663.

Goosby, B. J., Cheadle, J. E., & Mitchell, C. (2018). Stress-related biosocial mechanisms of discrimination and African American health inequities. *Annual Review of Sociology, 44,* 319–340.

Hacker, K. (2013). *Community-based participatory research*. Los Angeles: SAGE.

Harari, M. J., Waehler, C. A., & Rogers, J. R. (2005). An empirical investigation of a theoretically based measure of perceived wellness. *Journal of Counseling Psychology, 52*(1), 93–103.

Hash, K. M., & Rogers, A. (2013). Clinical practices with older LGBT clients: Overcoming lifelong stigma through strength and resilience. *Clinical Social Work Journal, 41*(3), 249–257.

Heller, K., Thompson, M., Trueba, P., Hogg, J., & Vlachos-Weber, I. (1991). Peer support telephone dyads for elderly women: Was this the wrong intervention? *American Journal of Community Psychology, 19,* 53–74.

Hoy-Ellis, C. P., & Fredriksen-Goldsen, K. I. (2016). Lesbian, gay, & bisexual older adults: Linking internal minority stressors, chronic health conditions, and depression. *Aging & Mental Health, 20*(11), 1119–1130.

Hughes, M. E., Waite, L. J., Hawkley, L. A., & Cacioppo, J. T. (2004). A short scale for measuring loneliness in large surveys. *Research on Aging, 26*(6), 655–672.

Kim, H.-J., Goldsen, Fredriksen, Bryan, A. E. B., & Muraco, A. (2017). Social network types and mental health among LGBT older adults. *The Gerontologist, 57*(S1), S84–S94.

Leavy, P. (2017). *Research design: Quantitative, qualitative, mixed methods, arts-based, and community-based participatory research approaches*. New York: Guilford Press.

Levine, M. E., & Crimmins, E. M. (2014). Evidence of accelerated aging among African Americans and its Implication for Mortality. *Social Science and Medicine, 118,* 27–32.

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697.

Miyawaki, C. E. (2015). Association of social isolation and health across different racial and ethnic groups in older Americans. *Ageing & Society, 35,* 2201–2228.

Nicholson, N. R. (2012). A review of social isolation: An important but underassessed condition in older adults. *The Journal of Primary Prevention, 33*(2–3), 37–152.

Orel, N. A., & Coon, D. W. (2016). The challenges of change: How can we meet the care needs of the ever-evolving LGBT family? *Generations, 40*(2), 41–45.

Padgett, D. K. (2008). *Qualitative methods in social work research*. Los Angeles: Sage.

Petersen, J., Kaye, J., Jacobs, P. G., Quinones, A., Dodge, H., Arnold, A., et al. (2016). Longitudinal relationship between loneliness and social isolation in older adults: Results from the Cardiovascular Health Study. *Journal of Aging and Health, 28*(5), 775–795.

Porter, K. E., Brennan-Ing, M., Chang, S. C., Dickey, L. M., Singh, A. A., Bower, K. L., et al. (2009). Providing competent and affirming services for transgender and gender nonconforming older adults. *Clinical Gerontologist, 39*(5), 366–388.

Poscia, A., Stojanovic, J., La Milia, D. I., Duplaga, M., Grysztar, M., Moscato, U., et al. (2018). Interventions targeting loneliness and social isolation among the older people: An update systematic review. *Experimental Gerontology, 102,* 133–144.

Preston, C., & Moore, S. (2019). Ringing the changes: The role of telephone communication in a helpline and befriending service targeting loneliness in older people. *Ageing & Society, 39*(7), 1528–1551.

Proescholdbell, R. J., Roosa, M. R., & Nemeroff, C. J. (2006). Component measures of psychological sense of community among gay men. *Journal of Community Psychology, 34*(1), 9–24.

SAGE Metro Detroit and ACLU (2019). The LGBT Inclusivity Guide for Area Agencies on Aging, available at https://www.sagemetrodetroit.org/wp-content/uploads/2019/03/ACLU-Toolkit_Web-Version_02.27.19.pdf.

Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE). (2014). *Out & visible: The experiences and attitudes of lesbian, gay, bisexual, and transgender older adults, ages 45–75*. New York: SAGE.

Services and Advocacy for Gay, Lesbian, Bisexual and Transgender Elders (SAGE) & National Center for Transgender Equality (NCTE). (2012). Improving the lives of transgender older adults: Recommendations for policy and practice, available at https://transequality.org/sites/default/files/docs/resources/TransAgingPolicyReportFull.pdf.

Taylor, H. O. (2019). Social isolation, loneliness, and health among older men. *Annual Review of Gerontology and Geriatrics, 39*(1), 107–124.

Witten, T. M. (2017). Health and well-being of transgender elders. In K. M. Hash & A. R. Rogers (Eds.), *Annual review of gerontology and geriatrics: Contemporary issues and future directions in lesbian, gay, bisexual, and transgender aging* (pp. 27–41). New York: Springer Publishing.

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.

Angela K. Perone is a doctoral candidate in the Joint Doctoral Program in Social Work and Sociology at the University of Michigan. After overseeing a national LGBT Elder Law program, she returned to school to pursue a Ph.D. at the University of Michigan, where she also earned an M.S.W. and M.A.

Berit Ingersoll-Dayton is a Professor Emeritus of Social Work at the School of Social Work at the University of Michigan. She is interested in social support and clinical research with respect to families in later life. She has assessed various group interventions with older adults and intergenerational family therapy approaches.

Keisha Watkins-Dukhie is the Friendly Caller Program Coordinator at SAGE Metro Detroit, an organization that focuses on services and advocacy for LGBT older adults. Keisha has over 10 years of experience developing culturally diverse multigenerational support groups.