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Comfort among Older Lesbian and Gay People in Disclosing their Sexual Orientation to Health and Aged Care Services

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Ethical approval

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Abstract

Being comfortable in disclosing one's sexual orientation to health and aged care providers is important for older lesbian and gay adults, given that non-disclosure is associated with poorer health and well-being outcomes. In a sample of 752 lesbian and gay adults aged 60 years and older living in Australia, we found only 51% of lesbian women and 64% of gay men felt fully comfortable to disclose their sexual orientation to health and aged care service providers. For both the women and the men, those who felt fully comfortable to disclose reported significantly less internalised homophobia, had fewer experiences of discrimination in the past year, and reported greater LGBTI community connectedness. Feeling fully comfortable was also predicted by fewer experiences of lifetime discrimination among the men. These findings may help those seeking to assist older lesbian and gay people in feeling comfortable being open with health and aged care service providers.

Keywords: healthcare policy; sexuality; disparities; stigma

Introduction

Research suggests that many older lesbian and gay adults do not feel comfortable in disclosing their sexual orientation to health and aged care service providers. In the Australian context, 'aged care' refers to services such as residential care facilities and care workers who visit older people in their homes. A study of lesbian, gay, bisexual, and transgender (LGBT) adults aged 50 and over in the United States found that more than 20% were not 'out' to their primary physician (Fredriksen-Goldsen et al., 2011). Similar patterns have been found in Australia. A recent study of lesbian, gay, bisexual, transgender, and intersex (LGBTI) adults aged 50 and over in Australia found that 23% had not disclosed their sexuality or gender variance to their general practitioner (Hughes, 2017). Sexual orientation concealment in healthcare settings is known to relate to negative health and well-being outcomes, such as poorer mental health (Durso & Meyer, 2013), poorer self-rated physical health (Mor et al., 2015), lower service use (Mor et al., 2015), lower likelihood of health screening and testing (Mor et al., 2015; Ruben & Fullerton, 2018), reduced likelihood of receiving appropriate healthcare (Petroll & Mosack, 2011), and lower satisfaction with care (Mor et al., 2015; St. Pierre, 2012). In addition, non-disclosure can result in the invisibility of the patient's partner or their other sources of support (Fogel, 2016). Further, qualitative research in the United States (Dunkle, 2018) and Australia (Waling et al., 2019) demonstrates the importance that many older lesbian women and gay men place on being 'out' to service providers. This growing body of research indicates the importance of lesbian and gay people being comfortable to disclose their sexual orientation when accessing these services.

Access to appropriate care is increasingly important as people become older, as health issues tend to increase, and the need for aged care can arise. In addition, concerns around sexual orientation disclosure to health and aged care service providers can be even greater among older than younger lesbian and gay people for a number of reasons. Older generations

of lesbian and gay people grew up during a time when homosexuality was far more stigmatised, and was pathologised within the medical profession (Brotman, Ferrer, Sussman, Ryan, & Richard, 2015). Evidence also suggests that older lesbian and gay people experience stigma and discrimination around their sexual orientation in health and aged care settings (Alba et al., 2020; Fredriksen-Goldsen et al., 2011; Hughes, 2007; Waling et al., 2019), and that service providers often lack gay and lesbian cultural competence (Portz et al., 2014). As a result, older people might be particularly vulnerable to feeling unsafe when accessing these services, and therefore uncomfortable about disclosing their sexual orientation. With such discomfort potentially posing a barrier to seeking the most appropriate care, there is a need for research that identifies factors that may be related to a comfort to disclose.

When looking at lesbian, gay, and bisexual participants of all ages, a meta-analysis showed that disclosure of sexual orientation to healthcare service providers is greater in studies with more men, adults, and patients who were more highly educated and had a relationship partner (Ruben & Fullerton, 2018). Studies involving lesbian and gay adults of all ages in the United States (Austin, 2013; Durso & Meyer, 2013; St. Pierre, 2012) and Canada (Coleman et al., 2017) also found that internalised homophobia predicted non-disclosure to healthcare providers. Further, disclosure to healthcare providers is predicted by greater connectedness to the LGBT community (Durso & Meyer, 2013), having more LGBT friends and LGBT community resources (Austin, 2013), as well as having a partner and greater social support from LGBT communities (Coleman et al., 2017). While one of these studies found that disclosure to a primary care provider was associated with more frequent experiences of sexual orientation prejudice (Coleman et al., 2017), others have found no relationship between experiences of discrimination and disclosure (Austin, 2013; Durso & Meyer, 2013). However, research on lesbian and gay adults in Australia has found that many

participants were fearful of disclosing their sexual orientation due to expectations of homophobia or suboptimal care (Hughes, 2009; Koh, Kang, & Usherwood, 2014).

