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The Healthcare Experiences of LGBT + Individuals in Europe: A Systematic Review

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Abstract

Introduction LGBT + individuals are less likely to access and utilize healthcare services compared to the general population. Moreover, they are more likely to report unmet healthcare needs due to experiences of heterosexism and cisgenderism within healthcare settings. This systematic review aims to present an overview of the current state of the experiences of LGBT + individuals in healthcare settings across Europe.

Method A systematic search for quantitative and qualitative studies was conducted in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines. The Scopus, PubMed, and Web of Science databases were searched up to May 2024 to identify eligible records for inclusion in the review. Boolean operators were used to combine terms related to the LGBT + population and their experiences in healthcare settings across Europe.

Results A total of 29 articles were included in the review, whose results were grouped into three main themes: (1) barriers to accessing healthcare services, (2) cis- and hetero-normativity in perinatal care, and (3) protective factors in healthcare experiences.

Conclusions The barriers to accessing healthcare services and the perceived need to educate healthcare professionals about their specific health needs often result in LGBT + individuals not receiving adequate care, negatively affecting their health and well-being.

Policy Implications A deeper understanding of the processes underlying the healthcare needs of LGBT + individuals should be accompanied by political and social policies that support and promote the fundamental rights of the LGBT + population. This includes ensuring adequate healthcare services free from discrimination and educating healthcare professionals about the specific health needs of the LGBT + community.

Keywords Healthcare · Health Disparities · LGBT + · Europe · Systematic Review

Introduction

“LGBT + ” is an acronym that encompasses all individuals who identify as lesbian, gay, bisexual, and/or transgender. The sign “ + ” is meant to include all other possible forms of gender and sexual diversity (e.g., queer/questioning, intersex, and agender). The LGBT + population includes various types of individuals with minoritized sexual and gender identities, namely, individuals whose sexual orientation is not heterosexual and those whose gender identity does not align with the sex assigned at birth (transgender) or does not conform to the binary gender norms endorsed by society (non-binary). To address specific sub-groups within the LGBT + community, we will use the acronym TNB (transgender and/or non-binary) to refer to the transgender and non-binary population. Meanwhile, the population comprising lesbian women, gay men, and bisexual individuals will be referred to as LGB (lesbian, gay, or bisexual).

LGBT + individuals are known to suffer from higher levels of health problems compared to the general population (e.g., Meyer., 2010). In addition to the societal stigma,

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discrimination, and homo- and/or transnegativity they experience, especially within healthcare contexts (Institute of Medicine, 2011), the health disparities affecting LGBT + individuals are also associated with the barriers they encounter to healthcare access and utilization, which include perceived and anticipated social stigma (Newman et al., 2008), discrimination by healthcare providers (Owens et al., 2007), lack of professionals' knowledge of LGBT + specific health issues (Safer et al., 2016), and concealment of gender identity and/or sexual orientation due to the fear of marginalization (Durso & Meyer, 2013). Overall, such barriers render it more difficult for LGBT + individuals to properly use the healthcare system and thus have their health-related needs met.

The health disparities affecting individuals with minoritized sexual and gender identities can be better understood through the *Health Equity Promotion Model* (HEPM; Fredriksen-Goldsen et al., 2014), which considers both positive and adverse factors that influence the health pathways of the LGBT + population. This model examines behavioral, social, psychological, and biological processes from a life course development perspective (Scandurra et al., 2017a, 2017b). The HEPM posits that the structural- and individual-level contexts in which LGBT + individuals live represent important factors influencing their health and well-being and highlights the relevance of the heterogeneity and intersectionality affecting individuals within LGBT + communities.

The HEPM is based on the *Minority Stress Theory* (MST; Meyer, 2003), which theorizes the unique, chronic, and socially based nature of distal and proximal stressors affecting individuals with minoritized sexual identities while also highlighting the crucial role of resilience factors in buffering the impact that minority stressors have on the individual's health. As an extension of the MST, the *Gender Minority Stress and Resilience* framework has been articulated to include the experiences of TNB individuals (Testa et al., 2015), who tend to feel a specific type of "gender pressure" to conform to stereotyped gender norms within a society abiding by cis- and hetero-normative views of gender (Egan & Perry, 2001; Mezzalira et al., 2023).

On this basis, this systematic review aims to outline the healthcare experiences of LGBT + individuals in Europe. Numerous reviews have been published regarding the needs and utilization of specific healthcare services—such as primary care, emergency rooms, cancer care, gender-specific services, and mental healthcare settings—by specific subpopulations within the LGBT + community (e.g., TNB or LGB individuals; Call et al., 2021; Snow et al., 2019). Most of these reviews have been conducted in the USA, focusing on the limitations and opportunities presented by US healthcare services. Regarding the encounters of LGBT + individuals with healthcare professionals, existing reviews have addressed the healthcare experiences of the transgender population (White Hughto et al., 2015), examined homosexuality as a barrier to accessing healthcare services for LGBT + individuals (Alencar Albuquerque et al., 2016), and explored health inequalities faced by LGBT + individuals and the challenges healthcare professionals encounter when providing care (Zeeman et al., 2019). However, a systematic review of the healthcare experiences of the entire LGBT + population in Europe is still lacking in the recent scientific literature.

Therefore, we aimed to investigate the experiences of LGBT + individuals across all healthcare settings in Europe, encompassing diverse minoritized gender identities and/or sexual orientations. This investigation is particularly relevant given the significant variation in healthcare systems across Europe compared to other countries—especially the USA—as well as the diverse landscape of progress and trends concerning the human rights situation of LGBT + individuals in Europe (ILGA., 2024).

Method

Search Strategy

The present systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines (Page et al., 2021). Three databases, namely Scopus, PubMed, and Web of Science, were searched until 21st March 2024—and updated on 20th May 2024—for eligible records to include in the review. The search strategy was based on Boolean operators combining terms related to the LGBT + population and their experiences in healthcare settings in Europe. The exact search term combinations were as follows: [(lgbt* OR lesbian* OR gay* OR bisexual* OR transgender* OR queer*) AND (health care setting* OR health care system* OR health care provider*) AND (experience* OR perception* OR outcome*) AND (well-being OR wellbeing OR mental health)]. To retrieve extensive data, these terms were all placed within titles, abstracts, and keywords of the main documents.

Eligibility Criteria

To be included, studies had to meet the following criteria: (1) being published in peer-reviewed journals, (2) being focused on healthcare experiences, (3) containing a sample of LGBT + individuals, (4) having been conducted in European countries, (5) being English-written, and (6) including quantitative and/or qualitative original data. Studies were excluded if (1) they contained a non-European sample, (2) did not focus on LGBT + individuals, (3) did not address healthcare experiences, (4) were written in languages other than English, (5) lacked original data (e.g., merely theoretical), and (6) comprised gray literature (i.e., editorials, letters to the editor, commentaries, and abstracts). No temporal restriction for the year of publication nor the age of participants was introduced.

