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# Resilience among LGBTQ+ older adults: implications for nursing practice and the organization of integrated care

## Odporność psychiczna osób starszych z grupy LGBTQ+: implikacje dla praktyki pielęgniarskiej i organizacji opieki zintegrowanej

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**STRESZCZENIE**

**ODPORNOŚĆ PSYCHICZNA OSÓB STARSZYCH Z GRUPY LGBTQ+: IMPLIKACJE DLA PRAKTYKI PIELĘGNIARSKIEJ I ORGANIZACJI OPIEKI ZINTEGROWANEJ**

**Cel pracy.** Celem niniejszego badania było zbadanie odporności psychicznej osób starszych z grupy LGBTQ+ oraz przeanalizowanie jej implikacji dla praktyki pielęgniarskiej i organizacji zintegrowanej opieki zdrowotnej i społecznej.

**Materiał i metody.** Zastosowano projekt badania jakościowego. Dane zebrano w drodze pogłębionych, częściowo ustrukturyzowanych wywiadów z 11 osobami starszymi z grupy LGBTQ+ w wieku 50 lat i starszymi, wybranymi metodą kuli śnieżnej. Wywiady zostały przepisane dosłownie i poddane jakościowej analizie treści przy użyciu oprogramowania NVivo.

**Wyniki.** Nadrzędna kategoria – radzenie sobie ze starzeniem się i opieką w kontekście trwającego przez całe życie stresu związanego z przynależnością do mniejszości – ukazuje odporność psychiczną jako dynamiczny proces kształtowany przez doświadczenia związane z dyskryminacją i opieką zdrowotną. Chociaż odporność psychiczna wspierała autonomię, mogła również maskować niezaspokojone potrzeby. Klimat organizacyjny, kompetencje zawodowe oraz uwarunkowania strukturalne miały wpływ na ujawnianie problemów i dostęp do usług, ujawniając luki w edukacji i zintegrowanej opiece, które mogą utrwalać strukturalną niewidzialność.

**Słowa kluczowe:** opieka pielęgniarska, odporność psychiczna, opieka zintegrowana, kultura organizacyjna, osoby starsze z grupy LGBTQ+

**ABSTRACT**

**RESILIENCE AMONG LGBTQ+ OLDER ADULTS: IMPLICATIONS FOR NURSING PRACTICE AND THE ORGANIZATION OF INTEGRATED CARE**

**Aim.** The aim of this study was to explore resilience among LGBTQ+ older adults and to analyse its implications for nursing practice and for the organisation of integrated health and social care.

**Material and methods.** A qualitative study design was applied. Data were collected through in-depth semi-structured interviews with 11 LGBTQ+ older adults aged 50 years and over, recruited using the method of snowball sampling. Interviews were transcribed verbatim and underwent qualitative content analysis supported by NVivo software.

**Results.** The overarching category, navigating ageing and care in the context of lifelong minority stress, illustrates resilience as a dynamic process shaped by discrimination and healthcare experiences. While resilience supported autonomy, it could also conceal unmet needs. The organisational climate, professional competence and structural conditions influenced disclosure and access to services, revealing gaps in education and integrated care that may perpetuate structural invisibility.

**Conclusions.** The mental resilience among LGBTQ+ older adults should be understood not only as an individual psychological resource, but also as a phenomenon shaped by organisational and societal contexts. Nursing practice and integrated care systems must include culturally competent education, inclusive procedures and coordinated service delivery to support equitable ageing and reduce the cumulative effects of minority stress.

