"I felt like a freak when I would go to the doctor": Investigating healthcare experiences across the lifespan among older LGBT and transgender/gender diverse adults

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ABSTRACT

In the past several decades, the United States has enacted civil rights legislation protecting lesbian, gay, bisexual, transgender, and queer (LGBTQ) populations from discrimination, including enacting proactive healthcare laws such as the Affordable Care Act. However, given today's divisive politics, LGBTQ people's access to appropriate and respectful health care is precarious. This study explored the disconnections from and connections to health care and the respective health effects among two self-identified groups: i) older LGBT adults and ii) transgender and gender-diverse (TG/GD) adults. Using a life course perspective, qualitative data from 17 older LGBT and TG/GD participants were analyzed. Thematic and content analyses indicated that despite progress made, discrimination and prejudice in obtaining health care persist, particularly among TG/GD people of color. The results highlight the ongoing challenges LGBTQ populations face as they risk being denied care by healthcare providers and disconnected from the healthcare system.

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Introduction

The lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities have made significant strides in garnering the right to lead a life free of prejudice and stigmatization in the last 50 years (Kunzel, 2018). In prior decades, discriminatory laws and policies against individuals who identify as LGBTQ permeated throughout institutions, including the U.S. healthcare system. People identifying as transgender and gender diverse (TG/GD) are currently the target of attacks, with their right to receive gender-affirming care being threatened or banned in many states (Kindy, 2023). The current study explored the experiences of older LGBT adults and TG/GD adults in their disconnection from and connection to the U.S. healthcare system, comparing the barriers and protective factors between the two groups and their respective health effects.

Older LGBT adults

Conservative estimates indicate that approximately 1.1 million adults aged 65 and older identify as LGBT in the United

States (Fredriksen-Goldsen et al., 2014). Due to a lack of inclusion in the national census, we do not have an exact count of older LGBT adults in the U.S. Americans born before 1955 who experienced formative years at a time when being open about their sexual orientation or gender identity was deemed morally reprehensible; they may not have revealed their LGBT identities due to continued fear of stigma or discrimination (Fredriksen-Goldsen et al., 2017). Exposing one's LGBT identity posed significant risks in every aspect of their life including family rejection, being fired at work, and being arrested. Before the 1969 Stonewall riots and uprisings in Los Angeles and San Francisco, when the modern gay movement emerged, LGBT people faced a hostile world where the lack of social and legal protections was a way of life (D'Emilio, 1998).

Reflecting society at the time, medical and mental health providers also tended to be unaccepting of LGBT people. In a 25-year literature review spanning 1984 to 2008, Fredriksen-Goldsen and Muraco (2010) found that older lesbian, gay, and bisexual (LGB) adults reported skepticism of healthcare professionals due to historical discrimination and pathologizing of their communities. Before 1973, the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) classified "homosexuals" as having sociopathic personality disorders, including sexual deviation, addiction, and antisocial reactions (McHenry, 2022). Fearing humiliation and possible reprisals from providers, LGBT people hid their sexual and gender identities. Staying closeted and invisible for years often resulted in social isolation, substance use, depression, or suicide (Fredriksen-Goldsen et al., 2014). The American Psychiatric Association (APA) has since removed homosexuality as a mental disorder in the DSM. However, gender dysphoria is still considered a psychiatric illness (American Psychiatric Association, 2022).

In recent years, protections under the law and a more accepting public have facilitated access to healthcare for LGBTQ people. Despite continued biases that might exist among some healthcare providers, the American Medical Association (AMA) and APA officially support the principle that all individuals, regardless of sexual orientation and gender, receive non-discriminatory medical and mental health care and that transgender populations obtain gender-affirming care (AMA, 2023; APA, 2023). Facilities treating LGBTQ individuals can be found in hospitals, general clinics, LGBT centers, and Pride clinics.

Community support and connectedness have also been associated with improved well-being among LGBT people (Roberts & Christens, 2021). Social support from enduring queer social networks has had a significant positive impact. Families of choice (e.g., individuals who care for one another as a biological family) have been lifelines of belonging for many (Allen & Lavender-Stott, 2020). Furthermore, strong community cohesion from LGBT-specific organizations and support groups has been associated with improved health outcomes, especially mental health (Choi & Meyer, 2016).

TG/GD adults

Recent estimates indicate that in the United States, over 1.6 million people (13 years and older) identify as transgender, with over a quarter (25.6%) of transgender adults identifying as nonbinary (Herman et al., 2022). TG/GD people face several challenges when seeking health care, including overt discrimination. Using data from *The Report of the 2015 U.S. Trans Survey* (n=27,715), Kattari et al. (2020) found that almost eight percent of participants reported being denied trans-specific care; more than three percent reported being denied general health care. TG/GD participants were significantly more likely to be refused access to care based on their race, class, disability status, education, and age. TG/GD people reported avoiding seeking care due to anticipated gender-based discrimination and transphobia, particularly among those who held multiple marginalized identities.