Very little research has looked at the predictors of disclosure to health and aged care service providers in older lesbian and gay people. Qualitative studies in Australia have found that some participants expressed feelings of stress around disclosure to health and aged care service providers due to fears of unfair treatment, and felt the need for staff to provide an environment where disclosure was facilitated (Barrett, Crameri, Lambourne, Latham, & Whyte, 2015; Hughes, 2007). Qualitative studies in the United States (Putney, Keary, Hebert, Krinsky, & Halmo, 2018), Canada (Furlotte, Gladstone, Cosby, & Fitzgerald, 2016), and Europe (Löf & Olaison, 2018) have also found that older lesbian women and gay men report concerns around disclosing their sexual orientation in health and aged care settings due to fear of discrimination. A quantitative study of older LGBT people in the United States found that many participants reported fearing that knowledge of their sexual orientation by their healthcare providers would lead to differential treatment (Morales, King, Hiler, Coopwood, & Wayland, 2014). While these studies reveal that older lesbian and gay people often express a reluctance to disclose their sexual orientation to healthcare providers due to fear of discrimination, we know of no quantitative studies in older samples that have examined a wide range of predictors of comfort in disclosing. It is particularly important to examine whether people feel fully comfortable to disclose, as any level of discomfort may potentially pose challenges to disclosing their sexual orientation.

The following study involved a large nationwide sample of lesbian and gay adults in Australia aged 60 years and over. We had two main aims: 1) to investigate the proportion of participants who felt fully comfortable to disclose their sexual orientation to health and aged care service providers; and 2) to identify predictors of feeling fully comfortable to disclose one's sexual orientation to health and aged care service providers. We examined comfort to

disclose rather than actual disclosure, given the possibility that older lesbian and gay people may disclose to a service provider despite experiencing discomfort in doing so. Therefore, comfort to disclose may provide insights regarding potential psychological barriers to disclosure, while accounting for the fact that people may disclose despite their discomfort. Furthermore, older people are likely to engage with a range of health and aged care service providers to whom they might feel more or less comfortable disclosing their sexual orientation. Therefore, we wanted to gauge the general level of comfort in disclosing to health and aged care providers more broadly, rather than examining disclosure to specific providers. This allows us to capture general perceptions and experiences as a starting point. It is also possible that some people may not have disclosed previously because they were not in contact with a healthcare provider, or they felt that disclosing their sexual orientation was not relevant at the time.

Given that many older people report a fear of sexual orientation discrimination in health and aged care settings, and due to mixed results from previous research on experiences of discrimination and disclosure, we examined both recent and lifetime experiences of sexual orientation discrimination as predictors of whether participants felt fully comfortable to disclose. Furthermore, since research involving samples of all ages suggests that lower internalised homophobia (Austin, 2013; Coleman et al., 2017; Durso & Meyer, 2013; St. Pierre, 2012) and greater connectedness to LGBTI communities (Austin, 2013; Coleman et al., 2017; Durso & Meyer, 2013) predicted disclosure to healthcare providers, we included these variables as potential predictors. We also examined sexual identity affirmation, given that those who feel proud of their sexual orientation may be more likely to feel comfortable to disclose. This study was exploratory, with a broad aim of identifying significant predictors. As such, we did not make specific hypotheses.

Method

Participants

We recruited a sample of 895 adults aged 60 years and older between August and December 2017, who completed an online survey covering a range of topics related to health and well-being. A small number of participants in this sample indicated they were transgender women (n = 35), transgender men (n = 4), or had a gender identity other than male, female, or transgender (n = 16). There was also a small number who were bisexual (n = 48) or had a sexual orientation other than lesbian, gay, or bisexual (n = 56). These groups are likely to have a range of unique histories and experiences related to disclosure and would therefore require separate analysis. This was not possible in our study due to small group numbers. The analysis therefore focused on the older lesbian women and gay men. We also excluded participants who did not respond to the outcome variable (n = 4), leaving a final sample for analysis of 511 cisgender gay men and 241 cisgender lesbian women. The sample was aged 60 to 85 years (M = 65.93, SD = 4.71).

