

Chapter 11

Sam: An Older, Gay Man Who Appears Depressed



Sam identifies as a 68-year-old Caucasian, gay, cisgender male. He has bright white hair and an athletic build and stands just over 6 feet tall. Despite his apparent excellent physical health, he walked into the therapy room slowly and looked very tired. He stated his primary care doctor referred him to this small group psychotherapy practice after his doctor ruled out a physical reason for his symptoms. According to Sam, about 4–6 weeks ago, he began feeling “very tired,” had difficulty concentrating, and stopped exercising, which he had done on average of five times a week “for as long as [he] could remember.” Although he had stopped exercising, he had lost about 10 lbs. over the last several months, which he stated was because “I just don’t have the energy to eat.” In addition, Sam said that he had been staying home more, and not attending social functions or dinners with friends. He states that the activities he used to enjoy are “just not the same and it feels like such an effort to go and pretend I am having fun when I am not.” When asked about any recent changes in his life, he could not think of any immediate changes. However, during the history gathering stage of the interview, he discussed several significant changes that had occurred in the last 5 years.

Five years ago, he moved his mother into a nursing home near to his home and became primarily responsible for her care. Although he has three other siblings, they are estranged from him and have been since he came out as gay almost 25 years ago. He described his family as a very conservative “Bible Belt” family. They would not accept his sexual orientation. After his father died about 10 years ago, his mother began to reconnect with Sam, and they worked on rebuilding their relationship. After only 9 months after his mother’s move near him, she died quite suddenly, and he felt cheated since he felt like it was “finally [their] time together” while at the same time some relief since her care was quite exhausting.

About 8 years ago when he turned 65, Sam decided to retire. He looked forward to spending time with his partner of 17 years who was about 7 years older and who was already retired. For 2 years, they traveled and attended concerts and shows that they “had been meaning to see.” They did other activities together that they had

“never gotten to because we were both working so much.” However, about 2 years later, his partner suffered a stroke and went into a coma and died 2 months later.

Sam feels he coped well at the beginning. He stated that his friends and his community were a wonderful source of support for him. However, it has been over a year since his partner died, and he now is experiencing the symptoms described above that led him to seek consultation from his doctor. He and his partner, while connected to friends in their community, still lived a relatively “solitary life.” They had no children, and both of their families had distanced themselves from them decades previously. Many of his peers are now not around in the same way that they 10–15 years ago. Many have retired and moved closer to their grandchildren, frequently travel, or have moved to warmer climates. Without work in his life, Sam feels like he has “no purpose.” He cannot find the motivation to even get up some days, as he often questions “What is the point?”

Sam is seeking services to help him “at least feel some energy” and interest in some of his previously enjoyable activities, such as running, traveling, and enjoying the arts. He stated that this was the time he had planned to “really enjoy life,” but now he states he cannot find the joy he once had.

Applying the Six Steps of EBP to the Case

As you will recall from Chap. 2, the steps of EBP are:

1. Drawing on client needs and circumstances learned in a thorough assessment, identify answerable practice questions and related research information needs.
2. Efficiently locate relevant research knowledge.
3. Critically appraise the quality and applicability of this knowledge to the client’s needs and circumstances.
4. Actively and collaboratively discuss the research results with the client to determine how likely effective options fit with the client’s values, preferences, and culture.
5. Synthesizing the clinical needs and circumstances with the views of the client and the relevant research, develop a plan of intervention considering available options.
6. Implement the intervention.

We will use each of these steps as the outline for examining how to apply the EBP practice decision-making model in clinical practice.

Step 1: Drawing on Client Needs and Circumstances Learned in a Thorough Assessment, Identify Answerable Practice Questions and Related Research Information Needs

In the first step of EBP, the clinician must work with the client to identify the primary clinical issue around which to focus the EBP process. As discussed in Chap. 4 on assessment, it is essential to work with your client to identify the issue that he or she feels is the highest priority. This preliminary step of assessment is the hidden foundation of the EBP practice decision-making process.

