

Depression and Suicidality in Gay Men: Implications for Health Care Providers

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Abstract

Gay men are a subgroup vulnerable to depression and suicidality. The prevalence of depression among gay men is three times higher than the general adult population. Because depression is a known risk factor for suicide, gay men are also at high risk for suicidality. Despite the high prevalence of depression and suicidality, health researchers and health care providers have tended to focus on sexual health issues, most often human immunodeficiency virus in gay men. Related to this, gay men's health has often been defined by sexual practices, and poorly understood are the intersections of gay men's physical and mental health with social determinants of health including ethnicity, locale, education level, and socioeconomic status. In the current article summated is literature addressing risk factors for depression and suicidality among gay men including family acceptance of their sexual identities, social cohesion and belonging, internalized stigma, and victimization. Barriers to gay men's help seeking are also discussed in detailing how health care providers might advance the well-being of this underserved subgroup by effectively addressing depression and suicidality.

Keywords

gay men's health, depression, suicidality, men's health, men's help seeking

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Introduction

Depression is prevalent among gay men, wherein gay men are three times more likely to experience depression compared with the general adult population (Cox, 2006; King et al., 2008). Depression is a risk factor for suicide (Oliffe & Phillips, 2008), and suicide is a leading cause of male death (Statistics Canada, 2014). Within this context, there is strong evidence that gay men are more likely than heterosexual men to experience suicidality (Brennan, Ross, Dobinson, Veldhuizen, & Steele, 2010; Hottes, Bogaert, Rhodes, Brennan, & Gesink, 2016; King et al., 2008). Depression and suicidality may also increase gay men's risk of alcohol and drug overuse, unprotected anal intercourse, and human immunodeficiency virus (HIV; Cox, 2006; Ferlatte, Dulai, Hottes, Trussler & Marchand, 2015). In terms of potential causes of depression and suicidality in gay men, relationship problems, accepting one's homosexuality, experiencing homophobia, institutional discrimination, and alienation from gay communities have been reported as underpinning issues (Cox, 2006; Haas et al., 2011; Wang, Plöderl, Häusermann, & Weiss, 2015).

Scant research exists about gay men's health beyond sexual health issues, most often HIV (Hottes, Ferlatte, & Gesink, 2014). Though gay men self-report that they rank mental health as one of their top health concerns (Grov, Ventuneac, Rendina, Jimenez, & Parsons, 2013) depression and suicidality in the lives of gay men are poorly understood (Haas et al., 2011; King et al., 2008). The current article details individual and societal risk factors for depression among gay men, the connections to suicidality, and potential barriers to help seeking. Additionally, implications for health care providers (i.e., medical doctors, nurses, social workers, psychologists, etc.) are chronicled in detailing strategies to advance the mental

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health and reduce depression and suicide among this vulnerable and underserved subgroup. This is an important contribution because the role of health care providers in suicide prevention among gay men has not been described in detail. Yet the majority of men who suicide have had contact with a health care provider in the year preceding their death (Luoma, Martin, & Pearson, 2002) suggesting that health care providers have the potential to identify male suicidality and reduce the potential for self-harm. However, to tap into the potential to reduce gay men's depression and suicide, health care providers need to be better equipped to discuss and evaluate connections between depression, suicide, and sexuality.

Depression

Depression is defined clinically as the experience of a depressive mood or loss of interest or pleasure in nearly all activities over a 2-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" (American Psychiatric Association, 2013). When these symptoms interfere with an individual's daily functioning and are present for most of the day, nearly every day, for a minimum of 2 weeks, depression can be formally diagnosed. In general, men may express depression through other symptoms including anxiety, irritability, anger, alcohol and drug overuse, and violence (Campaign Against Living Miserably, 2014; Körner et al., 2008; Olliffe & Phillips, 2008). These male depressive symptoms likely manifest in gay men as well. For example, Körner et al. (2008) noted that general practitioners used anxiety-related symptoms to identify additional signs of depression in gay men.