**Key words:** nursing care, resilience, integrated care, organisational culture, LGBTQ+ older adults

## INTRODUCTION

Population ageing represents not only a demographic challenge but also an organisational challenge for health and social care systems, requiring coordinated and person-centred models of integrated care. Older adults are a highly heterogeneous population, but sexual and gender minorities (hereafter referred to as LGBTQ+) within this group remain largely underrepresented in research, policy and clinical practice [1]. The term LGBTQ+ is used as an umbrella term to refer to diverse sexual orientations, gender identities and/or gender expressions. LGBTQ+ older adults face additional challenges related to lifelong exposure to stigma, discrimination, and social exclusion, which significantly influence their ageing trajectories, health outcomes, and interactions with healthcare systems [2]. Although there is no universally agreed definition of "older" in this context, LGBTQ+ older adults are commonly defined in research as individuals aged 50 years and above. This lower age threshold reflects established practice in LGBTQ+ ageing studies and accounts for the specific life-course experiences of sexual and gender minorities [3].

Previous research indicates that LGBTQ+ older adults experience inequalities in terms of physical and mental health, social support and access to inclusive healthcare and social services [4]. Heteronormative assumptions and fear of discriminatory treatment in healthcare settings often result in the concealment of sexual orientation or gender identity, reduced trust in healthcare professionals and delayed or avoided use of health and social care services [5]. These issues are particularly relevant to nursing practice, as nurses frequently represent the first point of contact within integrated care systems.

Comparative European studies indicate that healthcare professionals in countries with more integrated LGBTQ+ education (e.g., Spain) report a higher levels of knowledge and preparedness than those in contexts where such training is limited (e.g., Poland) [6]. In addition, Spanish healthcare professionals demonstrate more affirmative practices toward gay and lesbian patients, while lower levels of affirmative practice in Poland are associated with limited training and gender differences [7]. These findings highlight the importance of systematically integrating LGBTQ+-related education into healthcare training to promote culturally competent and inclusive care.

Despite these challenges, many LGBTQ+ older adults develop strong adaptive capacities over the life course. Lifelong exposure to minority stress may foster resilience, which may be understood as a dynamic process of successful adaptation in the context of adversity [8]. It has been previously described that resilience among LGBTQ+ populations arises from coping strategies, self-acceptance and accumulated life experiences, contributing to psychological well-being and autonomy in later life [9].

Within the framework of successful ageing, resilience represents an important psychosocial resource that may shape how older adults engage with care environments [10]. However, resilience can have ambivalent effects. While it may support independence and self-reliance, it can also mask unmet care needs, leading healthcare professionals to interpret resilience as an absence of vulnerability or need for support [11]. This highlights the importance of recognising resilience as a clinically relevant concept in nursing and integrated health and social care.

Considering the limited number of qualitative research focusing on resilience among LGBTQ+ older adults, particularly within European healthcare systems, further exploration of this phenomenon is needed not only to inform inclusive nursing practice but also to support the organisational development of integrated health and social care. Understanding resilience as a complex adaptive process shaped by minority stress may contribute to improving clinical decision-making, fostering culturally competent care, and strengthening organisational frameworks that enable safe disclosure and equitable access to services. The study was conducted in Slovenia, where healthcare is publicly funded and universally accessible, but LGBTQ+-specific services and training remain limited [12]. This context is relevant for interpreting the findings, particularly regarding access and inclusivity of care.

Building on a life-course and minority stress perspective, this study therefore explores how life experiences of discrimination shape resilience, mental health and interactions with healthcare, and examines the implications for nursing practice and the organisation of integrated care.

## MATERIALS AND METHODS

### Sample

Eleven individuals aged 50 years and older who self-identified as members of the LGBTQ+ community participated in in-depth interviews. Participants in Slovenia were recruited using the snowball sampling, which is a method commonly employed to access hidden and hard-to-reach populations, such as LGBTQ+ older adults. The inclusion criteria required participants to be at least 50 years old and to self-identify as LGBTQ+ individuals.

