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RESEARCH ARTICLE

LGBTQ+ identity social support and care access among LGBTQ+ caregivers of individuals living with mild cognitive impairment, Alzheimer's disease, and related dementias

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Abstract

INTRODUCTION: This study examines the associations of caregiver role with lesbian, gay, bisexual, transgender, and queer (LGBTQ+) identity social support, relationships, and care outcomes among LGBTQ+ older adults.

METHODS: We use LGBTQ+ Social Networks, Aging, and Policy Study Wave 3 data (QSNAPS; $N = 982$). Descriptive and logistic regression analyses were conducted to examine associations between caregiver role and outcomes.

RESULTS: Eighty respondents (8.1%) care for 90 individuals with neurocognitive disorders, a majority of whom are parents of the respondent. LGBTQ+ older adult caregivers were half as likely to have family support ($p < 0.05$); 40.6% less likely to have coworker support ($p < 0.1$); and 45.6% less likely to have neighbor support ($p < 0.05$) for LGBTQ+ identities. Caregivers were more likely to receive practical help from others ($p < 0.01$), but experienced issues related to their own access to health care.

DISCUSSION: Understanding LGBTQ-identity social support and care access can inform targeted interventions to reduce LGBTQ+ caregiver health disparities.

KEYWORDS
Alzheimer's disease and related dementias, care, caregiver, LGBTQ+, sexual and gender minority, social support

Highlights

- Transgender and gender diverse adults were more likely to be mild cognitive impairment/Alzheimer's disease and related dementias (MCI/ADRD) caregivers.
- LGBTQ+ MCI/ADRD caregivers primarily provide care to parents and familial relatives.
- MCI/ADRD care recipients hold differing political views than LGBTQ+ caregivers.
- LGBTQ+ caregivers were less likely to have family, coworker, and neighbor support.
- LGBTQ+ caregivers were less likely to receive LGBTQ-affirming care communication.

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1 | BACKGROUND

Prior research has increasingly recognized lesbian, gay, bisexual, transgender, and queer (LGBTQ+) older adult caregivers of individuals living with mild cognitive impairment, Alzheimer's disease, and related dementias (MCI/ADRD) as an understudied and medically vulnerable population.[1–3] Due to policy barriers and negative societal attitudes limiting access to marriage and family formation, LGBTQ+ older adults in the United States are significantly more likely to be unmarried or single, childfree, and live alone compared to their heterosexual and cisgender peers.[3,4] The long-standing culture of mutual care within LGBTQ+ communities increases the likelihood that an LGBTQ+ person with MCI/ADRD is receiving care from an LGBTQ+ friend or community member rather than a family relative or spouse.[5–7] Because informal caregiver services are often designed for legal and biological family members or spouses, LGBTQ+ caregivers face additional structural barriers in accessing necessary caregiver services, support, and resources.[8,9]

Prior research indicates that LGBTQ+ older adult caregivers frequently encounter unavailable or low-quality family support, hold feelings of social isolation and loneliness, and have limited social networks.[10–12] Such disparities are often attributed to LGBTQ+ stigma and exclusion from immediate family members[13] or community networks (e.g., faith communities),[14] and lack of access to LGBTQ+ community support and resources,[15] leading many LGBTQ+ caregivers to report greater levels of caregiver burden and poor social connections.[16] Despite these challenges, many LGBTQ+ older adult caregivers demonstrate resilience by maintaining LGBTQ+ supportive social networks and relationships.[17] However, prior research is mixed regarding the network compositions of relationships between LGBTQ+ caregivers and their care recipients. Some studies, for example, explain how LGBTQ+ older adult caregivers mostly provide care to chosen family members—supportive individuals who are not legally or biologically related to them, whom they consider to be family.[16,17]

LGBTQ+ older adult caregivers of individuals with MCI/ADRD face significant obstacles in accessing quality care for themselves due to caregiving demands and barriers to obtaining LGBTQ-affirming care.[2,18] MCI/ADRD caregivers often prioritize the needs of care recipients over their own, thereby reducing the time, energy, and resources available for managing their own health.[19] LGBTQ+ older adult caregivers often report navigating care settings that are unwelcoming or discriminatory toward LGBTQ+ patients,[20] further hindering their access to LGBTQ-affirming care. Despite these challenges, research on LGBTQ-affirming care access and utilization for this population remains limited.

Conceptual frameworks relevant to these issues include minority stress[21,22] and caregiver stress process models.[23] Minority stress model posits that LGBTQ+ individuals face unique stressors related to their LGBTQ+ identities, leading to poor health and social support outcomes.[21,22,24] LGBTQ+ older adult caregivers report facing LGBTQ+ stigmatization and discrimination in care settings, which can heighten their risk of caregiver burden.[17] Caregiver stress process model posits how caregiving stress manifests through primary (e.g., care demands) and secondary (e.g., social, financial) stressors. LGBTQ+ caregivers may face heightened caregiver stress when care recipients lack LGBTQ-identity social support for their care partners.[23] We define LGBTQ-identity social support as the emotional, logistical, financial, and/or affirmational assistance LGBTQ+ individuals receive from their social networks in ways that affirm and respect their LGBTQ+ identities, relationships, and/or experiences. Understanding these stressors through these frameworks can inform efforts to improve the social support and care outcomes for LGBTQ+ older adult caregivers of individuals living with MCI/ADRD.

In this study, we examine how LGBTQ+ MCI/ADRD caregiver role impacts levels of LGBTQ-identity social support and care outcomes among LGBTQ+ older adults by considering factors related to social, cultural, and systemic influences on caregiver health disparities. Using Wave 3 data (N = 982) of the LGBTQ+ Social Networks, Aging, and Policy Study (QSNAPS), we first conducted descriptive analyses to estimate caregiver sample characteristics and the network compositions of relationships with care recipients. We then employed chi-square tests and logistic regressions to examine the associations between MCI/ADRD caregiver role and outcomes related to LGBTQ-identity social support from family, friends, coworkers, and neighbors, along with LGBTQ-affirming care practices. Examining how LGBTQ-identity social support and care access impacts LGBTQ+ MCI/ADRD caregivers is essential for reducing LGBTQ+ caregiver health disparities.

RESEARCH IN CONTEXT

1. **Systematic review**: We reviewed the nascent literature using traditional scholarly databases. Although research on social support and care outcomes for LGBTQ+ older adults is expanding, there remains limited knowledge on the unique needs, relationships, and experiences of LGBTQ+ older adult caregivers for individuals living with MCI/ADRD.
2. **Interpretation**: This study utilized Wave 3 data from the LGBTQ+ Social Networks, Aging, and Policy Study (QSNAPS; N = 982), focusing on a cohort of LGBTQ+ older adults in the Southern United States. Our findings demonstrate that LGBTQ+ caregivers often confront significant challenges, including lack of support from family, coworkers, and neighbors, as well as difficulty receiving LGBTQ-affirming care communication.
3. **Future directions**: Future research should investigate the effectiveness of interventions and policy changes aimed at reducing and eliminating the challenges identified in this study. For instance, studies could examine how different health care or community organizations are structured such that they provide LGBTQ+ MCI/ADRD caregivers with adequate support.