In terms of cause-effect and triggers for depression, a range of factors have been detailed, many of which are intertwined with the stress that can accompany being part of socially marginalized gay communities (Mays & Cochran, 2001; Meyer, 1995, 2003). Meyer's (1995, 2003) minority stress model highlighted four interconnected factors: (a) prejudice events, (b) expectations of rejection and discrimination, (c) concealment of identity, and (d) internalized homophobia. In the specific context of prejudice events, which refers to the multiple forms of antigay violence and discrimination (Meyer, 2003), a Canadian study reported that 47% of gay men had experienced harassment, 42% bullying, 16.1% workplace discrimination, and 13% physical violence because of their sexuality (Ferlatte, Dulai, Hottes, Trussler, & Marchand, 2015). Additional studies have also demonstrated that such events are associated with depression and emotional distress (Diaz, Ayala,

Bein, Henne, & Marin, 2001; Hatzenbuehler, McLaughlin, Keyes, & Hasin, 2010; Herek, Gillis, Cogan, 1999; Herek, Gillis, Cogan, Glunt, 1997; Huebner, Rebchook, & Kegeles, 2004; Lea, de Wit, & Reynolds, 2014; McCabe, Bostwick, Hughes, West, & Boyd, 2010; Meyer, 2003). Research has reported that depression in gay men often starts early on in adolescence and continues into young adulthood (Marshal et al., 2011). Depression among young gay men has been associated with prejudice events such as school-based victimization (Burton, Marshal, Chisolm, Sucato, & Friedman, 2013; Russell, Ryan, Toomey, Diaz, & Sanchez, 2011). Young gay men can experience prejudice in their family in the form of rejection, often after disclosing their sexual orientation during adolescence, which in turn can heighten young men's risk for depression (Ryan, Huebner, Diaz, & Sanchez, 2009).

The expectations of discrimination and homophobic rejection can also negatively affect gay men's mental health (Hatzenbuehler, 2009; Meyer, 2003). For example, in an American study of gay men, those who perceived increased homophobia and the world as dangerous for gay men were more likely to report depressive symptoms (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008). Concealment of one's identity can be a strategy adopted by some gay men to ward off potential discrimination and violence (Herek, Chopp, & Strohl, 2007; Meyer, 2003). This strategy can be exhausting and has been reported to increase the risk of emotional distress among gay men (Cohen, Blasey, Taylor, Weiss, & Newman, 2016; Walch, Ngamake, Bovornusvakool, & Walker, 2016). With the persistence of antigay messaging, gay men can have difficulty accepting their sexual orientation and experience inner conflict (Körner et al., 2008; McAndrew & Warne, 2010). As a result, this can heighten internalized homophobia further contributing to the risk for depression (Feinstein, Goldfried, & Davila, 2012; Frost, Parsons, & Nanin, 2007). Self-acceptance is therefore a critical element for gay men's well-being, as is being accepted by others (Ash & Mackereth, 2013).

In addition to the four factors detailed in Meyer's (1995, 2003) minority stress model, a lack of acceptance and rejection from the gay community can also increase the risk for gay men's depression. Particularly at risk of rejection from other gay men are men living with HIV (Courtenay-Quirk, Wolitski, Parsons, Gómez, & Seropositive Urban Men's Study Team, 2006) as well as men from racial/ethnic minority groups (Bowleg, 2012; Haile, Rowell-Cunsolo, Parker, Padilla, & Hansen, 2014; Riggs, 2012). Rejection from the gay community can lead to social isolation, which in turn increases the risk for depression (McAndrew & Warne, 2010; Newman et al., 2008). Gay men living with HIV are also at increased risk for depression across the entire illness trajectory including diagnosis of HIV, initiation of HIV treatment, treatment

failure, diagnosis of AIDS, and/or having a friend diagnosed with AIDS (Körner et al., 2008). The impact of being diagnosed with HIV can also lead to the loss of income, career, relationships, and family and social support (Körner et al., 2008). Health care providers working with HIV positive gay men have confirmed that the isolation and loss of social relationships and family support experienced as a result of this health status are significant triggers for depression (Körner et al., 2008).

