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EDITORIAL

Disparities in the Treatment of the LGBTQ Population in Chronic Pain Management

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It is becoming increasingly important to recognize discrepancies in the care of lesbian, gay, bisexual, transgender, or queer (LGBTQ) patients in all medical subspecialties, and in pain management there is no exception. The percentage of Americans aged 18 or older who identify as LGBTQ has risen from 4.5% in 2017 to 5.6% in 2020. One in six adults in Gen Z identify as LGBTQ.[1]

Unique Chronic Pain Needs

The LGBTQ population experiences unique needs regarding chronic pain management compared to the general population. Sexual minority adults experience more frequent functional limitations due to pain[2] and are more likely to experience pain from multiple sites compared to heterosexual adults; headaches, migraines, abdominal pain, digestive complaints, back pain, shoulder/neck pain, and arthritis are more common in this population.[2,3] Additionally, mostly heterosexual females and gay males are more likely than same-gender completely heterosexuals to have headaches, and mostly heterosexual and bisexual females are more likely to have muscle or joint pain. Compared to same-gender heterosexual males, gay males were more likely to report headaches.[4]

The relationship between depression and pain is well established. The prevalence of chronic pain in patients suffering from depression has been reported to be 51.8–59.1%,[5–7] and depression is a risk factor for the onset of chronic pain.[8,9] Furthermore, depression worsens prognosis in treating chronic pain,[10,11] and comorbid pain and depression lead to more interference in activities of daily living, work, and social interactions.[12] These conditions are strongly linked to each other and lead to worse outcomes when patients suffer from both.

The link between depressive disorders and the LGBTQ population is also well established. Sexual minority adults experience higher rates of depressive symptoms and disorders than heterosexual individuals.[13] Sexual minority adolescents report a higher incidence of depression, anxiety, and increased suicidal behaviors than heterosexual adolescents.[14] This population experiences high levels of institutionalized prejudice, social stress and exclusion, hatred and violence that contribute to an increased incidence of depression and anxiety, among other health problems. Increased drug and alcohol misuse also contribute to comorbid mental health disorders.[15,16]

Within the LGBTQ population, unique challenges and social stress are linked with high levels of depressive disorders. These mental health challenges produce

a population with high levels of chronic pain, worse outcomes, and unique challenges in treating them.

Barriers to Care

The LGBTQ population faces challenges in access to healthcare. A larger portion of LGBTQ individuals lack access to health insurance and live in poverty than is the case in the general population.[17] LGBTQ individuals are more likely to delay medical care or forgo it entirely.[18] Reasons for avoiding healthcare include discrimination from health care providers and even denial of care.[19,20] A 2015 study found that 33% of transgender individuals reported one or more negative experiences related to being transgender such as being refused treatment, being harassed or assaulted, or receiving incompetent care.[21]

Discrimination and receiving incompetent care are reasonable fears. Bias and lack of education of this population is common among healthcare providers. A study of medical students demonstrated that approximately half of the students reported having negative attitudes toward lesbian and gay people.[22] Additionally, most medical schools and residency programs do not educate sufficiently on LGBTQ healthcare. In American and Canadian medical schools, an average of only 5 hours is spent on LGBTQ-specific content; many reported no such education at all.[23]

Education and cultural competency can improve outcomes for the LGBTQ population.[24] A history of discrimination leading to socioeconomic challenges has led to barriers to utilizing healthcare which have created worse health outcomes. This population deserves better care, and it is our responsibility as providers to work to educate ourselves and examine possible biases we have that are contributing to barriers in care.

Discussion

Unique and unfortunate socioeconomic stressors have led to high amounts of comorbid mental health disorders and chronic pain in the LGBTQ population. This population is more likely than their heterosexual counterparts to report chronic pain in multiple sites causing functional limitations. Comorbidity with mental health disorders leads to worse prognoses in the treatment of chronic pain and more interference with relationships and activities or daily life. Therefore, special attention should be paid to the care of these patients and efforts should be made to improve access to care.

Provider education and dedication to improving cultural competency are measures that the medical community can take to help this population gain confidence in utilizing healthcare. Additionally, improving access to health insurance remains a necessary step. Through acknowledging the unique challenges and health problems of the LGBTQ, we can strive to better treat chronic pain and improve the quality of life of all of our patients. Our failure to do so would represent a violation of the bioethical principle of justice, and as the number of people acknowledging LGBTQ identification continues to increase, we can hardly afford to do so.

Disclosure

Dr Michael E Schatman serves as a research consultant for Modoscript. The authors report no other conflicts of interest in this work.

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