2 | METHODS

2.1 | Sample and study design

For this study, we utilized Wave 3 data from the QSNAPS (*N* = 982). Funded by the National Institute on Aging, QSNAPS is an innovative panel study examining LGBTQ+ older adults in the Southern United States. QSNAPS gathered longitudinal data on participants' personal networks, caregiving experiences, life events, chronic stressors, health behaviors, health care utilization, social support, and health outcomes. To meet eligibility criteria, QSNAPS respondents had to: (1) self-identify as lesbian, gay, bisexual, transgender, gender diverse, and/or queer; (2) be 50 years or older at the time of Wave 1 enrollment; (3) reside in Alabama, Georgia, North Carolina, or Tennessee at the time of Wave 1 enrollment; and (4) provide informed consent for study participation. Wave 1 data (*N* = 1256) were collected from April 2020 through September 2021; Wave 2 data (*N* = 1138) were collected from December 2021 thru September 2022; and Wave 3 data (*N* = 982) were collected from March 2023 thru December 2023. QSNAPS respondents were recruited through targeted online and venue-based sampling, linked referrals, and community outreach to organizations that serve LGBTQ+ and older adult populations in each Southern U.S. state.

The Wave 1 QSNAPS sample is broadly representative of the LGBTQ+ population aged 50 to 76 years in the sample states and the Southern United States as compared to the U.S. Census Bureau's Household Pulse Survey (HPS), Phase 3.2, weeks 34–39.[25] Compared to weighted HPS estimates of demographic characteristics of LGBTQ+ residents in the U.S. South census region, QSNAPS respondents report higher levels of formal education, are less likely to identify as bisexual, and are less likely to identify as Hispanic/Latino.[26] Vanderbilt University Institutional Review Board approved this study, and the secondary analysis of de-identified QSNAPS Wave 3 data was classified as exempt from human subjects research by the University of South Florida Institutional Review Board.

2.2 | Measures

2.2.1 | Caregiving measures

To assess whether respondents hold an MCI/ADRD caregiver role, QSNAPS Wave 3 respondents were asked whether they "currently help take care of an adult with memory problems such as dementia, Alzheimer's, or another cognitive impairment?" (1 = "Yes"; 0 = "No"). We also assess whether respondents hold a non-MCI/ADRD age-related caregiver role by asking the following: "Are you currently assisting an adult who needs help with daily activities due to age or disability?" (1 = "Yes"; 0 = "No"). We combined these responses to create a trichotomous variable: 1 "MCI/ADRD Caregiver" for those who answered "Yes" to the first question; 2 "Age-Related Caregiver" for those who answered "No" to the first question but "Yes" to the second; and 3 "Non-Caregiver."

Following both caregiver-related questions, QSNAPS Wave 3 respondents were asked to provide the name, initials, or some other information that identifies individuals for whom they provided care. These questions aimed to capture caregiving ties in their broader social networks that may not have been identified by other role-related name generator questions used in egocentric social network data collection. If new individuals were identified that had not been named by the respondent previously, QSNAPS respondents were asked to identify their relationship to the care recipient (e.g., parent, spouse, unmarried partner, friend, neighbor, or other family member) and respond to several measures assessing homophily between respondent and care recipient, including whether the recipient was the same age or older, the same gender, the same race, held the same political views, and so forth, compared to the respondent.

2.2.2 | Social support measures

LGBTQ-identity social support was assessed across four domains: family, friends, coworkers, and neighbors. To assess LGBTQ-identity social support from family, respondents were asked, "On average, how supportive are members of your immediate family (mother, father, sisters, brothers, etc.) of your sexual orientation or gender identity?" To examine LGBTQ-identity social support from friends, respondents were asked, "On average, how supportive are your friends of your sexual orientation or gender identity?" To assess LGBTQ-identity social support from coworkers, respondents were asked, "In general, how supportive are/were your co-workers of your sexual orientation or gender identity?" To examine LGBTQ-identity social support from neighbors, respondents were asked, "In general, how supportive are your neighbors of your sexual orientation or gender identity?" Responses for each measure were recorded on a Likert scale ranging from 1 "Very unsupportive" to 5 "Very supportive," with an additional option of 6 "[Group] does not know about my sexual orientation or gender identity." Those who selected "Very supportive" or "Supportive" were categorized as 1, indicating "[Group] supportive of my sexual orientation or gender identity," whereas all other responses were coded as 0, representing "[Group] unsupportive of my sexual orientation or gender identity."

Social support during a serious event was assessed in two domains: family and friends. To assess whether respondents could rely on family members in the event of a serious issue, they were asked, "If you had a serious problem, like a life-threatening illness or possibly losing your home, do you feel that you have some relatives that you can rely on to help?" To examine whether respondents could depend on friends in a serious situation, they were asked, "If you had a serious problem, like a life-threatening illness or possibly losing your home, do you feel that you have some friends that you can rely on to help?" QSNAPS respondents were given four response options for both measures: 1 "Probably don't have," 2 "Might have," 3 "Probably have," and 4 "Definitely have." Those who selected "Probably have" or "Definitely have" were coded as 1, indicating "Definitely or probably have some [familial relatives/friends] to rely on if a serious problem occurs," whereas all other responses were coded as 0, indicating "Probably don't or might have some [familial relatives/friends] to rely on."

To assess whether QSNAPS respondents had received any practical help, they were asked, "In the last few months, have any friends, relatives, or acquaintances (who do not live with you) given you any practical help, such as moving furniture, doing repairs, picking up something at the store, looking after a child, giving you a ride, or similar tasks?" with yes/no responses.

2.2.3 | LGBTQ+ affirming care measures

To examine whether respondents had an LGBTQ-affirming health care provider, they were asked, "Do you have an LGBTQ-affirming health care provider? "LGBTQ-affirming" refers to a health care provider (such as a doctor, physician assistant, or nurse practitioner) who treats you with respect and dignity regarding your LGBTQ identity and can address LGBTQ-specific health needs." Respondents were presented with the following responses: 1 "Yes, they are my primary health care provider," 2 "Yes, I see them in addition to another health care provider," 3 "No, I don't need or want an LGBTQ-affirming health care provider," 4 "No, I cannot find an LGBTQ-affirming health care provider in my area," 5 "I don't know," and 6 "No answer." Those who responded with "Yes, they are my primary health care provider" or "Yes, I see them in addition to another health care provider" were coded as 1 "Yes, I have an LGBTQ-affirming health care provider," whereas all other responses were coded as 0, "No, I do not have an LGBTQ-affirming health care provider."

To assess whether respondents observed LGBTQ-friendly materials in their health care providers' offices, they were asked, "My doctor or other health care provider had materials in their office that let me know they were LGBTQ+ friendly." Respondents were presented with a Likert scale with the following responses: 1 "Always," 2 "Often," 3 "Sometimes," 4 "Rarely," 5 "Never," 6 "Not applicable, I did not have any healthcare appointments since the last survey," and 9 "Prefer not to answer." Responses "Always" or "Often" were coded as 1, indicating "Yes, my doctor or other health care provider had materials in their office that let me know they were LGBTQ+ friendly." All other responses were coded as 0, indicating "No, my doctor or other health care provider did not have materials in their office that let me know they were LGBTQ+ friendly."