Gay men who belong to an ethnic minority are at higher risk for depression. For example, Hispanic cultural norms marginalize gay men because it is feared that they will display effeminate behaviors, violating traditional codes of masculinity (Guareno, 2007). Pressure to conform to such rigid gender norms creates unique discriminatory environments (Guareno, 2007), and gay Hispanic men report higher rates of family rejection and negative mental health outcomes compared with their Caucasian male counterparts (Ryan et al., 2009). An American study of gay Hispanic men reported homophobic experiences during childhood, including being told that gays are not normal people (91%), amid harboring beliefs that their sexual orientation would hurt and embarrass their family (70%; Diaz et al., 2001). These men also experienced discrimination in the gay community; 26% of the men reported feeling unease in environments with primarily gay Caucasian men (Diaz et al., 2001). A study by De Santis, Colin, Vasquez, and McCain (2008) with predominantly gay Hispanic (75%) men reported similar issues in noting that gay Hispanic men who had depressive symptoms were likely to engage in sexual practices with high risks for exposure to HIV.

Research regarding HIV positive gay men and/or ethnic minority gay men is emergent (De Santis et al., 2008) and future work might usefully focus on identifying and addressing the unique depression risk factors among these vulnerable subgroups as a means to improving their mental and physical health.

Suicidality

Defined as thoughts, plans, and/or suicide attempts, suicidality occurs more often in gay men compared with their heterosexual male counterparts (Brennan et al., 2010; Hottes et al., 2016; King et al., 2008). Gay men also consider suicide with a stronger intention to die compared with heterosexual males who experience suicidality (Plöderl, Kralovec, & Fartacek, 2010). In recent years, more Canadian-based gay men have died from suicide than from HIV-related causes (Hottes et al., 2014). The risk factors for suicide include depression and previous suicide attempts, problems with relationships, as well as factors described in the minority stress model such as victimization, rejection, and conflict with one's sexual

identity (Haas et al., 2011; Mustanski & Liu, 2012; Wang et al., 2015). A Swiss study of 762 gay men highlighted three main reasons for suicide attempts: (a) problems with their relationship, (b) accepting one's homosexuality, and (c) family rejection (Wang et al., 2015).

Prejudice events, including the experience of verbal threats and insults, having property damaged, and being physically or sexually assaulted, has been identified as risk factors for suicide among gay youth (Mustanski & Liu, 2012) and adults (Ferlatte et al., 2015). In a study with 350 lesbian, gay, and bisexual participants younger than age 21, gay men experienced significantly more verbal attacks, threats of violence, and objects thrown at them (D'Augelli, Pilkington, & Hershberger, 2002). Important to note, the level of victimization experienced was positively related to mental illness symptoms, and as a result, 42% of male participants disclosed they had experienced suicidal ideation (D'Augelli et al., 2002). In a study of 8,382 Canadian adults identifying as gay and bisexual, a majority of respondents reported experiencing antigay marginalization such as bullying, harassment, physical violence, and workplace discrimination (Ferlatte et al., 2015). These forms of violence were all positively associated with suicidal ideation and attempts (Ferlatte et al., 2015).

Lack of familial support is a strong predictor of suicidality. Gay men who have experienced rejection by their parents when revealing their sexual orientation have heightened risk for suicide attempts (Haas et al., 2011; Ryan et al., 2009; Wang et al., 2015). A study of 224 gay, lesbian, and bisexual youth concluded that individuals who experienced rejection by their family were 8.4 times more likely to report having attempted suicide (Ryan et al., 2009). In contrast, Mustanski and Liu (2012) reported that family support was as a protective factor in lowering the risk for suicide. As previously described, gay men may have difficulties accepting their gay identity because of the society's negative views on homosexuality, and as such gay men can feel compelled to hide their identity and experience inner conflict amid despising their sexual orientation (Körner et al., 2008; McAndrew & Warne, 2010). These thoughts of internalized homophobia have been described as increasing the risk for self-harm among gay men (McLaren, 2016; Plöderl et al., 2014).