Selection Procedure

The initial search identified a total of 3230 publications. After duplicate removal, 2458 records were screened. Three authors (SM, GC, and MQ) independently assessed titles and abstracts according to the inclusion criteria. Disagreements between these reviewers were resolved involving one other author (CS). A total of 2235 records were excluded from the screening process, which resulted in the retrieval of 223 records. The full text of these articles was obtained and reviewed by three authors (SM, GC, and MQ), and any discrepancies between them were resolved through discussion meetings involving one additional reviewer (CS). At this stage, 194 full-text articles were excluded following the eligibility assessment. As a result, a total of 29 articles matched the inclusion criteria and were included in the review. The details of this procedure are outlined in Fig. 1.

Data Extraction Process

Data were extracted from each full-text article by two reviewers (SM and VB), which included author(s) and year of publication, country, study design, sample characteristics (participants, age, sample size), outcome measures (for quantitative studies) and/or focus (for qualitative studies), and main themes emerged (for qualitative studies only). The data extraction was cross-checked by one additional author (NC). The details of this procedure are outlined in Table 1.

Quality Assessment

The quality assessment was performed separately for quantitative and qualitative studies. The National Institutes of Health's Quality Assessment Tool for Observational Cohort and Cross-Sectional Studies (National Heart, Lung, and Blood Institute, 2014) was used to rate the quality of the

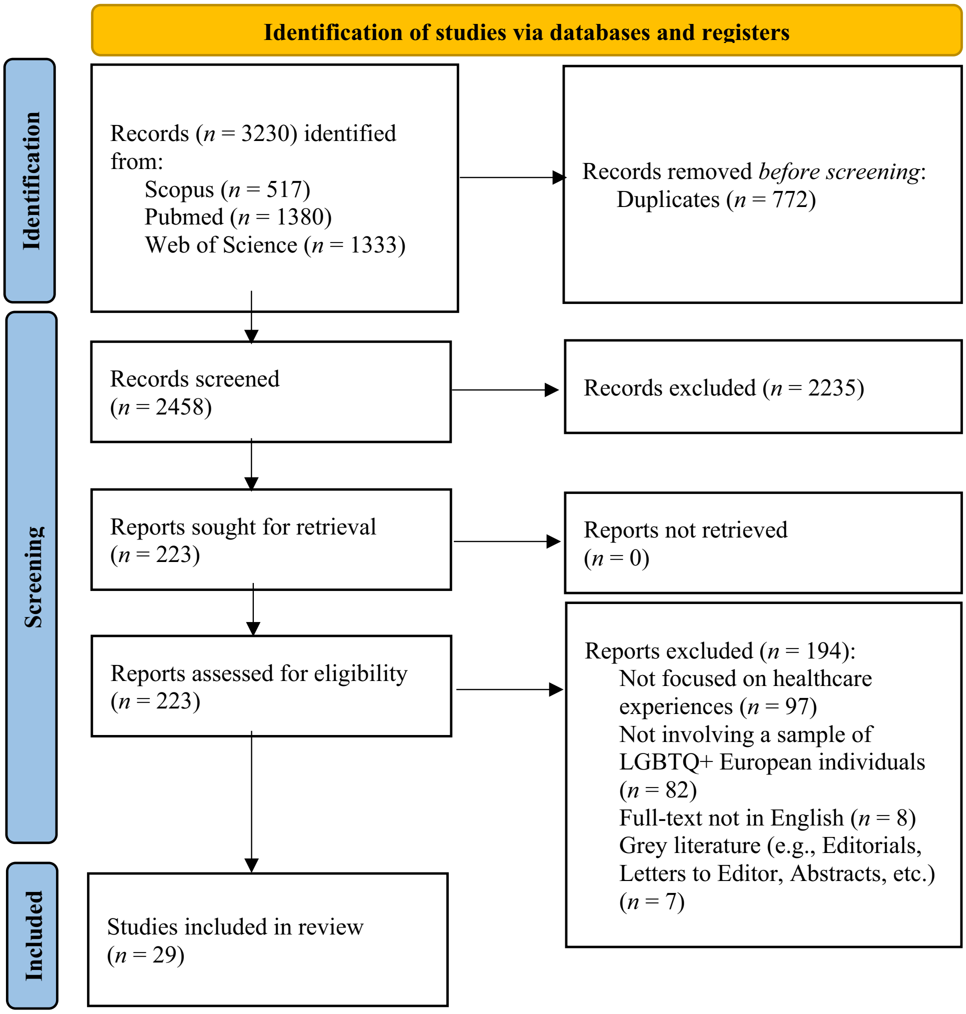

Fig. 1 PRISMA 2020 flow diagram

Table 1 Main characteristics of included studies

Author(s), year	Country	Study design	Sample size and characteristics *	[Age range] *Mean* (*SD*)	Outcome measures (quantitative studies)/focus (qualitative studies)	Key themes identified (qualitative studies only)
1. Allory et al. (2020)	France	Qualitative	27 trans individuals	[> 18] N.R	- Difficulties in accessing healthcare services - Expectations concerning the healthcare system	1. Main ethical principles (self-determination, depsychiatrization of trans individuals) 2. A genuine healthcare partnership 3. A central place for the general practitioner in the healthcare pathway 4. A respectful attitude without financial barriers to access health care
2. Burgwal and Motmans (2020)	Georgia, Poland, Serbia, Spain, Sweden	Quantitative, cross-sectional	853 trans (*n* = 623) and gender diverse (*n* = 230) individuals	- Trans [> 16] 27.1(10.3) - Gender diverse [> 16] 24.7(8.1)	- Experiences in general healthcare services - Access to, experiences, and evaluation of trans-specific healthcare services	N.A
3. Carlile (2020)	UK	Qualitative	65 trans youth and their parents (*n* = 27 families)	[12–18] N.R	- Experiences in health-care services	1. Professionals' perceived lack of clinical and therapeutic knowledge 2. Mental distress caused by excessive waiting lists 3. Professionals' stereotyped gender assumptions 4. Direct discrimination within healthcare settings 5. Lack of attention to parent and child voice
4. Czimbalmos and Rask (2022)	Finland	Qualitative	14 trans (foreign) individuals	[20 s–60 s] N.R	- Experiences in the gender-affirming healthcare system	1. Perceived barriers when accessing gender-affirming care 2. The necessity of "performing identities"
5. Doran et al. (2018)	UK	Qualitative	12 gay men with prostate cancer	[49–82] 61	- Experiences with the healthcare system	1. Information needs 2. Relationships with healthcare providers 3. Support networks 4. Relationships

Table 1 (continued)

