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Italian Sexual Minority Older Adults in Healthcare Services: Identities, Discriminations, and Competencies

Fausta Rosati[1] · Jessica Pistella[1] · Roberto Baiocco[1]

Abstract

Purpose This study explores perceptions and experiences related to healthcare utilization in a group of Italian sexual minority older adults, to understand the unique challenges faced by this population when accessing healthcare services. Older adults represent one of the subgroups exposed to the highest risk within sexual minorities with regard to physical and mental health.

Method Data collection occurred between October 2018 and April 2019. Semi-structured interviews were carried out with 23 participants over 60 years, including questions about participants': experiences when dealing with physical/mental healthcare services; tendency to disclose sexual orientation in clinical contexts; preferences and desires when seeking care. Data were analyzed using Interpretative Phenomenological Analysis (IPA), in order to provide qualitative information on participants' experiences.

Results Three interconnected themes were identified: the relevance of clinician and patient's identities in determining confidence and satisfaction; expectations and experiences of discrimination; the need for specific competencies on sexual minority concerns.

Conclusion Access and utilization of healthcare services can be considered as a multi-faceted phenomenon which involves people's past and current experiences, perceptions, expectations and desires. Participants' perception of having to deal with heterosexist healthcare settings influences health behaviors and outcomes.

Policy Implications Interventions directed to healthcare providers are needed, to increase specific competencies and ensure safe and affirming environments.

Keywords Sexual minority · Older adults · Health disparities · Access to care · Competencies

Introduction

Sexual minority (SM) people—e.g., lesbian, gay, bisexual, trans, queer, and intersex people (LGBTQI+)—of all ages experience higher rates of health disparities when compared with their cisgender (people whose current gender identity label matches with birth-assigned sex category) and/or heterosexual counterparts (Lick, Durso, & Johnson, 2013; Institute of Medicine, 2011; Russell & Fish, 2016). The poorer health status affecting this population is mainly caused by three orders of factors: (1) The chronic stress due to the past and current experiences of discrimination, stigma, and victimization because of their sexual minority status (Frost, Lehavot, & Meyer, 2015; Gessner, Bishop, Martos, Wilson, & Russell, 2019; Mays & Cochran, 2001; Meyer, 2003); (2) the presence of homophobia (negative stereotypes and attitudes toward sexual minorities) and heterosexism (belief that heterosexuality is normative/superior than non-heterosexuality, which manifests in a more subtle form compared to homophobia) in clinical contexts, resulting in discriminatory attitudes or lack of knowledge on the part of healthcare professionals, which in turn create (3) disparities in healthcare (Brotman, Ryan, Jalbert, & Rowe, 2002; Irwin, 2007; Morrison & Dinkel, 2012).

Older adults represent one of the subgroups exposed to the highest risk within the SM population with regard to physical and mental health, because of some specific characteristics related to their generation (Almack & King, 2019; D'Augelli, Grossman, Hershberger, & O'connell, 2001; Fredriksen-Goldsen et al., 2011; Kneale, French, Henley, &

✉ Roberto Baiocco
roberto.baiocco@uniroma1.it

Fausta Rosati
fausta.rosati@uniroma1.it

Jessica Pistella
jessica.pistella@uniroma1.it

[1] Department of Social and Developmental Psychology, Faculty of Medicine and Psychology, Sapienza University of Rome, Rome, Italy

Thomas, 2018; Kuyper & Fokkema, 2010; SAGE, 2010). Many SM older adults (SMOA) lived their youth and early adulthood in an adverse historical context, in which homosexuality was considered a mental disease and criminalized in several countries all over the world. Therefore, the concealment of their sexual identity (SI) represented a functional strategy to survive and became an internalized mechanism generally hard to deconstruct in later life (Cohler & Hostetler, 2007; Rosenfeld, 2009).Then, when dealing with the healthcare services, the fear of being discriminated could easily lead SMOA to avoid disclosing their SI (Addis, Davies, Greene, MacBride-Stewart, & Shepherd, 2009; Czaja et al., 2016; Grigorovich, 2015).

Negative expectations concerning residential care facilities emerge from several studies, in which SMOA' beliefs of being discriminated are linked to the fear of having to go back into the closet and to hide important aspects of their life (Cronin, Ward, Pugh, King, & Price, 2011; Johnson, Jackson, Arnette, & Koffman, 2005; King & Dabelko-Schoeny, 2009; Lambda Legal, 2010). Some studies found a tendency of SMOA not to come out with their family doctor (Brotman, Ryan, & Meyer, 2006; Gardner, de Vries, & Mockus, 2014; Fredriksen-Goldsen et al., 2011). Finally, there are some evidence of SMOA' experiences of discrimination in clinical settings, ranging from low-quality treatments to victimization (Brotman, Ryan, & Cormier, 2003; Coon, 2003; Czaja et al., 2016; Fredriksen-Goldsen et al., 2011; SAGE, 2010).