To assess whether respondents felt comfortable asking their care providers about their health and health care, they were asked, "I felt comfortable asking my doctor or other health care provider about all aspects of my health or care." Respondents were presented with a Likert scale with the following responses: 1 "Always," 2 "Often," 3 "Sometimes," 4 "Rarely," 5 "Never," 6 "Not applicable, I did not have any health care appointments since the last survey," and 9 "Prefer not to answer." Responses "Always" or "Often" were coded as 1, indicating "Yes, I felt comfortable asking my doctor or other health care provider about all aspects of my health or care." All other responses were coded as 0, indicating "No, I did not feel comfortable asking my doctor or other healthcare provider about all aspects of my health or care."

To examine whether respondents observed their health care providers using LGBTQ-affirming language in-person or on patient intake forms, they were asked, "My doctor or other health care provider used inclusive language in-person or on forms that let me know they were LGBTQ+ friendly." Respondents were presented with a Likert scale with the following responses: 1 "Always," 2 "Often," 3 "Sometimes," 4 "Rarely," 5 "Never," 6 "Not applicable, I did not have any health care appointments since the last survey," and 9 "Prefer not to answer." Responses "Always" or "Often" were coded as 1, indicating "Yes, my doctor or other health care provider used inclusive language in-person or on forms that let me know they were LGBTQ+ friendly." All other responses were coded as 0, indicating "No, my doctor or other health care provider have not used inclusive language in-person or on forms that let me know they were LGBTQ+ friendly."

To assess whether respondents observed their health care providers using gender-affirming language when discussing their health, they were asked, "My doctor or other health care provider used inclusive and gender-neutral or gender-affirming language when discussing my health. That is, they ask and use your pronouns, they may say spouse instead of husband or wife, or otherwise reflect the language that you use to describe yourself and others involved with your care." Respondents were presented with a Likert scale with the following responses: 1 "Always," 2 "Often," 3 "Sometimes," 4 "Rarely," 5 "Never," 6 "Not applicable, I did not have any health care appointments since the last survey," and 9 "Prefer not to answer." Responses "Always" or "Often" were coded as 1, indicating "Yes, my health care provider has used inclusive and gender-neutral or gender-affirming language when discussing my health." All other responses were coded as 0, indicating "No, my health care provider has not used inclusive and gender-neutral or gender-affirming language when discussing my health."

2.2.4 | Covariates

For covariates, we included a variety of respondent sociodemographic characteristics including gender identity, sexual orientation, race/ethnicity (Black, non-Hispanic/Latino; White, non-Hispanic/Latino; and Other Race/Ethnicity or Multiracial), education (less than bachelor's degree; bachelor's degree; and graduate or professional degree), personal income, household income, married/partnered status, and employment status.

We measured race and ethnicity using a two-step process. First, respondents were asked, "What is your race?" with the options: "White," "Black/African American," "American Indian/Alaska Native," "Asian," and "Other." Second, to assess Hispanic/Latino ethnicity, respondents were asked, "Are you of Hispanic, Latino, or Spanish origin?" with a yes/no response. We incorporated race/ethnicity as a two-step measure in this study to account for the well-documented experiences of interpersonal and structural racism faced by racial and ethnic minority LGBTQ+ communities, particularly among Black LGBTQ+ older adults.

In the QSNAPS Wave 3 sample, 5.8% of respondents self-identified as Black, non-Hispanic/Latino; 2.7% as Multiracial; 0.6% as American

Indian or Alaska Native; 0.1% as Asian; 4.7% as White, Hispanic/Latino; 1.9% as other race; and 84.2% as White, non-Hispanic/Latino. Due to the small sample sizes of QSNAPS participants identified as Asian, Hispanic/Latino, American Indian or Alaska Native, Multiracial, or Other Race, we combined these groups to enhance statistical power. Therefore, race/ethnicity was categorized into three groups: "White, non-Hispanic/Latino," "Black, non-Hispanic/Latino," and "Other Race/Ethnicity or Multiracial."

2.2.5 | Analysis

All statistical analyses were performed using Stata 18.5. Descriptive statistics were utilized to examine sample characteristics and the composition of LGBTQ+ older adult caregivers' social networks, detailing the frequencies and percentages of various types of relationships with care recipients. We used chi-square tests and logistic and Poisson regressions to examine relationships between caregiver role and levels of LGBTQ+ identity social support from family, friends, coworkers, and neighbors, as well as relevant LGBTQ-affirming care outcomes. We assessed differences in care recipient relationship (e.g., parental, spousal/partner) and homophily characteristics using chi-square tests by caregiver role (any vs none; MCI/ADRD vs age-related care). Adjusted analyses controlled for factors identified in prior research that predict social support and health outcomes among LGBTQ+ older adults,[9] including age, gender identity, sexual orientation, race/ethnicity, marital or partnered status, education, personal income, and employment status.

3 | RESULTS

Among the QSNAPS Wave 3 sample, 1 of 12 LGBTQ+ older adult respondents (8.1%) care for individuals living with MCI/ADRD, 1 of 8 respondents (12.6%) care for individuals living with age-related conditions (i.e., age-related caregivers), and 79.3% of respondents are non-caregivers. Table 1 displays the demographic characteristics of the QSNAPS Wave 3 sample categorized by caregiver role.

Regarding sample characteristics by caregiver role, transgender and gender diverse (TGD) older adults reported caring for an adult with MCI/ADRD more frequently compared to TGD age-related caregivers (10.0% vs 9.7%, $p < 0.1$) and TGD non-caregivers (10.0% vs 5.4%, $p < 0.1$). LGBTQ+ older adults caring for an adult with MCI/ADRD more frequently reported earning less than $45,000 in annual household income compared to age-related caregivers (16.3% vs 13.5%, $p < 0.05$) and non-caregivers (16.3% vs 7.6%, $p < 0.05$). LGBTQ+ older adults with full-time employment more often identified as non-caregivers than age-related caregivers (46.3% vs 35.5%, $p < 0.05$) and MCI/ADRD caregivers (46.3% vs 42.0%, $p < 0.05$).

QSNAPS respondents reported ties to over 13,173 individuals at Wave 3. Of these, LGBTQ+ older adult caregivers reported a total of 80 individuals to whom they provided MCI/ADRD care and 204 individuals to whom they provided age-related care (see Table 2 for network composition).

Although parents constitute 3.6% of all network ties reported by QSNAPS respondents, they make up nearly half of MCI/ADRD care recipients (50.0%) and over one-third of those receiving age-related care (37.7%) from LGBTQ+ older adult caregivers. Spouses and partners account for 9% of individuals who receive MCI/ADRD care and about one-fifth (17.3%) of those receiving age-related care from LGBTQ+ older adult caregivers. Other caregivers' familial relationships with care recipients include those who are other familial relatives (14.4% for MCI/ADRD care and 12.6% for age-related care); siblings (3.3% and 2.3%); children (1.1% and 2.3%); and chosen family members (6.7% and 5.6%). Caregivers' relationships with non-familial care recipients include those who are roommates (0.0% for MCI/ADRD care and 3.3% for age-related care); friends (3.3% and 2.8%); neighbors (3.3% and 7.9%); and individuals who respondents know another way (8.9% and 8.4%).