Measures

Comfort to disclose sexual orientation. Participants were asked: "Overall, how comfortable are you or would you be in disclosing your sexual orientation or gender identity/transgender history or intersex variation/s to health and aged care service providers?". The additional options of gender identity/transgender history or intersex variation/s were included to allow responses from a potentially diverse sample. Participants responded on a five-point scale from 1 (Not at all comfortable) to 5 (Extremely comfortable). Scores from 1 to 3 (Not at all comfortable to Moderately comfortable) were re-coded to "Not fully comfortable" and scores from 4 to 5 (Very to Extremely comfortable) were re-coded to "Fully comfortable" in order to distinguish more clearly between participants who did or did

not feel fully comfortable disclosing, and because any level of discomfort in disclosing may be a barrier to actually disclosing.

Internalised homophobia and identity affirmation. Internalised homonegativity (extent to which one rejects their LGB identity) and identity affirmation (extent to which one affirms their LGB identity) were measured using two subscales from the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Kendra, 2011). Each subscale has three items measured on a scale from 1 (Disagree strongly) to 6 (Agree strongly), which are averaged to produce a subscale score. In this study, the Cronbach's alpha was $\alpha = .77$ for internalised homonegativity and $\alpha = .70$ for identity affirmation.

Experiences of sexual orientation discrimination. We measured experiences of lifetime discrimination by asking, "Thinking back across your lifetime, to what degree have you been treated unfairly as a direct result of your sexual orientation?" and recent experiences by asking, "In the last 12 months, how often were you treated unfairly as a direct result of your sexual orientation?". Both questions were answered on a scale that depicted frequency of experiences from 1 (Not at all) to 5 (Very often).

LGBTI community connectedness. LGBTI community connectedness was measured by asking, "How much do you feel a part of either lesbian, gay, bisexual, transgender or intersex communities?", with a response scale from 1 (A lot) to 4 (None). This was reverse-scored, so that higher scores reflected greater community connectedness. We referred to the LGBTI community in this question since the survey was developed for a diverse range of participants.

Socio-demographic variables. Participants were asked a range of socio-demographic questions. These included gender, sexual orientation, age (coded as 60-64 years, 65-69 years, 70+ years), residential location (coded as urban vs regional/rural), highest educational qualification (coded as non-university educated vs university educated), employment status

(coded as working, retired, other), pre-tax income (coded as $0-$49,999, $50,000-$99,999, $100K plus), country of birth (coded as Australia vs overseas), and relationship status (coded as in a relationship or not).

Procedure

An online and paper version of the survey was promoted through various methods. Paid advertisements on Facebook were used to promote the online version. It was also promoted in LGBTI ageing and aged care newsletters and the contact lists of LGBTI community organisations, where they were also informed they could request a paper version of the survey. The paper version was further distributed at an LGBTI ageing conference and promoted at a range of other LGBTI seniors' events in Victoria, Australia. Reply-paid envelopes to return the surveys to the research team were provided with the paper versions. An information statement assured participants their responses were anonymous. The study was approved by the La Trobe University Human Ethics Committee (reference S17-088).

Data Analysis

A sample profile was computed using descriptive statistics for all the main variables. Each predictor variable was examined separately in univariable logistic regressions predicting comfort to disclose to health and aged care service providers. Any predictor variables with a *p*-value over .25, which is a commonly used threshold when selecting variables for inclusion in a multivariable regression (Hosmer, Lemeshow, & Sturdivant, 2013), were then entered into a multivariable logistic regression to examine the unique contribution of the variables predicting comfort to disclose. All regressions were conducted separately for the women and men, with participants excluded from a specific analysis if they had missing data on any of

the variables in that analysis. The data were analysed using Stata, Version 14.1 (StataCorp, College Station, TX).