Clinical contexts are often characterized by ageist assumption (Wyman, Shiovitz-Ezra, & Bengel, 2018), which result in negative attitudes such as infantilizing (lack of communication and involvement of patients in medical decisions) and desexualizing (perceive a person as not interested in sexual activity and not attractive) elderly people. The interplay between ageism and heterosexism contributes to the invisibility that distinguishes this population (Blando, 2001; Comfort et al., 2010; Grossman, Frank, & McCutcheon, 2013) and, together with discrimination, creates unique challenges for SMOA. As a result, many SMOA tend to delay or avoid preventive check-up and needed medical care (Addis et al., 2009; Ard & Makadon, 2012; Price, 2005).

The life course perspective (Elder, 1994) can be considered particularly suitable to understand how the historical and social context SMOA grew up in impacted their identity development (Hammack, 2005; Hammack, Frost, Meyer & Pletta, 2018; Rosenfeld, 2009). The SM older generation went through at least two remarkable historical events that are strictly connected to their sexual identity: The civil rights movements started with the Stonewall riots in 1969, and the advent of AIDS which marked several decades between the last and the current century. These cohort-defining events affect the experience of minority stress in a unique way that distinguishes SMOA from the younger generations (Shankle. Maxwell, Katzman & Landers, 2003).

In terms of healthcare access, the life course perspective allows to consider the way in which different cohort-defining events influence health behaviors and outcomes (Halfon & Hochstein, 2002; Fredriksen-Goldsen et al., 2014a). Indeed, access to healthcare is currently defined by the Institute of Medicine (IOM) as the use of health services to achieve the best possible outcomes, and is well documented how the individuals' opportunities to achieve their full potential for good health and well-being is strongly influenced by life experiences (D'Augelli et al., 2001; Fredriksen-Goldsen & Kim, 2017). Thus, access to healthcare can be considered as the result of factors that are both internal and external to the individual, influenced by past experiences with healthcare services—such as exclusion, rejection, pathologization, and imposed treatment regimens—and current institutional policies concerning sexual orientation and gender identity issues.

The Present Study

In Italy, where this research is carried out, there is still an important lack of empirical studies and inclusive policies with regard to SMOA (Rosati, Pistella, Ioverno, e Baiocco, 2018; Scandurra, Mezza, Bochicchio, Valerio & Amodeo, 2017). Italian healthcare is provided to all citizens by a mixed public-private system, where the public part is guaranteed by the National Healthcare Service. Therefore, people who need medical treatment are not tied to economic barriers such as insurance restrictions. Nevertheless, there are no healthcare venues specifically designed to address the needs of SMOA people. The few existing scientific investigations have found a tendency to concealment often linked to a lack of recognition of one's own lesbian and gay (LG) identity (Pietrantoni, Sommantico, & Graglia, 2000); and the need of specific training programs for healthcare professionals (Baiocco & Pistella, 2019), in order to improve service delivery and quality of life of SMOA (Lelleri, 2012a, 2012b).

By adopting a life course perspective (Elder, 1994), together with the minority stress theory (Meyer, 2003), this research tries to understand the effects of meaningful historical events and social context on the identity development of SMOA. Qualitative data gathered from individual semi-structured interviews with a group of Italian SMOA were examined to understand the following: (1) how do SMOA perceive the quality of clinical contexts in terms of healthcare access?; (2) what kind of experiences do SMOA have in clinical contexts?; (3) and to what extent SMOA' experiences and perceptions influence their behaviors and desires when interacting with healthcare professionals?

Methods

Participants and Procedure

Participants were recruited through purposive and snowball sampling techniques, through the personal acquaintances and the related connections of the first author/lead interviewer, as well as using a flyer containing information about the research which was spread online and posted on LGBTQI+ organization centers, bars, and other meeting places. Inclusion criteria were (1) self-identifying as SM person and (2) being at least 60 years old. Following the consent process, participants first completed a questionnaire which allowed to obtain demographic information and other potential intervening variables, such as critical mental health conditions. Then, they took part in individual semi-structured interviews which lasted on average 60 min each. All the interviews were conducted by the first author of this paper and most of them took place at the Department of Social and Developmental Psychology of Sapienza University of Rome, while others at participants' homes, based on their preferences. All the interviews were administered in a quiet room with a closed door, following the same protocol of main questions. Data collection occurred between October 2018 and April 2019. A total of 23 LG people took part in the study. All participants were White and Italians and currently residing in a metropolitan area, mostly in Rome (91%). Table 1 shows some key characteristics of the sample.