Consistent with this focus on parents as MCI/ADRD care recipients, we find that MCI/ADRD care recipients are less likely to be identified as "also LGBTQ+" by LGBTQ+ older adult caregivers in the QSNAPS sample compared to those to whom caregivers provide age-related care (16.7% vs 29.6%, $p < 0.05$), a category that includes more spouses, chosen family, and nonkin. LGBTQ+ older adult caregivers were also more likely to report that individuals to whom they provided MCI/ADRD or age-related care held political opinions that were different from their own (30.1% vs 11.0%, $p < 0.001$). Despite differences in political opinion and less LGBTQ-identity support from family, LGBTQ+ older adult caregivers were more likely to be out as LGBTQ+ to relationship ties that involved any MCI/ADRD or age-related care compared to other ties that did not involve a caregiving relationship (85.1% vs 60.5%, $p < 0.001$).

Regarding social support and care mechanisms by caregiver role, we find that LGBTQ+ older adult caregivers for individuals living with MCI/ADRD more frequently reported having LGBTQ+ unsupportive family members compared to age-related caregivers (44.3% vs 28.5%, $p < 0.1$) and non-caregivers (44.3% vs 33.1%, $p < 0.1$). In addition, MCI/ADRD caregivers reported having LGBTQ+ unsupportive neighbors more often than age-related caregivers (63.3% vs 46.3%, $p < 0.1$) and non-caregivers (63.3% vs 53.4%, $p < 0.1$). And finally, MCI/ADRD caregivers reported receiving practical help from others more often than non-caregivers (65.0% vs 52.6%, $p < 0.01$), but less frequently than age-related caregivers (65.0% vs 66.9%, $p < 0.01$).

Regarding respondent's own access to health care, LGBTQ+ older adult caregivers for individuals living with MCI/ADRD more frequently reported that they received health care in settings that did not display LGBTQ-affirming materials (86.3% vs 77.2%, $p < 0.1$); they did not feel comfortable discussing aspects of their health and care (25.0% vs 11.3% vs 18.9%, $p < 0.05$); and did not use gender-inclusive or affirming language when discussing their health (51.3% vs 41.7, $p < 0.1$) compared to other groups.

After controlling for demographic characteristics, LGBTQ+ older adult caregivers for individuals living with MCI/ADRD were 52.3% (95% confidence interval [CI]: 27.7, 82.2; $p < 0.01$) less likely to receive LGBTQ-identity social support from family; 41.7% (95% CI: 33.4, 101.6; $p < 0.1$) less likely to receive LGBTQ-identity social support from

TABLE 1 Sample demographic characteristics by MCI/ADRD and age-related caregiver status.

		By MCI/ADRD and age-related caregiver status			
Demographic characteristic	**Overall number (column %)**	**Non-caregiver (row %)**	**Age-related caregiver (row %)**	**MCI/ADRD caregiver (row %)**	***p*-value**
Gender identity					**< 0.1**
Cisgender man	535 (54.5)	438 (81.9)	58 (10.8)	39 (7.3)	
Cisgender woman	385 (39.2)	298 (77.4)	54 (14.0)	33 (8.6)	
Transgender or gender diverse[a]	62 (6.3)	42 (67.8)	12 (19.4)	8 (12.9)	
Sexual orientation					< 0.8
Lesbian or gay	836 (85.1)	665 (79.5)	106 (12.7)	65 (7.8)	
Bisexual	94 (9.6)	72 (76.6)	13 (13.8)	9 (9.6)	
Not lesbian, gay, or bisexual	52 (5.3)	41 (78.8)	5 (9.6)	6 (11.6)	
Race and ethnicity					< 0.6
White, non-Hispanic/Latino	827 (84.2)	659 (79.7)	102 (12.3)	66 (8.0)	
Black, non-Hispanic/Latino	50 (5.1)	42 (84.0)	5 (10.0)	3 (6.0)	
Asian, Hispanic/Latino, Multiracial, or Other	105 (10.7)	77 (73.3)	17 (16.2)	11 (10.5)	
Education					< 0.2
Less than a bachelor's degree	245 (25.8)	197 (80.4)	24 (9.8)	24 (9.8)	
Bachelor's degree	294 (30.9)	237 (80.6)	41 (13.9)	16 (5.4)	
Grad or professional degree	411 (43.3)	323 (78.6)	55 (13.4)	33 (8.0)	
Personal income					< 0.2
< $45,000	389 (40.3)	299 (76.9)	50 (12.9)	40 (10.2)	
$45,000–$74,999	270 (28.0)	220 (81.5)	37 (13.7)	13 (4.8)	
>$75,000	307 (31.7)	247 (80.5)	35 (11.4)	25 (8.1)	
Household income					**< 0.05**
<$45,000	49 (9.1)	32 (65.3)	10 (20.4)	7 (14.3)	
$45,000–$74,999	92 (17.0)	67 (72.8)	13 (14.1)	12 (13.1)	
≥$75,000	400 (73.9)	325 (81.2)	51 (12.8)	24 (6.0)	
Employment status					**< 0.05**
Full time	408 (44.7)	341 (83.6)	38 (9.3)	29 (7.1)	
Part time	85 (9.3)	71 (83.5)	5 (5.9)	9 (10.6)	
Unemployed	38 (4.2)	25 (65.8)	9 (23.7)	4 (10.5)	
Retired	381 (41.8)	299 (78.5)	55 (14.4)	27 (7.1)	
Married/partnered status					< 0.6
Not married/partnered	534 (54.4)	427 (80.0)	62 (11.6)	45 (8.4)	
Married/partnered	448 (45.6)	351 (78.3)	62 (13.8)	35 (7.9)	
Total	982 (100.0)	778 (79.3)	124 (12.6)	80 (8.1)	

Note: Boldface indicates statistical significance; "ns" indicates nonsignificance.

[a] Gender identity was assessed using multiple measures, including current gender identity (multiple selection allowed), sex assigned at birth, a direct "are you transgender?" item, and, for transgender and other gender diverse respondents, daily gender presentation (i.e., man, woman, both, neither).

coworkers; and 47.0% (95% CI: 29.7, 94.3; $p < 0.05$) less likely to receive LGBTQ-identity social support from neighbors compared to non-MCI/ADRD caregivers. No significant associations were observed between MCI/ADRD caregiver role and other social support or care outcomes in the QSNAPS Wave 3 sample (see Figure 1).

Table 3 presents adjusted odds ratios for MCI/ADRD and age-related caregiver role and social support and care outcomes. After controlling for demographic characteristics, LGBTQ+ older adult caregivers for individuals living with MCI/ADRD were 50.9% (95% CI = 28.4, 84.8; $p < 0.05$) less likely to receive LGBTQ-identity social

TABLE 2 LGBTQ+ older adult caregiver's relationship to named network members receiving MCI/ADRD and age-related care.

