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Clinician Approaches and Strategies for Engaging Older Men in Depression Care

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Abstract

OBJECTIVE—The aim of this study is to explore primary care physicians' (PCPs) and depression care managers' (DCMs) approaches to diagnosing and treating depression in older men. The authors focus on older men because studies have shown that they are under-treated compared with women and younger groups. The authors contribute to previous research by identifying facilitators of care for older men from the perspective of clinicians.

METHODS—Participants in this study were part of the Improving Mood-Promoting access to Collaborative Treatment (IMPACT) trial, an effectiveness study of collaborative care for late-life depression in 18 diverse primary care practices. Nine PCPs and 11 DCMs were interviewed to collect information on specific roles in caring for depressed patients and their experiences in working with depressed older men. All interviews were tape-recorded, transcribed verbatim and analyzed thematically in several steps using standard qualitative data analysis techniques.

RESULTS—The authors identified three general approaches to building trust and talking about the depression: 1) an indirect approach ("call it something else"), 2) a gradual approach ("building up to depression"), and 3) a direct approach ("shock and awe"). The authors also found specific strategies that PCPs and DCMs used to manage depression among elderly male patients, such as increased monitoring of mood, treating somatic symptoms first, medicalizing depression, and enlisting the cooperation of family. In our interviews, enlisting family involvement was the most prominent strategy used by clinicians.

CONCLUSIONS—A variety of approaches and strategies are used by clinicians for diagnosing and treating depressed older men. Clinicians change strategies as a response to a patient's compliance with treatment and the decision about which strategy to pursue is usually made on an "on-the-go" basis throughout the course of clinician-patient interaction. Based on clinicians' experience, depression management requires concerted efforts and persistence, and the family seems to play an important role in how older men receive the diagnosis of depression and adhere to clinicians' prescribed treatment. However, more research is needed to discover the best way of engaging and working with family members to facilitate effective depression care for older adults.

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Keywords

Clinicians' approaches; depression; older men; facilitators of care; qualitative methods

INTRODUCTION

The Institute of Medicine "Chasm" report concluded that, despite the advancements of modern medicine in developing pharmacologic and behavioral treatments for most chronic medical disorders, few patients receive optimal treatment¹. For depression, these gaps exist despite the development of effective intervention models for primary care^{2, 3}. There are many areas for quality improvement, from the initial identification and diagnosis of depression to appropriate acute and maintenance therapy. Along pathways to depression care, there are multiple points for improvement in the quality of care and multiple stakeholders in this process⁴.

Understanding the barriers and facilitators of care among older men is important for several reasons. When compared with older women, older men are less likely to receive a diagnosis of or treatment for their depression⁵. Lower rates of depression treatment in older men may contribute to the elevated risk of suicide in this population⁶. When effective treatments are made available to older men, including men from ethnic minority groups, the treatments seem to be as beneficial as they are for women⁷. The literature suggests that these differential rates of diagnosis and treatment are due to differences in the care-seeking behaviors of depressed women and men, specifically in terms of gender roles and ideologies. For example, some studies suggest that traditional attitudes toward masculinity are related to negative attitudes toward depression and help seeking^{8, 9}. In general, past research has found that men have lower rates of health service utilization and are less likely to seek mental health services¹⁰⁻¹². A number of other factors may also contribute to reduced help seeking for depression among older men, including perceived stigma⁵, a traditional masculine self-image that emphasizes independence and stoicism¹³, the experience of depression in less typical ways⁵, and aversion to antidepressant medications.

However, less is known about the role of clinicians in influencing gender differences with respect to depression. Although the studies of physicians are not focused specifically on older men, they have found additional barriers to diagnosis and treatment of depression, ranging from systemic or organizational (e.g. fragmentation of mental health system, reimbursement), qualities of the patient-physician interaction (i.e., physician difficulty with recognizing presentation of distress, competing demands, patient resistance), and the expertise of primary care physicians themselves^{14, 15}.