Measures

The interview used in this study was part of the "Generations Study" (Frost et al., 2019; in press), which aimed to examine several aspects of life experiences in different generations of SM people in the USA (more information regarding the qualitative methods used by the Generation study are available at the following link: http://www.generations-study.com/methods). The whole interview protocol is organized in eight sections which progressively move from open unstructured sections, such as the life story, to more specific content-oriented questions, such as healthcare utilization. The interview has been designed to allow researchers to examine the complex interrelation of SI development, minority stress, and social change through an integrative methodological approach. The interview protocol was translated and adapted to the Italian context by the authors, though keeping unchanged the original structure such as the key questions and order of the sections.

For the purpose of this study, we focused on the healthcare utilization section, that is theoretically based on the behavioral model of health service use (Andersen, 1995) applied to sexual minorities (Martos, Wilson, Gordon, Lightfoot, & Meyer, 2018). From this perspective, people's experiences as sexual minorities influence healthcare preferences, which in turn represent a predisposing factor for healthcare utilization. This section of the interview includes questions about participants' (1) experiences when dealing with physical/ mental healthcare services (e.g., "Tell me about the last time you felt you needed healthcare but didn't seek help"); (2) tendency to disclose their SI in clinical contexts (e.g., "When you talk to a provider about a health concern, how open are you about your sexual identity?"); (3) preferences and desires when seeking care (e.g., "Is it important to you to go for healthcare at an LGBT-specific clinic or provider?").

Table 1 Descriptive of participants' characteristics

	Participants (*N* = 23)
Identity Characteristics	M (SD) or *n* (%)
Age	64,35 (4,18) (Min = 58, Max = 71)
Gender Identity/Sexual Orientation	
Woman/Lesbian	11 (48%)
Man/Gay	12 (52%)
Socioeconomic Status	
Low	2 (9%)
Average	18 (78%)
High	3 (13%)
Education	
High School Diploma	9 (39%)
Bachelor's Degree	10 (44%)
Doctoral Degree	4 (17%)

Data Analysis

All the interviews were conducted, transcribed, and analyzed in Italian. The extracts chosen for the "Results" section were translated to English after the analysis by the first author and lead interviewer/analyst. A team of three researchers (corresponding to the authors of this study) took part to the data analysis following the *Interpretative Phenomenological Analysis* (IPA; Smith, Flowers & Larkin, 2009), which was particularly suitable for the purpose of the study, as IPA enables an in-depth exploration of lived experiences' interpretation, and requires small homogeneous sample sizes and semi-structured interviews.

The first author initially examined all data, starting with two transcripts which were deemed to be particularly salient in terms of content emerged and representative of some aspects of the SMOA population. The transcripts were taken from a gay man participant aged 61 years old who went through several physical challenges because of his HIV status, with experiences close to death, finally resulting in a proud and resilient sense of self, and a lesbian woman aged 71 years old, whose experiences were dominated by the theme of invisibilization, resulting in a current tendency to conceal her sexual identity.

These different narratives, similar to the *affirmative* (psychological adjustment, identity's claim and affirmation) and the *stereotypic* (higher levels of stigma, loneliness, depression, isolation) SMOA identities conceptualized by Friend (1989), were used to find the first emergent codes and to help orient the subsequent analysis which involved the rest of participants' transcripts. The most salient points from participants' narratives were highlighted and reread several times, before being organized in a table of emerging codes.

Consistent with the IPA approach (Smith et al., 2009), the extracted concepts were first ordered in a chronological way, by following the sequence they came up with. Then, the authors discussed the emerged codes in different meetings, by gradually determining the final order corresponding to a theoretical structure, through the identification of convergence and divergence between codes, as well as the creation of connections, clusters, and superordinate concepts.

Examples of emerging codes are as follows: mistrust toward doctors; experiences of discrimination (both in medical and psychological settings); positive experiences in medical and psychological contexts (with the sub-codes "identification" and "specialization"); avoiding assistance; disclosure tendency with doctors and psychologists (with the sub-code "encouraged by clinicians' identity"); SM-specific healthcare clinics and providers (with the sub-codes "desires and absence" and "need for competencies"); expert patient (both with doctors and with psychologists); access to healthcare because of HIV+ status. This process led to the first hierarchical thematic structure composed by themes and sub-themes, which was discussed, modified, and reviewed with the coauthors until achieving the final set of results.