Relationship type	MCI/ADRD care (Freq.)	MCI/ADRD care (%)	Age-related care (Freq.)	Age-related care (%)
Parent	45	50.0%	81	37.7%
Spouse/partner	8	9.0%	37	17.3%
Sibling	3	3.3%	5	2.3%
Child	1	1.1%	5	2.3%
Other relative	13	14.4%	27	12.6%
Chosen family	6	6.7%	12	5.6%
Roommate	0	0.0%	7	3.3%
Friend	3	3.3%	6	2.8%
Neighbor	3	3.3%	17	7.9%
Know another way	8	8.9%	18	8.4%
Total	90	100.0%	215	100.0%

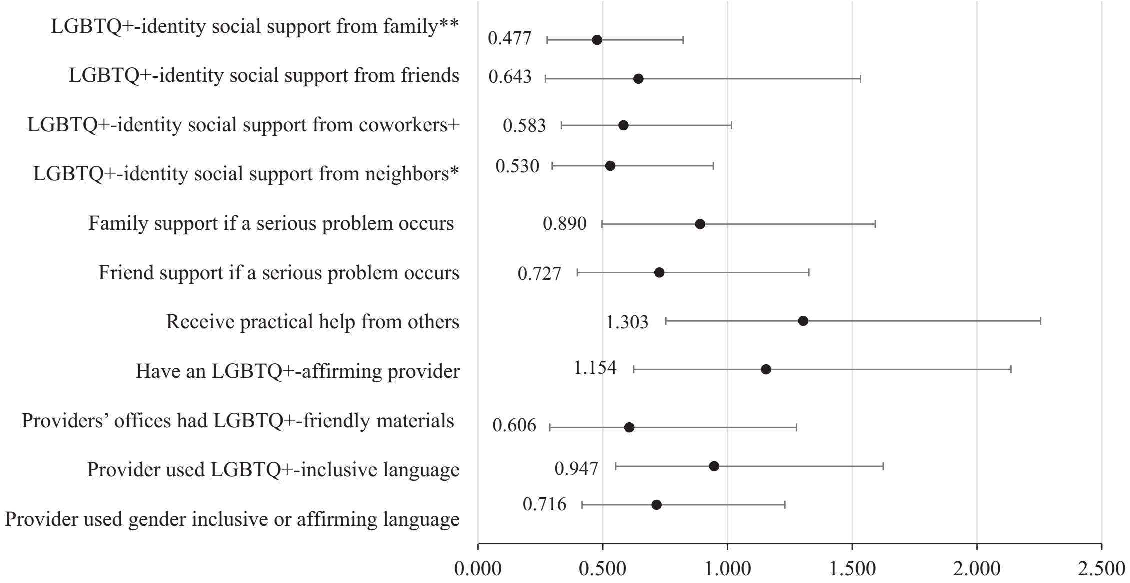

FIGURE 1 Adjusted odds ratios of social support and care outcomes (reference is non-caregiver role). $+p < 0.10$, $^{*}p < 0.05$, $^{**}p < 0.01$. QSNAPS, The LGBTQ+ Social Networks, Aging, and Policy Study. *Source*: QSNAPS, Wave 3 Sample ($N = 982$). LGBTQ+, lesbian, gay, bisexual, transgender, and queer.

support from family; 40.6% (95% CI: 33.9, 103.8; $p < 0.1$) less likely to receive LGBTQ-identity social support from coworkers; and 45.6% (95% CI: 30.5, 97.1; $p < 0.05$) less likely to receive LGBTQ-identity social support from neighbors compared to non-caregivers. After controlling for demographic characteristics, LGBTQ+ older adult caregivers for individuals living with age-related conditions were 86.2% (95% CI = 1.183, 2.933; $p < 0.01$) more likely to receive practical help from others; 75.2% (95% CI = 1.031, 2.979; $p < 0.05$) more likely to have LGBTQ-affirming health care provider; 69.4% (95% CI = 1.043, 2.752; $p < 0.05$) more likely to be in health care settings that display LGBTQ-affirming materials; and 80.0% (95% CI = 0.925, 3.504; $p < 0.1$) more likely to feel comfortable asking their care providers about their health and health care compared to non-caregivers. No significant associations were found between MCI/ADRD and age-related caregiver role and other social support and care outcomes among LGBTQ+ older adults in the QSNAPS Wave 3 sample (see Figure 2).

4 | DISCUSSION

This study is among the first to examine the associations of MCI/ADRD caregiver role with LGBTQ-identity social support and care outcomes among LGBTQ+ older adults. Nearly 1 of 12 respondents (8.1%) reported providing care for an adult with MCI/ADRD. Our findings indicate that TGD older adults, as well as those with lower household annual incomes, are more likely to identify as MCI/ADRD care-

TABLE 3 Unadjusted and adjusted social support and care outcomes by MCI/ADRD and age-related caregiver role.

		Caregiver role					
Outcomes of interest	**Overall *N* (%)**	**Non-caregiver (*N* = 778)**	**Age-related caregiver (*N* = 124)**	**MCI/ADRD caregiver (*N* = 80)**	**Adjusted odds ratio for MCI/ADRD caregiver (95% CI)**	**Adjusted odds ratio for age-related caregiver (95% CI)**	**Sample size**
Social support							
Has LGBTQ-identity social support from family	651 (66.6%)	66.9%	71.5%	55.7%	**0.491** (0.284, 0.848)*	1.261 (0.777, 2.048)	978
Has LGBTQ-identity social support from friends	892 (91.2%)	91.2%	91.9%	89.9%	0.656 (0.274, 1.571)	1.191 (0.499, 2.841)	978
Has LGBTQ-identity social support from coworkers	618 (63.3%)	63.5%	66.7%	55.7%	**0.594** (0.339, 1.038)+	1.163 (0.724, 1.869)	977
Has LGBTQ-identity social support from neighbors	457 (46.7%)	46.7%	53.7%	36.7%	**0.544** (0.305, 0.971)*	1.232 (0.789, 1.924)	978
Has family support if a serious problem occurs	697 (71.0%)	72.4%	65.3%	66.3%	0.857 (0.477, 1.540)	0.753 (0.472, 1.202)	982
Has friend support if a serious problem occurs	755 (76.9%)	76.9%	79.8%	72.5%	0.737 (0.402, 1.349)	1.123 (0.657, 1.919)	982
Receives practical help from others	544 (55.4%)	52.6%	66.9%	65.0%	1.404 (0.809, 2.436)	**1.862** (1.183, 2.933)**	982
Care access							
Has an LGBTQ+-affirming provider	674 (68.7%)	67.8%	75.8%	66.3%	1.229 (0.663, 2.279)	**1.752** (1.031, 2.979)*	981
Providers' offices had LGBTQ-friendly materials	216 (22.0%)	21.9%	28.2%	13.8%	0.650 (0.307, 1.376)	**1.694** (1.043, 2.752)*	980
Felt comfortable asking provider about health or care	800 (81.6%)	81.1%	88.7%	75.0%	0.921 (0.469, 1.810)	**1.800** (0.925, 3.504)+	981
Provider used LGBTQ-inclusive language	444 (45.3%)	44.9%	50.0%	42.5%	0.982 (0.571, 1.689)	1.328 (0.863, 2.041)	980
Provider used gender-affirming language	564 (57.5%)	57.5%	62.9%	48.8%	0.749 (0.435, 1.289)	1.442 (0.913, 2.279)	981