TG/GD individuals may delay or forego seeking care due to additional factors, including a lack of TG/GD-educated providers' understanding of dysphoria and health insurance barriers. In an extensive literature review of physician competence in transgender care, Korpaisarn and Safer (2018) found a deficiency in formal education at all medical field levels, from generalist practitioners to specialty care. TG/GD clients often need to educate ill-prepared medical, nursing, and mental health providers to fill the knowledge and practice gaps required for their care (Fadus, 2019; Moore et al., 2023). In addition to the lack of adequate care, transgender-specific care is often financially out of reach due to denial by insurance companies or exorbitant care costs. James et al. (2016) also reported in *The Report of the 2015 U.S. Transgender Survey* that one-third (33%) of the participants did not access needed care because it was unaffordable.

Like older LGBT people, TG/GD individuals thrive from support from families of choice, peers, friends, and partners. They are connected to TG/GD communities, including LGBT centers and Pride clinics. Factors that facilitate TG/GD people receiving gender-affirming and respectful health care include knowledgeable, trusted, and sensitive providers/clinic staff, welcoming office, clinic, and hospital environments (equality signs and gender-neutral language, etc.), having health insurance, peer support, and trans resiliency (e.g., accepting being transgender, disclosing trans identity, and self-advocacy) (Kia et al., 2021; Rabasco & Andover, 2021).

Using a life course perspective, the purpose of this study was to compare the experiences of two self-identified groups—older LGBT adults and TG/GD adults—in their disconnection from and connection to healthcare and the respective health effects. In life course research, the dynamic social, cultural, and developmental processes a person experiences throughout their lifetime are associated with their later life outcomes (Mayer, 2009). This lens was important in understanding the trajectory and health outcomes among older LGBT people born before the gay liberation movement and TG/GD people fighting for their rights today. In addition, minority stress theory (MST) was applied to identify the systemic levels of discrimination that sexual and gender minorities (SGM) face and the effect support and community advocacy may have in their lives (Meyer & Frost, 2013).

Materials and Methods

This study was part of a more extensive project investigating how different SGM populations (youth, older LGBT adults, transgender and gender diverse people, and staff from an LGBT center) connected to and disconnected from the U.S. healthcare system (Braveheart et al., 2023a). The current study was a secondary analysis of data obtained from two of the five self-identified groups: older LGBT and TG/GD participants. The inclusion criteria included: i) participants 18 years or older, ii) SGM-identified, and iii) stakeholders at an LGBT center in the Midwest. The research was approved by Case Western Reserve University's Institutional Review Board (STUDY20200359).

Participants

Participant selection in the parent study was based on purposive criterion sampling, which predetermines criteria in selecting participants—in this case, older LGBT and TG/GD adults who were stakeholders at a particular LGBT center. The older LGBT group self-identified demographically as SGM older adults (65+). The TG/GD group self-identified demographically as transgender or gender expansive. Recruitment methods included developing and distributing flyers about the study, making presentations at community support group sessions, and requesting participation through service providers. The original study's co-principal investigators had prior collaborative relationships with members of the LGBT center staff who were able to assist with recruitment efforts. Compensation for the participants consisted of an Amazon gift card for their participation.

Data collection and procedures

In the original study, interactive focus groups were conducted on Zoom in the spring and fall of 2021 (Braveheart et al., 2023a). In two sessions, participants shared their experiences about connections to and disconnections from healthcare. In the first session, one broad question was asked: "What are the factors related to connections and disconnections to healthcare throughout our lifetime, including physical and mental healthcare?" Participants' responses were clarified and mapped using group-model building (Hovmand, 2014). The second session refined the model from the participants' responses. The focus groups lasted 60 to 90 minutes, were video and audio-recorded, and uploaded to Box.

Seventeen people participated in the older LGBT and TG/GD groups and self-identified demographically (see Table 1). The older LGBT age group participants had a mean age of 69 years, while the transgender participants' mean age was 37. Participants primarily identified as White (*n*=10); most participants of color were in the transgender group. Gender identities in the older LGBT group were diverse; half of the participants identified as men, while the rest identified as transwomen or women. The TG/GD group had five trans women and four trans men. Regarding sexual orientation, six participants identified as gay, six as heterosexual, two as bisexual, one as lesbian, and one as pansexual.

Data analysis

In the parent study, the first three authors independently coded the group transcripts (*n*=13) during the spring, summer, and fall of 2022 using ATLAS.ti 22 (Braveheart et al., 2023b). The recordings were transcribed, cleaned, and double-checked for transcription accuracy. Case identification numbers and pseudonyms were used to protect participants' confidentiality. Each week, coded transcripts were reviewed in Zoom meetings, and codes were discussed in-depth. Coding differences were reconciled after discussing potential biases and assumptions. A coding dictionary was developed and refined throughout the coding process, with categories and subcategories emerging during the analysis. The methodological rigor and trustworthiness of the coding and analyses were based on Lincoln and Guba's seminal work (1985).