Results

Three main themes emerged: (1) the relevance of clinician and patient's identities; (2) expectations and experiences of discrimination; and (3) the need for specific competencies on SM concerns.

Relevance of Identities

One central theme that was identified in participants' narratives in terms of frequency and relevance was the importance of identities, regarding both personal and professional aspects of the clinician's identity and the way in which they intersect with participants' SI (Table 2).

The perceived SI of the clinician seemed to strongly influence the participants' tendencies to disclose their own SI, because they felt comfortable when dealing with a SM professional: "Um, I do it [disclose SI] if I'm really forced, but no, I don't feel at ease...absolutely. Unless on the other side there is a person like me, in that case yes. But if is a straight person, no" (62-year-old lesbian woman). The clinician's SI also had an impact on the quality of participants' experiences when accessing healthcare services, as one 60-year-old lesbian woman stated: "I have this gynecologist friend and, whatever I need, I refer to her. She works also in the hospital and I can go there. She takes care of me and treats me as a person. [...] She is lesbian too".

Regarding the professional aspects related to the clinician's identity, we specifically refer to the specialization practiced by the healthcare professional. Participants' experiences in terms of confidence and satisfaction appeared to strongly differ if they were dealing with a psychologist or a doctor specialized in sexual fields rather than with a general practitioner. Concerning participants' disclosure tendency, it seemed obvious and natural for most of the sample's members to come out to a psychologist, whereas it was not usual to do the same with doctors: "I am completely open [with a psychologist], otherwise there's no point. I immediately told everything to my therapist" (60-year-old gay man). Even when participants held their family doctor in high esteem, they tended not to disclose their SI to them: "With my [family] doctor, that is a smart person, I never told to him I'm gay. I mean, I never really hided, but I can't openly talk about my intimate life […] I don't know why, I am probably ashamed, that's why" (67-year-old gay man).

An exception within the medical context concerned those professionals specialized in sexual health, such as gynecologists, urologists, or experts in sexually transmitted diseases (STDs), with whom participants were almost forced to share aspects of their affective-sexual life: "With my urologist […] at the first meeting I told him what my nature was, my identity: *Yes! I'm homosexual*, and he […] started asking me some questions about my partner and sexual life. So, I told him that sex at my age has become so peripheral that I rarely think about it. He told me that I was wrong because sexuality is important for the organism's balance, and I should practice masturbation and go to that places in which I could find a partner [laugh] He is such a modern doctor" (70-year-old gay man).

An interesting finding in terms of access is related to the subgroup of HIV seropositive participants. Being inserted in the specific clinical setting with experts in STDs made them feeling part of a safe environment, with qualified and sensitive personnel. As explained by one 61-year-old gay man: "The fact of being seropositive leads you in an environment in which homosexuality is accepted. They [experts in STDs] treat you and they know you, because they have continuous experiences. They have a relationship with homosexual people. I know very well that clinic, I feel at home there". Given that being seropositive entails a long-lasting struggle in people's life story, this kind of narrative can be interpreted in the light of these participants' ability to make meaning of both negative and positive experiences related to their HIV story, which lead them to develop a specific form of resilience.

Table 2 The relevance of clinician and patient's identities: thematic structure and representative quotations

Theme	Sub-theme	Context	Representative Quotation
Identities (*n* = 42)*	Sexual Identity (*L* = *5; G* = 4)*	Disclosure	*Yes, this situation occurred when I went to the doctor once, because I had to talk about my sexual life. But in that case, I had no problem because she is part of the community* [lesbian] (61-year-old lesbian woman)
		Access	*For instance, my proctologist is gay and when I go to him I feel calmer when I talk and we understand each other immediately* (63 year-old gay man)
	Clinician's Specialization (*L* = 13*; G* = 20)*	Disclosure	*I don't give a shit! What am I supposed to tell them* [referring to doctors]*? If I am sick what does this have to do with my sexual orientation? On the contrary with the psychologist, yes… it's the first thing that comes out, sure. This probably underlines other aspects, or shortcomings maybe, because by now doctors and general practitioners don't have holistic approaches, they treat your toothache, that's it. But if the psychologist doesn't have a holistic approach, he's actually sabotaging the patient and the treatment, you know?* (70-year-old lesbian woman)
		Access	*When I said that I was seropositive things totally changed for the better.* [...] *Because in my opinion, there is a form of… I believe that is a positive fact of awareness, in the health personnel, on how to relate to people who have this problem, who are seropositive* (62-year-old gay man)

Note: * In parenthesis the frequencies of quotations and the number of times they occurred based on gender (G = Gay men; L = Lesbian women)

Expectations and Experiences of Discrimination

Discrimination appeared in two main forms of expectations and experiences that we consider as two sub-themes strongly interconnected (Table 3).