Author(s), year	Country	Study design	Sample size and characteristics *	[Age range] *Mean* (*SD*)	Outcome measures (quantitative studies)/focus (qualitative studies)	Key themes identified (qualitative studies only)
6. Ellis et al. (2015)	UK	Mixed methods (quantitative and qualitative)	621 and 202 trans individuals (mental health services and gender identity clinics, respectively)	[18–78] N.R	- Access to and experiences of mental health services and gender identity clinics	N.R
7. Ercan Sahin et al. (2020)	Turkey	Quantitative, cross-sectional	140 LGBT individuals	[> 18] 25.75 (6.22)	- Healthcare access and experiences - Perceived barriers to healthcare access	N.A
8. Falck et al. (2021)	Sweden	Qualitative	12 trans masculine individuals	N.R	- Experiences in healthcare settings in relation to pregnancy, delivery, and nursing	1. Expectations and experiences of pregnancy-related care 2. Maneuvering to ensure needs
9. Fish and Anthony (2005)	UK	Mixed methods (quantitative and qualitative)	1066 lesbian women	[< 20 to > 70] N.R	- Risk perceptions - Experiences of health care - Health-seeking behavior	N.R
10. Gieles et al. (2023)	The Netherlands	Qualitative	14 trans (women $n=7$; men $n=6$) and non-binary ($n=1$) individuals	[> 18] N.R	- Experiences with access to primary sexual and reproductive health care	1. 'They say: we have never seen that here before': navigating cisgender assumptions 2. 'She just accepts me […] so I am quite happy with my general practitioner': depending on your healthcare provider 3. 'Stand up for yourself, it is your health!': access requires labor
11. Gómez-Ibáñez et al. (2024)	Spain	Qualitative	21 non-binary individuals	[19–43] 29.05	- Experiences with the healthcare system	1. This is me 2. I do not exist for the health system
12. Higgins et al. (2021)	Ireland	Mixed methods (quantitative and qualitative)	1064 LGBT + individuals	[14–25] 19.69 (3.10)	- Barriers to accessing mental health services	1. Mental health system barriers 2. Individual-level barriers
13. Hirsch et al. (2016)	Germany	Quantitative, cross-sectional	766 lesbian women	[18–67] 32.5(9.6)	- Experiences within the healthcare system - Disclosure of sexual orientation to medical practitioners	N.A

Table 1 (continued)

Author(s), year	Country	Study design	Sample size and characteristics *	[Age range] *Mean* (*SD*)	Outcome measures (quantitative studies)/focus (qualitative studies)	Key themes identified (qualitative studies only)
14. Hulbert-Williams et al. (2017)	UK	Quantitative, cross-sectional	568 lesbian/gay (n = 425) and bisexual (n = 143) individuals (+ 61,398 heterosexuals)	Lesbian/gay [N.R.] 57.5 (13.4) Bisexual [N.R.] 64 (14.9) Heterosexuals [N.R.] 66 (12.3)	- Inequalities in cancer care experiences between LGB individuals and the general population	N.A
15. Kearns et al. (2024)	Ireland	Qualitative	30 transgender and non-binary individuals (n = 10), their parents (n = 10), and healthcare providers (n = 10)	[19–28] (TNB) N.R	- Perception of factors helping or hindering access to gender-specific healthcare services	1. Needing bricks to build (structural factors) 2. Enduring and convincing (diagnostic factors) 3. Being me, hiding me (personal factors) 4. It takes a tribe (interpersonal factors)
16. Klittmark et al. (2023)	Sweden	Qualitative	22 LBTQ individuals (n = 12 birth parents; n = 10 non-birth parents)	[28–40] 34.2	- LBTQ individuals' experiences during births where complications have arisen	1. Invalidated as an LBTQ family 2. Disrespectful treatment during birth 3. Lack of information and support
17. Lampalzer et al. (2019)	Germany	Qualitative	6 LGBTI individuals	[30–63] N.R	- Disadvantages in specific treatments - Lack of knowledge - Availability of information - Attitudes toward LGBTI people - Influence of the community to the use of health care	1. Health care structures 2. Human resources 3. Prevention measures 4. Diagnostic and treatment procedures
18. Larsson and Dykes (2009)	Sweden	Qualitative	18 lesbian women (7 couples + 4 single mothers) with experience of pregnancy and childbirth	N.R	- Views and experiences of care during pregnancy and childbirth	1. Recognition of sexual orientation 2. Openness 3. Relationships within the homosexual family 4. Different encounters and attitudes within the healthcare system

Table 1 (continued)

Author(s), year	Country	Study design	Sample size and characteristics *	[Age range] *Mean* (*SD*)	Outcome measures (quantitative studies)/focus (qualitative studies)	Key themes identified (qualitative studies only)
19. Leone et al. (2023)	Italy	Mixed methods (quantitative and qualitative)	305 oncology healthcare providers (OHPs); 190 TGD individuals	[>18] N.R	- OHPs' knowledge of TGD individuals' health disparities - TGD individuals' experiences with cancer healthcare services	N.A
20. Linander et al. (2017)	Sweden	Qualitative	14 trans and non-binary/intergender individuals (women, $n=7$; men, $n=4$; non-binary or intergender, $n=3$)	[23–69] N.R	- Experiences in navigating and negotiating access to gender-confirming medical procedures	1. Being evaluated and dependent 2. Governed through time 3. Negotiating the expert-lay relationship 4. Shifting responsibility of support
21. Linander et al. (2019)	Sweden	Qualitative	14 trans and non-binary/intergender individuals (women, $n=7$; men, $n=4$; non-binary or intergender, $n=3$)	[23–69] N.R	- To examine how gender performances can be regulated in trans-specific care	1. (Re)constructing 2. A linear gender 3. Regulation 4. Negotiations 5. Changes
22. Mills et al. (2023)	UK	Qualitative	12 trans male, masculine, or non-binary individuals (participants in individual interview, $n=3$; in the focus group, $n=9$)	[23–44] 28.9 (6.7)	- Experiences of gender transition with a focus on the barriers encountered during medical transition	1. Conceptualizing stages of transition 2. NHS [National Health System] communication and support 3. Medicalization, power, and non-disclosure
23. Röndahl et al. (2009)	Sweden	Qualitative	10 lesbian women	[30–46] N.R	- Experience in antenatal care, childbirth, and postnatal care	N.R
24. Rosati et al. (2021)	Italy	Qualitative	23 lesbian ($n=11$) and gay ($n=12$) individuals	[58–71] 64.35 (4.18)	- Perceptions and experiences related to healthcare utilization	1. The relevance of clinician and patient identities 2. Expectations and experiences of discrimination 3. The need for specific competencies on sexual minorities concerns
25. Rosati et al. (2022)	Italy	Qualitative	25 non-binary individuals	[19–35] 27.44 (4.31)	- Experiences within therapeutic relationships	1. The self of the psychotherapist 2. The practice of the psychotherapist 3. The therapeutic relationship

Table 1 (continued)