For the current study, coded data for the older LGBT and TG/GD group participants were separated from the other groups, and a new file was created. Thematic analyses from Braun and Clarke (2006) and computer-aided thematic content analysis from Friese et al. (2018) were used to analyze the data. Both types of analyses use similar thematic analysis methods (e.g., familiarization, generating initial codes, searching for themes, etc.). However, Braun and Clarke allowed for an inductive and constructivist approach when generating themes. Content analysis methods from Friese et al. further triangulated data using ATLAS.ti tools.

Initial analysis indicated there were over 200 codes generated between the older LGBT and TG/GD group participants. Data were cleaned by combining codes with similar definitions and meanings, deleting redundant coding, and renaming codes when indicated. All the codes and sub-codes were exported to an Excel spreadsheet and re-analyzed. Constant comparison methods were

Table 1. Sociodemographic characteristics of the total number of older LGBT and TG/GD participants (N=17).

Pseudonym	Age	Race	Gender Identity	Sexual Orientation
Betsy	67	White	Trans woman	Heterosexual
Joanee	66	White	Woman	Lesbian
Alan	67	White	Woman	Heterosexual
Bob	69	White	Man	Gay
Boris	64	White	Man	Gay
Randy	59	White	Man	Gay
William	78	White	Man	Gay
Anthony	82	White	Man	Gay
Aaliyah	28	Black	Trans woman	Heterosexual
Brandy	41	White	Trans woman	Pansexual
Mark	50	Bi-racial (Black/White)	Trans man	Heterosexual
Charice	29	White	Trans woman	Heterosexual
Chloe	29	Mixed Race	Trans man	Bisexual
Jasmine[a]	63	Pink Nation	Trans woman	Female
Leah	45	Bi-racial (Black/White)	Trans woman	Gay
Leon	22	Middle Eastern	Trans man	Bisexual
Abdullah	23	Arab Middle Eastern	Trans man	Heterosexual

[a]Jasmine, who identified her sexual orientation as female, was omitted from the count for identifying her race as "Pink Nation."

used to analyze the data for implicit and explicit ideas between the two groups. Codes were placed in hierarchical order depending on the groups' similarities and differences regarding disconnection and connection experiences in healthcare. Excel tabs helped organize participants' use of different tenses (i.e., older LGBT group participants' frequently use of the past tense when discussing disconnection from care). Data were re-entered and re-analyzed in ATLAS.ti to ensure that the hierarchical structure of higher and lower codes sufficiently supported emerging patterns and themes.

Data were placed in a code document table and co-occurrence table (Friese et al., 2018) to analyze group differences among the participants' past and current healthcare experiences and related constructs. The co-occurrence table provided frequency counts of the number and percentage of individual older LGBT and TG/GD participants who discussed their care experiences. Figures from the frequency counts helped to visualize the similarities and differences between the two groups.

Content analysis

Figures 1 and 2 illustrate past and current disconnection from health care. Six major constructs related to disconnection from care emerged from the data: Structural LGBTQ discrimination (including policies, media, etc.), family rejection, financial burden, homophobia/transphobia in healthcare, lack of services, and adverse health effects. In Figure 1, among eight older LGBT participants, four or more expressed *past* disconnection to healthcare in four of the six constructs: structural LGBTQ discrimination (n=7), homophobia/transphobia in care (n=4), lack of services or training (n=5), and adverse health effects (n=7). None of the nine TG/GD participants discussed 50% or more of the *past* disconnection to care constructs. In Figure 2, the reverse occurs. More than half of the nine TG/GD participants discussed all the *current* disconnection to care constructs except for family rejection. In contrast, four or more of the eight older LGBT participants discussed only two of the six *current* disconnections to care constructs: Lack of services and training (n=5) and adverse health effects (n=4).

In Figure 3, eight constructs emerged related to participants' current connection to healthcare: positive structural changes (anti-discrimination policies, media, etc.), moved to resources (i.e., relocated to obtain more LGBT, TG/GD resources and support), alternative care, intra-community support, inter-community support, LGBT centers/Pride clinics, affirming or gender-affirming care, and positive health effects. Fifty percent or more of the older LGBT and TG/GD participants discussed at least half of the current connection-to-healthcare constructs. More older LGBT participants discussed connections to care than TG/GD group members.

Thematic analysis

Three overlapping themes among the older LGBT and TG/GD groups emerged, capturing a richer and more nuanced story: past rejection-disconnection from healthcare, current rejection-disconnection from healthcare, and current protection-connection to healthcare. Major constructs from the content analyses were integral to the thematic analysis.