Expectations of discrimination can result from past experiences, as explained by a 61-year-old gay man: "I try to avoid private clinics for hospitalization, because it happened to me, that they have agreements with the Vatican, religious personnel, a Catholic head nurse and I don't want to experience this anymore". This kind of expectations emerged often as a form of mistrust toward doctors, which could lead to avoid certain clinics or delay treatments: "Yes, it happened that I needed healthcare but I didn't seek help. Basically because of fear. Lack of trust toward doctors. I always remember how they looked at me at the diagnosis moment [HIV+]" (63-year-old gay man). Expectations of discrimination also occurred when participants did not experience a direct act of discrimination toward themselves, but used to be part of homophobic environments: "When I looked for a psychoanalyst [...] there was this famous therapist and I used to go to his seminars, which were generally very crowded, and the way he treated homosexual people was terrible. He considered homosexuality as a mental illness. I never came out at that time" (70-year-old gay man).

Concerning participants' actual experiences of discrimination, we refer to an explicit form of negative attitude—such as rejection—exercised by clinicians and linked to participants' SI. Within medical context, we found that those participants who experienced rejection were part of the subgroup of seropositive persons, who had been denied medical treatment from some doctors, especially dentists, because of the fear of being

Table 3 Expectations and experiences of discrimination: thematic structure and representative quotations

Theme	Sub-theme	Context	Representative Quotation
Discriminations (*n* = 13)*	Expectations (*L* = 1; *G* = 5)*	Medical	*I'm in the closet, because I don't trust them* [doctors]*. They are cold, detached. And what I think is "I would never talk to them about my intimate sphere"* (61-year-old gay man)
		Psychological	*Yes, this was a problem for me, because with a psychologist I had to come out and I didn't want to do it. I didn't know which kind of person I could encounter, you know, I heard about all that negative stories […]* (62-year-old lesbian woman)
	Experiences (*L* = 2; *G* = 5)*	Medical	*Yes, it happened a long time ago. I remember for instance a dentist which as soon as I told I was seropositive she threw me out, by refusing to treat me* (63-year-old gay man)
		Psychological	*Well, I was looking for a psychotherapist and I found one. After our first meeting, where I came out as lesbian, she told me she couldn't treat me without explaining clearly why. She only told me she believed that for me was better a male therapist and that she was too busy to find a place for me. Ironically, an acquaintance of mine went to the same therapist one or two week later and she* [therapist] *immediately accepted her as a client. So I got confirmation of the rejection* (71-year-old lesbian woman)

Note: * In parenthesis the frequencies of quotations and the number of times they occurred based on gender (G = Gay men; L = Lesbian women) infected: “I needed to do a series of dental treatments and I was looking for a dentist. So I found one and I took an appointment during which I filled out the anamnestic form where I clearly stated I was ‘HIV+’. And the evening before the next appointment her husband – also a doctor – called me to explain that his wife might want to have children, family, etc. and that she would rather not treat me. I felt I was really treated like shit” (61-year-old gay man). Other participants also reported being rejected by psychotherapists, as one 70-year-old gay man said: “I was looking for a psychoanalyst […] at the 3rd session he mistreated me by telling me: *I deal with real problems and you don’t have any problem! Don’t waste my time… even with the homosexual aspects of your person*”.

The Need for Specific Competencies on Sexual Minority Concerns

The last theme that was identified concerns the need for competencies related to SM issues in several clinical contexts. This theme is characterized by four dominant narratives which constituted the interconnected sub-themes (Table 4).

Participants often expressed the desire to find a SM-specific clinic or provider, as one 63-year-old lesbian woman reported: “It would be a dream [the existence of a SM-clinic]. In the future I wish there was an LGBT organization to look after LGBT people health when they no longer have the strength, when they become old and remain alone”. The desire for a SM clinic was often automatically linked to aging, because the idea of being dependent on medical services could represent an important source of concern among SMOA.

