

**DEPRESSION IN GAY MEN:
CONSIDERATIONS AND RECOMMENDATIONS FOR NURSE PRACTITIONERS**

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Introduction

In 2011, suicide was the seventh leading cause of death in Canadian males (Statistics Canada, 2014). Depression is a known risk factor for suicide, and is prevalent in homosexual males, wherein gay men are three times more likely to experience depression compared to the general public (Cox, 2006). Depression and suicidal behaviours in gay men have been linked to: relationship problems, accepting one's homosexuality, experiencing homophobia and discrimination, and alienation from the gay community (Cox, 2006; Wang, Plöderl, Häusermann, & Weiss, 2015). In addition, depression may also increase gay men's risk of alcoholism, drug addiction, suicide and human immunodeficiency virus (HIV); as it is associated with risk-taking by engaging unprotected anal intercourse (Cox, 2006).

This article examines the risk factors for gay men's depression and the connections to suicide. Additionally, barriers to help-seeking are discussed in providing recommendations for how nurse practitioners might advance the mental health of gay men and reduce suicide amongst this vulnerable yet underserved sub-group.

Depression

According to the American Psychiatric Association (2013), depression is clinically diagnosed if an individual experiences a depressive mood or loss of interest or pleasure in nearly all activities over a two week period, along with four of the following symptoms: "changes in appetite or weight, sleep, and psychomotor activity; decreased energy; feelings of worthlessness or guilt; difficulty thinking, concentrating, or making decisions; or recurrent thoughts of death or suicidal ideation or suicide plans or attempts". When these symptoms interfere with the individual's daily functioning and are present for most of the day, nearly every day, for a minimum of two weeks, depression can be formally diagnosed.

Men in general, may express depression through other symptoms including anxiety, irritability, anger, alcohol and drug overuse and violence (Campaign Against Living Miserably [CALM], 2014; Körner et al., 2008; Oliffe & Phillips, 2008). These symptoms may manifest in gay men as well. For example, Körner et al. (2008) noted in their Australian study that general practitioners were able to identify signs of depression in gay men through anxiety-related symptoms. Additionally, drug misuse is common amongst gay men (Centre for Addiction and Mental Health [CAMH], 2007; Cox, 2006; Gay & Lesbian Medical Association [GLMA], 2006).

In terms of cause-effect and triggers for depression an array of factors have been cited as contributing to gay men's depression. Marshal et al. (2013) indicated that homosexual youths reported higher rates of depression and suicidality compared to heterosexual males during their early adolescence and as they transitioned into young adulthood. The risk factors for depression in gay men include: having difficulties accepting their homosexual identity and experiencing rejection from either the gay community or from their family (Ash & Mackereth, 2013; Körner et al., 2008; Mills et al., 2004). Personalized stigma is positively correlated to stigma concealment and symptoms of depression (Frost, Parsons, & Nanin, 2007). Gay men who have not accepted their sexual orientation can experience inner conflict, which may cause them to detest their sexual orientation (Körner et al., 2008; McAndrew & Warne, 2010). As a result this can contribute to gay men's risk for depression. Not only is self-acceptance a critical element for a gay man's wellbeing, but being accepted by others as well (Ash & Mackereth, 2013). Gay men tend to experience rejection more than females (Ryan, Huebner, Diaz, & Sanchez, 2009). The lack of acceptance from the gay community can lead to individuals experiencing social isolation, which as a result can increase their risk for depression (McAndrew & Warne, 2010; Newman et al., 2008). Additionally, young sexual minority adults who have experienced family rejection

during their adolescence when they disclosed their sexual orientation were 5.9 times more likely to report high levels of depression (Ryan et al., 2009).

Gay men with HIV also are at risk for depression. The impact of being diagnosed with HIV can lead to the loss of income, careers, relationships, and family and social support (Körner et al., 2008). Isolation experienced through the loss of social relationships and family support, were noted by general practitioners experienced in providing care to HIV positive gay men, to be significant triggers for depression (Körner et al., 2008). Additional risk factors for gay men's depression identified by general practitioners included: diagnosis of HIV, initiation of HIV treatment, treatment failure, diagnosis of AIDs or having a friend being diagnosed with AIDs (Körner et al., 2008).