Note: Data derived from the QSNAPS Wave 3 sample (R01AG063771). Boldface indicates statistical significance (+$p < 0.1$; *$p < 0.05$; **$p < 0.01$). Number is the raw count and % is the raw proportion. Adjusted odds ratio adjusts for age, gender identity, sexual orientation, race and ethnicity, education, personal income, married/partnered status, and employment status.

givers than age-related caregivers and non-caregivers. Notably, most LGBTQ+ older adult caregivers reported parent-child relationships with their care recipients. Recipients of MCI/ADRD care were more likely to be heterosexual and cisgender, aware of the caregiver's sexual orientation and gender identity, and hold political views that were different from that of caregivers. Overall, this study contributes a deeper understanding of the unique challenges that LGBTQ+ older adults may encounter while caring for people living with neurocognitive disorders.

4.1 | Associations of caregiver role with sample demographics

Our findings reveal significant patterns in the sample demographic characteristics. TGD older adults were more likely to identify as MCI/ADRD caregivers compared to both TGD caregivers of individuals with age-related conditions and TGD non-caregivers. TGD individuals encounter distinct minority stressors and caregiver stressors in MCI/ADRD caregiving, such as transphobia, TGD-specific discrimination, and systemic barriers like financial insecurity and limited access to TGD-affirming caregiver resources.[1,27] Despite these barriers, we find that TGD respondents in QSNAPS Wave 3 are more likely to be MCI/ADRD caregivers, which raises critical questions about their unique needs, experiences, and relationships with care recipients. Future work should adapt and enhance existing MCI/ADRD research, interventions, and resources to effectively address the distinct challenges faced by TGD older adult caregivers.

Financial and employment insecurities are associated with the MCI/ADRD caregiver role as well. LGBTQ+ older adults with an annual household income of less than $45,000 were more likely to report being an MCI/ADRD caregiver compared to other groups. Those engaged in full-time employment were also less likely to identify as caregivers for individuals with MCI/ADRD or age-related conditions. In fact, previous studies note that ADRD caregivers often experience financial hardships because of lost wages and reduced work hours related to their caregiving obligations.[28,29] Financial strain thus, as suggested by the caregiver stress process model,[23] operates as a secondary stressor, emerging from caregiving responsibilities that disrupt economic stability and planning.

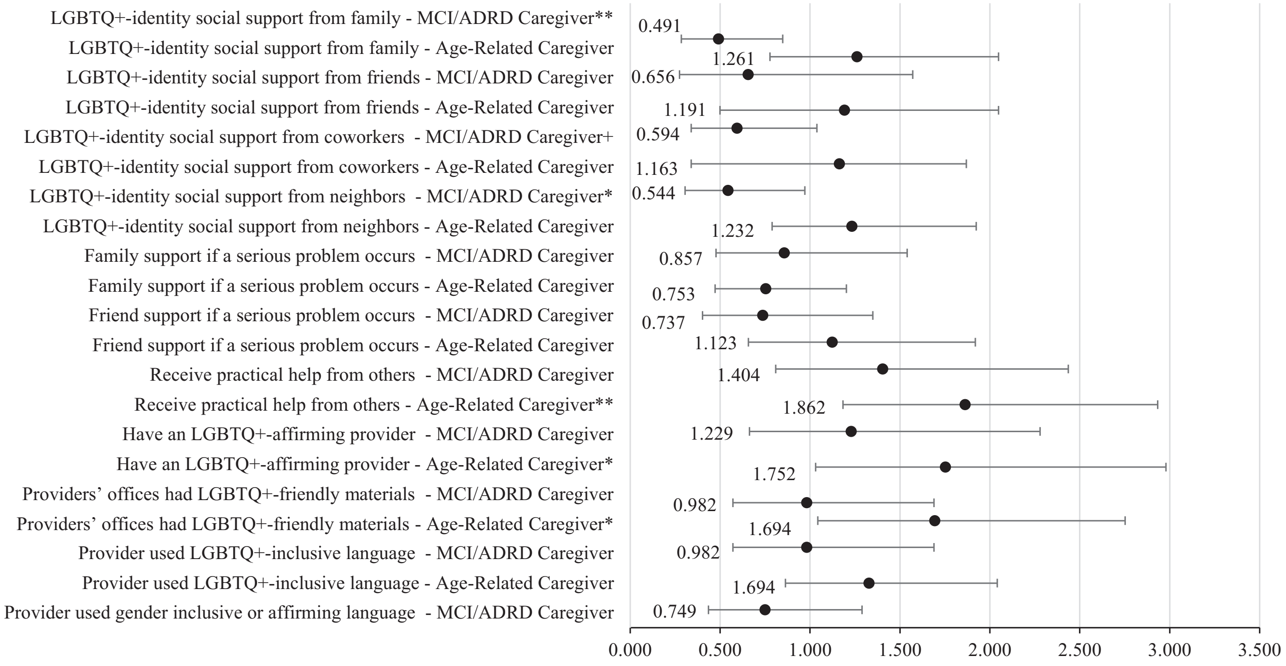

FIGURE 2 Adjusted odds ratios of LGBTQ-identity social support and care outcomes (reference is non-caregiver role). $+p < 0.10$, $*p < 0.05$, $**p < 0.01$. QSNAPS, The LGBTQ+ Social Networks, Aging, and Policy Study. *Source*: QSNAPS, Wave 3 Sample ($N = 982$). LGBTQ+, lesbian, gay, bisexual, transgender, and queer.

In addition, some LGBTQ+ older adult caregivers, particularly those caring for their parents, may receive financial compensation for their caregiving responsibilities.[1] However, access to such compensation is often challenging, as payment programs for family caregivers are subject to strict eligibility criteria, vary widely across states, and may not fully alleviate financial stress for LGBTQ+ caregivers.[30] These findings underscore the need for enhanced policy initiatives that deliver targeted financial and logistical support for this medically vulnerable population.

4.2 | Network composition of caregivers' relationships with care recipients

Regarding network compositions of LGBTQ+ older adult caregivers' relationships with individuals who receive MCI/ADRD and age-related care, parental relationships constituted the largest segment of these networks. Among relationship types, half of caregiver relationships with individuals receiving MCI/ADRD care were parental relationships. This unique finding differs from prior research that emphasizes caregivers' relationships with care recipients from their chosen families—supportive individuals outside of biological or legal family networks.[5,7] Such finding underscores the need to further examine caregivers' relationships with MCI/ADRD care recipients who are familial relatives and how these relationships may differ compared to care recipients from chosen family networks, particularly as it relates to the impact of familial acceptance or rejection on LGBTQ+ caregiver health.