Results

Sample Profile

Table 1 presents the sample profile. The largest proportion of both the women and the men were in the 60-64 year age group and the smallest in the 70 years and older group. Almost two-thirds of the men and just over half of the women lived in an urban area. While the majority of the women had a university education, less than half of the men did. Over half of the men and women were retired, and approximately a third were still working. Slightly over half of the men and women were earning between AU$0-$49,999 per year, and under a third were earning AU$50,000-$99,999 per year. Three-quarters of the men and a slightly smaller proportion of the women were born in Australia. Almost two-thirds of the women but only about half of the men were in a relationship.

Comfort to Disclose to Health and Aged Care Providers

As displayed in Table 1, 51.0% of women and 64.0% of men felt fully comfortable disclosing their sexual orientation to health and aged care providers. This difference was significant in a chi-square analysis, $\chi^2(1) = 11.44$, $p = .001$. For the women, predictors of comfort to disclose are presented in Table 2. In the univariable analysis, feeling fully comfortable was significantly predicted by lower internalised homophobia ($p < .001$), fewer experiences of sexual orientation discrimination in the past year ($p < .001$), fewer experiences of lifetime sexual orientation discrimination ($p = .004$), higher identity affirmation ($p = .03$), and higher community connectedness ($p = .001$). In the multivariable analysis, lower internalised homophobia ($p = .001$), fewer experiences of sexual orientation discrimination in

the past year ($p < .001$), and higher community connectedness ($p = .03$) remained as significant unique predictors. Thus, among women, identity affirmation and experiences of lifetime sexual orientation discrimination were no longer significant in the multivariable analysis and were therefore not significant unique predictors after accounting for other variables in the analysis.

For the men, predictors of comfort to disclose are presented in Table 3. In the univariable analysis, feeling fully comfortable was significantly predicted by being in a relationship ($p = .001$), lower internalised homophobia ($p < .001$), fewer experiences of sexual orientation discrimination in the past year ($p < .001$), fewer experiences of lifetime sexual orientation discrimination ($p < .001$), higher identity affirmation ($p < .001$), and higher community connectedness ($p < .001$). In the multivariable analysis, lower internalised homophobia ($p = .003$), fewer experiences of sexual orientation discrimination in the past year ($p = .03$), fewer experiences of lifetime sexual orientation discrimination ($p = .04$), and higher community connectedness ($p = .004$) remained as significant unique predictors. Thus, relationship status and identity affirmation were no longer significant in the multivariable analysis and were therefore not significant unique predictors after accounting for other variables in the analysis.

Discussion

This study examined predictors of whether lesbian and gay adults in Australia aged 60 years and older felt fully comfortable to disclose their sexual orientation to health and aged care service providers. About two-thirds of the older gay men and slightly over half of the older lesbian women reported feeling fully comfortable. The men were significantly more likely to report feeling fully comfortable than the women, which is consistent with previous research involving lesbian and gay participants of all ages (Ruben & Fullerton, 2018). This

may be partly due to the history of the HIV/AIDS epidemic, which led to the establishment of clinics focused on men's sexual health, as well as greater targeting of the sexual health needs of men who have sex with men within mainstream clinics. Recent research involving LGBTI adults in Australia aged 50 years and older found approximately three-quarters had disclosed their sexuality or gender variance to their general practitioner (Hughes, 2017). Differences in samples and methodology make comparisons difficult, but if actual disclosure rates are higher, as indicated by this previous study, then it may suggest that in some cases people disclose despite not feeling comfortable doing so. Feeling fully comfortable is inherently important, however, as it may be linked to whether a person discloses again to another service provider or whether they disclose to any at all.

None of the socio-demographic variables were significant predictors of feeling fully comfortable to disclose after taking into account all variables in the multivariable analyses. This contrasts with studies that have found that those with a higher education (Ruben & Fullerton, 2018) and those living in urban areas (Austin, 2013) were more likely to have disclosed. These differences may in part be due to measuring comfort to disclose rather than actual disclosure. It is also worth noting that this study involved an older sample, so it may be possible that predictors in younger samples are not necessarily the same as those for older groups. For example, research among older LGBTI people in Australia found no association between disclosure and geographical location (Hughes, 2017).