The lack of a clinic or providers specifically trained in dealing with SM needs is a current issue in Italy. This is also evident when participants expressed the perception of educating clinicians about the specific issues related to their SI, taking up the role of “expert patient”: “Thanks to me, my therapist had a great experience in this field [sexual orientation], and was easier for her to deal with the subsequent [SM] patients. I often said she should pay me for that” (71-year-old lesbian woman). This underlines a reciprocal exchange between patients and therapists, which nevertheless was often described by participants as a positive turning point: “My psychoanalyst said to me: *at the beginning I thought I had no problems with homosexuality, you know? And then thanks to this analysis I made with you, I realized that I have problems with homosexuality*, and from that moment the thing has changed” (70-year-old gay man).

The need for competence can be linked to identification with the provider, that is the patients’ desire to share their own experiences with someone able to understand in depth their own intimate aspects of life, as one 66-year-old lesbian woman explained: “I believe that is better to deal with people who have had experiences very close to yours. […] Given that these kinds of profession [healthcare providers and psychologists] require to be able to relate to other people, the more empathy there is, the better. Also, to be able to get rid of the symptom you must relate to someone who knows exactly what you’re talking about, which is why I think it’s important”. These participants probably perceived the SM identity as a central component of the self, representing a prerequisite to develop competencies such as empathy and active listening in healthcare professionals.

In other cases, the clinician’s expertise was perceived as more important than identification: “I had very negative experiences […] I found an ethical lack of expertise in these psychotherapists, all of them who supported the idea that my homosexuality was a form of regression. […] A person with specific knowledge and competencies would be good. Not necessarily a gay person. I mean, skills are more important than just being gay. As I said, I’m paying the effect of this lack of LGBT competencies” (69-year-old gay man). In cases like this, the participants’ judgment was not based on the

Table 4 The need for specific competencies on SM concerns: thematic structure and representative quotations

Theme	Sub-theme	Representative Quotation
Competencies ($n = 24$)*	Desires ($L = 2$; $G = 4$)*	*I would definitely like an LGBT clinic, yes, to have also specialists in... for example there is not a specialist who* […] *is specialized in that kind of diseases, aren't they? The pathologies that concern more specifically… exclusively homosexual people* (70-year-old gay man)
	Expert Patient ($L = 3$; $G = 4$)*	*I try to be as open as possible about this ... also because I go to a woman who is not ... a ‘gay counselor’, so I go to a normal professional, and I think that she learns a lot from me too and so here's the deal: "I help you and you help me”* (63-year-old gay man)
	Identification ($L = 1$; $G = 5$)*	*It could be very important* [to deal with a SM provider] *because I could bluntly, I would feel more understood rather than with a stranger* [heterosexual] *I would feel more comfortable describing situations, even “scabrous”, to a member of the community rather than an external one* (64-year-old gay man)
	Informed Knowledge ($L = 0$; $G = 5$)*	*Well, I suffered this state of discomfort and I couldn’t figure out why [...] and every time I tried to explain that to some doctors they told me I had nothing, but I felt sick and they never understood me. I never had any kind of support for so many years* (60-year-old gay man)

Note: * In parenthesis the frequencies of quotations and the number of times they occurred based on gender (G = Gay men; L = Lesbian women) clinician's SI: they prioritized an informed knowledge, that is an in-depth and interested research on a topic—in this case related to SM identities—that differ from opinion, which on the contrary depends on personal beliefs and is usually based on a limited amount of evidence, often resulting in heterosexist attitudes: "A professional shouldn't have prejudices because they can have a serious impact on you […] I think that a professional should be scrupulous, he should take care of me and not of his prejudices or expectations about people" (60-year-old gay man).

Discussion

The current findings demonstrate that access and utilization of healthcare services can be considered as a multi-faceted phenomenon which involves people's past and current experiences, perceptions, expectations, and desires. SMOA face unique challenges when interacting with healthcare services (Foglia & Fredriksen-Goldsen, 2014; SAGE, 2010).

Through participants' narratives, we identified the primary role of identities in conditioning participants' experiences when using healthcare services. Both clinicians' personal—such as SI—and professional characteristics—such as their specialization—strongly influenced participants' confidence and satisfaction related to their experiences using healthcare services (Martos et al., 2018). Within the medical context, SMOA tended not to disclose their SI unless they were sure to interact with a SM provider or when it was clearly necessary. This finding is coherent with the previous findings of Brotman et al. (2006), who showed an overall passive attitude toward coming-out on the part of SM seniors to healthcare providers. Participants in our sample perceived doctors in general as cold and detached professional figures, with whom they did not feel the need to come out or they feel uncomfortable to share intimate aspects of their life.