Examining sample characteristics of care recipients, we find that LGBTQ+ older adult caregivers were more likely to provide MCI/ADRD care to heterosexual, cisgender individuals. In addition, care recipients were more likely to be aware of the caregiver's sexual orientation or gender identity, consistent with a focus on kin and close nonkin. Although identity awareness can foster deeper care partnerships,[31] LGBTQ+ older adult caregivers also frequently reported that MCI/ADRD care recipients held differing political opinions, which may introduce anticipatory minority stressors (e.g., LGBTQ-specific social conflict) into the care partnership. Such findings add further complexity to LGBTQ+ older adult caregivers' relationships with their care recipients, potentially increasing their risk of caregiver burden.

Interventions tailored to LGBTQ+ caregivers of people living with ADRD have shown promise in reducing these specific challenges. The Savvy Caregiver Program, adapted for LGBTQ+ ADRD caregivers, demonstrated feasibility and acceptability with LGBTQ+ participants reporting reductions in ADRD caregiver burden and depressive symptoms.[18] Such interventions demonstrate how LGBTQ+ culturally tailored strategies and programs can foster a more supportive care environment for LGBTQ+ older adult caregivers and their care partners.

4.3 | Associations of caregiver role with social support and care mechanisms

LGBTQ+ older adult caregivers of individuals living with MCI/ADRD were significantly more likely to have LGBTQ+ unsupportive family members and neighbors compared to age-related caregivers and non-caregivers. Furthermore, MCI/ADRD caregivers more frequently received practical assistance from others. After adjusting for demographic characteristics, MCI/ADRD caregivers were significantly less likely to receive LGBTQ-identity social support from family, coworkers, and neighbors compared to non-MCI/ADRD caregivers.

As a minority stressor, the absence of LGBTQ-identity social support from family, coworkers, and neighbors can negatively impact the health of LGBTQ+ MCI/ADRD caregivers and strain their care partnerships. In addition, LGBTQ+ older adults face increased feelings of social isolation and psychological distress stemming from LGBTQ-related rejection from familial and other domains of social life.[31,32] Thus, LGBTQ+ unsupportive social environments can limit access to essential resources and networks culturally tailored to the needs of LGBTQ+ older adult caregivers of individuals with MCI/ADRD.[16,17]

Regarding caregiver's own care access, MCI/ADRD caregivers more frequently reported receiving health care in settings that did not display LGBTQ-affirming materials and did not use gender-inclusive or affirming language. This finding suggests that MCI/ADRD caregivers may have less access to care environments that signal LGBTQ+ affirmation compared to non-caregivers. Southern U.S. states with anti-LGBTQ+ legislation (e.g., gender-affirming care bans) or a lack of LGBTQ+ anti-discrimination protections may have fewer LGBTQ-affirming providers, leading to higher reports of discrimination or avoidance of care among respondents.[9] This may explain why QSNAPS respondents reported not experiencing LGBTQ-affirming care. Especially among those who are TGD, no or limited gender-affirming communication in health care settings may disproportionately affect LGBTQ+ ADRD caregivers.[33] Consequently, LGBTQ+ caregivers may turn away from formal care systems, relying instead on informal care networks to manage and protect their health. Enhancing LGBTQ+ affirmation in care environments can help reduce the minority stressors faced by LGBTQ+ older adult caregivers of individuals with MCI/ADRD.

Of interest, no significant associations were found between MCI/ADRD caregiver role and other care outcomes. This finding suggests that although LGBTQ+ older adults generally benefit from LGBTQ-affirming social support and care, MCI/ADRD caregiver responsibilities may hinder their access to such LGBTQ-specific services, supports, and networks.

4.4 | Limitations and future directions

This research study has several limitations to consider. First, due to the limited caregiver sample size, the MCI/ADRD caregiver measure in QSNAPS Wave 3 captures all respondents who provide care for an adult with memory issues, such as dementia, AD, or other forms of cognitive impairment. As a result, we cannot determine whether the care recipients of MCI/ADRD caregivers are specifically managing ADRD or a milder neurocognitive disorder (e.g., MCI) that may not impair daily functioning or require as much caregiver assistance. This distinction could lead to variations in caregiving experiences among QSNAPS respondents. Future research on LGBTQ+ older populations should continue to incorporate more detailed survey measures of caregiver roles and care recipient conditions, differentiating between those who provide care or live with ADRD, MCI, or other cognitive impairments.

Second, although the study sample broadly reflects LGBTQ+ older adults in the Southern United States,[34] it underrepresents racial/ethnic minority LGBTQ+ populations, bisexual individuals, and those with fewer years of formal education. Some of these groups, such as minoritized racial and ethnic communities, are more likely to be family caregivers for individuals with ADRD and face higher risks of caregiver burden and poor health outcomes.[35,36] Future research should oversample minoritized racial and ethnic communities to better capture the unique impacts on LGBTQ+ caregivers from these medically vulnerable populations and to ensure more comprehensive, equitable findings in ADRD research.

Finally, the MCI/ADRD and age-related caregiver measures were first collected during Wave 3. Although QSNAPS is a longitudinal study, the use of cross-sectional analyses to examine associations of MCI/ADRD and age-related caregiver role with LGBTQ-identity social support and care restricts our ability to assess changes over time or establish causal relationships in this study. Future waves of QSNAPS will incorporate these caregiver measures, which will be vital for researchers when conducting comprehensive analyses of the needs, relationships, and experiences of LGBTQ+ older adult caregivers.

Despite these limitations, this study offers valuable insights into LGBTQ-identity social support, care mechanisms, and relationships of LGBTQ+ caregivers who provide care to people living with neurocognitive disorders. Our findings highlight the necessity of addressing disparities in LGBTQ-identity social support and care mechanisms among LGBTQ+ older adult caregivers. Future research should continue informing and developing targeted interventions aimed at reducing health disparities faced by LGBTQ+ caregivers for individuals living with ADRD and other cognitive impairments.

5 | CONCLUSION

LGBTQ-identity social support, relationships with care recipients, and care mechanisms greatly impact the unique needs and experiences of LGBTQ+ older adult caregivers. Future studies should prioritize LGBTQ+ inclusion in study samples and diversify existing LGBTQ+ caregiver samples to better capture the varied nuances of ADRD caregiving experiences. By addressing these gaps and developing targeted interventions that address the challenges identified in this study, researchers, clinicians, and policymakers can better work toward mitigating existing disparities faced by LGBTQ+ older adult caregivers of individuals living with ADRD and other cognitive impairments.

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CONSENT STATEMENT

This study received approval from the Institutional Review Boards of Vanderbilt University and the University of South Florida and was conducted in compliance with the latest Declaration of Helsinki guidelines, including obtaining informed consent from all study participants.

CONFLICT OF INTEREST STATEMENT

The authors declare no conflicts of interest. Author disclosures are available in the supporting information.