Author(s), year	Country	Study design	Sample size and characteristics *	[Age range] *Mean* (*SD*)	Outcome measures (quantitative studies)/focus (qualitative studies)	Key themes identified (qualitative studies only)
26. Santander-Morillas et al. (2022)	Spain	Qualitative	16 trans individuals	[N.R.] 36.68 (13.24)	- Healthcare experiences	1. Overcoming obstacles 2. Training queries 3. Coping strategies
27. Schaub et al. (2023)	UK	Qualitative	20 LGBTQ + individuals	[16–24] 19	- Residential social care experiences and needs	1. Widespread discrimination and marginalization 2. Unmet mental and sexual health needs 3. Importance of affirming professional relationships and resilience 4. Self-relying strategies
28. Skuban-Eiseler et al. (2023)	Germany	Qualitative	14 trans individuals	[18–54] 31.14	- Experiences of discrimination in healthcare and limited access to healthcare	1. Experiences of discrimination 2. Reasons assumed by transgender individuals for discrimination in healthcare 3. Measures against discrimination in healthcare proposed by interviewees
29. van Amesfoort et al. (2023)	The Netherlands	Qualitative	5 trans men	[23–35] 29 (4.8)	- Family planning, pregnancy, childbirth, puerperium and perinatal care	1. From reproductive intent to conception 2. Pregnancy 3. Puerperium and parenthood 4. Perinatal care 5. Informal support 6. Barriers in logistics and facilities

Notes. *LGBTIQ*, lesbian, gay, bisexual, transgender, intersex, queer or questioning; *TGD*, transgender and gender diverse; *TNB*, trans and non-binary; *N.R.*, not reported; *N.A.*, not applicable

*We utilized the same terms used by the authors to describe the participants in their respective studies quantitative studies. This instrument comprises 20 items that assess various factors associated with the internal validity of the study (e.g., clarity of research question and methods, representativeness of the study sample, sample size justification, and appropriateness of study measures). Each study included in the present systematic review was scored for each of the 14 domains as yes, no, not applicable (N.A.), and not reported (N.R.). Based on these scores, an overall rating was obtained, which allowed for a determination of the quality of each study as poor, fair, or good. Two authors completed the quality assessment of studies independently (SM and VB). Any discrepancies between assessors were solved by discussion with one additional reviewer (CS). Cohen's kappa (Cohen., 1960) was used to calculate the agreement between evaluators and yielded a score of ($\kappa = 0.91$), indicating strong agreement.

The guidelines based on the article by Walsh and Downe (2006) were used to rate the quality of the qualitative studies. As to these scores, an overall rating was obtained, which determined the quality of each study as poor, fair, or good based on the responses to the quality assessment criteria. The quality assessment of the studies was completed independently by two authors (SM and VB). Any discrepancies between assessors were solved by discussion with one additional reviewer (CS). Cohen's kappa (Cohen., 1960), used to calculate agreement between evaluators, yielded a score of ($\kappa = 0.93$), indicating very strong agreement. The details of these procedures are available in Supplementary information 1 and 2.

Systematic Synthesis Process and Main Themes Emerged

As to the metasynthesis of the contents of the included articles, we first separated quantitative and qualitative studies. In doing so, however, we realized that the outcome measures of the former were comparable with the focuses of the latter. Therefore, a two-step detection of the outcomes of the quantitative studies and the focuses of the qualitative studies was performed to let emerge the main themes and subthemes addressed in both types of studies. As a first step, two authors (SM and NC) identified the main outcomes and/or focuses of each included article, as well as the related subthemes, comparing their findings until a consensus was achieved. As a second step, a bottom-up analysis of the emergent themes and subthemes was performed to group them together based on differences and/or similarities. In both steps, inconsistencies between SM and NC were resolved by consulting one additional author (CS). As a result, three main domains emerged, which targeted the healthcare experiences of LGBT + European individuals: (1) *barriers to accessing healthcare services*, (2) *cis- and hetero-normativity in perinatal care*, and (3) *protective factors in healthcare experiences*. These domains are outlined in Table 2. The "Results" section is subdivided accordingly.

Results

Main Characteristics of the Included Studies

In total, 29 articles were included in the current systematic review. Among these, 72.42% ($n = 21$) were qualitative, 13.79% ($n = 4$) were quantitative, and 13.79% ($n = 4$) used a mixed-method design. Regarding the gender identities and/or sexual orientations of the participants, 58.62% ($n = 17$) articles had exclusively TNB participants, 24.14% ($n = 7$) articles focused on samples comprised of LGB individuals, and 17.24% ($n = 5$) articles involved mixed samples (i.e., LGBT + individuals). As to the settings in which the studies were carried out, 37.93% of the studies ($n = 11$) addressed primary and/or general healthcare services, 20.69% ($n = 6$) focused on gender-specific healthcare, 17.24% ($n = 5$) on sexual/reproductive healthcare, 10.35% ($n = 3$) on mental healthcare, 10.35% ($n = 3$) on cancer care, and 3.44% ($n = 1$) focused on residential care. As concerns their geographical locations, 24.14% of studies ($n = 7$) were carried out in the UK, 20.7% ($n = 6$) in Sweden, 10.35% ($n = 3$) in

Table 2 Themes and subthemes identified in the metasynthesis process

Theme	Subthemes
1. Barriers to accessing healthcare services	
	1.1. The pathologization of LGBT + individuals
	1.2. The stressful necessity of LGBT + patients to educate healthcare professionals on their specific health needs
	1.3. Gender prejudice and other barriers affecting TNB individuals in healthcare contexts
2. Cis- and hetero-normativity in perinatal care	
3. Protective factors in healthcare experiences	
	3.1. Individual-level protective factors within healthcare settings
	3.2. Group-level protective factors within healthcare settings

Germany, 10.35% ($n=3$) in Italy, 6.9% ($n=2$) in the Netherlands, 6.9% ($n=2$) in Spain, 6.9% ($n=2$) in Ireland, 3.44% ($n=1$) in France, 3.44% ($n=1$) in Turkey, and 3.44% ($n=1$) in Finland, whereas 3.44% ($n=1$) study was performed at a multinational level (i.e., Georgia, Poland, Serbia, Spain, and Sweden; Burgwal & Motmans., 2020).

Theme 1: "Barriers to Accessing Healthcare Services"

All studies included in this review highlighted various forms of discriminating interactions between professionals and LGBT + individuals in healthcare contexts, involving all types of samples included in the LGBT + population. The pathologization of LGBT + individuals in healthcare contexts represents a significant barrier that fosters negative healthcare experiences in this population (subtheme 1.1), who frequently need to "educate" healthcare professionals due to their scarce education on LGBT + -specific health concerns (subtheme 1.2). This paradoxical situation produces high levels of stress in LGBT + individuals, which represents a significant barrier to healthcare access. Furthermore, stereotypical (i.e., binary, cis- and hetero-normative) gender positions are often constructed in general and gender-specific care services, rendering it difficult for TNB individuals to have positive experiences in healthcare contexts (subtheme 1.3).

Subtheme 1.1: "The Pathologization of LGBT + Individuals"

Barriers to LGBT + individuals' healthcare access include disclosure of LGBT + status to healthcare professionals, societal stigma, fear of being labeled, negative attitudes of healthcare providers, dissatisfaction with healthcare services, and lack of financial resources (Ercan Sahin et al., 2020; Higgins et al., 2021). Individual-level barriers mentioned by LGBT + individuals in the included studies also comprise personal beliefs about the severity of need (i.e., not viewing one's mental problems as so severe to need a mental health professional), the ability to cope (i.e., the belief to be able to manage problems without the help of a professional), and the person's confidence to engage in services, mainly due to issues regarding trust, feelings of nervousness, and dislike of opening up to others (Higgins et al., 2021).