On the contrary, participants perceived the psychological setting as naturally set up to embrace the issues related to their SI. Moreover, when dealing with doctors specialized in sexual fields, the fact of being inserted in an explicit context with regard to sexuality encouraged SMOA to talk more openly about their sexual activity and SI. This frequently resulted in positive experiences, underlying the strong interconnection between disclosure and improvement of healthcare services use (Durso & Meyer, 2012; Steele, Tinmouth, & Lu, 2006).

Those participants who are HIV+ reported an interesting life path that highlighted the several ways through which it is possible to deal with stigma. These participants experienced the first wave of HIV/AIDS epidemic, whose consequences—stigma, long-lasting medical ordeals, friends' and lovers' deaths—are still imprinted in the memory of the SM community. They represent the only sub-group in our sample who reported explicit experiences of discrimination in medical contexts, consisting mostly in dentists' refusal to treat them (Giuliani et al., 2005). Nevertheless, their narratives not only focused on past negative memories but also extended on current resilient aspects, such as the perception of a "privileged way" to access healthcare services. Specifically, their long-term clinical experiences have finally led them to feel included in a safe medical environment, composed by a network of experts specialized in STDs who take care of them and are generally more open and competent in HIV-related care as well as in the SM field.

The resilient aspects related to the HIV topic are not unusual in SMOA stories. Positive coping strategies entailed by HIV stories management can include not only the presence of rich social networks of friends, partners, seropositive peers, and medical providers (Cantor, Brennan, & Karpiak, 2009; Tobin & Latkin, 2017), but also the positive re-enactment of lifetime adversities, such as generative processes by which older generations feel to raise awareness on HIV-related topics among the younger SM population (Bower, Lewis, Bermúdez, & Singh, 2019). Therefore, both internal (individual) and external (community) strength factors are implicated in positive narratives. Participants in our study showed a similar pattern but contextualized in the healthcare area, by reporting, on the one hand, their attitude to optimal adjustment in facing challenges (Kimmel, 2015) and, on the other hand, the fundamental role played by competent and sensitive healthcare providers who shared with them a long-life path.

We found that participants' tendency to delay or avoid healthcare, or to conceal their SM identity when seeking healthcare, was influenced by the fear of being discriminated by healthcare providers (Ard & Makadon, 2012; Gessner et al., 2019; Li, Matthews, Aranda, Patel, & Patel, 2015; Stein, Beckerman, & Sherman, 2010). In a similar way, Martos et al. (2018) found that the real or perceived negative attitudes toward participants in their study—defined as stigma—strongly influenced their communication with providers and clinic choice. According to the minority stress model (Meyer, 2003), we defined this phenomenon as expectations of discrimination, which can result from having experienced a direct form of discrimination on the part of healthcare providers; having witnessed the negative attitudes of clinicians toward homosexuality; having heard about mistreatments against other SM people.

As reported by some participants, it was not unusual to experience these different situations in past clinical contexts, when SM identities were mainly represented through a pathological connotation by the medical model. For this reason, it is necessary to consider that SMOA are more likely to have gone through experiences of felt and enacted forms of stigma compared with the younger SM generations, resulting in a strong tendency to concealment (Vaccaro, 2009). Moreover, some participants tended to avoid those clinics with religious personnel because they were perceived as potentially threatening, underlining the complex relationship between religion and SM identity (Baiocco et al., 2018; Arthur, 2015) and the impact of structural forms of stigma on sexual minorities' health outcomes (Hatzenbuehler, 2014). Participants always referred to the public healthcare system where the staff and the professionals are not bound to a specific religious faith; however—with Italy being a traditionally Catholic country—it is usual to find Catholic practitioners within the medical staff. Expectations of discrimination were frequently linked to an overall mistrust of doctors, who are at times considered as judgmental and/or barely experienced with regard to SM issues.

The lack of knowledge and awareness on the part of healthcare providers represented another central theme of our findings, which emerged as the need for specific "cultural competencies" on SMOA identities (American Geriatrics Society Ethics Committee, 2015; Arthur, 2015; Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014b). Healthcare professionals need not only to be informed but also to reflect on the influence of their own values and beliefs on the services they provide (Crameri, Barrett, Latham, & Whyte, 2015), in order to actively deconstruct heterosexism in clinical contexts, and allow a wider access to services.

As shown by its sub-themes, this topic particularly affects the Italian SM older generations. For instance, participants reported the perception of being "expert patients" with regard to SM health issues (Gendron et al., 2013): They taught their specialists—especially psychotherapists—some basic aspects of non-heterosexual identities and relationships. This content constitutes an important historical evidence demonstrating the fundamental role played by many SMOA in introducing SM issues in clinical settings, thus crucially contributing to deconstruct sexual prejudice in clinical contexts.