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REFERENCES

1. Anderson JG, Flatt JD, Jabson Tree JM, Gross AL, Rose KM. Characteristics of sexual and gender minority caregivers of people with dementia. *J Aging Health*. 2021;33(10):838-851.
2. Candrian C, Burke ES, Kline D, Torke AM. Experiences of caregiving with Alzheimer's disease in the LGBT community. *BMC Geriatr*. 2023;23(1):293.
3. Alzheimer's Association and SAGE: Advocacy & Services for LGBT Elders. Issues brief: LGBT and dementia; 2016.
4. Fredriksen-Goldsen KI, Jen S, Muraco A. Iridescent life course: LGBTQ aging research and blueprint for the future—a systematic review. *Gerontology*. 2019;65(3):253-274.
5. Fredriksen-Goldsen KI, Jen S, Bryan AEB, Goldsen J. Cognitive impairment, Alzheimer's disease, and other dementias in the lives of lesbian, gay, bisexual and transgender (LGBT) older adults and their caregivers: needs and competencies. *J Appl Gerontol*. 2018;37(5):545-569.
6. Shiu C, Muraco A, Fredriksen-Goldsen K. Invisible care: friend and partner care among older lesbian, gay, bisexual, and transgender (LGBT) adults. *J Soc Soc Work Res*. 2016;7(3):527-546.
7. Knauer NJ. LGBT older adults, chosen family, and caregiving. *J Law Relig*. 2016;31(2):150-168.
8. Anderson JG, Flatt JD. Characteristics of LGBT caregivers of older adults: results from the national caregiving in the U.S. 2015 survey. *J Gay Lesbian Soc Serv*. 2018;30(2):103-116.
9. Lampe NM, Barbee H, Tran NM, Bastow S, McKay T. Health disparities among lesbian, gay, bisexual, transgender, and queer older adults: a structural competency approach survey. *Int J Aging Hum Dev*. 2024;98(1):39-55.
10. Di Lorito C, Bosco A, Peel E, et al. Are dementia services and support organisations meeting the needs of lesbian, gay, bisexual and transgender (LGBT) caregivers of LGBT people living with dementia? A scoping review of the literature. *Aging Ment Health*. 2022;26(10):1912-1921.
11. Anderson JG, Jabson Tree JM, Flatt JD, Gross AL, Williams IC, Rose KM. A comparative analysis of family quality of life between heterosexual and sexual minority caregivers of people with dementia. *J Appl Gerontol*. 2022;41(6):1576-1584.
12. Breder K, Bockting W. Social networks of LGBT older adults: an integrative review. *Psychol Sex Orientat Gend Divers*. 2023;10(3):473-489.
13. Allison K, Power R, Ussher JM, Perz J; Out with Cancer Study Team. "Queer people are excellent caregivers, but we're stretched so very thin": psychosocial wellbeing and impacts of caregiving among LGBTQI cancer carers. *BMC Cancer*. 2024;24(1):36.
14. Lampe NM, McKay T. Associations of faith community rejection with social support and health outcomes among LGBTQ+ older adults. *J Gerontol B Psychol Sci Soc Sci*. 2025;80(5):gbaf009.
15. Stinchcombe A, Oueis J, Wilson K, Wright DK. Safer dementia care spaces: perspectives from LGBTQ+ people with cognitive impairment and caregivers. *Dementia*. 2025;24(2):214-234.
16. Xie Z, Hamadi H, Terrell K, George L, Wells J, Liang J. Loneliness and social and emotional support among sexual and gender minority caregivers. *JAMA Netw Open*. 2024;7(12):e2451931.
17. Fredriksen-Goldsen K, Shuman A, Jen S, Jung HH. Stress and resilience among sexual and gender diverse caregivers. *Res Aging*. 2023;45(9-10):654-665.
18. Kittle KR, Lee R, Pollock K, et al. Feasibility of the Savvy Caregiver Program for LGBTQ+ caregivers of people living with Alzheimer's disease and related dementias. *Int J Environ Res Public Health*. 2022;19(22):15102.
19. Gaugler JE, Jutkowitz E, Peterson CM, Zmora R. Caregivers dying before care recipients with dementia. *Alzheimers Dement Transl Res Clin Interv*. 2018;4(1):688-693.
20. Candrian C, Cloyes KG. "She's dying and I can't say we're married?": end-of-life care for LGBT older adults. *Gerontologist*. 2021;61(8):1197-1201.
21. Brooks V. *Minority stress and lesbian women*. Lexington Books; 1981.
22. Meyer IH. Minority stress and mental health in gay men. *J Health Soc Behav*. 1995;36(1):38-56.
23. Pearlin LI, Mullan JT, Semple SJ, Skaff MM. Caregiving and the stress process: an overview of concepts and their measures. *Gerontologist*. 1990;30(5):583-594.
24. Meyer IH. Resilience in the study of minority stress and health of sexual and gender minorities. *Psychol Sex Orientat Gend Divers*. 2015;2(3):209-213.
25. McKay T, Tran NM, Barbee H, Min JK. Association of affirming care with chronic disease and preventive care outcomes among lesbian, gay, bisexual, transgender, and queer older adults. *Am J Prev Med*. 2023;64(3):305-314.
26. McKay T, Akré ER, Henne J, Kari N, Conway A, Gothelf I. LGBTQ+ affirming care may increase awareness and understanding of undetectable = untransmittable among midlife and older gay and bisexual men in the US South. *Int J Environ Res Public Health*. 2022;19(17):10534.
27. Maestre G, Hill C, Griffin P, et al. Promoting diverse perspectives: addressing health disparities related to Alzheimer's and all dementias. *Alzheimers Dement*. 2024;20(4):3099-3107.
28. Zhang J, Wang J, Liu H, Wu C. Association of dementia comorbidities with caregivers' physical, psychological, social, and financial burden. *BMC Geriatr*. 2023;23(1):60.
29. Sadavoy J, Sajedinejad S, Duxbury L, Chiu M. The impact on employees of providing informal caregiving for someone with dementia. *Aging Ment Health*. 2022;26(5):1035-1043.
30. Feinberg LF, Newman SL. A study of 10 states since passage of the National Family Caregiver Support Program: policies, perceptions, and program development. *Gerontologist*. 2004;44(6):760-769.
31. Smith L, Chesher I, Fredriksen-Goldsen K, Ward R, Phillipson L, Newman CE, Delhomme F. Investigating the lived experience of LGBT+ people with dementia and their care partners: a scoping review. *Ageing Soc*. 2024;44(4):843-866.
32. Flatt JD, Cicero EC, Kittle KR, Brennan-Ing M. Recommendations for advancing research with sexual and gender minority older adults. *J Gerontol Ser B*. 2022;77(1):1-9.
33. Nowaskie DZ, Sewell DD. Assessing the LGBT cultural competency of dementia care providers. *Alzheimers Dement*. 2021;7(1):e12137.
34. Barbee H, McKay T. Do supportive work environments matter for minority aging? Work stress and subjective cognitive impairment among middle-age and older lesbian, gay, bisexual, transgender, and queer adults. *Acta Psychol*. 2023;237:103949.

35. Liu R, Chi I, Wu S. Caregiving burden among caregivers of people with dementia through the lens of intersectionality. *Gerontologist*. 2022;62(5):650-661.
36. Gaugler JE, Borson S, Epps F, Shih RA, Parker LJ, McGuire LC. The intersection of social determinants of health and family care of people living with Alzheimer's disease and related dementias: a public health opportunity. *Alzheimers Dement*. 2023;19(12):5837-5846.

SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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