Suicide

Suicide is the death of an individual as a result of self-inflicted injuries with the intent to die (Centers for Disease Control and Prevention [CDC], 2015). Suicide attempts are non-fatal, self-inflicted injurious behaviors with an intent to die that may not result in an injury (CDC, 2015). Suicidal ideation comprise thoughts and/or consideration of planning suicide (CDC, 2015). Gay men have four times the risk for suicidal behaviors compared to their heterosexual male counterparts (Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; King et al., 2008). Gay men consider suicide with a strong intention of dying compared to heterosexual males contemplating suicide (Plöderl, Kralovec, & Fartacek, 2010). It was estimated that in 2011, more gay and bisexual Canadian males died from suicide than from causes related to HIV (Hottes, Ferlatte, & Gesink, 2014).

The risk factors for suicide include: symptoms of depression, previous suicide attempts, problems with relationships, accepting one's homosexuality, family rejection, and victimization

(Haas et al., 2011; Mustanski & Liu, 2012; Wang et al., 2015). A Swiss study of 762 gay men identified the top three justifications for their first suicide attempt as: 1) problems with their relationship, 2) accepting one's homosexuality, and 3) family rejection (Wang et al., 2015). Men who have not accepted their gay identity may feel compelled to lead a double life, in which they experience inner conflict and despise their sexual orientation (Körner et al., 2008; McAndrew & Warne, 2010). As a result, gay men can be self-deprecating and at risk for self-harm.

Additionally, gay men's lack of familial support is a predictor of non-fatal suicidal actions. Gay men who have experienced rejection by their parents when revealing their sexual orientation, were noted to be at a high risk for attempting suicide (Haas et al., 2011; Ryan et al., 2009; Wang et al., 2015). A study conducted by Ryan et al. (2009), noted that those who experienced rejection by their family were 8.4 times more likely to report having attempted suicide. In contrast, Mustanski and Liu (2012) noted in their study that having family support was as a protective factor in lowering the risk for suicide.

Victimization was also noted to be a risk factor for suicide attempt (Mustanski & Liu, 2012). Victimization includes experience of verbal threats and insults, being chased, having property damaged, and being physically or sexually assaulted (Mustanski & Liu, 2012). D'Augelli, Pilkington and Hershberger (2002) conducted a study with 350 lesbian, gay and bisexual participants under the age 21. The study retrospectively examines the relationship between previous sexual orientation victimization directed towards the youths at high school and their current mental health. The male participants experienced significantly more verbal attacks, threats of violence, and objects being thrown at them compared to the female participants (D'Augelli et al., 2002). The participants were more likely to experience victimization in high school if they were aware of their attraction to the same sex at an early age, identified as being

lesbian gay or bisexual, and disclosed their sexual orientation to others for the first time (D'Augelli et al., 2002). Additionally, the total of victimization experienced was positively related to the mental health symptoms D'Augelli et al., 2002). 42% of the male participants disclosed they sometimes or often experience suicidal ideations (D'Augelli et al., 2002).

The causal relationship of HIV on suicide behavior is limited due to insufficient longitudinal studies and varying illness definitions and sample characteristics (Haas et al., 2011). A systematic review by Catalan et al. (2011) identified via autopsy studies that 2.4 to 9.4% of male suicides were HIV positive. However, a literature review conducted by Haas et al. (2011) noted sexual orientation is not routinely included in death records amongst the North American studies, thus the researchers have to rely on the deceased's family and friends accounts to determine the deceased's sexual orientation. As a result, there is likely an underreporting of the suicide among gay men.

Help-seeking

Men can be reluctant to seek help for physical and mental health problems (Addis & Mahalik, 2003). For gay men there are limited services available to meet the demands of their community (Ash & Mackereth, 2013; Rutherford, McIntyre, Daley, & Ross, 2012). This can be an additional help-seeking barrier for gay men wanting to address their mental and emotional wellbeing. In a study conducted by Ash and Mckereth (2013), some gay men did not seek help because they were accustomed to services being inadequate in providing health care catered towards to their needs.

