




Gay men's experiences with prostate cancer: Implications for future research

Journal of Health Psychology
2020, Vol. 25(3) 298–310
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DOI: 10.1177/1359105317711491
journals.sagepub.com/home/hpq


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Abstract

Gay men's experiences with prostate cancer and its impact on health-related quality of life are poorly understood. This qualitative study explored gay men's experience with prostate cancer with a focus on the emotional, physical, and sexual impact of cancer; support needs; and healthcare interactions. Three semi-structured focus groups of gay men with prostate cancer were conducted. A conventional content analytic approach was used to identify six primary content areas that described poignant aspects of the men's experience with prostate cancer: minority stress, intimacy and sexuality concerns, impact on life outlook, healthcare experiences, social support and the gay community, and intersectional identities.

Keywords

gay men, health-related quality of life, minority stress, prostate cancer, support

Introduction

Men living with prostate cancer (PC) and the numerous side-effects of its treatment often experience a range of complex, long-term survivorship issues. These can include psychological distress, relationship challenges, and various physical issues such as body appearance changes and sexual functioning difficulties (Latini et al., 2009), with resulting impacts on health-related quality of life (HRQOL) and psychological adjustment (Gore et al., 2009; Litwin et al., 2001). PC is the most common solid tumor in men in the United States (American Cancer Society, 2016)—and, of the 2.85 million men affected (Howlader et al., 2016), it is expected that at least 140,000 identify as gay, given estimates that gay men make up 4–5 percent of the male population

(Purcell et al., 2012). However, gay men are largely under-represented in research (Rosser et al., 2016; Thomas et al., 2013), despite the potential for PC survivorship to involve unique challenges for gay men.

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In addition to physical and sexual complications, particularly regarding receptive anal sex, the psychosocial distress associated with PC may be especially challenging for many gay men, given evidence of disproportionately high rates of stress-sensitive mental health problems (e.g. anxiety and depression; Cochran and Mays, 2009; Gilman et al., 2001; Meyer, 2003) among this population, and the experience of minority stress which is implicated in these disparities (Meyer, 1995, 2003). Minority stress theory, as applied to gay men, contends that the experience of gay-related stigma and discrimination—whether structural (e.g. laws, social practices, and religion), interpersonal (e.g. daily negative interactions), or intrapersonal (e.g. internalization of negative societal attitudes)—contributes to mental health disparities among gay men. These experiences of stress, stemming from a devalued and stigmatized social status compared to heterosexuals, increase gay men's vulnerability to poor HRQOL and adjustment to illness, and are associated with health disparities across the lifespan (Balsam et al., 2005; Herek et al., 1999; McLaughlin et al., 2010).

A wealth of empirical evidence offers support for minority stress theory (e.g. Eldahan et al., 2016; Frost et al., 2015; Hatzenbuehler et al., 2008, 2013; Zamboni and Crawford, 2007). Despite research highlighting the potent influence of interrelated contexts (e.g. disease, individual differences, and macro-level and interpersonal factors) on coping processes and long-term trajectories of cancer-related distress and HRQOL (see Hoyt and Stanton, 2012; Stanton et al., 2015), the implications of minority stress theory have not yet been adequately applied to understanding gay men's experiences with PC.

In relation to healthcare utilization, gay men tend to have poorer healthcare access, lower likelihood of health insurance coverage, and limited access to culturally competent care providers (Frazer, 2009). In addition to issues of access, many gay men report negative experiences with healthcare providers involving sexuality-based discrimination including refusal for

treatment, verbal abuse, and disrespectful behaviors, as well as other forms of failure to provide adequate and culturally competent care (Institute of Medicine (IOM), 2011; Quinn et al., 2015). As a result, gay men report lower satisfaction with healthcare (Gay Lesbian Medical Association (GLMA), 2010) and substantial discomfort with disclosing their sexual identity to providers (Bernstein et al., 2008), including cancer care providers (Frazer, 2009; Katz, 2009). Moreover, lack of disclosure of sexual orientation to cancer care providers is associated with poorer self-reported health (Kamen et al., 2015).