Even though clinicians are important stakeholders in the process of depression care, only a handful of prior studies have examined their perspectives to identify barriers and facilitators of care. Although physicians view depression care as part of their clinical responsibility, they cite a number of barriers to diagnosis and treatment, including lack of knowledge^{16, 17}, therapeutic nihilism¹⁶, medical complexity when depression co-exists with other problems, and constraints of practice settings, such as lack of sufficient referral resources¹⁶. A few studies have delved more deeply into how physicians approach clinical care of persons with depression in an effort to overcome these barriers. For example, one focus group study of PCPs and their approach to depression diagnosis found that physicians used three different approaches: a) a biomedical exclusionary approach that prioritizes the exclusion of physical causes, b) a mental health approach that emphasizes psychosocial issues, and c) a synergistic approach that simultaneously pursues both physical and psychosocial causes¹⁸. One study found that general practitioners viewed the depression label as potentially stigmatizing and often used alternative language to label the problem and "sell the diagnosis"¹⁶. A recent mixed-methods study of 389

primary care office visits with older adults found that although 50 % of the patients had significant depression symptoms, clinicians only discussed mental health topics in 22 % of the visits¹⁷. And when mental health topics were discussed, the typical discussion lasted about 2 minutes. Given these time limitations in ‘real world’ practice, it is crucial to ‘make the most’ of the limited time primary care providers have to recognize depression and to effectively engage their patients in treatment.

The study reported here draws on 20 in-depth interviews with clinicians. The aim of this qualitative study was to move beyond an account of barriers to focus specifically on identifying approaches that PCPs and depression care managers (DCMs) treating depressed older adults use to engage older men in depression care. We focus specifically on older men because previous work has shown that they suffer from higher levels of undertreatment than do younger age groups and that men may differ from women with some gender-specific barriers to help seeking and care for depression^{5, 13}. We contribute to this body of literature by identifying facilitators of care for older men from the perspective of clinicians. This study also builds upon a prior published work describing challenges clinicians perceive in diagnosing and treating depression in older men⁵.

METHODS

The methods for this study have been previously described⁵. Participants in the study were part of the Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) study, an effective study of collaborative care for late-life depression in 18 diverse primary care practices. As part of the study, participating PCPs who referred patients, and DCMs who provided depression care were interviewed. Although the format of the interviews with these two groups differed somewhat (focusing on their specific roles in caring for depressed patients), all were queried about the same topic – their experiences in working with depressed older men. All interviews were tape-recorded and transcribed verbatim. Interviews with each of the two groups are now described in more detail.

Interviews with PCPs

After the completion of IMPACT, a convenience sample of eight PCPs (six men and two women, all family practice physicians or internists) who had referred patients to IMPACT study were identified at two of the participating study sites (group model HMO clinics in Northern and Southern California). Semistructured qualitative interviews were conducted in participants’ offices (six interviews) or by telephone (two interviews). An interview guide was developed and standard techniques for qualitative interviewing were used¹⁹. Topics included physician training and background, challenges faced in care of depressed older men, perceptions of gender similarities or differences in depression care, and experiences in referring older men for the IMPACT study. Interviews lasted 30-60 minutes. For this study, one PCP unaffiliated with IMPACT study who participated in a pilot interview is also included, giving a total of nine PCPs.

Interviews with DCMs

All 11 active IMPACT DCMs who worked in 18 primary care clinics in five states were interviewed through telephone during the treatment phase of the project²⁰. All were women, including nine nurses and two psychologists. The 60-90 minute qualitative interview focused on an array of issues related to performing the role of care manager for older depressed adults in primary care settings. A section of the interview focused on patient characteristics, including gender, and their relationship to identification and treatment of depression. Open-ended questions in this section explored how DCMs think age affects the way a person answers questions about depression symptoms, how gender affects a person's answers to such questions,

and what care managers might have noticed about communication styles among patients who might influence whether their depression gets recognized. Responses pertaining to gender-specific factors in recognizing and treating late-life depression were examined for this paper.

Qualitative analysis

Transcribed interviews were analyzed thematically in several steps using standard qualitative data analysis techniques²¹. In the first step, two of the authors reviewed the transcripts and via open coding identified repeating patterns (i.e., themes) related to how study participants' clinician's talked about their approach to working with older depressed men. Initial coding was done by each coder independently. The lists of themes each recognized were then reviewed, discussed and compared by all authors. This resulted in the identification of three general approaches to talking with men about their depression, along with a number of additional specific strategies that particular participants used to engage men in depression treatment. Finally, two of the authors systematically coded these themes by hand in all the interviews to index the data to facilitate its retrieval and the analysis process. Illustrative examples and typical quotes for each theme are noted in the following text.