LGBT + individuals often complain of discrimination, harassment, isolation, and threats related to their sexual orientation and/or gender identity or expression in various types of health-related contexts, including residential care settings, where they can meet a lack of support from social workers who treat their sexual orientations and/or gender identities as pathological (Schaub et al., 2023). LGBT + individuals in the included studies also complained that they were not treated with dignity in cancer care, where they reported to be often regarded as "a set of symptoms" rather than as a whole person (Hulbert-Williams et al., 2017) or to meet scarce sensitivity, empathy, understanding, and even homophobic attitudes from healthcare professionals (Doran et al., 2018). Furthermore, LGBT + individuals who are seropositive can be denied access to specific healthcare services, such as dental care, because of the clinician's fear of being infected (Rosati et al., 2021). Overall, the need for a depathologization of the LGBT + individuals' gender identity and/or sexual orientation was voiced by various participants in the included studies, along with a wish for open-mindedness and knowledgeable treatment targeting this population, as well as freedom of self-determination (Allory et al., 2020; Lampalzer et al., 2019).

Negative healthcare experiences do not universally act as barriers to accessing healthcare services among LGBT + individuals. For instance, the findings of one article (i.e., Fish & Anthony, 2005) indicated that for both breast and cervical screening, lesbian women reported more positive than negative experiences. More specifically, as opposed to negative experiences, positive experiences, characterized by adequate attitudes of health care providers and no pain or embarrassment, were associated with an increased likelihood to attend screening procedures, perhaps due to the mobilization of protective factors, which is the topic of Theme 3.

Subtheme 1.2: "The Stressful Necessity of LGBT + Patients to Educate Healthcare Professionals on their Specific Health Needs"

LGBT + individuals often perceive that their healthcare professionals lack adequate knowledge and understanding of their specific needs. As a result, they are often compelled to "educate" clinicians about their needs, thus taking up the role of "expert patients" (Falck et al., 2021; Gieles et al., 2023; Higgins et al., 2021; Rosati et al., 2021; Santander-Morillas et al., 2022). This can be a stressful experience for LGBT + individuals, which represents a significant barrier preventing them from accessing healthcare services. Indeed, the need to "teach," "explain," and "clarify issues" to healthcare professionals can make the visits to health centers frustrating and exhausting for LGBT + individuals, who can feel like "outsiders" within the system (Gómez-Ibáñez et al., 2024). When information is not provided by clinicians, LGBT + individuals often turn to the Internet or to peer support to find adequate information (Doran et al., 2018; Gieles et al., 2023; Kearns et al., 2024). LGBT + individuals going through cancer care can also feel not as involved as much as they would like in decision-making processes about their care and treatment or receive information difficult to understand (Hulbert-Williams et al., 2017). Several lesbian women in Hirsch et al.'s (2016) study expressed unfulfilled global healthcare needs and the need to request special care due to their sexual orientation, whereas only a minority of women tended to positively judge the physicians' knowledge about lesbian-specific healthcare concerns.

Similarly, TNB individuals frequently report a lack of adequate knowledge and/or experience in clinicians, even within gender-specific healthcare services (Carlile, 2020; Ellis et al., 2015; Gómez-Ibáñez et al., 2024; Kearns et al., 2024; Leone et al., 2023; Linander et al., 2017; Santander-Morillas et al., 2022). In addition to desiring more adequate knowledge about TNB health-specific issues by healthcare professionals (or their willingness to learn if knowledge is insufficient), TNB individuals significantly value their healthcare providers' interpersonal skills (Allory et al., 2020). However, poor training of healthcare professionals or the lack of information provided on TNB issues can translate into aggressive ignorance toward these individuals (Santander-Morillas et al., 2022; van Amesfoort et al., 2023).

Subtheme 1.3: "Gender Prejudice and Other Barriers Affecting TNB Individuals in Healthcare Contexts"

As all papers including TNB samples reported that these individuals are very likely to be discriminated against within healthcare contexts due to their gender diversity, gender prejudice within healthcare settings is particularly important to address. Gender prejudice can be defined as a set of negative attitudes, emotional reactions, and behaviors toward individuals who do not identify within a cis-normative, binary gender system (Savin-Williams et al., 2010). In this regard, the articles included in this review highlighted how the encounters with some professionals can be alienating, dehumanizing, and stigmatizing for TNB individuals (Santander-Morillas et al., 2022), which lead them to be often discriminated against, harassed, objectified, or denied care in both general and trans-specific care (Burgwal & Motmans, 2020; Skuban-Eiseler et al., 2023).

Similarly, TNB individuals often witness their gender diversity being viewed as unusual or "other" by primary care providers, who can perceive these individuals as existing outside the "normal" categories of male and female, or even belonging to a different human "category" (Gieles et al., 2023). As a result, a dilemma emerges whereby disclosing one's TNB identity can be simultaneously necessary and precarious to have one's healthcare needs met, which adds to the fear that the person's gender identity would be regarded as the cause of all reported symptomatology (Gieles et al., 2023). A perceived cis- and hetero-normative view of gender and sexuality can lead TNB individuals to "play it safe" in order not to render their gender-specific healthcare experience traumatic (Ellis et al., 2015).

"Passing" is often thought of as implying that there are "right" ways to be feminine or masculine (Linander et al., 2019). Specifically, the non-binary individuals participating in the included studies complained that there are different genders away from the classic dichotomy of "masculine vs. feminine." However, the absence of the "non-binary" option in most healthcare documents renders it stressful for them to "fit" into such stereotyped gender categories, which results in avoiding visiting health centers at all to avoid anticipated discrimination (Gómez-Ibáñez et al., 2024). Whereas some TNB individuals hide their mental health issues to more easily progress in the gender-affirming path, others overemphasize their distress (e.g., by exhibiting frustration and suffering) because they believe that this can accelerate the process (Kearns et al., 2024).

TNB individuals often report experiencing misgendering and deadnaming in healthcare contexts, which have the detrimental effect of "outing" them in the presence of others and can prevent them from seeking adequate care (Allory et al., 2020; Carlile, 2020; Falck et al., 2021; Leone et al., 2023; Rosati et al., 2022; Skuban-Eiseler et al., 2023; van Amesfoort et al., 2023). This can be due to the gender-related stereotyped assumptions often endorsed by healthcare professionals who support binary and/or cis-normative views of gender (Allory et al., 2020; Carlile, 2020; Ellis et al., 2015; Kearns et al., 2024).

TNB individuals can be reluctant to discuss their gender identity due to the anticipation of rejection by healthcare professionals (Gieles et al., 2023). They frequently mention the power exerted over them by the healthcare providers within gender identity services, as well as the fear that exhibiting doubt or uncertainty would delay or even stop their transition process (Mills et al., 2023). As a result, individuals can feel powerless and learn to say only what is expected from them (Linander et al., 2017; Mills et al., 2023).