Table 1 presents the basic characteristics of the participants. The mean age was 56.2 years, with the oldest participant

Tab. 1. Basic characteristics of interview participants

| Person | Age | Sex assigned at birth | Sexual orientation | Gender identity |
|---|---|---|---|---|
| Person 1 | 59 | man | bisexual | man |
| Person 2 | 50 | man | homosexual (gay) | man |
| Person 3 | 50 | man | homosexual (gay) | man |
| Person 4 | 60 | man | homosexual (gay) | man |
| Person 5 | 63 | man | homosexual (gay) | man |
| Person 6 | 69 | man | homosexual (gay) | man |
| Person 7 | 51 | man | homosexual (lesbian) | transgender woman |
| Person 8 | 52 | man | homosexual (lesbian) | transgender woman |
| Person 9 | 54 | man | heterosexual | transgender woman |
| Person 10 | 58 | man | homosexual (lesbian) | transgender woman |
| Person 11 | 52 | woman | homosexual (lesbian) | woman |

being 69 years old. The sample included individuals with diverse gender identities and sexual orientations: five cisgender gay men, one cisgender lesbian woman, one cisgender bisexual man, and four transgender women (with varying sexual orientations). We found that certain groups within the broader population of LGBTQ+ older adults were more difficult to access, particularly lesbians and bisexual women and transgender men, whom we were unable to recruit, even with the support of the TransAkcija association.

Data collection was concluded after eleven interviews, as thematic saturation was reached, with responses beginning to recur and no new information emerged with additional participants.

## Data collection

In-depth interviews were conducted individually with each participant. To ensure that participants felt safe and comfortable, the interview location was agreed upon individually with each person. Some participants preferred to be interviewed in their homes, where they felt most secure and relaxed, while others particularly bisexual men and some transgender women asked for the interview to take place in a public setting (e.g. a café or a park) in order to protect their anonymity. One interview was conducted remotely via the Zoom platform due to objective circumstances.

The duration of the in-depth interviews varied, with an average length of approximately 25 minutes. Prior to the interviews, participants were informed about the purpose of the study. They were then introduced to the interview questions and given time to reflect before the interview commenced. All interviews were audio-recorded.

A semi-structured interview guide was used. The interviews covered several key thematic domains, including the life experiences of participants, experiences of stigma and discrimination, mental health and wellbeing, coping strategies, and interactions with healthcare systems. Open-ended questions were used to encourage participants to elaborate on their experiences.

## Data analysis process

The analysis of interview data was conducted using the qualitative data analysis software NVivo, version 14.23.2. The process of qualitative content analysis comprised the following phases: verbatim transcription of audio recordings, review of transcripts and initial coding of statements, systematic coding through the identification of meaningful segments of text relevant to the research question, and the categorization process, that is the synthesis of codes into thematic categories [13], supported by the advanced functionalities provided by NVivo.

## Ethical considerations

The study protocol, including the qualitative research design and data collection instruments, was reviewed and approved by the Ethics Committee of Alma Mater Europaea University (approval no. 14/2022–23). The study was conducted in accordance with ethical principles for research involving human participants.

In order to ensure participant anonymity and confidentiality, all identifying information was removed from the transcripts and pseudonyms were used in reporting the findings. Given the small and potentially identifiable sample, particular care was taken to avoid including details that could indirectly reveal participants' identities (e.g., specific locations or personal circumstances). The audio recordings and transcripts were securely stored in password-protected files and were accessible only to the research team. All of the study participants provided informed consent prior to participation.

# RESULTS

The qualitative content analysis identified one overarching theme, Navigating ageing and care in the context of lifelong minority stress, encompassing three interrelated categories: life experiences, mental health, and healthcare access and experiences. Table 2 provides an overview of the main topic, categories, subcategories and codes. The categories were organised to distinguish between sources of minority stress (life experiences), mental health and interactions with healthcare systems.