The causal relationship between HIV and suicidality is limited due to insufficient longitudinal studies and varying illness definitions and diverse study sample characteristics (Haas et al., 2011). Suicide among gay men who are HIV positive is associated with a recent experience of HIV stigma such as rejection, harassment, and physical violence (Ferlatte, Hottes, Oliffe, Marchand, & Trussler, 2016). Haas et al. (2011) also pointed out that sexual orientation was not information routinely collected for death records; therefore, researchers had to rely on accounts

from the deceased's family and friends to determine the deceased's sexual orientation. As a result, the prevalence of suicide among gay men is approximated and likely underreported.

Gay men who suicide embody diverse complex identities beyond their sexual orientation, and intersectionality research has argued the need to account for multiple social influences in apprehending insights to gay men's suicide. A population study of 8,000 gay Canadian-based men highlighted education, income levels, and ethnicity as factors implicated in respondents depression and suicidality (Ferlatte et al., in press). The risk for a suicide attempt was five times higher among men with low income (under \$30,000 annually) and no university education; suicide attempts were twice as likely for First Nations males compared with Caucasian men (Ferlatte et al., in press). This research illustrates the value of studying and addressing the multiple intersecting social factors on the health disparities experienced by gay men (Ferlatte et al., in press).

Help Seeking

Regardless of sexual orientation, men can be reluctant to seek help for mental health problems (Addis & Mahalik, 2003). An American study reported that less than one quarter (23%) of gay men who attempted suicide sought mental health or medical treatment (Meyer, Teylan, & Schwartz, 2015). For gay men, there are limited specialist health services and this can also be a barrier to help seeking (Ash & Mackereth, 2013; Rutherford, McIntyre, Daley, & Ross, 2012). Reticence for help seeking can stem from gay men's exposure and subsequent resignation in regard to the inadequacies of health care services and the failure to meet their specific needs (Ash & Mackereth, 2013). Unfortunately, gay men who do seek help may experience discrimination in the health care system. A study of 130 U.K.-based respondents revealed that many gay men felt invisible and ignored when services specific to their needs were not available, or when personnel were insensitive to their needs (Ash & Mackereth, 2013). The lack of targeted resources and provider inattentiveness may reflect the low levels of awareness and education regards gay men's health needs. This negatively affects health care patient-provider relationships. For example, gay men who attended clinics for sexually transmitted infections or HIV screening felt stigmatized for their sexual orientation, suggesting they were treated based on generalizations and stereotypes instead of their self-reported sexual practices and overall health (Knight, Shoveller, Oliffe, Gilbert, & Goldenberg, 2012). As a result, gay men may feel "othered" and withhold information from health care providers about their sexual orientation.

Within the context of receiving effective help, a range of potential issues have also been highlighted, including antidepressants' side effects, illicit substance and alcohol overuse, and health care provider misinterpretation of depressive symptoms. For example, erectile dysfunction resulting from pharmaceutical drugs for the treatment of depression can be a deterrent for sexually active gay men (Newman et al., 2008). Substance overuse is at least 1.5 times more common in gay men compared with heterosexual males, and 3.4 times more common when gay men experienced family rejection for their sexual orientation (King et al., 2008; Ryan et al., 2009). Substance overuse has been highlighted by health care providers as an expression of depression among gay men (Centre for Addiction and Mental Health [CAMH], 2007; Cox, 2006; Gay & Lesbian Medical Association [GLMA], 2006). Confounding this, substance overuse and withdrawal symptoms are often similar to somatic depressive symptoms such as sleep, appetite, and weight changes (Bryant et al., 2012). Further complexities exist wherein depression is widely perceived as a stereotypical feminine disorder and gay men's depressive symptoms may be concealed by patients and/or inadvertently missed by health care providers (Michniewicz, Bosson, Lenex, & Chen, 2016).