Written informed consent was obtained from all study subjects and the study was approved by the Institutional Review Boards at Kaiser Permanente, University of California, Los Angeles, and University of California, Davis.

RESULTS

In the sections that follow, we first describe the three general approaches that the clinical staff (PCPs and DCMs) used to talk with older men about their depression. We then describe a number of specific strategies, highlighting the theme of family involvement in care and how this strategy was used by clinicians to engage older men in depression care. It is important to emphasize the analytic distinction that we are making between "approach" and "strategy." In using the term "approach," we refer to a participant's general philosophy or method in dealing with or in broaching the diagnosis and management of depression among elderly male patients. We thus make an analytical distinction between a health worker's approach and the particular strategies or behaviors that the health worker uses in the course of diagnosing and managing depression. Regardless of the general approach used, all these participants all relied on various strategies to get patients to consider and accept the depression diagnosis and to engage them to initiate and participate in the treatment.

Clinicians' Approaches to Engaging Older Men

Clinicians told us that building rapport and establishing trust with patients, and often with their families, were essential for successful and effective depression care. In further exploring this issue, it became clear that this rapport and trust was pursued in different ways; PCPs and DCMs had distinct approaches they used with patients when thinking depression may underlie a chief complaint or recurrent office visits. Clinicians emphasized the paramount importance of how depression was framed and the specific language that was used during their discussion with older men to negotiate a way of talking about the problem. Within our sample, there was considerable variability in how clinicians actually went about this clinical task, reflecting in part the value (whether positive or negative) that they placed on the use of the diagnostic term depression. As said by one of our physicians, the term "[depression] ...has got a lot of emotional baggage with it." Clinicians mentioned that the emotional baggage of depression reflects both lay connotations of the term (e.g., emotions, feelings) as well as the potentially stigmatizing consequences of this for older men⁵.

In further analyzing this variability, we identified three general approaches to building rapport or trust and talking about the problem: 1) an indirect approach in which there was an avoidance of the term depression and a preference for alternative language (“call it something else”), 2) a gradual approach in which patients were brought around to the diagnosis in a slow and measured fashion (“building up to depression”), and 3) a direct approach prioritizing early and sometimes forceful use of term “depression” to educate patients (“shock and awe”).

Indirect Approach: Call It Something Else

A common approach PCPs and DCMs described was an indirect one that focused primarily on discussing depression symptoms (particularly somatic symptoms such as lack of energy or fatigue) without referring to the term depression. This allowed patients to express themselves about how and what they felt in an open-ended fashion and prompted the patient's feedback about potential treatment of the symptoms they endorsed. As one physician told us, “I try to put the patient at ease. To inquire how they are feeling regardless of what the presenting complaint is... getting some sense of how they are feeling on that particular day and giving them the opportunity to talk at some length.” Clinicians who espoused this indirect approach were more likely to continue to circumvent the term depression during their interaction with patients. As a physician with >20 years of experience put it: “sometimes you have to use words other than depression... you could substitute ‘stress,’ and have a pretty good conversation with people.” In a similar light, a DCM said, “I do not think the word depression is a helpful word... particularly for older adults... they really do not like that... so I try to play around [it] a bit...” Clinicians using this indirect approach were particularly mindful of the “baggage” attached to lay conceptions of depression in our culture and the stigma attached to being labeled as depressed, especially for older men.

Most importantly, those who had an indirect style to approaching and managing depression among elderly men tended to focus their discussion in terms of somatic manifestations of depression—one of the strategies we outline later. “I may ask about sleep... I ask about their appetite,” a PCP said, “but really trying to get a feeling about how their mood is in general.” Another physician put it in these words when describing her approach:

I always start by ‘what brings you in today, how are you feeling.’ [I] try to be open-ended... More typically patients in this setting would present with... fairly vague symptoms... or a litany of symptoms... like fatigue, malaise, ‘I just do not feel right,’ lack of energy... poor sleep... that opens the door.

Highlighting this point, a DCM said, “...they can be more willing to admit to physical symptoms, like trouble with sleeping or trouble with eating, being fatigued...” In this way, clinicians used somatic symptoms as a substitute and alternative to the use of the word depression. In summary, clinicians who espoused an indirect approach to initial diagnosis and treatment of depression among elderly male patients tended to rely on subtle talk that emphasized somatic manifestations, sought to treat those symptoms effectively, and avoided the explicit use of depression-like terms.