Gay male cancer survivors have been shown to experience more psychological distress than their heterosexual counterparts (Kamen et al., 2014). Recently emerging studies have provided evidence that gay men living with PC also experience comparatively poorer outcomes—reporting lower HRQOL (especially regarding mental and sexual functioning; Hart et al., 2014; Kleinmann et al., 2012), higher distress, and lower treatment satisfaction (Ussher et al., 2016), and, when surgery is involved, worse sexual bother, ejaculatory function, and ejaculatory bother (Wassersug et al., 2013). The possibility that sexual side-effects impact gay men differently after PC surgery is compounded by the challenges these men may have accessing adequate provision of prostate-related healthcare. Focus group data suggest that gay men have limited understanding of their prostate and the range of sexual challenges associated with PC treatment (Asencio et al., 2009). Also, gay men might have different priorities and concerns regarding loss of sexual function—for example, anal sensitivity and bowel functioning might be more concerning for gay men who prefer receptive intercourse (Blank, 2005). Furthermore, as medical schools teach little with regard to sexuality, particularly among sexual minorities (IOM, 2011), limited knowledge and cultural competency about sex-related issues by practitioners during treatment decision-making and symptom management may be particularly damaging to gay men with PC.

Another source of minority stress for gay men that may compound distress, while also depriving them of valuable emotional and practical support, is the possibility of estrangement from their family. Many studies have demonstrated the beneficial effects of support from family members and romantic partners when facing a chronic illness (Revenson and DeLongis, 2011). However, families sometimes disappoint and fail to provide needed or expected support (Lepore and Revenson, 2007). Accordingly, for gay men who may not be “out” to their families or who have faced rejection due to sexual orientation, the lack of close family support may put them at a disadvantage when coping with PC.

In addition, a sense of belonging and the ability to depend on a supportive community may be critical to understanding health outcomes among sexual minorities (Kertzner et al., 2009; Meyer, 2003). Gay men with PC report deficient social support (Capistrant et al., 2016), and the minority stress model posits that connectedness to a sexual minority community can mitigate the negative effects of minority stress on health (Frost and Meyer, 2012). As a result of discrimination and rejection from families of origin, community connectedness has been identified as a group-level coping resource in counteracting the negative impact of social stressors for gay men (Major and O’Brien, 2005; Meyer, 2003). Yet, research illustrates that many gay men report higher levels of social isolation than their heterosexual counterparts (Frazer, 2009).

In sum, we suggest that a number of intrapersonal, interpersonal, and societal factors combine to influence gay men’s psychosocial adjustment to PC. With minority stress, the capacity to contend with the stressors associated with PC diagnosis and treatment may be further diminished. For instance, cancer-related stressors (e.g. low satisfaction with care) may act synergistically with minority stress processes (e.g. chronic experiences of discrimination) to negatively impact adjustment. However, little work has examined this possibility in the context of PC or related disease models. Indeed, the need for more research to inform more

culturally aware, gay-supportive healthcare for gay men living with PC has been highlighted in calls from the American Cancer Society (Wender et al., 2016), the National Institute of Health (Alexander et al., 2016), and the IOM (2011).

Accordingly, we conducted a qualitative study to better understand gay men’s PC experiences and to begin to shape a model of gay men’s psychosocial adjustment to PC. Our primary objective was to describe the unique experiences of gay men with PC from their own perspective. Using minority stress theory and the broader literature on psychological adjustment to cancer as guides in introducing domains of inquiry, we explored unique gay-related stressors associated with the medical care for PC; the role of support networks; perceived stigma and discrimination; and other coping resources in cancer adjustment.

Methods

Participants and procedures

Three focus groups were conducted with gay men with a history of localized PC ($N=11$, M age=65.8 years, standard deviation (SD)=13.6; range=43–84 years). Participants were recruited via advertisement for a study of the “experiences of gay men with prostate cancer,” urologic clinics, and community-based cancer-serving and LGBT (lesbian, gay, bisexual, and transgender)-centered organizations from a large metropolitan area in the Northeastern United States. Participants were diverse in terms of race/ethnicity, education, employment status, and treatment history (see Table 1).