Implications for Health Care Providers

The education curriculums for health care providers may not adequately equip them to address the needs of gay men (Blackwell, 2015; Gee, 2006; Rutherford et al., 2012; Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). Health care providers working with gay men concede that there is a lack of professional education and training opportunities that specifically address the issues and needs of gay men (Blackwell, 2015; GLMA, 2006; Rutherford et al., 2012). In providing care for gay men, it is essential that health care providers create a safe environment in which men can confide and discuss their sexual orientation and mental health issues openly. Creating such an environment will help health care providers identify those who are at risk for depression and suicidality. In hopes of reducing the risk of suicide among gay men the following five recommendations are provided.

First, establishing trust is essential. Health care providers, by displaying empathy and open-mindedness and withholding judgments can establish rapport with gay men. In this context, it is important not to make assumptions about men's sexual orientation (Blackwell, 2015). For example, some men may have sex with men, but not identified as gay. Diverse degrees of "outness" exist within the gay community and as such many men may feel reluctant to disclose their sexuality to a health care

provider. As such, it is important for providers to discuss confidentiality with their patients, including how patient information is recorded and potentially shared.

CAMH (2007) provides an online guide for health care providers to use when assessing lesbian, gay, bisexual, and transgender (LGBT) individuals. The guide contains a patient intake questionnaire and provides health care providers with rationales for asking specific questions to help them understand gay men's health issues. The questionnaire covers issues including mental health, substance use, HIV, support system, and involvement in the gay community. The template can be filled out by the patient or by conversing with the patient during the initial clinic visit. The use of the questionnaire can help facilitate an open discussion with the patient about their sexual orientation and mental health history. This approach along with the reassurance of confidentiality helps establish trust with the patient, improving the likelihood that the patient will feel safe and secure enough to disclose mental health concerns and, ideally, return for follow-up. 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 the use of appropriate language amid identifying and confronting any internalized discriminatory beliefs about gay men and their health issues (GLMA, 2006). Learning to identify and confront internalized discriminatory beliefs is important because some health providers may have inaccurate perceptions about gay patients due to their lack of awareness of LGBT issues (GLMA, 2006). This lack of awareness can also result in the health provider being perceived as insensitive when providing care (Ash & Mackereth, 2013).

Second, because family support has been identified as a protective factor in lowering the risk for depression and suicidality (Mustanski & Liu, 2012), health care providers should explore the degree to which the man is "out" to his family and friends, and the extent of his support system. Because many adult gay men rely on friends for social support, a formal assessment of social support networks is also likely to be beneficial. It may be helpful for health care providers to explore men's level and type of participation in gay communities as well. Identifying with the gay community can correlate with improved mental health (GLMA, 2006; Ryan et al., 2009). Health care providers should ask open-ended questions about the patient's disclosure of their sexual orientation, how it was received, how it affected their relationships, if drugs and alcohol were involved, and if their mental health was affected (CAMH, 2007). This will assist health care providers to evaluate the patient's self-acceptance and potential for social isolation. The lack of self-acceptance and the disintegration of social relationships have been identified as risk factors for depression (Körner et al., 2008).

Patients may turn to alcohol and substances to cope with rejection, social isolation, or conflicts related to their sexual identity (CAMH, 2007). A strong support system is necessary in recovering from substance and/or mental health issues (CAMH, 2007). Health care providers can effectively intervene by providing information and community resources to extend health resources beyond their services.