Gradual Approach: Building Up to Depression

Another common approach clinicians used in managing elderly men whom they suspected might have depression was a gradual one, where they would build up to the actual use of the word depression in the course of several clinic visits or an extended period of time.

Clinicians who had a gradual approach to announcing a depression diagnosis and treatment explained that patients, particularly older men, were more likely to keep “their emotions to themselves” (making initial diagnosis a tricky process) or deny altogether that they are “depressed” but instead say that they are “tired.” “...Just kind of sit with them,” a physician

reflected when thinking about the issue, “like peeling a banana, and go through their problems,” indicating a gradual building up to the depression diagnosis and a patient's acceptance of it. Many clinicians mentioned that, patients commonly had misconceptions about anti-depression medication. As a physician told us, “Most of them [patients] tend to say “I don't want to be on this forever. Sometimes they use different terminology like “I do not want to be addicted to it,” or “I do not want to have to rely on it.” Therefore, clinicians who relied on a gradual approach tended first to inquire about how the patient was generally feeling, followed with a discussion and treatment of any somatic symptoms (e.g. sleep trouble, weight gain/loss, headache), and then assessed patient compliance to initial treatment and prognosis throughout an extended period of time. The words of a geriatrician are illustrative:

I am not afraid to let people know to make the diagnosis of depression and to tell people this is what I think they have. But I do tend to wait... see if we could get them some education, kind of get them into treatment modality that allows us to explore things in a way that doesn't mark with depression...

Clinicians discussed using this gradual approach as a way of establishing sufficient rapport and trust to avoid initial patient resistance to depression diagnosis. “So you'd be sort of educating them about depression... how they talk about depression,” said a DCM when asked about her experience with depressed elderly men. Thus, this gradual approach gave PCPs and DMCs more room to educate and negotiate with the patient and make a decision about what treatment works best for them. As one physician told us when discussing his approach:

I often look at my job as giving good information that people understand and then allowing people to make a decision about how they want to manage it. ...If they make a decision that I feel is incorrect, I think about how I presented and try to present it again...I tend to minimize the idea of depression and talk about the symptoms... [which] we can correct with different maneuvers... [if older men resist this] then I try to emphasize that these are signs of depression, that I believe there is... depression here, this is all I have to offer you...

In short, this gradual approach slowly introduced older men to the idea of depression and its symptoms, allowing clinicians to “test the waters” and evaluate how receptive a patient may be to recognizing and accepting this as a diagnosis. In their view, this gradual process was fundamental in their ability to prescribe an effective treatment to depression.

Direct Approach: Shock and Awe

Although there was support for the indirect and gradual approaches among both PCPs and DCMs, we found that only physicians adopted a direct, straight-to-the-point method. “[I] sort of really come at it with both guns firing rather than with my side pistol on the right,” one physician said when asked about how he would approach older men with depressive symptoms. Members of this group would tell patients immediately that they suspected depression and took a more forceful stance at getting the patients to comply with office visits and treatment. Another physician told us:

[I approached them] fairly directly. I...try to stop my spiel... And ask directly ‘what do you think about what I'm saying? I think that a lot of the symptoms you are describing to me fits with depression.

Physicians who pursued a direct approach to depression diagnosis and treatment considered this approach to be the most effective because of older men's resistance to accepting the diagnosis or even initially recognizing that their problems were in fact depressive symptoms. Briefly describing this issue, a physician said:

Most of them [older male patients] do not seem to have much insight, and it takes some coaxing to get them to see the diagnosis. [Even when they may recognize the

symptoms] you still have to cajole them into doing something about it or push a medication on them.

Physicians who adopted this style thought that directness ultimately paid off when patients admitted to being depressed. A PCP recalled:

We sat down and explained to him what was happening to him. We kept saying, ‘this is not how you are expected to behave’ ... We kept hammering at him that this [depression] is what is happening to him and he had to come out...” And, he [the patient eventually said] ‘...you are right. I definitely was depressed.’