Groups lasted 2–3 hours and were facilitated by a clinical psychologist using a semi-structured protocol, which allowed for participant-driven inquiry. Major domains of exploration included the following: experiences of diagnosis and medical decision-making; emotional, physical, and sexual impact of PC; support needs; and the social impact of PC. Groups were audio-recorded and transcribed verbatim. Participants received US\$50. Procedures were

Table 1. Participant characteristics.

Participant	Age (years)	Race	Relationship status	Highest level of education	Year of diagnosis	Treatment received
101	64	White	Divorced/separated	Master's degree	2011	Surgery
102	84	White	Widowed	Bachelor's degree	2004	Radiation, surgery
103	51	African American	Single	Bachelor's degree	2012	Radiation, hormone therapy
104	70	White	Single	Doctoral degree	2012	Surgery
105	80	White	Single	Master's degree	1994	Radiation
106	62	African American	Single	Bachelor's degree	2004	Surgery
107	62	White	Committed/partnered	Bachelor's degree	2008	Active surveillance
108	59	White	Widowed	Bachelor's degree	2008	Surgery
109	57	African American	Single	High school diploma	2012	Radiation
111	83	African American	Single	High school diploma	1999	Surgery
113	43	African American	Single	High school diploma	2012	Surgery

approved by the University Institutional Review Board.

Analytic approach

We utilized a conventional content analytic approach (Hsieh and Shannon, 2005; Vaismoradi et al., 2013) using Dedoose software (version 6.1.18) to facilitate collaborative analysis by four coders. We approached data analysis without a preexisting conceptual framework in order to allow for the coding process to generate new insights. Given the aims of the study and lack of knowledge on the topic, this was determined to be an advantage of conventional content analysis, allowing us to remain responsive to the data without focusing men's lived experiences into existing theoretical constructs (Hsieh and Shannon, 2005). We followed established guidelines for team-based codebook creation (MacQueen et al., 1998). Coders read each transcript to achieve data immersion; two members of the coding team reread the transcripts independently and engaged in open coding whereby they generated ideas for codes by noting concepts in the

data that were relevant to the research question. The two independently generated lists of codes were preliminarily synthesized, and after discussion by all four coders, the list was refined into a final list. The codebook was then applied to the data by the two coders who did not develop the codes. Discrepancies in code application were resolved by discussion. After primary content areas were identified in the data, we drew on relevant theories and previous research in order to bolster our interpretation of the present findings and relate the findings to the research literature.

Results

Six primary content areas were identified in the analysis: minority stress, intimacy/sexuality concerns, impact on life outlook, healthcare experiences, social support and the gay community, and intersectional identities.

Minority stress

Participants described experiences of stigma, prejudice, and discrimination throughout PC

diagnosis and treatment. These experiences were unique to gay men and aligned with the types of prejudice-related social stressors that have been characterized as “minority stress” (Meyer, 2003). For example, men described stress related to managing the disclosure of their sexual identities to healthcare providers, noting that they felt it was important, but that some doctors never asked:

Well, my GP knew. One of the reasons I chose a man who I knew was a gay man was because he would understand health issues from our perspective. The specialists: the question was never asked. (Participant 108)

Another man echoed this by indicating a lack of caring and understanding from providers:

... nobody—I don’t even think anyone cares to ask the question of whether you’re gay or not. Because no one wants to look at it—they don’t look at it—I personally think that they don’t look at it the way we do. (Participant 113)

Men also discussed doctors assuming they were heterosexual by the nature of the medical questions they were asked:

Well I’m always tested for various diseases, not specific to gay men. But I’ve never had a straight doctor do anything to inquire anything about anal intercourse, or the repercussions of or the pleasures of or the possibilities of [PC] ... (Participant 101)

Men talked about how their concerns regarding the effects of PC treatment on their bodies and sexual functioning were uniquely experienced as gay men. When such concerns were not taken seriously by providers, they felt as though they were not taken seriously as patients. One man stated,

I can’t speak for all of us, but a lot of gay men, you know, we—having fought for our sexual identity, having to fight battles and then having a sexual self that you’ve fought for, and you refine and you go to the gym and you do this and you try to become attractive and whatever,

and then somebody says, oh—you know, and they’re not even acknowledging that that’s something that’s important to you. (Participant 108)

In these instances, men’s descriptions of their experiences demonstrate how heteronormativity is engrained in the healthcare context such that gay men described feeling as though their concerns are not important or valid, thereby resulting in feelings of marginalization and minority stress.