Tab. 2. The table of summary of codes, subcategories, categories and main category

| Codes | Subcategory (n) | Category | Main Category |
|---|---|---|---|
| discrimination, non-disclosure | Discrimination (20) | Life experiences | Navigating ageing and care in the context of lifelong minority stress |
| homophobia, internalized homophobia | Homophobia (7) | | |
| verbal violence, other forms of violence | Violence (11) | | |
| acceptance within society | Social acceptance (4) | | |
| psychological violence, verbal violence, physical violence, other forms of violence | Violence-related experiences (16) | | |
| struggle for rights, childlessness, mental health problems, discomfort, fear, psychological pressure, low mood | Stress and emotional responses (28) | Mental health | |
| depression, anger, minority stress syndrome, anxiety | Mental health outcomes (26) | | |
| staff attitudes, lack of access to hormone therapy, incompetence of healthcare professionals, referral practices (e.g. to infectious disease specialists), discrimination | Healthcare professionals (12) | Healthcare access and experiences | |
| no reported problems, non-disclosure of sexual orientation or gender identity, absence of negative experiences | Positive healthcare experiences (7) | | |

Note. n refers to the frequency with which a code appeared across the interviews.

## First category: Life experiences

The analysis aimed to explore whether participants had experienced homophobia, biphobia, transphobia, stigma or other challenges arising from prevailing social norms and how these experiences were reflected in their health. This category identified four interrelated subcategories: discrimination, homophobia, violence (including violence-related experiences), and social acceptance. Among these, discrimination was the most frequently reported subcategory.

The study participants' narratives indicated that experiences of discrimination often occurred early in life and could persist across the life course. One participant described experiencing discrimination already during their school years: "*In the past, I experienced discrimination at school*" (Person 10). Another participant illustrated how discrimination continued into adulthood, particularly in professional and cultural contexts: "*So, this is still happening… especially when the children's poetry collection was published. When they saw who the author was. Even though the poems are for children and not all poems are heteronormative, once they saw who the author was, it became a problem. They didn't want to take the book into libraries. They didn't want me to come and perform, and so on.*" (Person 5)

In contrast, a bisexual man reported not experiencing discrimination, which he explicitly attributed to concealment of his sexual orientation: "*Actually, no discrimination at all, because people don't know*". According to his account, it became evident that fear of disclosure was substantial, as he was married, had a family and described living a "double life." Since his bisexual orientation was known only to his wife, he did not encounter overt discrimination in his social environment. These findings highlights concealment as an adaptive coping strategy that may reduce exposure to discrimination, while simultaneously reinforcing invisibility.

The most prominent psychological consequences identified within the mental health category included anxiety, stress, fear and depression. Participants frequently described experiences of anxiety, persistent fear, stress, depression and psychological pressure. One transgender woman reflected on the mental health impact of gender transition: "*I fell into depression because of gender transition.*" A 63-year-old gay man described chronic stress associated with repeated disclosure: "*These can be very traumatic things… in the LGBT community, we don't come out of the closet just once. We have to come out almost every day of our lives, and that is extremely stressful.*" He further emphasised the enduring fear surrounding disclosure: "*This fear of coming out is still very strong whether in Eastern, Western, or Central Europe, everywhere. Because you never know how your family or your closest circle will react, whether you will be accepted or rejected.*" (Person 5)

Another participant described the cumulative psychological effects of long-term exposure to social pressure and fear: „*At the level of anxiety, when these pressures and fears manifest over a long period of time, they definitely leave traces on a person's mental health.*" (Participant 2) Similarly, a 50-year-old gay man described the coming-out process as particularly stressful during early adulthood: „*When I came out to my family and friends in my early twenties, it was a huge psychological pressure.*" (Person 3)

Apart from affecting mental health, experiences of violence and hostility were also shown to have broader psychosocial consequences. A 52-year-old lesbian woman explained how exposure to violence and hatred affected her civic and political engagement: "*Because of such violence and hatred, the consequences were not directly on my health, but on my political engagement. For about ten years, I didn't dare to attend protests.*" (Person 11)

Positive experiences were also reported by some participants. A transgender woman described not experiencing any transphobia, expressing surprise at the supportive response of her social environment: "*No, I was actually quite surprised. People have always known me, they know who I am. You know, this is a small town, and I never really experienced anything negative. Probably because they knew me before. That's why some people say that older adults somehow go through transition more easily.*" (Participant 10)

This highlights how long-term social familiarity and established community relationships may function as protective factors, mitigating experiences of discrimination and supporting adaptive coping in later life. Overall, participants' accounts illustrate how lifelong exposure to discrimination, stigma and social pressure is closely intertwined with mental health and shapes adaptive strategies, disclosure practices, and broader engagement in social and civic life.