However, we identified a range of other significant unique predictors in the multivariable analyses. Lower internalised homophobia, fewer experiences of sexual orientation discrimination in the past year, and greater community connectedness were all unique predictors of feeling fully comfortable to disclose for both the women and the men. Among the men, feeling fully comfortable was also predicted by fewer experiences of lifetime sexual orientation discrimination. It is possible that some of the ways in which the

older gay men experienced historical discrimination, or how they coped with it, may be a factor, which would also require further research. Although this variable was not significant for the older lesbian women, they were less likely to feel fully comfortable if they were experiencing higher levels of internalised homophobia. Although there may be multiple causes, past experiences of stigma and discrimination are also likely to be contributors to internalised homophobia.

Overall, these findings are consistent with previous research in younger samples that found that non-disclosure of sexual orientation to healthcare providers is related to internalised homophobia (Austin, 2013; Coleman et al., 2017; Durso & Meyer, 2013; St. Pierre, 2012) and lower connectedness to lesbian, gay and bisexual communities (Austin, 2013; Coleman et al., 2017; Durso & Meyer, 2013). While some studies did not find that experiences of sexual orientation discrimination related to disclosure (Austin, 2013; Durso & Meyer, 2013), Coleman et al. (2017) found that those who had disclosed to a primary care provider were more likely to have experienced sexual orientation prejudice. This was explained as being likely due to a higher level of 'outness' in general, leading to a greater visibility of sexual orientation. Our study suggests that more frequent experiences of discrimination could potentially contribute to a lack of feeling fully comfortable to disclose. This is in line with studies that found older lesbian and gay people report fears of disclosing their sexual orientation due to expectations of discrimination (Barrett et al., 2015; Furlotte et al., 2016; Hughes, 2007; Löf & Olaison, 2018; Morales et al., 2014; Putney et al., 2018), so it is possible that previous experiences of discrimination contribute to fears of future discrimination.

These results reveal some of the factors among older lesbian and gay adults that may be associated with whether they feel fully comfortable in disclosing their sexual orientation to health and aged care providers. It is the first quantitative study that we know of to examine a

wide range of potential predictors of comfort in disclosing one's sexual orientation among older gay and lesbian people. The study also provides additional insight into feelings around disclosure, rather than just disclosure itself. Given that little more than half of participants felt fully comfortable in disclosing their sexual orientation, there is likely to be a role for health and aged care service providers in assisting older lesbian and gay adults to feel safer in disclosing their sexual orientation.

To improve comfort, providing assurances about confidentiality and a non-judgmental environment by service providers are likely to be important. Service providers can work to make their services more inclusive by ensuring culturally competent practices, with staff adequately trained to work with lesbian and gay clients (Fogel, 2016). In particular, the unique needs of older generations of lesbian and gay people should be understood, given the historical factors that might make them additionally wary of disclosing to health care services (Fredriksen-Goldsen, Hoy-Ellis, Goldsen, Emlet, & Hooyman, 2014). Service providers can communicate an inclusive environment through affirmative signage and information in waiting areas and on websites, and appropriate terminology on forms (Fredriksen-Goldsen et al., 2014; Hughes, 2007), which have been found to encourage disclosure (St. Pierre, 2012). Such steps are important, as facilitating openness about sexual orientation can be especially important for ensuring appropriate care and improving health outcomes and satisfaction with care (Durso & Meyer, 2013; Mor et al., 2015; Petroll & Mosack, 2011; Ruben & Fullerton, 2018; St. Pierre, 2012). Governments might also play a role by implementing policies that encourage or require services to develop practices that help people feel more comfortable in talking about their sexuality. In Australia, some health care services have undergone LGBTI cultural safety training. However, it is not a requirement to undertake such training, and many have not done so. That said, programs such as the Rainbow Tick

(http://www.rainbowhealthvic.org.au/rainbow-tick) are available, which aim to assist services and organisations in creating safe and inclusive enviroments for LGBTI populations.

Our study findings are also useful for identifying potential reasons for not feeling fully comfortable in disclosing one's sexual orientation to health and aged care services. Those working with older lesbian and gay adults, such as psychologists, counsellors, social workers, and community organisations, may need to be aware of and responsive to some of the factors identified in this study. For example, addressing internalised homophobia and the psychological and social impact of discrimination are potential areas of focus. Given our finding that LGBTI community connectedness was associated with greater comfort in disclosing to health and aged care service providers, fostering a sense of community and connecting older lesbian and gay adults with community resources might also play a role in assisting them to feel fully comfortable to disclose their sexual orientation.