Stereotypical (binary) gender positions limiting TNB individuals' self-determination are thus constructed in general and gender-specific care services, which sometimes regard the dimensions of "man" and "woman" as oppositional, norm-conforming, stable, and mutually exclusive categories (Linander et al., 2019). For instance, healthcare professionals can take for granted that transgender men would never wish to be pregnant, thus not recognizing that gender is not linear and discrediting a pregnant man as not being a "real man" due to the stereotyped equation between pregnancy and the female gender, as outline in Theme 2 (Falck et al., 2021; Linander et al., 2019).

TNB individuals' voiced barriers to accessing gender-specific healthcare settings are also associated with the need to acquire a referral and the "diagnostic" process itself (Czimbalmos & Rask, 2022). The mental evaluation, which is required in some countries prior to initiating gender-affirming hormone therapy and/or surgery, can be viewed as pathologizing by TNB individuals (Linander et al., 2017). More specifically, the mandatory mental health assessment prior to initiating the medicalized gender affirmation path can be experienced by TNB individuals as stressful, as they have to “fight” for a diagnosis they do not even necessarily want, but also, other times, as a positive step validating their gender affirmation path (Kearns et al., 2024).

In addition, those who occupy further unprivileged and marginalized positions in society (e.g., refugees and asylum-seekers, non-White individuals) can find it more difficult to receive gender-affirming care, which points to the pervasive stigmatization of intersectional identities (Czimbalmos & Rask, 2022). Access to gender identity services can be perceived as a “battleground” by TNB individuals, where the individual must “fight for every step” (Mills et al., 2023), which is worsened by the fact that an “outsider” (i.e., the medical provider) has the power to permit or deny the gender affirmation process, which is indeed a very personal journey in nature.

Waiting list times and lengthy treatment pathways are also frequently voiced by TNB individuals as regards their gender affirmation path (Carlile, 2020; Ellis et al., 2015; Kearns et al., 2024; Mills et al., 2023). In trans-specific care, waiting can have an intentional aspect, in that TNB individuals standing the test of time can be interpreted as a sign of an authentic need. However, the intentional aspect of waiting can also be interpreted based on the stereotyped assumption that gender is something fixed and cannot change (Linander et al., 2019). The experience of long waiting is often associated with feelings of distress, anxiety, and sleeping problems, in addition to the feeling of powerlessness and being deprioritized within the healthcare system (Linander et al., 2017).

In addition to these barriers, the TNB individuals recruited in the included articles reported a dearth of collaboration between healthcare practitioners, the parents of TNB children, and their schools, which led to feelings of insignificance and an institutionalized situation of invisibility (Carlile, 2020; Gómez-Ibáñez et al., 2024). Furthermore, the lack of integration between mental health services and medical services can result in a perception of dissatisfaction both among young TNB individuals and their parents (Kearns et al., 2024).

Theme 2: “Cis- and Hetero-Normativity in Perinatal Care”

The second theme addresses the parenting aspirations of LGBT + individuals, who often encounter stereotyped assumptions among healthcare professionals who hold that an LGBT + parent family is something “other” from the socially normative cis- and heterosexual parent family. LGBT + individuals often describe negative experiences associated with cis- and hetero-normative assumptions by healthcare professionals during pregnancy, childbirth, and perinatal care (Klittmark et al., 2023; Larsson & Dykes, 2009). Frequently, non-birth parents feel invisible as parents since they are regarded as friends, siblings, or other community members. Furthermore, the non-birth parent is often called a “partner,” which invalidates their role as a parent.

Disrespectful attitudes toward childbirth by healthcare professionals make LGBT + individuals experience a loss of control and a sense of powerlessness, which can seriously undermine their trust in the healthcare system (Klittmark et al., 2023). LGBT + individuals also complain that parent education offered within the healthcare system tends to be focused on a “mother and father” situation, which marginalizes other (e.g., homosexual) couple- and family-related experiences, and that the healthcare professionals’ focus on homosexuality should be shifted to pregnancy and future parenting (Larsson & Dykes, 2009; Röndahl et al., 2009).

Furthermore, a specific focus outlined in the included articles concerns the experience of transgender men during pregnancy, childbirth, and perinatal care. Accordingly, the stereotypical association between pregnancy and femaleness is detrimental to transgender men’s experiences of reproductive healthcare services during childbirth. Indeed, some healthcare professionals find a paradox between pregnancy and the male gender and are not able to think of the existence of masculine pregnancies (Falck et al., 2021; van Amesfoort et al., 2023). To avoid triggers of gender dysphoria or microaggressions, transgender men often renounce having their needs met, which results in a sense of anger, sadness, anxiety, helplessness, and personal invalidation (Falck et al., 2021). Also, most reproductive health facilities tend to focus on cisgender and heterosexual women, with cis- and hetero-normative information often less suitable for transgender individuals and individuals in non-heterosexual relationships (van Amesfoort et al., 2023).

Theme 3: “Protective Factors in Healthcare Experiences”

Protective factors are necessarily mobilized by LGBT + individuals to face discriminating and marginalizing attitudes often endorsed by healthcare professionals as to their gender identities and/or sexual orientations. In this regard, individual-level coping strategies refer to subjective resilience factors helping LGBT + individuals to deal with the discrimination and marginalization they face in healthcare contexts (subtheme 2.1), whereas group-level factors such as social support networks can aid LGBT + individuals in coping with the pathologization of their identities in healthcare settings (subtheme 2.2).

Subtheme 3.1: "Individual-Level Protective Factors within Healthcare Settings"

The LGBT + individuals participating in the included studies voiced various individual-level protective factors that helped them cope with adversities and pathologization within healthcare contexts, such as performing art, nurturing religious beliefs, self-managing their care journey, and showing self-sufficiency to have their needs met (Schaub et al., 2023).

Individual-level protective factors are also mobilized by TNB individuals to overcome the barriers and negative experiences that can occur in healthcare settings. For instance, TNB individuals often "naturalize" or "normalize" healthcare encounters or enhance the "passing" process (Santander-Morillas et al., 2022). In this regard, in addition to being regarded as a barrier, the "passing" strategy generally refers to the desire to be perceived not as transgender but as a cisgender person (i.e., in accordance with one's experienced gender), thus allowing TNB individuals to fit into the binary social norms and providing them "invisibility" in the eyes of society (Santander-Morillas et al., 2022). Even though this strategy surely has negative aspects in the TNB individuals' experiences, passing can nonetheless protect them from further discrimination within a discriminating and stigmatizing society.

For transgender men going through pregnancy and childbirth, the need to enact effective coping strategies is essential to protect themselves from discrimination: such strategies consist of disconnecting pregnancy from gender identity and ignoring being pregnant, isolating to avoid negative interactions, and desiring to eventually start their medical affirmation after childbirth (van Amesfoort et al., 2023). Even though such strategies can produce concealment and isolation, they are nonetheless mobilized to avoid more negative consequences of the discriminating attitudes endorsed by healthcare professionals.