The client must be actively engaged in the assessment process. Therefore, in working with Sam, it is essential to discuss with him what his personal priorities are and what does he feel he is most motivated to address in treatment. In Sam's situation, he has several areas that could be the focus of the clinical work with him, including grief work around the losses of his partner and his mother, his depressive symptoms, his life transition from working to retirement, his estrangement from his family, and his social isolation. In conversations with Sam, he identifies that his depressive symptoms are the highest priority for him at this time. He states that while he knows that the other areas are caused by his grief, including his isolation and all of the other previously identified problem areas, he does not feel he has "the energy right now to tackle" those until he can "get some energy back." As such, he and the clinical social worker agree that the primary treatment goal will be to help him increase his coping strategies to manage more effectively his depressive symptoms. Therefore, the practice question is: What are effective treatments for depression with older gay males?

In the *PICO* model, the *Population* is older gay men with depression. The *Interventions* under consideration are psychotherapies and similar psychosocial interventions as well as medications. *Comparisons* would be between different therapies or psychosocial interventions and among medications and combinations of medications and psychosocial therapies. The *Outcomes* would be increasing Sam's energy and social involvement. The focus for Sam is on determining likely effective treatment options.

Step 2: Efficiently Locate Relevant Research Knowledge

The search process began with web sites that provide summative knowledge regarding mental health and effective treatments. Starting with the Cochrane Collaboration Library (www.cochranelibrary.com), the first search used the following keywords in the search engine: older, gay, men/man, and depression. However, no results were returned by this search. A second search using just the terms depression, older adult, and males returned several unrelated articles; oddly none were specific to depression though one addressed sleep problems. While the worker attempted to conduct

a search that combined the multiple aspects of Sam's identity and needs, these searches did not immediately lead to systematic reviews that directly corresponded to his situation and characteristics.

However, by broadening the search further using the terms depression, males, and older adults, numerous articles were identified by the web site's search engine that appeared to address older adults with depression, the primary clinical question. Unfortunately, many of the reviews were dated. A systematic review (SR) by Wilson, Mottram, Sivananthan, and Nightingale (2001) examined antidepressant medications for elders who have depression. They report that tricyclic antidepressants (odds ratio 0.32; 95% CI, 0.21–0.47), as well as SSRIs (OR 0.51; 95% CI, 0.36–0.72) and MAO inhibitors (OR 0.17; 95% CI, 0.07–0.39), were all more effective than were placebos. (These odds ratios indicate that placebos are 0.32 time *less* likely to help than are tricyclic medications; 0.51 times less likely to be beneficial than are SSRIs; and 0.17 times less likely to be beneficial than are MAO inhibitor medications. All the 95% confidence intervals are small compared to the OR values, indicating that the results are likely to be meaningful in the larger population.) Overall, SSRIs and MAO inhibitors were more effective than placebo. Tricyclic medications also appeared effective but often had side effects participants did not like.

The authors of this review, however, concluded there are too few studies to draw any firm conclusions about any one's superiority over another. However, the authors did say that there is some preliminary support for the use of CBT with older adults to manage depressive symptoms. Similar results in another, later, SR by Mottram, Wilson, and Strobl (2006) lead the social worker to consider that a referral for a medication consult would be one possible course to offer Sam for consideration.

Also regarding medication, there is a third Cochrane SR regarding extended maintenance use of antidepressant medications. Wilkinson and Izmeth (2016) found that:

The long-term benefits and harm of continuing antidepressant medication in the prevention of recurrence of depression in older people are not clear and no firm treatment recommendations can be made on the basis of this review. Continuing antidepressant medication for 12 months appears to be helpful with no increased harms; however, this was based on only three small studies, relatively few participants, use of a range of antidepressant classes, and clinically heterogeneous populations. Comparisons at other time points did not reach statistical significance. (Authors' conclusions)

Extended use of antidepressants does not seem optimal but again would have to be determined by Sam and his prescribing physician.

Another systematic review by Stek, van der Wurff, Hoogendijk, and Beekman (2001) found that there is not enough research on electroconvulsive therapy (ECT) to recommend it as a treatment of depression in older adults.