Theme 1: Past rejection-disconnection from healthcare

Past rejection-disconnection from healthcare was when the older LGBT participants expressed being discriminated against (politically, socially, financially, etc.) and were denied care or needed to remove themselves to prevent further harm. Older LGBT group members described how discriminatory laws, policies, and the media targeting them were once rampant. For example, Boris, 64, a White gay man, remarked that the "prevailing attitude when we were all coming of age was that being LGBT was wrong, unhealthy, and illegal." Randy, 59, a White gay man, agreed and went further, stating:

> I think all the things Boris mentioned were also reflected in the media and the movies we saw. LGBT characters were most likely the murderers in the story or had other

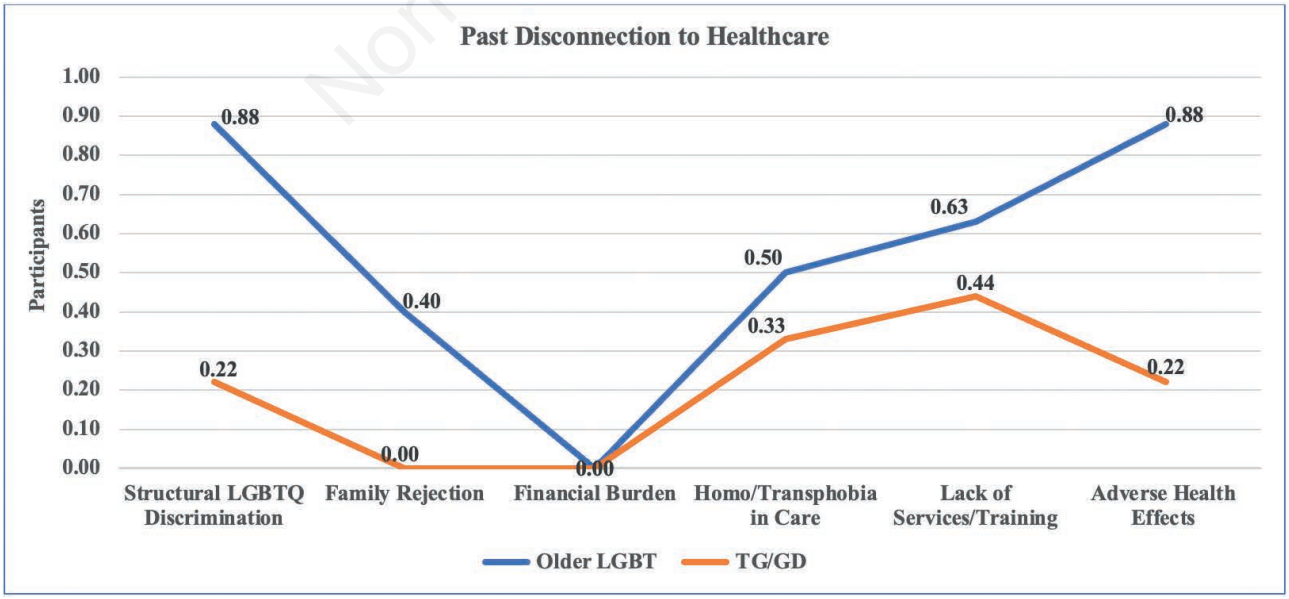

Figure 1. Past disconnection to healthcare among older LGBT and TG/GD: percentage of participants per construct.

> underlying problems. And we also didn't have any role models. There were no role models saying this is how you should live your life and you can be proud of yourself. And that was a huge factor.

The lack of role models left Randy with no path to follow, and he felt that negative media messages attacking LGBT people can be both overt and subliminal and profoundly affect a person's mental health and well-being.

Reflecting on societal discrimination against LGBT people, members recalled how their parents rejected them when they came out and that they had no place to turn to, including the healthcare system. Boris recounted:

> The American Psychological Association said we had a mental health disease. You had all kinds of legal bullshit that prevented us from being who you were. Look at the Stonewall riots and '68. It wasn't until 1972 that the American Psychological Association made homosexuality no longer a disease.