This shock and awe approach was, at least partly, successful because many of these physicians would ultimately adopt a medicalizing strategy (something we elaborate in more detail below). In short, physicians endorsing this approach did not shy away from introducing the term depression as soon as they suspected it and persistently continued referring to it until patients accepted the diagnosis.

Strategies for Managing Depression

We now focus on the specific strategies that PCPs and DCMs used to manage depression among elderly male patients. The strategies are as follows: 1) increase monitoring of mood, 2) treat somatic symptoms first, 3) medicalize depression as a pathophysiological illness, and 4) enlist the cooperation of family. We briefly describe the first three strategies—monitoring, treating, and medicalizing—and then focus on the fourth, enlisting family involvement, given that this was the most prominent strategy discussed in our interviews.

It is worth noting that not all clinicians equally used all these strategies (e.g. physicians were more likely to medicalize depression than were DCMs). Likewise, the strategies clinicians put in place depended on their assessment of how a patient reacted to the diagnosis and whether he complied with the prescribed treatment. “You get to a certain point [at an impasse]... you do a little bit of gamesmanship,” one of the physicians explained, “you [as a physician] say ‘we could treat you with medication or bring you back’ ... [sometimes] it’s [about] getting them to come in the first place...”

In other words, clinicians generally changed strategies when they felt the situation had reached a stalemate or realized that their management plan was ineffective. In general, although clinicians alternated, using all of these strategies, they all agreed that enlisting family cooperation was the most effective and powerful strategy in getting patients to accept their depression and comply with the treatment.

Increase Monitoring

One strategy that clinicians relied upon to effectively manage older men with depression was to increase the frequency of their office visits. They did this with the intention of monitoring more closely their patients’ mood and/or compliance with undergoing treatment. More office visits gave physicians the chance to “go over things” in a consistent manner. As a physician said, “the advantage [of seeing] older patients more often is... checking on if they are taking that medication... and seeing if we are getting some results.” In other words, clinicians could keep tabs on progress and potentially change course more readily.

Yet this strategy often proved ineffectual since patients were unlikely to maintain their scheduled visits. Then, once patients came back, clinicians had to “start all over again” without any guarantees that it would work in the future. Finally, clinicians also faced other problems such as insurance coverage, scheduling, and heavy workload when wanting to see their elderly men patients more frequently.

Treat Somatic Symptoms

Typically, clinicians initially attempted to treat depression by therapeutically addressing the myriad of somatic symptoms older men presented, such as trouble with sleep, appetite changes, headaches, aches and pains, and fatigue. By treating somatic symptoms, clinicians attempted to get patients to feel better in a short-term basis with the hope that they would later accept and adhere to an antidepressant treatment (whether pharmacology, psychotherapy, or a combination of these) in the long term. One physician explained, “I typically will focus on the symptoms that are related to depression... fatigue, poor appetite... [I tell patients] ‘we are going to treat these symptoms, these issues that you have’ ... so hopefully we get [the patients] to feel better right away...”

However, treating somatic symptoms first was not always a straightforward process. Certainly, older patients’ inability to accept the depression diagnosis, and their misconceptions about depression treatment, were in part responsible for this. Above all, patients’ tendency to normalize somatic symptoms or other life changing events (such as the mourning of a spouse) as an expected part of aging precluded them from recognizing that they had depression in the first place.

Medicalize Depression

When other strategies such as increasing frequency of office visits or treating somatic symptoms failed, a majority of clinicians commonly resorted to medicalizing depression. In other words, they fell back on making the “biochemical” or the “brain” argument. As an experienced PCP explained, “Well, for better or for worse, I tend to medicalize it. I think, especially for men, it helps to depict it as a treatable disease...So I try to frame it in the context that it is not different than treating their blood pressure or diabetes...”

Although it is unclear what the pros and cons of this medicalizing strategy may be, when faced with persistent resistance, lack of follow-up, or poor treatment compliance, clinicians presenting depression as a biochemical disorder located in the brain, brings medical legitimacy to the diagnosis, potentially dispelling misconceptions about it as well as likely reducing stigmatization (i.e., it breaks the “depression = craziness” equation). In essence, medicalizing depression moves the onus from the patient (particularly for older men who often may see depression as a personal weakness or flaw) to something biological or pathophysiological that is beyond the patient’s control. Medicalization couches depression as a legitimate organic pathology potentially prompts a patient’s acceptance of the diagnosis and compliance with treatment. When compared to the other strategies, clinicians reported that medicalizing depression proved very effective, especially when dealing with a particularly “bull-headed” patient or when sensing that a patient had difficulties overcoming the stigma attached to being identified as depressed.