Subtheme 3.2: "Group-Level Protective Factors within Healthcare Settings"

Support sources for the health pathways of LGBT + individuals include close friends, partners, the person's family, and even some healthcare providers (Doran et al., 2018). Various LGBT + individuals search for support outside the healthcare systems (e.g., among family and friends; Linander et al., 2017). Community groups can also provide security, information, and support when healthcare professionals fail to do so (Falck et al., 2021). Being out to a "good adult" (e.g., an adult friend, parent, support worker, teacher, health professional, or online contact) or being connected to the LGBT + community can be perceived by these individuals as protective, increasing confidence and helping to decrease perceived stress (Kearns et al., 2024).

Discussion

In the present review, we summarized the scientific contributions addressing the healthcare experiences of LGBT + individuals in European countries. The 29 articles included in the review focus on various dimensions of these experiences, which were grouped into three main domains, namely, (1) barriers to healthcare access, (3) cis- and hetero-normative assumptions in childbirth and perinatal care, and (3) protective factors buffering the impact of negative healthcare experiences on the individuals' health and well-being. In this regard, the three themes identified through the metasynthesis process are strictly intertwined, albeit different from each other. In fact, cis- and hetero-normative assumptions (Theme 2) can serve as barriers to accessing healthcare services (Theme 1). In the context of perinatal care, these barriers become even more significant, as they impact not only the individual but also their aspirations to build a family (Mezzalira et al., 2024). This includes achieving emotional stability with a potential partner and their child(ren), where attachment dynamics within the infant–caregiver dyad are shaped by the quality of care received. To overcome these barriers and address their healthcare needs, LGBT + individuals must mobilize resilience factors to mitigate the negative health outcomes that arise as a result (Theme 3).

As to the first dimension, the barriers encountered by LGBT + individuals in accessing healthcare services were highlighted, mainly focusing on the pathologization of LGBT + identities. Indeed, LGBT + patients are often required to "educate" their healthcare professionals on their specific health needs. Furthermore, gender prejudice appeared as a significant barrier to the healthcare utilization of gender minorities such as TNB individuals. The findings reported in this first dimension confirm previous literature addressing the health disparities affecting individuals with minoritized sexual and gender identities, as explained in the MST (Meyer, 2003) and the HEPM (Fredriksen-Goldsen et al., 2014). More specifically, the barriers encountered by LGBT + individuals when accessing healthcare services represent systemic and/or individual triggers of minority stress, which in turn elicits mental health problems (Mezza et al., 2024). For this reason, such barriers might be regarded as minority stressors, in that they hinder the health and well-being of LGBT + individuals by preventing them from receiving adequate care (Ercan Sahin et al., 2020; Higgins et al., 2021). Similarly, the need to educate healthcare professionals about one's specific health needs can also be viewed as a minority stressor, in that it segregates LGBT + individuals to a minority status where they do not meet expert advice to have their needs met (Gieles et al., 2023; Santander-Morillas et al., 2022).

As to the relationship between patients and healthcare professionals, the latter are often led (e.g., due to their biomedical education) to exhibit paternalistic attitudes (Mills et al., 2023), which leads them not to share their decision-making processes targeting LGBT + patients based on the role of power acquired. In addition, medical paternalism can produce mistrust in the relationship with the professional or lead to experiencing the uncomfortable need to constantly provide explanations, which adds to a perception of dependency upon the clinician (Linander et al., 2017).

According to the HEPM, multi-level structural and individual contexts interact with individual, social, behavioral, and biological health-promoting and adverse pathways leading to specific mental or physical health outcomes, based on the intersectionality of the individual's social positions and from a life course development perspective (Fredriksen-Goldsen et al., 2014). In this view, barriers to accessing healthcare services can be regarded as specific adverse pathways that can lead to poor health in LGBT + individuals. The barriers to healthcare access identified in this review seem to largely affect especially TNB individuals, who represent the most frequent type of sample of the included studies, perhaps because they are possibly even more stigmatized than other minorities in Western societies (Scandurra et al., 2019).

Even though, since the 1990s, Europe has witnessed progressively increasing tolerance toward LGBT + identities in Europe (FRA., 2013, 2015), European countries are strongly heterogeneous as to their legislative policies regarding LGBT + stigmatization, both in terms of anti-discrimination law, parenting rights, and anti-victimization punishments (Ayoub, 2015, 2016; Garretson, 2018; Taylor et al., 2018). In this regard, various European countries (e.g., Italy, the UK, and Hungary) are putting into doubt transgender care as recommended in the Standards of Care elaborated by the World Professional Association for Transgender Health (WPATH; Coleman et al., 2022). Overall, North-Western European countries (e.g., the Netherlands, Sweden, Belgium, Ireland, Spain, and Norway) seem to be higher in acceptance of LGBT + identities if compared to more easterly European countries like Russia or Hungary, where "propaganda laws" have denied basic human rights (e.g., same-sex marriage) to LGBT + individuals, who are constantly subject to non-punished violence and victimization (Belavusau, 2020; Bränström & van der Star, 2013).

In contrast, in countries like Spain, a strong commitment has grown in public administration to endorse measures aimed at achieving equality for LGBT + individuals (e.g., Cruells & Coll-Planas, 2013). Since national legislation and societal attitudes toward LGBT + individuals are strictly intertwined, in countries where discrimination toward LGBT + individuals is condemned, surveys show an important endorsement of less negative societal attitudes toward this population (Wilson, 2020). Notably, in the field of LGBT + advocacy, associations like the International Lesbian, Gay, Bisexual, Transgender and Queer Youth and Student Organization (IGLYO) have fostered the development of policies to actively include the voices of European LGBT + individuals in research (Vella et al., 2009).

Today, LGBT rights in Europe are associated with various political articulations, rendering the relationship between LGBT + rights and Europe a multifaceted picture based on different geopolitical backgrounds (Ayoub & Paternotte, 2019). Ultimately, Europe as an institutional entity is thus very heterogeneous and comprises countries advocating more substantially for LGBT + rights and others with less inclusive legislation as to this population. Notably, these differences in policies and practices lead to different potentialities to access and receive adequate care that can meet the specific health needs of LGBT + individuals (Zeeman et al., 2019). Indeed, LGBT + individuals in general, and especially those whose identity does not conform with the cis- and hetero-normative rules of society, are still stigmatized and discriminated against both within society and in healthcare settings in several European countries (Cruciani et al., 2024)—a phenomenon that should be contrasted through the implementation of inclusive policies and practice promoting LGBQ + rights (Sherriff et al., 2019; Skuban et al., 2022). Ultimately, our review highlighted that not differently from other reviews conducted in other countries, such as the USA (e.g., Call et al., 2021; Snow et al., 2019), several European countries are not exempt from acts of discrimination, marginalization, and victimization of LGBT + individuals even in the healthcare contexts that should provide them care.