Finally, there was a systematic review of the literature on psychosocial treatments for depression in older adults. Gay men were not specifically addressed in this review. Wilson, Mottram, and Vassilas (2008) included nine trials in their SR that compared cognitive-behavioral therapy (CBT) and psychodynamic psychother-

apies. These two types of therapies were the only ones included as there were no available studies on other forms of psychotherapy to include in the review. Seven studies compared CBT versus controls, but none of the psychodynamic trials used untreated control groups:

Based on five trials (153 participants), cognitive behavioural therapy was more effective than waiting list controls (WMD -9.85, 95% CI -11.97 to -7.73). Only three small trials compared psychodynamic therapy with CBT, with no significant difference in treatment effect indicated between the two types of psychotherapeutic treatment. Based on three trials with usable data, CBT was superior to active control interventions when using the Hamilton Depression Rating Scale (WMD -5.69, 95% CI -11.04 to -0.35), but equivalent when using the Geriatric Depression Scale (WMD -2.00, 95% CI -5.31 to 1.32). (Wilson et al., 2008, para 9)

The Wilson et al. (2008) review indicates that there is good research support for both CBT and psychodynamic intervention with older depressed males. The weighted mean differences are all quite large. However, the 95% confidence intervals are also large, indicating that results may not be the same in the larger population. These are important options to discuss with the client.

A second search using the SAMHSA web site led to toolkits created by SAMHSA ((2011), p. 10) to address depression in older adults that can be downloaded for free (<https://store.samhsa.gov/product/Treatment-of-Depression-in-Older-Adults-Evidence-Based-Practices-EBP-KIT/SMA11-4631CD-DVD>). Among these resources, the first document called “Depression in older adults: Key issues” highlights the following interventions to address depression in this population: (1) psychotherapy interventions including cognitive-behavioral therapy, behavioral therapy, problem-solving treatment, interpersonal psychotherapy, reminiscence therapy, and cognitive bibliotherapy; (2) antidepressant medications; (3) multidisciplinary geriatric mental health outreach services; and (4) collaborative and integrated mental and physical health care. Again, the studies on which this conclusion is based are not fully detailed and differ somewhat from the later Cochrane Library SR results for psychological treatments for depression.

Neither of these research summaries directly explored any potential differences for gay men. It is not clear whether psychological treatments would, or would not, be differentially effective for gay men. However, the impact of societal oppression for gays is evident in Sam’s family life and may influence the psychosocial sources of resilience and risk even in his later life. These earlier studies most likely used less stringent review standards than do current Cochrane Collaboration systematic reviews.

A general search on the web site Google Scholar using the keywords depression older gay males brings up several books that address this question, such as *Gay and Lesbian Aging: Research and Future Directions* by Herdt and De Vries (2004). However, if these books are not easily accessible, they may not be as immediately useful. In addition, without very careful review, the quality of the evidence on which such books base their conclusions is unclear. Therefore, it appears that the core EBM/EBP summative web sites are the most fruitful in the search for information on how to best help Sam address his depression.

Step 3: Critically Appraise the Quality and Applicability of This Knowledge to the Client's Needs and Situation

In conducting step 3 of the EBP process, it is essential to go back and see if the clinician can look to see the quality of the research provided in these summative studies. The Wilson et al. (2008) systematic review on the Cochrane Library site provides full details on all included and excluded studies – in the full review (which in the United States requires a paid subscription to access). For the psychotherapy interventions, the authors state that their findings are based on a meta-analysis of seven studies, yet the meta-analysis included a small number of trials and that the “review shows that there is relatively little research in this field and care must be taken in generalising what evidence there is to clinical populations” (para. 7). Samples sizes are also small, and there is no mention if any older gay men were included in the studies.

The information from the SAMHSA web site is less specific. The report lists recommendations but does not provide details on each included study. As a result, there is not much information on which to base a critical appraisal about the quality of the studies included in the report. It is an expert summary of research, compiled by a credible source, and includes a large number of studies, but it is not fully transparent in its methodology. Such summaries might be considered Level 5 expert opinion, the lowest grade of evidence in the EBM/EBP hierarchy. On the other hand, the conclusions of these experts are at least partly based on research. The lack of full detail undermines their credibility and makes them less useful as guides for clinical practice. Transparency and detail are real strengths of systematic reviews.

While it is difficult to find specific information on the design quality of some of these studies, the participants included in the studies are similar to Sam in terms of age and primary presenting issue. On the other hand, they do not specifically identify unique characteristics or challenges associated with being gay. That is, the populations included in these studies are not an exact fit with Sam's personal characteristics. Given what is available, it appears that this research may be a relatively good fit for Sam, albeit limited in the number of studies and in information on gay older adults.