## Second category: Mental health

The mental health category captures the psychological consequences of lifelong exposure to minority stress, including stress, anxiety, fear, and other forms of psychological distress. Most participants described the psychological impact of chronic stress and exposure to violence, which were closely linked to mental health condition. A 50-year-old gay man reflected on his experiences of psychological and verbal violence, particularly in online environments: "*If we talk about psychological and verbal violence, there was a lot of it. At the very least, texts about LGBT topics on social media and online news platforms are filled with terribly offensive and hateful comments. When you read that, it becomes a form of psychological and verbal violence that you experience.*" (Person 3) In contrast, a bisexual man reported not experiencing violence due to concealing his sexual orientation, although he described verbal violence within his intimate relationship: "*I was not exposed to violence, except verbal violence from my wife when she found out.*" (Person 1)

Participants also emphasized the severity of psychological violence. A 63-year-old gay man highlighted its enduring and exhausting nature: "*Sometimes psychological violence is even more brutal than physical violence. It feels easier to defend yourself against physical violence than against psychological coercion, especially emotional blackmail, which is extremely, extremely exhausting.*" (Person 5)

These accounts illustrate how persistent exposure to violence and stress contributes to psychological burden

and reinforces adaptive strategies, such as concealment and emotional self-regulation that may foster resilience while simultaneously placing sustained demands on mental well-being.

### Third category: Healthcare access and experiences

The following section presents participants' experiences with access to health and social care services. All participants referred primarily to healthcare services, and the analysis yielded two categories within this theme: healthcare professionals and positive healthcare experiences. Many LGBTQ+ older adults reported negative experiences when accessing healthcare, most notably related to the perceived lack of competence of healthcare professionals regarding LGBTQ+ issues. A 50-year-old gay man described an encounter with a general practitioner that revealed limited knowledge of sexually transmitted infections relevant to same-sex practices: "*I once asked my doctor whether it could be oral chlamydia. And she said, 'How? What is that? How do you even get that?*'" (Person 2)

Another participant highlighted gaps in clinical assessment linked to insufficient understanding of gay men's sexual health needs: "*My general practitioner is not specialised in LGBT issues. If I go to a dermatovenerologist because of condylomas, they only examine the outside of the anus. They don't check inside, although condylomas can also be internal. I then have to find another specialist, a proctologist, to do that. If someone had at least basic knowledge of gay sexual life, a dermatovenerologist could address these issues.*" (Person 3)

Challenges related to the healthcare system were also reported by a transgender woman, particularly regarding access to hormone therapy. She described inconsistencies and lack of coordination in care provision: "*The problem is hormone therapy. Sometimes they have estrogen, sometimes they don't, and they don't make sure you receive any alternative. If estrogen injections are unavailable, the doctor doesn't even call you—you have to ask yourself whether there is a substitute. It's very disorganised.*" (Person 9)

In contrast, some participants reported no negative experiences in healthcare settings. These accounts were often linked to assumed heterosexuality and non-disclosure. One lesbian woman explained:"Because I have a child and I don't look like a lesbian, people assume I'm heterosexual. In reality, I would have to constantly come out for others to see me as a lesbian." (Person 11)

Overall, these findings indicate that resilience among LGBTQ+ older adults is expressed through adaptive processes, including disclosure practices and concealment as coping strategies. Access to healthcare is shaped by a combination of professional competence, system-level organisation and these resilience-related behaviours, with concealment sometimes functioning as a protective strategy while simultaneously limiting opportunities for inclusive and person-centred care.