Boris pointed out that LGBT discrimination was, at the time, en-

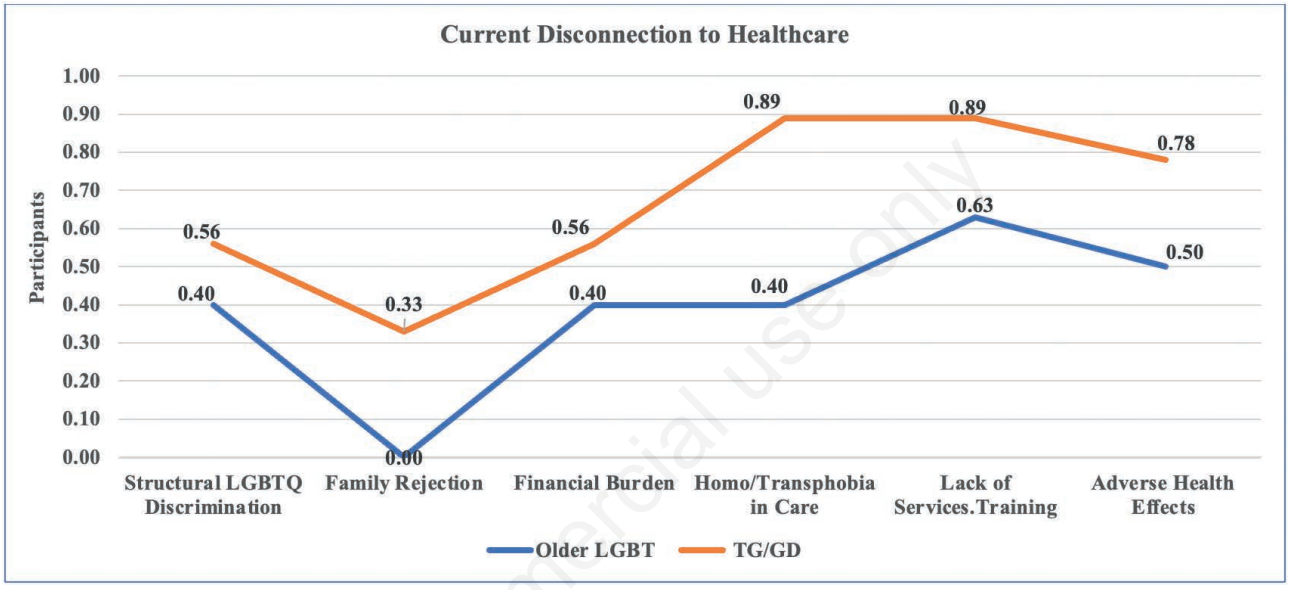

Figure 2. Current disconnection to healthcare among older LGBT and TG/GD: percentage of participants per construct.

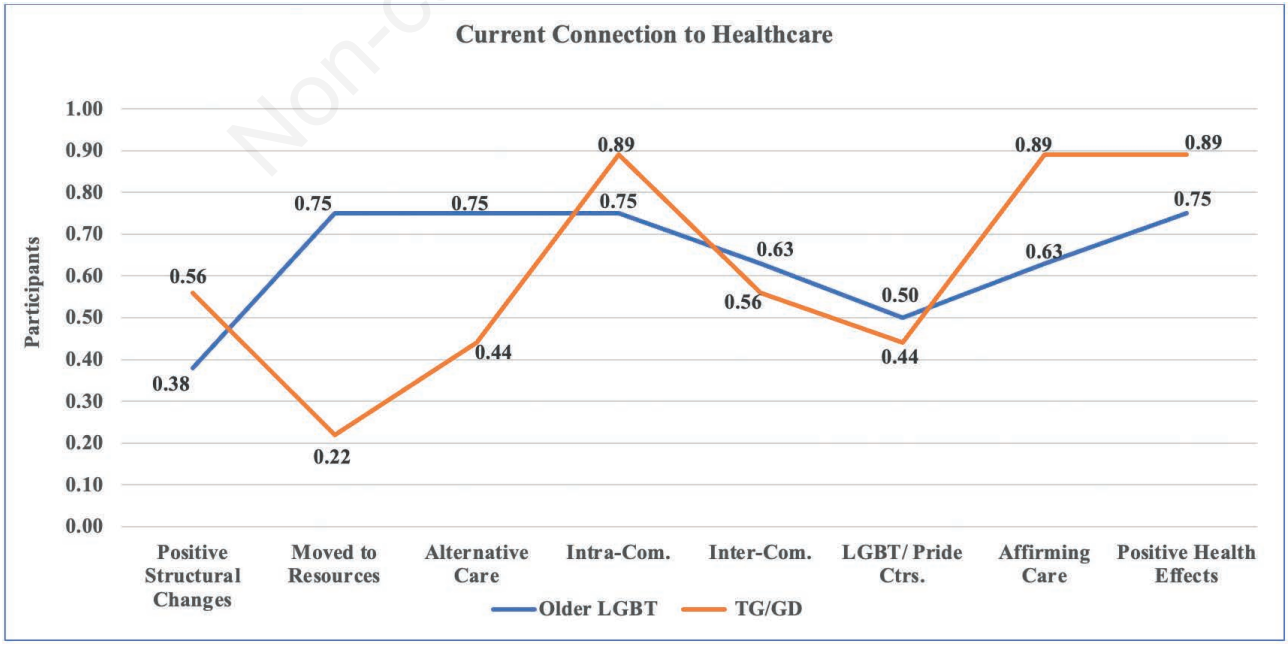

Figure 3. Connection to healthcare among older LGBT and TG/GD: percentage of participants per construct.

trenched in our medical and mental health institutions. Revealing one's sexual orientation to a health provider meant being at risk of being diagnosed with a mental illness. He felt it took a broad popular movement and an extended length of time before healthcare organizations recognized that being identified as LGBT was a human right deserving dignity and respect.

Rejection from all parts of society created enormous shame and stigma among the participants. Joanee, 66, a White lesbian, sadly remarked on the difficulties in discussing her lesbian identity with her healthcare provider:

> I think some of the lack of decent and appropriate health care, in addition to the avoidance altogether, was about not coming out to healthcare providers. Yeah, because it was so painful. It was so painful. I didn't know how to talk about being a lesbian. I had no idea. I felt like a freak when I would go to the doctor.

Joanee expressed how abnormal she felt for identifying as a lesbian and avoided seeking medical care. She could not confide in her healthcare provider, nor did she have the words to express who she was and stated how painful and debilitating that was.