Step 4: Actively and Collaboratively Discuss the Research Results with the Client to Determine How Likely Effective Options Fit with the Client's Values, Preferences, and Culture

In the next session with Sam, the clinical social worker had a conversation with Sam about the located research results. This conversation would include sharing with him with a summary of the information found and offer some approaches for consideration. The two forms of psychotherapy and medications found in the searches would need to be described in sufficient detail for Sam to understand his options,

their likely benefits, and their potential costs and side effects. The plain language summaries of the Cochrane Collaboration systematic reviews provide useful language to help share this information with the client for their consideration.

In addition to the information on psychotherapy research, the clinician would also want to share with him the information on the use of medication and discuss his feelings and thoughts about this type of intervention. With regard to medication and psychotherapy, the clinician should be prepared to discuss the pros and cons of each approach and how those align with Sam's wishes, values, and circumstances and be ready to answer any questions that he might have. During this conversation, Sam stated that he was willing to try medication. He added that he would rather work with his current primary care doctor rather than starting over with a new psychiatrist.

Finally, although support groups and social supports were not specifically listed in the research, based on the clinical social worker's experiences, she believes that expanding his social network in an effort to decrease his isolation would be helpful to him in further alleviating his depressive symptoms. This is consistent with Sam's concerns about social isolation, although this issue was not specifically addressed in the outcome research. The clinical social worker therefore suggests a group therapy or support group intervention, providing him with an array of options regarding the focus and/or composition of the group. For example, he may want to have a support group that is focused on grief and loss or one that is specifically targeted toward individuals who identify as GLBTQI or one that is aimed at older adults in general or a combination of any of the above. Sam says that he is open to this idea, and the clinical social worker and Sam agree that both will do some searching for group options. After further discussion, Sam can then decide which one feels is the best fit for him.

It would be important to point out that the studies did not include gay men and to ask Sam what he thinks of this omission. The goal is to be sure the client views the best evidence as truly applicable to him or her. It is not clear that the effectiveness of these treatments is different for gay men or lesbians, but one of the points of EBM/EBP is that differences we may not consider important may prove to have significant impact when rigorously researched.

Step 5: Synthesizing the Client's Clinical Needs and Circumstances with the Relevant Research, Finalize a Shared Plan of Intervention Collaboratively with the Client

Given the available research, it appears that psychopharmacological treatments and/or psychotherapy are the best options for helping to address Sam's depression. The next consideration is the expertise of the clinician and the availability of services one cannot personally provide. This aspect of planning involves whether to not the clinical social worker is trained and competent to provide the appropriate services or has them available within the agency or through consultation arrangements. If the

services are available, treatment may begin immediately. Clinicians must make a referral to a provider with appropriate expertise if such services are not directly available. In some cases, making such a referral will involve locating providers of the service.

In Sam's case, the assessing clinical social worker has expertise in both cognitive-behavioral therapies and in psychodynamically based psychotherapies. She also has experience working with individuals around depression and loss.

Based on this conversation, the following treatment plan emerges and is agreed upon by both Sam and the clinical social worker.

1. Sam will attend weekly brief psychodynamically oriented psychotherapy, contracting for 3 months. Within the therapy, the focus will be initially on his depressive symptoms, his understanding of their origins and helping him to develop more effective strategies to cope with the depressive feelings.
2. Sam will set up an appointment with his doctor and discuss the potential of starting him on an antidepressant, taking into consideration his age and the side effect profile. The social worker will consult with the doctor on a regular basis regarding possible side effects, medication efficacy, and changes in symptoms. (Sam signs the consent forms to authorize this communication.)
3. Sam and the social worker will both ask others they know about group therapy or support group options in the community. From the available options, Sam will pick one of the groups that he feels would most suit his personality and comfort level.

Step 6: Implement the Intervention

Sam and the clinical social worker identified a start date for the interventions to begin and the parameters around the treatment, including a targeted termination date. Sam and his clinical social worker agreed to monitor his energy level and social involvement on a session-by-session basis. They agreed that if progress is not apparent in a month, a more formal tracking of his progress would be initiated.

Alternately, Sam's depression could have been quantitatively assessed using a standardized measure of depression completed at regular intervals. This would allow for quantitative evaluation of progress using a single-case evaluation approach. Sam was comfortable with an ongoing, narrative assessment of his situation.

References

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