Moreover, the lack of SM-specific venues and competencies emerged in the present study as a central concern among participants and the medical setting was not perceived as a proper place to come out. As a result, SMOA were more likely to delay or avoid medical treatment (Addis et al., 2009; Ard & Makadon, 2012), and to have negative expectations about end-of-life care (Almack, 2018; Johnson et al., 2005; King & Dabelko-Schoeny, 2009). The desire to find a SM-specific clinic was often connected to the fear of being dependent on medical services because of aging. This is a recurring theme in SMOA-related literature (Addis et al., 2009; Gardner et al., 2014; King & Stoneman, 2017), that distinguishes the older from the younger generations of sexual minorities, highlighting a specific and pressing need of SMOA that should be considered in order to improve the quality of life of this population.

To conclude, it is important to consider gender differences regarding quotations' amount and content. Despite the attention paid in providing a gender-balanced composition of the sample, it is a fact that the most salient information on the issues considered in some themes was often provided by male participants. This obviously pose additional investigation inputs on the history of the lesbian community, its invisibilization that allegedly resulted into a reluctancy of lesbians (in particular in the Italian context) to publicly discuss and reflect upon their sexual identity, the challenges it entails, and the stigma they had to face as a consequence of their coming out (Munson & Cook, 2016; Traies & Munt, 2014). However, this study and the resulting paper are focused on the challenges and barriers SMOA face in accessing healthcare assistance and service, thus considering sexual orientation and older age as the main drivers of oppression and stigma. Gender identity is a crucial oppression driver for women that if combined with a lesbian sexual orientation and the older age may result in multiple-discrimination experiences. Despite considering intersectionality as a valuable and innovative approach, we decided to focus on two oppression drivers—that is age and sexual orientation—pitifully excluding others that are for sure crucial and might lead to future investigation inputs.

Limitations

This study has several limitations. First, although we refer to the SM population because we consider it as the most inclusive term, our sample is composed only by LG self-identified people. Nevertheless, non-heterosexual older people are more likely than younger people to use terms as lesbian, gay, or homosexual when defining their sexual orientation rather than bisexual, pansexual, or queer. Moreover, participants were only representative of the "youngest" generations among the population of SMOA. This shortcoming represents a common bias of research on SMOA (Shankle et al., 2003). Finally, all participants were White and most of them middle class, and well educated, underlining the difficulty in reaching the most at-risk subgroups (e.g., poor, migrants, and oldest) in the broader SMOA population. All the mentioned limitations must be considered when interpreting the results, in order to be cautious in their generalization to the whole target population.

Additionally, in order to obtain consistent findings on the healthcare theme, we only focused on one section of the Generations Study interview, with the risk of neglecting other important aspects of participants' life which could be linked to their current experiences and perceptions. Some examples of meaningful aspects to be considered in future research are the existence of informal caregiver and care networks (i.e., partner/s, friends, and relatives) and their role on SM older people experiences when accessing healthcare services; and SMOA concerns about aging in terms of health and dependence on healthcare services, such as residential and nursing homes.

Conclusion

SMOA have specific perspectives and experiences related to healthcare utilization that should be considered by healthcare professionals and researchers in order to create a safer and more effective clinical environment. The perception of having to deal with heterosexist settings when accessing healthcare services is still prevalent among older generations of SM individuals, resulting at times in a tendency to hide their own SI, avoid certain clinics, and delay medical treatments. SM patients prefer that their caregivers are aware of their sexual orientation and informed about the specific issues related to being a SM. Indeed, healthcare providers' ability to encourage their patients to come out is recognized as an integral part of high-quality care. The clinicians' lack of knowledge about sexual minorities could contribute to a risk for isolation and distress experienced by SMOA in clinical settings, especially for the very old generation who may require daily assistance.

Specific competencies on SM health issues should therefore be increased through targeted training programs, able to highlight not only the characteristics of SMOA as a group but also the individual differences using a person-centered focus. At an institutional level, a more inclusive approach should be adopted, including best practices to avoid the perpetuation of stigma and discrimination targeting this vulnerable sub-group of patients. Practical policy implications might benefit from tools and practices developed in the framework of diversity management policies in organizations, such as the following: the assessment of the level of knowledge and awareness on SMOA issues among practitioners; the development of awareness-raising and sensibilization campaigns on the contrast to homophobic stigma and discriminations; a more widespread representation of SM and aging issues in clinical teaching materials, seminars, workshops, and investigation projects.

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