Participants removed themselves from receiving needed health care to stay safe and minimize the harm placed upon them. Fear of the negative consequences of seeking care delayed the participants from coming out for many years. Betsy, 67, a White transgender woman, stated, "I knew I was trans at three! And I buried it for 62 years. I was just afraid. Self-fear, self-loathing, and shame."

The effects on the participants' health, from delaying healthcare or hiding their SGM identities, ranged from depression and isolation to self-harm. Bob, 69, a White gay man, recalled:

> After I left home, I started to need doctors of all sorts. And I still held off until I was in my 50s. And then, holy hell broke loose. And I need psych. I need pills. I need physical resistance. I need to watch what I do.

Bob described that he delayed seeking care even though he knew the toll it was having on his health. When he finally obtained healthcare, he needed medical care, mental health care, and resilience to endure the treatment. Half of the older LGBT participants described, at one point in their lives, self-medicating or being addicted to drugs.

Theme 2: Current rejection-disconnection from healthcare

Like the older LGBT participants, the TG/GD group members described discrimination and rejection in every sector of society. However, the TG/GD participants also expressed experiencing more disconnection in the current healthcare environment. Mark, 50, a biracial Black/White trans man, expressed experiencing multiple forms of discrimination:

> There is systematic racism. I feel systematic homophobic stuff. I don't care how much people try to hide it…. At a certain age, you get tired of doing that over, and over, and over: Black, trans, gay. Discrimination is discrimination. Hate is hate. And I've had enough.

Mark described the concept of "intersectionality," or interconnected constructs such as race, gender, and sexual orientation and their relation to how a person is treated. He felt having multiple marginalized identities made it challenging for him to function in society.

TG/GD participant difficulties also extended to health insurance companies. Jasmine, 63, a trans woman, recalled being denied surgery by her long-term health insurance provider. After Jasmine's health insurance company declined her request to have transition surgery, she needed to choose whether to pay out-of-pocket or go outside the U.S. and risk her health and safety:

> I'm still fighting daily to figure out how, where, and when the appropriate place to go would be. I was told if I go out of the country, that $6,000 is not a bad number to have. But I don't know if I trust going out of the country because I want to be safe.

Paying for transition surgeries was cost-prohibitive for Jasmine and many of the other TG/GD participants. Participants experienced tensions that also exist within the healthcare system regarding its responsibility for providing appropriate TG/GD care and the associated costs.

Discrimination, including by healthcare providers, had a negative cumulative effect on TG/GD participants' mental health and overall wellbeing. Mark recounted the distress he felt about coming out as a transgender man and having to endure his provider's biases:

> The mental anguish it does on trans. Because when I found out that I was trans, I wanted to reject that. I can deal with being lesbian. I can deal with being bisexual. But now, you're saying there's a word for what I'm feeling. And you call that transgender? I was like, "Oh, hell no." It took me about a year to really accept it. So, the trauma of just knowing and having to be questioned about it daily? And then denied it?

Mark felt his interactions with providers who regularly questioned him about being transgender took a toll on his mental health.

TG/GD participants recalled often being dismissed, not believed, or refused care by healthcare providers. They relayed story after story of degrading experiences. For instance, Abdullah, a 23-year-old, Arab Middle Eastern, trans man, recounted his harrowing experience with an emergency department nurse:

> Recently, I went to the ER, and one of the nurses wanted me to take off my shirt because she thought I was cis. And I didn't want to take off my shirt in front of her and the other person in the room. So, she's like, "Just do it." And she was forcing me to, and she said if I didn't, she'd call security on me. And she called security because I wouldn't take my clothes off in front of her. And she left to get security. I changed because she left. And the security came in. Three security guards came in. And they were like nothing was wrong. I just needed her to leave.

Abdullah's humiliation is palpable, especially when considering that fundamental medical and nursing standards of practice include respecting patients' privacy and autonomy and empowering them to make their own decisions, including preferences for how they expose their bodies.

TG/GD participants said they were hesitant to engage with the healthcare system for fear of transphobia, humiliation, discrimination, or the lack of understanding and training they might encounter from health professionals. They described how rejec-

tion by healthcare providers manifested physically and mentally, contributing to PTSD, depression, and self-medicating.

Theme 3: Current protection-connection to healthcare

In contrast to disconnections *from* healthcare, both groups described recent experiences where they were connected *to* healthcare. Protection-connection to healthcare was when the participants stated that their rights were respected or supported and that they could engage in traditional (Western) or non-traditional healthcare. Older LGBT and TG/GD participants said that federal and state laws and policies had changed from the past, making them feel more protected from discrimination. Boris, an older LGBT participant, noted:

> So, how many people leave a state like Texas to go to California? I just put that out as a posit. There are some cities and states that, by the nature of how they passed laws, are now more open to all the different flavors of the rainbow. Being a member of their community, you move toward them. It goes back to self-identity and self-esteem. You want to move to some place that boosts your self-esteem—reaffirms and boosts it so you no longer feel stigmatized and ashamed.

Boris felt that more progressive areas in the country were less stigmatizing and more protective of LGBT people's mental health and well-being.