Unfortunately, gay men whom seek help may experience discrimination. Participants of an English study involving 130 respondents, revealed that many gay men felt invisible and ignored when services for their needs were not available, or when personnel assisting them were

insensitive to their needs (Ash & Mackereth, 2013). The lack of resources and insensitivity may reflect the lack of awareness and education about the gay community's health needs. This can negatively impact the healthcare provider and patient relationship. For example, gay men who attended clinics for sexual transmitted infection or HIV screening felt stigmatized for their sexual orientation and felt they were being treated based on generalizations and assumptions instead of their self-reported sexual practices (Knight, Shoveller, Oliffe, Gilbert, & Goldenberg, 2012). This as a result, may cause some men to withhold disclosing their sexual orientation.

Barriers to Care

Substance misuse is at least 1.5 times more common in sexual minorities and 3.4 times more common if a gay man experiences family rejection (King et al., 2008; Ryan et al., 2009). Substance use and withdrawal symptoms can be similar to somatic symptoms of depression such as sleep, appetite and weight changes (Bryant et al., 2012). Substance use can also affect men's mood, mask symptoms, and influence medication adherence; thus making it difficult to diagnose and effectually manage depression (Bryant et al., 2012; Newman et al., 2008). Bryant et al. (2012) note in their study that general practitioners were able to rule out depression in gay men whom were not depressed and using recreational substances. However, they were less effective at identifying gay men who were depressed, especially in those using crystal methamphetamines frequently (Bryant et al., 2012).

Sexual functioning was noted by general practitioners as an obstacle for treating depression in gay men. In a study conducted by Newman et al. (2008), general practitioners disclosed that some depressed gay men were reluctant to take anti-depressants because of the potential side effect of erectile dysfunction. The potential for erectile dysfunction can be a significant concern for men wanting to engage with gay sexual cultures (Newman et al., 2008).

Finally, gay men may not express the typical symptoms of depression, and this may challenge health care providers to make a formal diagnosis. In an Australian study, general practitioners who routinely provided care for sexual minorities espoused discrepancies between the classic textbook depressive symptoms and the psychosocial aspect of depression in gay men lives (Körner et al., 2008). Gay men's depression rarely manifested in classic symptoms of anorexia, weight loss, self-worthlessness, and poor sleep patterns. Instead, gay men's depression emerged as agitation and anxiety related symptoms (Körner et al., 2008). Instead of relying on standardized diagnosing tools, these practitioners suggested they relied on their experience and relationships with these patients. They inquired about the patient's life and depressive symptoms in order to identify moods or social problems related to depression.

Nurse practitioners (NPs) have the ability to prompt and sustain conversations with patients regarding life experiences and/or feelings that may lead to depression (Gee, 2006). However, NPs education curriculums may not address the needs of the gay community (Gee, 2006). Health care provider's lack of education in regards to the health issues and needs of the gay community can be a barrier to providing effective health care to the gay community (Blackwell, 2015; Substance Abuse and Mental Health Services Administration, 2001; Rutherford et al., 2012). Health care providers caring for gay men often note that there is lack of professional education and training opportunities that specifically address the issues and needs of LGBT community (Blackwell, 2015; GLMA, 2006; Rutherford et al., 2012). The health care providers often have to seek out workshops or conferences to address such learning needs.

Recommendations

NPs comprise the fastest growing advanced practice nursing collective in Canada, as the role is intended to help improve the country's accessibility and quality of primary healthcare

(Donald et al., 2010). NPs are graduate level educated and trained advanced care nurses who are able to provide primary care by diagnosing and treating illnesses and injuries, and chronic illnesses (Health Canada, 2007). They also are able to prescribe medications and order and interpret diagnostic testing. NPs may work autonomously or in collaboration with other health care providers. As such, NPs can be a vital point of healthcare access for gay men.

In providing care for gay men, it is essential that NPs create a safe environment in which sexual minorities can confide and discuss their sexual orientation and health related issues openly. Creating such an environment will help NPs identify those who are at risk for depression and suicide. In hopes of reducing the risk of suicide amongst gay men the following recommendations are provided.