Third, because gay men are at higher risk for substance overuse (King et al., 2008), they should be assessed for substance overuse, and its potential to be used to self-medicate depression and/or suicidality, and alleviate distress. After exploring a patient's sexual orientation and history, health care providers can invite a dialogue about the patterns and situations involved with the use of substances (SAMHSA, 2012). Understanding these associations and relationships will help health care providers identify if the individual is using substances to cope with unresolved mental health issues. For example, gay men may use substances to blunt strong emotions, family reactions to their sexual orientation, and social isolation experienced after coming out (CAMH, 2007). Gay men may also overuse substances to express or suppress same-sex desire (CAMH, 2007; SAMHSA, 2012) as well as to enhance sexual pleasure (Cox, 2006; Mattison, Ross, Wolfson, & Franklin, 2001; Semple, Patterson, & Grant, 2002). Indeed, gay men may use substances purely for enjoyment and to socialize, given substances are often present at gay social venues (CAMH, 2007; SAMHSA, 2012). Being aware of a patient's substance use history is important because substance overuse may mask symptoms, and complicate making a diagnosis and/or providing treatment(s). Health care providers should attempt to offer gay friendly support and treatment options for those overusing substances. Health care providers can refer to online guides created by CAMH (2007) and SAMHSA (2012) for recommendation in regard to assessing and treating gay men with substance overuse. The CAMH's guide (available at http://www.camhx.ca/Publications/Resources_for_Professionals/ARQ2/arq2.pdf) was developed through a process of community-based research to guide health care providers in creating an environment wherein LGBT individuals can be comfortable self-disclosing. Being aware of a patient's sexual orientation is pertinent in effective treatment and counselling (CAMH, 2007). Patients may not feel comfortable in disclosing their sexual orientation to health care providers. Some of the factors contributing to this are not feeling safe, being judged by staff or other patients, and the use of biased and exclusive language (Ash & Mackereth, 2013; Blackwell, 2015; CAMH, 2007). Although health care providers may appreciate sexual orientation issues, they may lack finesse when inquiring about their patient's sexual orientation (CAMH, 2007;

Rutherford et al., 2012). To help overcome patient self-disclosure barriers, the CAMH (2007) provides a guide with questions for health care providers to use during their assessments. For example, one question asks if the reason for getting help for substance use is related to any issues around their sexual orientation. As noted earlier, gay men may overuse substances for various reasons other than recreational enjoyment. The guide provides probe questions for health care providers to ask during interactions in soliciting more depth and context about particular practices. For example, the “in what way?” is a recommended follow-up probe when patients disclose that they use alcohol and/or other drugs to cope with specific issues. This helps the health care provider more fully assess and understand the patient’s relationship with alcohol and/or drugs.

The SAMHSA (2012) resource (available at <https://store.samhsa.gov/shin/content/SMA12-4104/SMA12-4104.pdf>) was developed by a panel of experts to guide health care providers’ work in substance overuse with LGBT populations. It is an in-depth guide comprising three sections. The first section provides an overview of substance use within the LGBT community, legal issues related to treating LGBT patients, and treatment approaches. The second section guides health care provider’s round coming out processes for gay men and clinical issues specific to gay men. The third section, directed to program administrators, provides recommendations for policies and procedures, training, and education. Highlighted is the use of sensitive language as a sign of respect in creating and facilitating a safe environment for patients (SAMHSA, 2012). Health care providers should ask patients how they want to be addressed as some may react to the term “homosexual” because it triggers memories about homosexuality being positioned as a psychiatric disorder (SAMHSA, 2012). Additionally, men who have sex with men may not identify as being gay or bisexual (Meyer & Wilson, 2009). Health care providers should be aware that nonverbal gestures such as rainbow flags or gay affirming posters (such as posters featuring gay couples) can be used to signal safe environments (SAMHSA, 2012) and can help break down barriers (Ash & Mackereth, 2013). Establishing and maintaining confidentiality is another important aspect of assessing and treating gay men effectively. This can be advanced by creating confidentiality policies for staff and patients, and by educating patients about laws that protect their confidentiality (SAMHSA, 2012).