Like Boris, Charice, 29, a White woman in the TG/GD group, also noted that "since moving to [location], I have found that the doctors and nurses out here are way more accepting than they were in [location]. "Moving" was a recurrent theme among many participants in both groups. Relocating meant receiving medical and mental health management and treatment tailored to their needs. Cities were credited for offering LGBT and TG/GD resources that might not be available in suburban or rural areas. And LGBT centers with supportive and empathetic staff were particularly important to the participants.

Before the advent of LGBT centers and Pride clinics, members in the older LGBT and TG/GD groups said they connected to alternative sources. Older LGBT participants described the Mattachine Society and Alcoholics Anonymous (AA) meetings as important, safe, and supported spaces for care, while the TG/GD participants, in addition to AA and community support groups, obtained (and currently obtain) specific medications and treatments through the black market or from other countries. Both groups' participants said that they were connected to care through LGBT centers/Pride clinics and that intra- and inter-community support from chosen families, partners, and biological families improved their overall health. As Randy, a participant in the older LGBT group, remarked:

> I didn't go to A.A. I didn't go to counseling. I didn't have religious support. But it was through community, and specifically, my LGBT community, that led me to the nirvana that I enjoy today. And somewhere in there, that led to better health care.

Participants from both groups described recovering from depression and substance abuse, having higher self-esteem, and being better at advocating for themselves when connection to care occurred. However, for the TG/GD group participants, dedicated medical and mental health professionals providing gender-affirming care were critical. Aaliyah, 28, a Black trans woman, for example, recalled her experience with her primary care provider (PCP) after walking out of an emergency department when she did not receive treatment for an abscess:

> My doctor, [Dr. A.], got a call and said I had left the hospital. She said, "Aaliyah, what's going on? What happened? They said that you left the hospital." She called me at six o'clock. She could have just rolled over and went back to sleep. Then she called me to make sure I got to that doctor's office. She was on the phone with me and said, "Aaliyah, we are going up in here." It was like me and her walked in there together.

Aaliyah felt listened to, respected, and cared for—the opposite of what she experienced at the hospital. Aaliyah thus described her perceptions of an effective healthcare provider: actively listening to TG/GD patients, being empathetic, and creating a safe and supportive environment. Her physician went above and beyond what most physicians do, ensuring she was not further harmed. Aaliyah further added:

> [Dr. A.] is not only part of the LGBT community, but she's also a lesbian. She knows the actual struggle. She knows my story. For her to take that time to do that shows that she is not just wearing her doctor on her sleeve. She's actually wearing it on her heart. And she's taken the time to pay attention to the community.

For Aaliyah, identifying as lesbian meant that her physician understood on a personal level the discrimination Aaliyah experienced at the hospital. Like Aahliyah, many participants said having a provider who identified as LGBTQ helped them obtain better care. Similarly, TG/GD participants felt that specifically having a transgender provider when they were transitioning was especially helpful in understanding what they were experiencing.

Negative case analysis in connection to healthcare

Some older LGBT participants, while having strong connections to healthcare providers, said they currently opted not to seek gender-affirming care or transition. Alan, 67, a White woman remaining man-cisgender, described her feelings:

> I have been fortunate, in some ways, in that the health care that I received was accepting both when I thought I was gay and when I was transgender…. And I just decided I did not want to go about changing my physical appearance. Just because it seemed like it was just more of a pain in the butt than anything else. So, there's still suffering there because of that. I have Medicare, but don't care to participate in any psychiatric system.

Betsy agreed, saying her "healthcare professionals, without exception, were accepting and giving," but kept her "transgenderness" to herself.

Discussion

This study explored the experiences of older LGBT and TG/GD adults' disconnection from and connection to health care

and the resulting health effects. Comparing the experiences among the participants of both groups through a life-course perspective and minority stress theory (MST), data were analyzed using computer-aided content and thematic analyses. Major constructs generated from the content analyses were integral in three emergent themes: past rejection-disconnection from healthcare, current rejection-disconnection from healthcare, and current protection-connection to healthcare.

Findings indicated that older LGBT participants expressed experiencing disconnection from care in the past. In contrast, the TG/GD participants and members of the older LGBT group who identified as transgender reported current disconnection to care experiences. When participants experienced discriminatory laws, policies, or persistent homophobia/transphobia, they were "rejected" and denied care or removed themselves to thwart any further harm. When participants were more protected through anti-discrimination legislation and general acceptance from society, they were better connected to healthcare.

Using a life course lens, the trajectory of the older LGBT participants' lives reflected a continuum from being disconnected from the healthcare system to more current connections to care. The older group members lived through a 50+-year period of collective action (e.g., the Mattachine Society, the Stonewall riots, ACT-UP, etc.) and today have greater civil rights protections, including same-sex marriage, adoption, and employment (Agénor et al., 2022). Over the years, LGBTQ people have built community infrastructure, reducing their encounters with stigma, discrimination, and healthcare disparities (Institute of Medicine, 2011). Inter- and intra-community support, LGBT centers, and Pride clinics have provided safe spaces where participants can be more transparent and have their healthcare needs addressed.