Finally, some men described the ways gay-related stigma became internalized, or applied to the self, during key moments in the experience of PC. For example, one man at the time of his diagnosis questioned whether having PC was a moral punishment for being gay:

Like is this God’s punishment for me—is this God’s punishment for me for choosing this way of life because in his eyes this is wrong? (Participant 113)

This internalized form of stigma—evident in the interpretation that a PC diagnosis was a punishment from God for being gay—is just one example of how stigma perpetrated by society can become applied to the self in the form of internalized homophobia. This experience, combined with the erasure of the uniqueness of gay men’s concerns by healthcare providers, furthers the marginalization that many gay men experience in the context of dealing with cancer. One participant portrayed a powerful sense of internalized homophobia in his description of a compounded burden of being gay and having PC:

I am fearful of men; I’m fearful of gay men probably to an extent. I’m homophobic. Our culture is homophobic. As gay men I think we are all somewhat homophobic. I don’t believe it can be 100percent true that all gay men are totally, completely accepting of their sexuality or their gender identity or their sexual preference or whatever, and so I wish I weren’t so afraid of the gay community. (Participant 101)

Intimacy and sexuality concerns

Men spoke about the impact of PC on intimacy and desire, both in terms of experienced and anticipated impact. The importance of intimacy was illustrated by numerous descriptions of missing affection, basic human touch, cuddling and kissing, the sensation of ejaculating, and/or the feeling of being sexually desired. Some men also reported that some providers and friends had been dismissive of their intimacy concerns. One participant described his physician's response to him asking about erectile dysfunction:

I felt dissed. I just felt like there was a lack of empathy. It was just like—, “Well, if it's dead, it's dead.” I'm like, Really? Seriously? You know? I have to think that it had to do with me being gay or whatever. (Participant 108)

Another man described attempting to involve a partner in discussions of sexual rehabilitation:

I wanted to have my boyfriend at the time to be part of it—at the doctor and all that—it didn't seem he was welcome ... I wanted to know I still belonged. I'm still me. I'm still me with cancer. I wanted to be seen. (Participant 101)

Although desiring sexual contact, some men reported feeling “afraid,” “hesitant,” and “lacking confidence” in initiating intimate contact. As a result, some had gone without sexual contact for an extended time, and noted associations to increased sadness and depressed mood. One man referred to himself as “damaged goods” and described how overcoming intimacy challenges were different for single gay men than those in relationships. For instance, concerns about the impact of PC on sexual functioning prompted wariness about what to tell a new partner, worries about not being able to please a partner, and sadness at the loss of spontaneity with erectile dysfunction medication. One man spoke of having resigned himself to the prospect of his partner “having to go elsewhere for sex,” while another spoke of the “pity party” that one partner had displayed, leading him to question whether the partner genuinely loved him.

Men also discussed their ability to adapt. Some made adjustments (e.g. changing their expectations and emphasis on orgasm) and had innovated to overcome limitations (e.g. using sex toys). Others, however, reported feeling less able to change their expectations and practices regarding sex and intimacy, particularly in relation to their newly lowered level of desire or to their role as either the insertive or receptive partner in anal sex:

Being a top [insertive partner] was part of my identity and not being able to satisfy in that way really messed up my sense of who I was. (Participant 104)

This range of experience demonstrates the central role of sexual intimacy in their lives. Sexual adaptation in the face of the limitations of physical dysfunction is adaptive for most men. However, for men with histories of responding to minority stress experiences, this process might be particularly challenging to self image and identity.