Limitations and Future Directions

Our study had some limitations. First, while examining comfort in disclosing one's sexual orientation revealed potential psychological barriers to disclosure, we did not examine how this relates to actual disclosure to health and aged care service providers. Disclosure can also happen indirectly, such as when a partner is present in health and aged care settings, or by being advised by a family member or other provider. As mentioned earlier, comfort to disclose is, however, an important factor as there can be specific reasons for actually disclosing such as being faced with little choice. Future research should investigate the extent to which people may disclose despite not feeling comfortable. Feeling comfortable may also be indicative of the likelihood to actually disclose in the future. Of course, disclosure involves instances of interactions between one person, who has an ascribed stigmatised characteristic, with others. Further research would likely benefit from bringing groups of

people together, like older gay and lesbian people and their health practitioners, in focus group interviews. Researchers can observe how they discuss the process of disclosing or not disclosing in order to better understand how people facilitate, or not facilitate, opening up discussions about sexual orientation in clinical practices.

A related issue is whether the burden of disclosure should fall to a service user rather than the service provider. Past research has found that older lesbian and gay adults are more likely to disclose their sexual orientation than service providers are to invite them to do so (Stein & Bonuck, 2001). It would be useful to examine whether older lesbian and gay adults would prefer to be asked and in what ways, such as through intake forms or interviews about sexuality and relationships. Further, it is recommended that subsequent research examines comfort in disclosing to specific types of services, as comfort might vary depending on the service. We examined comfort more broadly as a starting point, but further work in relation to specific types of services would help identify particular challenges.

Second, this study was cross-sectional, so we cannot infer causality. In other words, we do not know whether comfort to disclose is the direct result of the predictor variables, or whether comfort to disclose and our predictor variables are related to one another due to other underlying variables. Our results are therefore suggestive, but causality would need to be confirmed through follow-up longitudinal research.

Third, there were only small numbers of participants in our sample who identified as bisexual or other sexual orientations, transgender or gender diverse, or intersex, which meant we were unable to include these groups in the analysis. As noted earlier, these groups are likely to have a range of unique histories and experiences related to the challenges of disclosure, and it is therefore important to provide separate analyses of each group. Future research should seek to recruit larger samples of specific populations, such as transgender or gender diverse populations, and focus on gathering population-specific data on comfort in

disclosing one's sexual orientation, gender identity and expression, or intersex variation/s in different contexts to health and aged care service providers.

Fourth, our sample was drawn predominantly from Facebook and through advertising via community channels. As a result, it may not be wholly representative of the broader population of older lesbian women and gay men. For example, given the use of community channels for part of the recruitment, it could be that the sample was more community connected than the broader population. In Australia, there is a lack of census data of the older lesbian and gay population, so it is currently not possible to determine what a representative sample would look like. That said, our sample was diverse in many respects, such as having participants from urban and rural areas and from a range of income categories. However, further work involving different sampling techniques is needed to corroborate our findings.

Finally, it is possible that experiences could have been different for those in the oldest age groups, such as people in their 80s or 90s. We did not have sufficient numbers in these age groups to examine them separately. Our study provides a broad indication of patterns related to those aged 60 years and older, but it would be beneficial for future research to acquire larger samples across finer-grained age categories. We also examined community connectedness. While this was assessed broadly and subjectively, participants may have had different ideas about what comprises community. It would therefore be useful in future to examine various forms of engagement, such as participating in social groups or online environments, to determine whether specific types of community connectedness may be linked to a comfort to disclose.

Another consideration for future work is the inclusion of people with high care needs. It is possible that those with the highest health and aged care needs may have been less likely to participate in our study, due to physical and health limitations. Future research would also benefit from examining discrimination in different ways. For example, frequency of

discrimination over the lifetime might only be one aspect of the overall experience of discrimination. The types of discrimination experienced and the severity of these may also be factors, which would need to be examined in future research.