A life course perspective may also reflect the experiences of the TG/GD participants, mirroring their disconnection to the healthcare system today that older generations of LGBT people endured in the past. In addition, minority stress theory (MST) was applied in this study to provide a more complex and nuanced understanding of what TG/GD people are currently experiencing. While MST was relevant to older LGBT group members who experienced stress from discrimination at the micro, mezzo, and macro levels of society, the TG/GD participants, comparatively, reported poorer connections to care, including numerous upsetting and demoralizing interactions with healthcare providers. The TG/GD group members were also more racially and gender diverse. Studies indicate that TG/GD people, particularly those with marginalized identities, are significantly more likely to experience disrespect, mistreatment, and microaggression from providers than those who do not identify as TG/GD (Johnson et al., 2020; Singh et al., 2021). Legal discrimination that permits health providers to shame and dehumanize patients significantly affects their physical and psychological health (Fredriksen-Goldsen & Kim, 2017).

Discrimination and stigma have not disappeared from the healthcare system for older LGBT people either. Like TG/GD individuals, older LGBT people are a heterogeneous population with intersecting identities (e.g., race/ethnicity, gender, class, religion, disability status, etc.). Two older LGBT participants, for example, reported identifying as gender diverse. They felt uncomfortable revealing their gender identity to healthcare providers. Internalized stigma, past victimization, and continued shame and discrimination can thus force older transgender people back into the closet and contribute to higher stress levels and depression (Fredriksen-Goldsen et al., 2014).

To live as their aligned gender, TG/GD people need specific transition-related protocols and treatment provided by knowledgeable and sensitive professionals who understand the challenges of transitioning (Jacob & Cox, 2017). The mental anguish and suffering that TG/GD people face when they attempt to receive gender-affirming care may be due to a lack of competently trained and culturally sensitive healthcare providers, unpleasant side effects of hormones and inaccessible surgeries, negative interactions with healthcare and insurance organizations entrenched in a binary system, anti-transgender legislation, assaults by social media feeds, and a general lack of understanding by the public (Bakko & Kattari, 2020; Kindy, 2023). Participants needed TG/GD advocacy to go above and beyond what is usually practiced by medical and mental health practitioners.

Limitations

While this is one of the first studies to compare the experiences of older LGBT and TG/GD participants, limitations need to be noted. This study was initially designed to explore the experiences of diverse groups of LGBTQ people's connection to and disconnection from care, and the interview questions were broadly asked. An interview guide with specific questions might have generated more detailed responses from the participants during the focus groups. Conducting a separate group of older transgender participants may have provided a better understanding of their experiences. Other areas of the study that could have been strengthened include having a larger, more diverse sample, particularly among the older LGBT participants, interviewing the participants more than two times, and conducting the interviews in person rather than on Zoom. Also, the findings of this study may not represent older LGTB and TG/GD populations in other localities.

Implications and future directions

Aside from the discrimination and stigma LGBTQ people encounter among health professionals, the educational gaps and limited clinical training in LGBTQ content remain, with the lack of TG/GD knowledge and care even more extensive (Nowaskie et al., 2020). Some medical and behavioral health programs have improved curricula and training opportunities, moving from strictly evidence-based and pathology-focused to more holistic and individual-centered LGBTQ care (Gibson et al., 2020; Ng et al., 2021). SGM health curricula need to be thoughtfully planned and developed, culturally responsive, sensitive to the diverse experiences of LGBTQ individuals, and taught by content experts (Pratt-Chapman et al., 2020).

Another aspect of developing sound educational curricula is incorporating a structural lens that captures the complexities of people's lives (Metzl & Hansen, 2014; van Heesewijk et al., 2022). A structural perspective is relevant in today's political climate, particularly considering partisan politics that target the health care provided to TG/GD people and create an environment for TG/GD discrimination (Perone, 2020). For example, numerous state legislatures prohibit physicians from providing gender-affirming care to youth and adults in certain states (Ghorayshi, 2023). Instances when people in positions of power single out marginalized groups without care or consideration for the effects of their actions can be consequential moments for academics in institutions of higher learning. Securing healthcare rights for all people, including TB/GD individuals, is inextricably intertwined with pedagogical strategies incorporating the complexities of TG/GD peoples' lived experiences and uphold-

ing the institutions that protect them. In addition, well-designed research is needed to capture the complexities of intersectional lived experiences, document the harm directed toward disenfranchised people, and proactively develop effective interventions to strengthen resilience in marginalized communities (Capriotti & Donaldson, 2022).

Conclusions

Older LGBT individuals' experiences of disconnections and connections to healthcare, in many respects, reflect what TG/GD people are experiencing in today's healthcare system. TG/GD individuals require specific medical and mental health treatment that financial institutions need to cover. Nondiscriminatory healthcare legislation, in addition to academic and research institutions that uphold TG/GD rights to appropriate gender-affirming care, will go a long way to securing all LGBTQ individuals' connection to healthcare in the U.S.

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