First, establishing trust is essential. NPs can establish trust by displaying empathy and open mindedness, and withholding judgements. Do not make any assumptions about an individual's sexual orientation (Blackwell, 2015). Some men may have sex with men, but may not consider themselves gay. The CAMH (2007) provides an online guide for health care providers to use when assessing LGBT individuals. The guide contains a patient intake questionnaire and provides the health care provider the rationale for the questions asked in order to help them understand the health issues of this vulnerable population. The questionnaire covers gay health issues such as mental health, substance use, HIV, support system and involvement in the gay community. The template can be filled by the patient or verbally asked to the patient during the patient's initial visit. The use of the questionnaire template can help enable the patient to openly discuss their sexual orientation and history without the NP making assumptions. Furthermore, the use of the template and reassurance of confidentiality can help establish rapport and a trusting relationship between the NP and the patient as the goal would be for the patient to

return, and to feel safe and secure enough to disclose their health issues openly without feeling discriminated.

In addition, all staff members engaging with patients should be provided with training to help create and maintain a safe open environment for gay men. The training should cover: using appropriate language when addressing the individual; how to identify and confront any internalized discriminatory beliefs about LGBT individuals; and LGBT health issues (GLMA, 2006).

Second, NPs should explore the degree to which the individual is “out” to their family and friends, and the extent of their support system. Mustanski and Liu (2012) noted family support to be a protective factor in lowering the risk for attempting suicide. Furthermore, NPs should explore the individual’s level of participation in LGBT community as well. Identifying with the community correlates with improved mental health (GLMA, 2006; Ryan et al., 2009). The CAMH provides (2007) example questions for health care providers to ask to assess the patient’s support system without judgement. For example, the patient should be asked open-ended questions about who they have told about their sexual orientation, how was it handled or how it affected their relationship, if drugs and alcohol were involved, and if it impacted their mental health (CAMH, 2007). This will help the NP assess the level of the patient’s self-acceptance and social isolation. Patients may turn to alcohol and substances to cope with rejection, social isolation, or conflicts related to the sexual identity (CAMH, 2007). Also, a strong support system is necessary in recovering from substance or mental health issues as well (CAMH, 2007). The level to which a person relates with a community is a significant resiliency factor (CAMH, 2007). NPs can intervene by helping provide the patient information to help normalize their experience and provide community resources for them to solicit support.

Third, gay men should be assessed for substance use, and the potential for it to be used for self-medicating depression and/or suicidality. Any stress related to their sexual orientation may be related to a patient's substance use (CAMH, 2007). Thus, after a patient's sexual orientation history has been explored they should be asked if their substance use is related to any of their issues around their sexual orientation (CAMH, 2007). The individual should also be asked specific information about the patterns and situations involved with the substance use (Substance Abuse and Mental Health Services Administration, 2001). Understanding this relationship will help the NP identify whether the individual is using the substances to cope with their issues or for other reasons. For example, gay men may use substance to deal with the emotions, reactions from family, and social isolation experienced with coming out (CAMH, 2007). They may also turn to substances to express or suppress same-sex desire (CAMH, 2007; Substance Abuse and Mental Health Services Administration, 2001). Inversely, gay men may use substances to socialize as there are more gay social venues in society with a considerable presence of substances (CAMH, 2007; Substance Abuse and Mental Health Services Administration, 2001). Thus, NPs should also ask patients if they primarily depend on bars or clubs to socialize. Being aware of the patient's substance use history is important as substance misuse may mask the individual's symptoms, which may complicate their diagnosis and treatment. NPs should offer gay friendly support and treatment options for those misusing substances. NPs can refer to online guides created by CAMH (available at http://www.camhx.ca/Publications/Resources_for_Professionals/ARQ2/arq2.pdf) or by the Substance Abuse and Mental Health Services Administration (available at <https://store.samhsa.gov/shin/content/SMA12-4104/SMA12-4104.pdf>) for recommendation in regards to assessing and treating gay men with substance misuse.