Men also discussed loss of emotional intimacy. Discussing intimacy beyond the physicality of sex, one participant commented, “yes, there is something missing ... besides my prostate.” Men described that sexual contact had in the past served as a conduit to experiences of closeness with other men. One man described,

For me, at 62, the goal of being in bed with somebody is not necessarily an orgasm any more—it is touch, it is connection, it is affection, and so now he has an orgasm and I don't. I don't care. (Participant 107)

Impact on life outlook

In addition to worries about prognosis and fear of relapse, which have been widely documented in the broader literature (Crist, 2013), men described multiple ways in which they felt changed by PC. One man described his feeling of now being in “a different body,” while others reported feeling less cheerful than before. Body image concerns were prominent for many, particularly regarding weight gain, reduced penis

size, and catheter use. One man stated that appearance concerns are particularly difficult for many gay men who "have worked very hard to appear physically attractive."

Men discussed their attempts to find meaning in their PC experience, with some reporting benefit (e.g. "[It] helped me grow in my faith to know that I can endure and persevere anything"), while others expressed struggles with resolving existential questions about why it happened. Some commented that they had not been substantially changed by the experience:

it's just something else that has happened with me ... I don't think it's handicapped me in any way. I don't feel special, I don't feel wounded, I don't feel tragic. (Participant 105)

Men spoke of the impact of PC on their outlook on life, noting that illness "reinforces how life is very short and valuable and to live more in the here and now." For some men, this prompted practical changes such as improved self-care (e.g. eating and sleeping well). Another noted the numerous changes he made from his pre-PC lifestyle:

I stopped partying, got rid of the drugs, no drinking, went back to school, I'm gonna go back to work ... you know, the whole idea of it is "you're still alive, you can survive this." (Participant 103)

Finally, some men noted that their experience had prompted a desire to "give back" by helping others, such as participating in support groups or research. Such perceptions of growth or benefits to self-care, for some gay men, might serve to redirect patterns related to coping with gay-related stigma (e.g. excessive drinking) or might reflect built resilience from gay-related experiences. That not all men experienced such benefits, however, indicates the wide range in how these men have been affected by cancer.

Interactions with healthcare providers

Participants indicated the manner of the doctor-patient relationship was important in determining

their satisfaction with their healthcare experiences. Reflecting the general cancer literature, participants cited empathy, trust, and openness as creating positive experiences, and poor judgment, lack of communication, and a "salesperson"-like style among doctors as negative.

With respect to their sexuality, participants approved of doctors who were more open toward and understanding of their identity. Men associated having "gay-friendly" doctors with "feeling more comfort" about being open about sex and sexuality, and how it could affect their treatment and HRQOL. Some participants chose physicians who were gay themselves because these providers "understand health issues from our perspective."

Some men faced heterosexism and discrimination in their healthcare experiences. Many were frustrated with a presumption of heterosexuality in treatment (e.g. "The follow-up questionnaires then are all from a heterosexual perspective"). Some even endured discrimination:

It pissed me off because [my doctor] was judging me ... come to find out his son was gay and him and his son had a very strained relationship because he didn't approve of his son's sexuality. (Participant 113)

For some, disclosure of sexual orientation was associated with feared consequences:

I don't want to tell them I am gay. They are going to operate on me. I don't know what kind of homophobe they are. (Participant 109)

These experiences represent a unique form of minority stress. The men's various experiences with providers' treatment of their sexuality attest to the importance of carefully navigating this identity in care.

Social support and the gay community

Participants were able to avail themselves of many different sources of support and validation, including family and friends, as are most cancer patients. However, they also emphasized

the importance of gay-specific, cancer-related community support. One man described,

This group is very important to me not just because I have cancer but because I am fortunate enough to have contact with other gay men and fortunate they are older gay men. That's important to me. I miss contact with the gay community. (Participant 101)

Men often identified how individuals providing PC-related support also supported their coming out or affirmed their gay identity. One man said,

I have an older brother who is one of my very best friends. And that's a very important statement for me to make because I have been alienated and marginalized from my family forever. (Participant 101)

He goes on to say,

I talk to him quite a lot about PC, but he's the only person. (Participant 101)

In fact, when asked about familial support, many men readily shared histories of abuse and alienation from their families.