Enlist the Family

Clinicians overwhelmingly agreed that enlisting family support was the most effective strategy in treating depressed older men. A majority of clinicians we interviewed spontaneously shared that their family members were a crucial dimension of depression management among elderly men. With a few exceptions, clinicians typically reported that the family was an asset to their diagnosis and care plan.

Over half of clinicians, especially PCPs, thought that involving the family was one of the most effective strategies for diagnosing and managing depression among elderly men. In their view, the family was a relatively reliable supplier of information regarding a patient’s symptoms and behavior. “The family members,” as one of them concluded, “often times have a lot of information...” More specifically, the family could sensitize physicians to the issue of

depression as a possible diagnosis. When discussing this, a PCP explained that “often... the relative or wife will tell me that they think the patient is depressed.” It is thus possible that a family's use of the term depression potentially helped clinicians to more easily rule out other diagnoses and interpret presenting symptoms as related to depressed mood.

In addition, clinicians said that the family provided a fairly continuous presence and monitoring away from the clinic, perhaps increasing a patient's visits to the clinic and compliance with physician's treatment orders. For example, clinicians often spoke of “family members reporting on what is going on rather than the patient reporting.” Finally, it serves as an important source of feedback for the physician as family members might not only have ideas about how best to approach a patient but also reaffirm the legitimacy of the diagnosis. In capturing the importance of enlisting family participation, a PCP put it in these terms:

It helps enormously if a family member is there with the patient in the room. It reinforces the whole process for the patient.

According to the clinicians we interviewed, this often proved to be a critical partnership that can, as a DCM said, “help the patient overcome it [depression].” But a minority of clinicians noted that sometimes family members can be an obstacle in the management of depressed elderly men.

In pointing to how family members can “make things worse,” a physician put it this way, “partially, it is the wife that makes it challenging...” Hence, working with an “overbearing family” required not only more negotiation but also that a clinician successfully establish her/his expertise in order to legitimize the depression diagnosis. As one PCP suggested when discussing one of his patients:

It's [difficult] when the wife says [to the patient] ‘you are not depressed... you don't need to take those pills...” So I'll have a spouse totally undermine me.

In these cases, family members can deny or fail to recognize that the patient is in fact depressed, normalize a patient's symptoms as part of the aging process, discourage a patient from maintaining a medication regimen, and even prevent them from seeing the clinician altogether.

Yet clinicians who viewed the family as an obstacle did not altogether deny that family can also be asset. Instead, they recognized that family involvement can be a double-edge sword. In other words, they said that specific circumstances around a patient, his family dynamics, and family members' personalities can hinder or make more challenging the diagnosis and treatment of depression. In summary, the family embodies a valuable collaborator in the process of getting older men to be diagnosed with the depression, accept their diagnosis, and abide by prescribed treatment. When family and clinician can collaborate, relying on each other for information and monitoring, it proved to be a very valuable partnership, which nonetheless involved concerted efforts from both parties over time. Yet family involvement can also introduce a host of challenges that clinicians must address and cope with in the process.

DISCUSSION

Based on qualitative interviews with PCPs and DCMs, our data highlight the impact of the stigma of depression and the challenge it poses for clinicians in the care of elderly male patients. From their perspective, clinicians' decisions about how and when to broach the topic of depression and when to use the word depression itself was a critical one and differentiates three general approaches that were identified in this study. It is noteworthy that some of the clinicians we interviewed preferred not to use the term depression at all while others sought to establish rapport before broaching this specific topic with their male patients. As we note elsewhere⁵, for older men depression may be a double stigma, as it connotes both severe mental illness as

well as weakness and vulnerability, all of which run counter to some traditional ideals of masculinity, especially those that emphasize stoicism, independence, and toughness⁵. Thus, despite considerable efforts to educate the public to reduce depression stigma and barriers to care for men, much work remains to be done.