Fourth, depressive symptoms and suicidality often times begins in adolescence, and gay youth can be a subgroup especially vulnerable to suicide. Parents need to be educated on how rejecting behaviors can negatively affect the mental health of their child (Ryan et al., 2009). A good source of information to provide parents is the

Parents and Friends of Lesbians and Gays (PFLAG) Canada website (www.pflagcanada.ca). PFLAG Canada is a national organization that helps support, educate, and provide resources for individuals with issues round sexual orientation, gender identity, and gender expression and provides an extensive information document for parents whose child identifies as gay (PFLAG Canada, 2010). The document covers topics including what the parent and the child may be experiencing, how to support the child, and resources available for the family.

Finally, health care providers should schedule frequent follow-up because the capacity to monitor and manage depression and/or suicidality effectively is significantly improved by regular consultations (Newman et al., 2008). In terms of screening for depression, there is no tool specifically designed for assessing gay men. While health care providers routinely use the Beck’s Depression Inventory or the Patient Health Questionnaire wherein the items correspond to the *Diagnostic and Statistical Manual for Mental Disorders—Fifth edition*, there is increasing evidence that male-specific tools can aid male depression assessment. Among them the Gotland Male Depression Scale includes questions about distress, irritability, aggression, alcohol use, and anger attacks (Gagnon & Oliffe, 2015; Zierau, Bille, Rutz, & Bech, 2002) and the male depression risk tool includes similar items more relevant to young men (Rice, Fallon, Aucote, & Möller-Leimkühler, 2013). Nevertheless, it is important that health care providers do not rely entirely on such tools. For example, in a study of health care providers who routinely provided care for gay men, discrepancies between the classic textbook depressive symptoms and the psychosocial presentation of depression in gay men’s lives were highlighted (Körner et al., 2008). Depression among gay men rarely manifested in classic symptoms of anorexia, weight loss, self-worthlessness, and poor sleep patterns. Instead, depression emerged as agitation and anxiety-related symptoms (Körner et al., 2008). Rather than relying on standardized depression screening tools, these health care providers relied on their experience and relationships with patients inquiring about the patient’s life and depressive symptoms in order to identify moods and/or social problems related to gay men’s depression (Körner et al., 2008).

To help assess and determine the severity of gay men’s suicidality, health care providers can use 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 man’s suicidality. Similar to evaluating depression, health care providers should directly engage

gay men in conversations about suicidality. Open-ended questions that norm suicidality such as “many men experience thoughts about suicide, what experiences do you have around such thoughts?” can provide gay men permission to self-disclose about ordinarily taboo topics.

Knowledge Gaps

Population-based studies have provided strong evidence that depression and suicidality among gay men is a significant issue (Haas et al., 2011; Hottes et al., 2014; King et al., 2008); however, these data likely underreport the magnitude of the issue. In addition, depression and suicide prevention strategies targeting gay men are poorly understood and underdeveloped. A literature view by Haas et al. (2011) suggested the lack of information may reflect sparse funding for studies focused on gay men's mental health and the absence of gender and sexual orientation data in many studies addressing mental illness. There is also scant knowledge about the specific risk and protective factors that influence depression and suicidality among gay men (Haas et al., 2011). Health care providers have important opportunities to contribute insights and hypotheses about the underlying problems and challenges as a means to addressing these knowledge gaps. Trust and continuity of care is central to garnering efficiencies in gay men's mental health services and understanding the role of health care providers in reducing depression and suicidality among this vulnerable subgroup.

Conclusion

Gay men are vulnerable to depression and suicidality for a variety of unique and complex reasons. Health care providers can champion gay men's health services by extending the focus on sexually transmitted infections and HIV screening and treatment to address gay men's mental health. By being cognizant of the risk factors, stigma, and vulnerabilities gay men face, health care providers can ably lead gay men's depression and suicide prevention efforts.

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