Men across the groups reported various unmet support needs and barriers to support. These included unmet needs from the gay community, such as a perceived lack of gay-specific support services, as well as general isolation. Most of the men were single and lived alone, lacking tangible support for daily assistance when needed. As one man reported,

I went home about the 3rd week of radiation and I started to feel its effects and there was no one there to talk to. And, in hindsight, I wish there was someone to help cook and clean so I didn't have to drag myself around. (Participant 103)

Most striking to us and relevant to adequate cancer care were the frequent comments on how PC has been invisible within the gay community. Participants identified the stark differences between community support for gay men affected by HIV/AIDS and those with PC:

It's like we're overshadowed by the gays with HIV and AIDS ..., no one is bringing you a cake, no one's coming to the hospital, no one's saying anything, and no one's doing anything about it. (Participant 113)

More broadly, men characterized PC as a disease related to aging and translated this into a need for a focus on the needs of older gay men. As one man stated bluntly,

There needs to be more recognition and more visibility for aging gay men ..., there is so much stress on youth culture ... with prostate cancer you have to deal with that ... there's a vacuum. (Participant 108)

Finally, men described worries that they had lost their place within the gay community because of physical changes, particularly loss of erectile function. They described difficulties negotiating spaces, such as gay bars and online dating sites, because they would not be able to perform sexually. One man with erectile dysfunction described,

I never go out. I never socialize. I used to go out to bars all the time. I never do because if I met someone—I consider myself a top—so if I met someone, what could I do? (Participant 106)

Intersectional identities

Men described various intersections between PC and a variety of other identities (e.g. being gay, African American, and an activist), health conditions (e.g. HIV and diabetes), and previous experiences with adversity (e.g. childhood abuse, incarceration, and family rejection). Some men felt their life experiences or other identities helped prepare them to cope more effectively with PC. For example, one man attributed his assertiveness in treatment decisions to his being an "old gay activist." He goes on to say,

I am a survivor. I came out before it was in fashion. I was at Stonewall. I watched everyone die of HIV. Prostate cancer isn't hard. (Participant 102)

Conversely, another man described that he had already struggled through enough adversity that made it more difficult to now meet PC challenges:

I was like "Wait a minute!" You mean to tell me I went through all of this shit, being gay, all of these problems, all of these social issues, all of these issues with my family, and now you're going to tell me that I got cancer? (Participant 113)

That PC might have an impact on some of these identities (such as being gay) was suggested by several men. One man described his impression that "so, there goes my social life, particularly if your social life is entirely focused around sexuality."

Discussion

For most men, regardless of sexual orientation, PC affects HRQOL across domains, including sexual function and, as a consequence, intimacy (Penson et al., 2005). For others, PC diagnosis can also inadvertently signal awareness of aging (Chambers et al., 2015). However, these issues take on a different, additional meaning for gay men for whom sexuality is central to their sense of self and connection to others in unique ways.

Interpersonal processes represent a fundamental coping resource for gay men. A sense of belonging and ability to depend on a supportive community may be critical to health outcomes among sexual minorities (Kertzner et al., 2009; Meyer, 2003). Stemming from experiences of rejection, community connectedness has been identified as a coping resource in counteracting the negative impact of social stressors for gay men (Frost and Meyer, 2012; Major and O'Brien, 2005). Yet, research illustrates that gay men report higher levels of social isolation than their heterosexual counterparts (Frazer, 2009). The fact that the men in this study felt isolated from the gay community because of their PC suggests that PC affects gay men in a different and perhaps more isolating way than

heterosexual men. It also suggests that resources need to be developed that specifically address these needs. Research that better identifies community-level structures that contribute to or diminish isolation of gay men with PC will improve the generalizability and intervention utility of this finding.

The findings from the present research bolster existing claims that gay men disproportionately experience healthcare barriers and unmet needs (Frazer, 2009; IOM, 2011). Gay men have reported experiencing refusal of treatment by healthcare providers, verbal abuse, and disrespectful behaviors, as well as many other forms of failure to provide adequate and culturally competent healthcare (IOM, 2011; Quinn et al., 2015). Our findings expand those of an earlier study that showed gay men had a limited understanding of their prostate and the range of sexual challenges associated with PC treatment (Asencio et al., 2009).

