An Introduction to the Experiences of Sexual and Gender Minorities affected by Cancer

It is estimated that 5-7% of the UK population identify as lesbian, gay or bisexual[1] and cancer has a higher incidence in these sexual minorities. There is an increased risk of breast cancer in lesbian women[2], gay men show a twofold increase diagnosis of cancer with HIV being a risk factor[3,4] and a higher risk of anal cancer[5,6,7] and trans* individuals report poorer health[8] and a higher incidence of late stage diagnoses due to healthcare access issues or avoidance[4,6,9].

An intersectional approach is key in appreciating the lifestyle factors and socioeconomic disparities associated with increased risks of cancer in sexual minorities[9,10,11]. Therefore, there needs to be a complimentary focus in sexual minority care to address these stressors and the subsequent behaviours evident in this population[9,12,13]. Smoking is an area that has received some recent attention[12] however research in the LGBTQIA+ (lesbian, gay, bisexual, trans*, queer, intersex, asexual and others) experience of cancer is largely underexplored[10]. Other socioeconomic factors for sexual minorities include barriers to education, gainful employment and access to healthcare[3,4,9,14]. Research is so sparse that in order to comment, inferences must be taken from around the globe and thus we must be mindful of cultural variations of accessing healthcare for queer patients, such as barriers to acquiring health insurance for private healthcare[8,10].

It is suggested that the social stigma experienced may give rise to these risk behaviours in sexual minorities[9,10,12] and thus this internalisation mechanism should be noted when entering the healthcare setting[12,15]. It is important for a patient's wellbeing for them to be their authentic selves[16], however, due to the difficulty in coming out or the fear that may arise from discussing ones sexuality or gender[3,10,17] especially for bisexual patients[15], patients may go 'back into the closet' in order to avoid anticipated complications in their clinical interactions[7,15,17,18]. Sensitivity is required to appreciate the compound stress of the social stigma from being both a sexual minority and a cancer patient[17]. One must note that whilst a healthcare provider may not be overtly prejudice microaggressions, heterosexist assumptions and behavioural cues can often give rise to this discordance[3,4,7,10,17,19,20,21,22,23]. Providers tend to report confidence regarding sexual minority care[24] despite gaps in their knowledge[24,25]. Of these respondents, around only a quarter spoke to their patients about gender or sexuality, contesting that their care was sufficient without including sexual minority consideration[4,24]. Recording gender identity or sexual orientation is often avoided out of fear of offence, despite only 10% of patients responding that they would feel this way[26]. Likewise, attempts at inclusion for sexual minorities must take into account the social stigmas and barriers faced by this population that leads to this psychosocial stress posing further risks to their health[9] in addition to the intersectional nature of race[3,4,11]. Without these considerations, patient adherence begins to wane as they lose confidence in their care and their agency in the decisions being made[3,17,23,27]. Currently there are no definitive early detection or preventative[4] or survivorship guidelines for LGBT persons[17]. Whilst our political and social climate moves towards acceptance, we must note that it was not until the Equality Act of 2010 that it was made illegal for organisations, such as the NHS, to discriminate against characteristics such as sexuality. Therefore, due to the typical higher age of cancer patients, this is a lived memory for some in addition to the AIDS epidemic and the illegality of homosexuality[21].

LGB and trans* patients report poorer quality of life and mood markers than heterosexual patients[4,9,29]. This self reported outcome is in part due to aforementioned healthcare interactions but also the additional support available to sexual minorities. LGB patients are significantly less satisfied with the written information provided around diagnosis and subsequent care[27]. In order to improve the uptake of information it is important to represent sexual minorities in supporting media and divert from the current over-representation of heterosexual imagery[17,30]. Moreover this is key in trans* patients and the gender assumptions about the body at screening,

during treatment and in remission[10,17,31,32]. An important example is in the case of the gendertyping of breast and gynaecologic cancers as women's cancers, which becomes a barrier for trans* patients seeking care and becomes an attributing factor to later stage diagnoses[10,32]. Also impacted is the outcome of potential mastectomy and the different nuances to be considered with non-binary or trans* patients when discussing their chest[23,31,32]. Likewise the conversation surrounding wigs is often gendered to overt femininity or relating to an assumed male partner, which leaves some patients avoiding the service all together[7].

Sexual minority patients are more likely to report that no family or friends are involved in their care[17,22,27]. Family and friends are key to both emotional and social support respectively[3,28], but one patient interviewed suggested that "An LGBTI person who has to live with his/her heterosexual family is more socially isolated than a heterosexual person in the same situation."[22]. Therefore it is important to find ways to support the psychosocial needs of sexual minority patients as a lack of adequate support leads to fatalistic attitudes and social isolation[3,17,21,27,28,29]. Patients emphasised the importance of support groups[9,17,21], especially those with a targeted focus reflecting their identity[22,25]. Patients report being more satisfied with support when it comes from someone who is aware of their orientation[26,28]. This reflects the importance of queer agency[31] in the patients' experience of the care system as they often demonstrate a clear understanding of the impact of their sexual minority status and how this intersects with other factors in their lives, such as illness[17,32]. The use of peer support through sexual minority specific support groups is a key source of information for trans* patients[32] as opposed to the heavily gendered presentation of other support groups that may be discussing specific cancers[32]. To give an example, the discussion of anal cancer in gay men is facilitated by social initiatives where sex and intimacy are discussed with greater ease than in the standard healthcare setting[7,17]. Community is a key factor in sexual minorities and building a supportive framework within these to compliment cancer therapy is a goal that benefits professionals, patients and future research[9,17].

The hesitation of individuals to discuss gender and sexual orientation is often rooted in a lack of information or confidence discussing these sensitive topics. Whilst accessing and supporting this patient demographic is vital it is also important not to 'out' an individual who has chosen not to disclose their sexual preference or are living 'stealth' as their desired gender. Instead, a more appropriate goal is to make the service applicable to every individual on the gender and sexuality spectrums so that patients may find a knowledgeable, accessible and supportive environment in which they might feel they can share themselves fully. Ultimately, engaging with patients about how their health intersects with their life is crucial in supporting their psychosocial needs, treatment adherence and also demonstrating sensitivity and compassion to a population who may otherwise fall into social isolation and additional detriment if not properly supported.

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