In all, slightly more than half of the older lesbian and gay adults in our study felt fully comfortable disclosing their sexual orientation. Feeling fully comfortable was predicted by lower internalised homophobia, fewer experiences of sexual orientation discrimination in the past year, and greater connectedness to the LGBTI community. In addition, feeling fully comfortable was also predicted by fewer experiences of lifetime sexual orientation discrimination among the older gay men. The predictors identified in this study add to our understanding of factors associated with older lesbian women and gay men feeling fully comfortable in disclosing their sexual orientation. The findings may be particularly helpful to service providers and policymakers seeking to ensure that older lesbian and gay adults feel included and not excluded or marginalised in health and aged care settings.

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Table 1

Sample profile (N = 752)

	Women		Men	
	No.	*%*	No.	*%*
Age group				
60-64 years	111	*46.1*	217	*42.5*
65-69 years	86	*35.7*	181	*35.4*
70+ years	44	*18.3*	113	*22.1*
Residential location				
Urban	126	*52.5*	321	*62.9*
Regional/rural	114	*47.5*	189	*37.1*
Education				
Non-university educated	97	*40.2*	271	*53.0*
University educated	144	*59.8*	240	*47.0*
Employment				
Working	83	*34.6*	169	*33.1*
Retired	125	*52.1*	295	*57.8*
Other	32	*13.3*	46	*9.0*
Income				
$0-$49,999	124	*52.8*	263	*53.0*
$50,000-$99,999	68	*28.9*	141	*28.4*
$100K plus	43	*18.3*	92	*18.6*
Country of birth				
Australia	163	*69.4*	377	*75.2*
Overseas	72	*30.6*	124	*24.8*

Relationship status				
Not in a relationship	82	*35.0*	246	*49.2*
In a relationship	152	*65.0*	254	*50.8*
Comfort to disclose				
Fully comfortable	123	*51.0*	327	*64.0*
Not fully comfortable	118	*49.0*	184	*36.0*

Note. The 'other' category for employment status included those who were unemployed, students, or selected the 'other' option for employment status. Comfort to disclose was on a five-point scale ranging from 1 (Not at all comfortable) to 5 (Extremely comfortable) and responses from 1 to 3 (Not at all comfortable to Moderately comfortable) were re-coded to "Not fully comfortable" and scores from 4 to 5 (Very to Extremely comfortable) were re-coded to "Fully comfortable".

Table 2

Variables predicting comfort to disclose sexual orientation to health and aged care service providers among lesbian women in Australia aged 60 years and over

	Comfort to disclose *n* (%)		Univariable		Multivariable[1]	
	Fully comfortable	Not fully comfortable	OR [95% CI]	*p*	OR [95% CI]	*p*
Age group				.77		-
60-64 years	54 (48.6)	57 (51.4)	-			
65-69 years	45 (52.3)	41 (47.7)	1.16 [0.66, 2.04]			
70+ years	24 (54.5)	20 (45.5)	1.27 [0.63, 2.55]			
Residential location				.71		-
Urban	66 (52.4)	60 (47.6)	-			
Regional/rural	57 (50.0)	57 (50.0)	0.91 [0.55, 1.51]			
Education				.24		.28
Non-university educated	54 (55.7)	43 (44.3)	-		-	
University educated	69 (47.9)	75 (52.1)	0.73 [0.44, 1.23]		0.71 [0.38, 1.32]	
Employment				.40		-
Working	47 (56.6)	36 (43.4)	-			
Retired	59 (47.2)	66 (52.8)	0.69 [0.39, 1.20]			
Other	17 (53.1)	15 (46.9)	0.87 [0.38, 1.97]			
Income				.55		-
$0-$49,999	61 (49.2)	63 (50.8)	-			
$50,000-99,999	33 (48.5)	35 (51.5)	0.97 [0.54, 1.76]			
$100K plus	25 (58.1)	18 (41.9)	1.43 [0.71, 2.89]			
Country of birth				.66		-
Australia	81 (49.7)	82 (50.3)	-			
Overseas	38 (52.8)	34 (47.2)	1.13 [0.65, 1.97]			
Relationship status				.66		-