It was also clear from this research that gay men have distinct priorities and concerns regarding loss of sexual function that differ from their heterosexual peers. Numerous men in our study voiced concerns about sexual functioning and sexual identity (such as having always been the insertive partner in anal sex) which resonated with findings in previous research (Blank, 2005). Men pointed to the fact that the often used clinical benchmark for sufficient erectile functioning is the ability to perform vaginal intercourse. Practitioners' cultural competency of sexual activity within this population may be particularly critical during treatment decision-making and symptom management activities.

For many of these men, PC brought to light the intersection of their gay identity, sexuality, and aging. For men who "came of age" during the so-called Stonewall era, sexuality remains a large part of one's identity. Thus, experiencing PC-related sexual dysfunction affects not only intimacy with partners but also one's identity within the larger community. Whether this is unique to PC or occurs with other cancers and illnesses cannot be answered with our data. However, many men felt "slighted" over the

attention paid to gay men with HIV/AIDS compared to the limited amount of attention to PC.

This study achieved a rich description of the experiences of gay men with PC. The exploration of identified content areas allowed for a thorough exploration resulting in saturation, and the analyses were guided by an expert team experienced in cancer survivorship and qualitative methodology. However, conclusions should be interpreted with possible limitations in mind. The use of focus groups provided unique opportunities for men to build interactive discussion; however, it is possible that individual interviews might have yielded unique insight. It is also possible that some men might have been uncomfortable disclosing in a group. However, this was not observationally apparent. In fact, most men displayed marked candor and openness. Finally, this study relied on a small sample of men recruited exclusively from a large urban area with limited representativeness across ethnicities and relationship statuses and may not be representative of all gay men with PC. Such limitations further the possibility that other themes were not raised.

A recent white paper (Burkhalter et al., 2016) outlined the critical need for more research to understand and address the needs and concerns of LGBT survivors across the cancer continuum. To support this mandate, we suggest that researchers combine both general and minority stress models to understand coping processes and psychological outcomes among gay men with PC. Only with this information, effective and culture-sensitive interventions can be developed and evaluated, if individual-level interventions are, indeed, appropriate. In articulating a focused research agenda, we highlight the value of studies utilizing a mixed methods approach. The combination of quantitative and qualitative data will allow for a rich and detailed description of the experience of gay men with PC. A second recommendation will be to identify the key psychosocial factors related to HRQOL and psychosocial outcomes at the individual, family, and community levels. Such research has the potential to significantly impact clinical

practice by identifying unique healthcare priorities, as well as factors of risk and resilience in gay patients. Achievement of these aims will highlight potential targets for future intervention for gay men with cancer generally, and those with PC specifically. To maximize the utility, we recommend that future research focuses not only on risk but also on resilience factors that shape adjustment to prostate and its long-term trajectory. And, finally, we suggest that studies facilitate and inform healthcare delivery and patient-centered questions. Our qualitative data shed light on what gay men can uniquely expect from their PC experience. By identifying unique healthcare priorities, researchers will be able to highlight potential targets for future intervention for gay men with cancer generally, and those with PC specifically.

As preliminary indicators suggest, large gaps in the delivery of culturally competent care exist. Research using a culturally sensitive minority stress framework has the potential to inform practitioners and patients about how to improve the outcomes that are most important to gay men with PC, or any form of cancer or chronic illness. This study highlights a number of unique challenges for gay men with PC within three main areas: challenges affecting the patient and his surroundings, challenges for the community at large, and challenges for healthcare providers and the system. For patients, more personalized support is needed that can be provided once sufficient awareness is achieved. For a community that is experienced in fighting for recognition and accustomed to coping with adverse health situations, the goal of raising awareness might be easily achieved if existing resources are being leveraged. Men in the study valued healthcare providers who were familiar with the unique challenges of gay men with PC. Only a minority of providers is sufficiently experienced to provide such tailored care, and most are concentrated in urban areas. It is therefore critical to educate providers, patients, *and* their families, and to provide the social and communication tools to provide such care.

Declaration of conflicting interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

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