Fourth, gay youth are a vulnerable subset of the gay community. Parents need to be educated on how rejecting behaviors experienced by their child will impact their mental health in the future (Ryan et al., 2009). Youths who have experienced rejection by their families are at risk for both depression and suicide. NPs can provide supportive resources to the youths and their families. A good source of information to provide parents is the PFLAG Canada website (www.pflagcanada.ca). PFLAG Canada is a National Canadian organization that helps support, educate, and provides resources for Canadians with issues of sexual orientation, gender identity and gender expression. The website provides an extensive information document for parents whose child has identified as being gay, lesbian or bisexual (PFLAG Canada, 2010). The document covers topics such as what the parent and the child may be experiencing, how to support the child and resources available for the family.

Finally, NPs should follow up with patients frequently. General practitioners note their capacity to manage and monitor depression was heightened by frequent follow up (Newman et al., 2008). Patients should be screened and monitored for signs of depression and suicidality routinely. There is not a depression screening tool available that is designed specifically for gay men. The NP can utilize the Patient Health Questionnaire (PHQ-9) as a screening tool. The PHQ-9 is used often in primary healthcare settings as it corresponds to specific attributes required for a depression diagnosis, based on the American Psychiatric Association's (2013) Diagnostic and Statistical Manual for Mental Disorders (DSM-5). An alternative to the PHQ-9 is the Beck's Depression Inventory (BDI) or the Gotland Male Depression Scale (GS). BDI is a widely used screening tool used to estimate the severity of the depression in individuals (Strömberg, Backlund, & Löfvander, 2010). GS is a depression screening tool that specifically targets males as it includes questions about distress, irritability, aggression, alcohol use and anger

attacks (Strömberg et al., 2010). A Swedish study compared the usefulness of the BDI and GS in identifying depression in men in a primary care drop in-clinic (Strömberg et al., 2010). In the study, 215 males completed both screening tools, in which 40 men in total were identified to be depressed. However, five males with mild depression were missed with GS compared with BDI (Strömberg et al., 2010).

To help assess and determine the severity of the individual's suicidality, the NP can utilize the Suicide Prevention Resource Center's Suicide Assessment Five-Step Evaluation and Triage (SAFE-T) (available at http://www.integration.samhsa.gov/images/res/SAFE_T.pdf). SAFE-T is a protocol for administering a suicide assessment, determining suicide risk, recognizing protective factors, and developing a treatment plan based on the severity of the patient's suicidality.

There are online resources in which NPs can turn to for support and guidance as well to help their practice.

1. Heads Up Guys (www.headsupguys.ca) is a Canadian website that provides men information about depression and suicide, and how their supporters can help them.
2. Gay Lesbian Medical Association (www.glma.org) is an international association with the mission of ensuring LGBT individuals and health care providers have equality in healthcare. They provide online resources for healthcare providers and hold an annual conference for them, addressing the issues and needs of the LGBT community. Additionally, they provide online information for patients and help them locate affiliated healthcare providers for them to access.
3. PFlag (www.pflagcanada.ca) is a Canadian national online resource that provides information for healthcare providers, families, and educators on various LGBT issues.

Individuals are able to locate local chapters in which they can join for additional support as well.

Knowledge Gaps

Population-based studies have provided strong evidence that depression and suicidality among gay men is a significant issue (Haas et al., 2011). However, the epidemiological picture is likely under-reporting gay men's suicide and the underpinnings of gay men's suicide more broadly are poorly understood. A literature review by Haas et al. (2011) suggested the lack of information may be the consequences of sparse funding for studies involving sexual minorities, and sexual orientation and gender identity data being omitted from sociodemographic characteristics of suicide and mental health studies.

There is also scant knowledge of the specific risk and protective factors for gay men (Haas et al., 2011). NPs have an opportunity to help contribute and expand this knowledge further. They are capable of providing trusting and continuity health care to gay men, which may provide important empirical evidence towards understanding the clinician role in reducing suicide rates among gay men while improving their mental health.

Conclusion

Gay men are a vulnerable sub-group at high risk for depression and suicide. NPs can champion gay men's health services to break with the longstanding focus of services on STIs and HIV under the guise of sexual health. By being cognisant of the risk factors and vulnerabilities NPs can ably address the mental health needs of gay men in contributing to preventing and/or effectually treating gay men's depression and suicidality.

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