Not in a relationship	44 (53.7)	38 (46.3)	-			
In a relationship	77 (50.7)	75 (49.3)	0.89 [0.52, 1.52]			
	M (*SD*)					
Internalised homophobia	1.18 (0.38)	1.52 (0.81)	0.36 [0.21, 0.62]	<.001	0.34 [0.18, 0.66]	.001
Identity affirmation	5.29 (0.96)	4.99 (0.99)	1.37 [1.04, 1.81]	.03	1.07 [0.75, 1.52]	.70
Discrimination in past year	1.40 (0.74)	1.96 (1.00)	0.47 [0.34, 0.66]	<.001	0.46 [0.31, 0.69]	<.001
Lifetime discrimination	2.63 (1.05)	3.04 (1.10)	0.70 [0.55, 0.89]	.004	1.01 [0.73, 1.39]	.97
Community connectedness	2.91 (0.89)	2.50 (1.00)	1.57 [1.19, 2.07]	.001	1.47 [1.04, 2.08]	.03

Note. Internalised homophobia and identity affirmation were measured using the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Kendra, 2011). Discrimination in the past year, lifetime discrimination, and community connectedness were all measured using single-item questions developed by the researchers.

[1] Only those variables that were associated with comfort to disclose at $p < .25$ in the univariable analyses were entered into the multivariable analysis.

Table 3

Variables predicting comfort to disclose sexual orientation to health and aged care service providers among gay men in Australia aged 60 years and over

	Comfort to disclose *n* (%)		Univariable		Multivariable[1]	
	Fully comfortable	Not fully comfortable	OR [95% CI]	*p*	OR [95% CI]	*p*
Age group				.55		-
60-64 years	133 (61.3)	84 (38.7)	-			
65-69 years	119 (65.7)	62 (34.3)	1.21 [0.80, 1.83]			
70+ years	75 (66.4)	38 (33.6)	1.25 [0.77, 2.01]			
Residential location				.32		-
Urban	211 (65.7)	110 (34.3)	-			
Regional/rural	116 (61.4)	73 (38.6)	0.83 [0.57, 1.20]			
Education				.32		-
Non-university educated	168 (62.0)	103 (38.0)	-			
University educated	159 (66.3)	81 (33.8)	1.20 [0.84, 1.73]			
Employment				.29		-
Working	116 (68.6)	53 (31.4)	-			
Retired	181 (61.4)	114 (38.6)	0.73 [0.49, 1.08]			
Other	30 (65.2)	16 (34.8)	0.86 [0.43, 1.71]			
Income				.06		.18
$0-$49,999	158 (60.1)	105 (39.9)	-		-	
$50,000-$99,999	91 (64.5)	50 (35.5)	1.21 [0.79, 1.85]		1.11 [0.67, 1.83]	
$100K plus	68 (73.9)	24 (26.1)	1.88 [1.11, 3.19]		1.82 [0.97, 3.42]	
Country of birth				.08		.19
Australia	232 (61.5)	145 (38.5)	-		1.40 [0.84, 2.31]	
Overseas	87 (70.2)	37 (29.8)	1.47 [0.95, 2.28]			
Relationship status				.001		.21

Not in a relationship	141 (57.3)	105 (42.7)	-		-	
In a relationship	182 (71.7)	72 (28.3)	1.88 [1.30, 2.73]		1.33 [0.85, 2.07]	
	M (*SD*)					
Internalised homophobia	1.42 (0.69)	1.82 (1.00)	0.57 [0.45, 0.71]	<.001	0.65 [0.49, 0.86]	.003
Identity affirmation	5.12 (0.91)	4.69 (1.00)	1.59 [1.30, 1.93]	<.001	1.26 [0.98, 1.61]	.07
Discrimination in past year	1.50 (0.89)	1.89 (1.12)	0.68 [0.57, 0.82]	<.001	0.76 [0.58, 0.98]	.03
Lifetime discrimination	2.51 (1.01)	2.93 (1.17)	0.70 [0.59, 0.83]	<.001	0.78 [0.61, 0.99]	.04
Community connectedness	2.71 (1.00)	2.34 (0.95)	1.47 [1.22, 1.77]	<.001	1.39 [1.11, 1.74]	.004

Note. Internalised homophobia and identity affirmation were measured using the Lesbian, Gay, and Bisexual Identity Scale (Mohr & Kendra, 2011). Discrimination in the past year, lifetime discrimination, and community connectedness were all measured using single-item questions developed by the researchers.

[1] Only those variables that were associated with comfort to disclose at $p < .25$ in the univariable analyses were entered into the multivariable analysis.