As to the second theme, namely childbirth and perinatal care experiences, the included articles highlight how cisgender and hetero-normative assumptions taken for granted by healthcare professionals substantially hinder the aspirations of LGBT + individuals to build their own families. Such hindrances, along with legislative policies prohibiting filiation and other ways to have children (e.g., adoption or surrogacy) to LGBT + individuals (especially TNB individuals) in various countries, can render their parenting aspirations unattainable phantasies (Mezzalira et al., 2024; von Doussa et al., 2015).

Here, again, gender minority stress and resilience factors can have a significant impact on the aspiration to build a family (D'Amore et al., 2023). The desire to build their own family, especially for TNB individuals, must be viewed considering their developmental tasks, which have different timings for each individual and need to consider the societal stigma and discrimination that they perceive daily (Tasker & Gato, 2020). In this sense, minority stressors within healthcare contexts negatively influence the aspiration to build a family, whereas positive attitudes are associated with greater life satisfaction (Shenkman et al., 2023).

Finally, as to the third dimension, which addresses protective factors, the included articles point out how LGBT + individuals need to foster often their resilience capacities to face stigma and discrimination within healthcare contexts. Resilience factors refer to individual- or group-based capacities such as the effort of relying on their support networks, including family, friends, and/or other LGBT + individuals (Della Casa et al., 2024a, 2024b; Della Casa, Malmquist, et al., 2024). For TNB individuals, we have also seen how the "passing" strategy can be regarded both as a barrier and as a protective factor (Bochicchio et al., 2024; Scandurra et al., 2017a, 2017b). On the one hand, passing is associated with internalized transphobia (Bockting et al., 2006) in that it relates to the stereotypical cis-normative gender rules that frequently enter the individual's self-concept. On the other hand, passing can also be viewed as a coping strategy (Hill, 2003) in that, albeit compelling TNB individuals to conform their identity to the stereotyped gender social norms, nonetheless, it allows them to avoid stigma and violence. In both cases, the passing strategy is always associated with a psychological burden and depends on the contextual circumstances where the individual is embedded.

Limitations

The results of our systematic review should be considered considering some limitations. First, the literature search was conducted in three databases (i.e., PubMed, Scopus, and Web of Science), thus possibly failing to identify relevant records not covered by these databases. Second, our review is limited to English-written, peer-reviewed, indexed studies. Therefore, contributions written in languages other than English and/or gray literature might have been missed. One further difficulty was represented by the substantial heterogeneity of the sample of the included articles, which made the comparability of their findings questionable and precluded meta-analysis.

It is worth noting that the studies included in this review do not cover all European countries since most of them have been carried out in Western Europe (e.g., Sweden, Germany), where the laws targeting the LGBT + population are at times very different from other European countries (ILGA, 2024) and vary even among Western countries as well. As a result, the need to conduct more studies in non-Western European countries can add to the value of the scientific research targeting European LGBT + individuals from a cross-national perspective that takes into account different socio-political environments. Finally, in most included articles, the ethnicity and the different ages of the participants were not reported. This did not allow us to fully discuss the role of intersectionality in addressing the healthcare experiences of European LGBT + individuals.

Recommendations for Future Research

Overall, our systematic review highlighted how the studies focusing on the healthcare experiences of European LGBT + individuals are more often qualitative than quantitative. This prompts the need for more extensive literature based on quantitative studies, which can provide data based on wider samples, help better detect health outcomes in the LGBT + population in Europe, and provide evidence-based findings. Furthermore, the representativeness of the European LGBT + population in the qualitative studies included in this review tends to be very low, given the small number of participants in most of the qualitative studies included. This adds to the need for more quantitative studies on this topic. In addition, more cross-national studies conducted in different European countries would add significant value to the research in this area since it would allow us to compare the social and cultural contexts of different environments in the healthcare experiences of LGBT + individuals. Finally, to better understand the intersectional stigma affecting LGBT + individuals in healthcare contexts, it would be necessary to focus on the relationship between the various subgroups of the LGBT + community (e.g., LGB and TNB) and other sociodemographic attributes such as age and ethnicity.

In this regard, some studies included in the review comprised samples of LGBT + individuals going through early life stages, namely, adolescence (e.g., Carlile, 2020) or emerging adulthood (e.g., Higgins et al., 2021; Schaub et al., 2023), whereas others comprised samples of older individuals (e.g., Doran et al., 2018; Rosati et al., 2021). Overall, however, most included articles focused on individuals ranging from very early to quite late life stages (e.g., Ellis et al., 2015; Hirsch et al., 2016). This adds to the complexity of the metasynthesis we performed, which resulted in a wide and complex picture of the healthcare experiences of LGBT + individuals going through very different life stages. Accordingly, the developmental tasks of LGBT + individuals are very different based on the life stage each person is going through and vary based on the milestones that each person has accomplished (or not, or not yet) in their life trajectories. As to other sociodemographic variables, the sample comprises, for instance, relatively similar ethnic backgrounds (e.g., most participants are White) with no disability reported. In this regard, future studies might take into account the intersection of different individual identities based on an intersectional paradigm to be more inclusive of ethnic, cultural, educational, and socio-economic status, as well as the degree to which sexuality or gender identity is important to the individual's self-definition (Bränström & van der Star, 2013).

Therefore, by considering the intersectionality of the different identities of the individual, as well as the different legislative frameworks present across European countries, the apparent uniformity of experiences of LGBT + individuals in Europe can acquire a more nuanced fashion, which future studies can and should contribute to better understand also considering and clarifying the construct of intersectionality within the LGBTQ + population.

Policy Implications

A deeper understanding of the processes underlying the healthcare needs of LGBT + individuals must be accompanied by political and social policies that support and promote their fundamental rights. This includes ensuring equitable access to healthcare services free from discrimination. Public funding should specifically target the education of university students on LGBT + health needs, integrating this content into medical and psychological curricula. Additionally, professionals across medical and psychological fields should have access to training programs and courses that address the unique health needs of the LGBT + population. Finally, governments must recognize and address the structural barriers that LGBT + individuals face in accessing and utilizing healthcare services, taking proactive measures to eliminate these obstacles.

Conclusions

The present systematic review highlighted the prevalence of discriminatory and pathologizing attitudes faced by LGBT + individuals in healthcare settings, which further marginalize their experiences and result in suboptimal care in both general and specialized contexts. Barriers to accessing healthcare services, coupled with the need to educate healthcare professionals on LGBT + health needs, can be understood as minority stressors, as they reflect the inadequate care frequently provided to this population. These barriers not only harm their health and well-being but also underscore the importance of developing training programs to help clinicians better understand and address the specific needs of LGBT + individuals (Carone et al., 2023; Santamaria et al., 2024).

At the same time, LGBT + individuals often draw on resilience factors, both individual (e.g., self-determination) and group-based (e.g., community connectedness), to navigate and counteract the stigma and pathologization of their gender identities and/or sexual orientations in healthcare contexts. Future research should continue to explore the experiences of LGBT + individuals in healthcare, with a focus on fostering health-promoting strategies and reducing health inequalities.

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Data Availability The corresponding author will provide the data supporting the present article upon request.

Declarations

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