## DISCUSSION

The findings of this study indicate that resilience among LGBTQ+ older adults is a complex and adaptive process, shaped by lifelong exposure to minority stress, stigma and discrimination. Consistent with minority stress theory, the participants' narratives demonstrate that chronic exposure to prejudice and the need for repeated disclosure of identity generate long-term psychological strain, including anxiety, depression and persistent vigilance [2, 14]. At the same time, these experiences foster adaptive coping strategies, self-reliance and autonomy, which align with contemporary conceptualisations of resilience as a dynamic developmental process rather than a fixed personal trait [9].

In addition to experiences of minority stress, the analysis also revealed several resilience-related processes. These included adaptive coping strategies, selective disclosure, reliance on social support and the development of psychological endurance over the life course.

Importantly, the results extend previous research by demonstrating that resilience not only affects psychological well-being but also shapes interactions with healthcare systems. While resilience may support independence and functional stability in later life, it can simultaneously obscure unmet needs within healthcare encounters. This ambivalent dimension confirms earlier concerns that resilience, when interpreted superficially, may lead professionals to underestimate vulnerability [11]. In organisational terms, this creates a structural blind spot: healthcare providers may interpret visible autonomy as an absence of need, thereby overlooking psychosocial distress or specific health risks.

The study findings further reveal that disclosure of sexual orientation or gender identity is strongly influenced by perceptions of organisational climate within healthcare settings. Participants frequently described non-disclosure as a resilience strategy aimed at avoiding potential discrimination. Such strategies, however, limit the possibility of person-centred care and may result in incomplete clinical assessments. Previous studies have shown that heteronormative assumptions within health and social care environments contribute to reduced trust and delayed service use among the LGBTQ+ populations [5,15]. The present findings suggest that disclosure does not merely constitute an individual decision but is deeply embedded in organisational culture, communication practices, and perceived inclusivity.

According to an organisational perspective, the reported lack of professional competence particularly in relation to sexual health and gender-affirming care points to systemic rather than individual shortcomings. Inadequate knowledge among healthcare professionals reflects gaps in education, lack of standardised curricula, and weaknesses in organisational quality management systems, as evidenced by studies showing that the quantity and quality of LGBTQ+-specific training across health professions remains insufficient and poorly integrated into formal education programs [16]. Cultural competence should therefore not be framed solely as an individual professional attribute

but as an organisational responsibility embedded within institutional policies, training programmes and clinical guidelines [5]. Strengthening organisational frameworks that promote inclusive practice may reduce reliance on concealment strategies and enhance equitable access to care.

The study also highlights implications for integrated health and social care. Integrated care models aim to ensure continuity, coordination and comprehensiveness of services, particularly for older adults with complex needs [17]. However, the findings indicate that without explicit inclusion of LGBTQ+ perspectives, integrated systems may reproduce structural invisibility. Resilience among LGBTQ+ older adults can mask fragmentation in service provision, particularly in areas such as access to gender-affirming care or specialist referrals, where structural barriers and limited coordination remain evident [17, 18]. This suggests that organisational models of integrated care must incorporate mechanisms that ensure continuity and coordination for marginalised populations, rather than assuming homogeneity among older service users.

Within the broader framework of successful ageing, resilience has often been associated with autonomy and adaptation [10]. However, the present findings challenge overly individualised interpretations of successful ageing by demonstrating that adaptive capacity develops in response to structural adversity. Consequently, successful ageing for LGBTQ+ older adults cannot be understood independently of organisational and societal conditions that shape access to care and social participation. Healthcare organisations play a critical role in either reinforcing or mitigating the cumulative effects of minority stress [19].

According to nursing practice, these findings underscore the importance of reflexive clinical assessment that goes beyond observable functional independence. Nurses frequently serve as the first point of contact within integrated care systems, positioning them at the intersection of individual experience and organisational structure. Recognising resilience as both a strength and a potential indicator of concealed vulnerability requires organisational support, including structured training, inclusive documentation practices and leadership commitment to equity [20]. The latest evidence suggests that LGBTQIA+ cultural competency training can significantly improve knowledge and culturally responsive practice; however, a recent scoping review highlights persistent gaps in standardisation, particularly regarding gender identity and intersectionality, and emphasises the need for structured curricula and faculty development within healthcare education programs [21]. Embedding LGBTQ+ health competencies within continuing professional development may contribute to safer disclosure environments and improved quality of care [22].

The latest research further reinforces the organisational dimension of equitable aging among LGBTQ+ older adults. A community-engaged qualitative study grounded in equitable aging theory demonstrates that health, housing, social connection and access to services are interrelated structural factors shaping the experiences of rural LGBTQ+ older adults, emphasizing the need for coordinated organisational and policy-level responses [23]. Complementing this structural perspective, a co-designed study in care home settings shows that collaboration between older LGBTQ+ people and care staff can translate inclusive principles into practical tools embedded in everyday care practices, highlighting the importance of organisational commitment and lived experience in fostering culturally responsive environments [24]. Collectively, these findings reinforce the argument that resilience should not be conceptualised solely as an individual capacity, but as a phenomenon shaped and mediated by organisational structures and policy environments.

### Limitations of the study

The present study should be interpreted in light of several limitations. Firstly, the sample was relatively small and situated within a specific national context, which may limit the transferability of findings to other healthcare systems or sociocultural settings. Although qualitative research does not aim for statistical generalisation, the perspectives represented may not fully capture the diversity of experiences across the broader LGBTQ+ older population. Secondly, certain subgroups were underrepresented, particularly lesbian women and transgender men, which may have influenced the thematic emphasis of the findings. Differences related to gender identity, sexual orientation, socioeconomic status and rural–urban context may require further exploration in future research. Thirdly, participants were recruited through community networks, which may have resulted in a sample of individuals who were relatively connected, engaged or willing to share their experiences. More socially isolated or marginalised individuals may have different perspectives on resilience and healthcare navigation. Finally, as with all qualitative research, the interpretation of data is shaped by the researchers' analytical framework. Although systematic content analysis was employed and efforts were made to ensure rigour and transparency, alternative interpretations remain possible.

Although this study employed a qualitative design, future research could benefit from incorporating validated quantitative instruments, such as the LGBTQ+ Healthcare Experiences Scale (LGBTQ+ HCES) [25], to enable a more systematic and comparable assessment of patient experiences. Future studies should include more diverse samples, comparative cross-national designs and mixed-method approaches to further examine the organisational dimensions of resilience and integrated care for LGBTQ+ older adults.

## CONCLUSIONS

The present study conceptualises the personal experiences of LGBTQ+ older adults through the overarching theme of navigating ageing and care in the context of lifelong minority stress. The findings demonstrate that ageing for LGBTQ+ individuals is not a neutral life phase, but an ongoing process of negotiating identity, disclosure and access to services within healthcare systems shaped

by structural inequalities. Resilience emerges as a central adaptive mechanism within this navigation process, fostering autonomy and psychological endurance while simultaneously carrying the risk of concealing unmet needs.

The placement of resilience within this broader context highlights that successful ageing for LGBTQ+ older adults cannot be separated from the organisational and societal environments in which care is delivered. Healthcare organisations play a decisive role in either alleviating or perpetuating the cumulative effects of minority stress through their policies, educational structures, leadership practices and integrated care models.

Considering framing resilience as both an individual and organisational phenomenon, this study contributes to a more systemic understanding of inclusive nursing practice. Strengthening culturally competent education, standardising inclusive procedures and embedding LGBTQ+ perspectives within integrated health and social care are essential for supporting equitable ageing and ensuring that navigation through later life does not depend solely on individual resilience but on responsive and inclusive care systems

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