Our interview data show that clinicians have a variety of approaches ranging from indirect (“call it something else”), gradual (“building up to depression”), to direct (“shock and awe”) when diagnosing and managing depression among elderly male patients. As we have documented, however, clinicians across these approaches use a variety of specific strategies in order to get patients to accept the depression diagnosis and adhere to their prescribed treatment plans. For instance, clinicians may choose to increase the number of office visits, treat somatic symptoms first, or medicalize depression as a means to accomplish their care plan. Typically, clinicians change these strategies throughout the course of interaction with a patient when they think a particular strategy is not effective at managing the condition. So, it is not uncommon that clinicians will make these decisions on an “on-the-go” basis throughout the course of prolonged interaction with a patient. Overall, it is clear from our interviews that depression management requires concerted efforts and persistence on the part of clinicians to get positive results for elderly men.

Our findings contribute to the existing literature on depression treatment in primary care settings by providing a typology of approaches and strategies not identified in the past, especially as it relates to the diagnosis and management of depressed elderly men. Our focus on clinicians’ reported approaches, strategies, and perspectives sheds light on a commonly unexplored area of research that could lead to important considerations in the construction of guidelines for the depression care for elderly men. Moreover, although the literature has documented well the barriers and facilitators of depression care at the level of mental health services, health care system, and physician training, our understanding of how clinicians in primary care settings informally deal with these barriers and successfully utilize their tacit knowledge about what facilitates adherence to depression care in elderly men is quite limited. The approaches and strategies we have identified represent clinicians’ informal attempts to overcome barriers and optimize what they have learned—through experience—facilitate depression treatment for a population that is likely to resist it. Deeper examination of clinicians’ tacit knowledge, views, and experiences is a promising area for further research that could lead to useful recommendations for improving depression care for the elderly. Likewise, our study suggests that current guidelines promoting a “one size fit all” approach is inadequate in addressing the problem of low detection and under treatment of depression in elderly men in primary care settings. Meaningful outcomes may be contingent on how PCPs tailor their overall approach and specific treatment strategies based on older men's attitudes and cultural and socio-economic factors.

Our study also has important limitations that demand generalizations to be made with caution. This small, convenience sample (N=20) of clinicians was drawn from a wide geographic area, various disciplinary backgrounds and a diversity of practice settings. Moreover, unlike some other recent work²², only clinician self-reports of the strategies were available rather than direct observation of actual strategies used. Likewise, more extensive socioeconomic and demographic data on clinicians and patients was unavailable limiting this study to a descriptive level. Our findings await confirmation by larger studies with more carefully controlled samples and means of data collection. Nevertheless, these results are provocative and help advance understanding of clinician management of depression in older men.

Our data also allow for some speculation regarding the relationship between the three approaches and the four strategies discussed in the Results section. In general, we suspect that clinicians who had an indirect approach also had a tendency to rely first on treating somatic

symptoms as a main strategy. Likewise, our data were also suggestive of a relationship between clinicians who espoused a gradual approach and increased monitoring of mood through more frequent office visits. Finally, clinicians who said they use a direct approach were possibly more likely to medicalize depression or enlist family right away in order to move forward with their care plans. Many important questions remain unanswered, for example: Did an individual provider (PCP or DCM) use more than one approach? Which provider was more likely to use what approach and/or combination of strategies? How did the type of patient and patient characteristics determine which approach was used by clinicians? What are the positive or negative aspects of the medicalizing strategy? Because of the limitations in our data, we are unable at this time to provide empirically based answers to these important questions. But, they certainly pose matters to be further tested empirically about the linkage among clinicians' training, clinical approaches (and strategies), patients' characteristics and conceptions/experiences of mental health, and behavioral changes in treatment compliance, especially around stigmatizing conditions such as depression. Teasing this out may provide more clues as to how we can efficaciously treat elderly men suffering from depression.

Our findings also highlight the importance of the family both in terms of its role in the management of depression but also as a strategy clinicians rely on for adequate compliance to treatment. On the one hand, family can be helpful or, on the other hand, family can obstruct a clinician's care plan goals. In other words, family can be on-the-side reinforcement or can inhibit clinicians' efforts to treat elderly men. When clinicians understand the role of family in a patient's life and medical care, they can then make better-informed decisions about how to manage depression. If they can enlist family support to provide reliable information and/or survey medication compliance, clinicians may face a more favorable situation in moving forward with treatment. Heretofore the role of the family has been poorly analyzed and, when asked, caregivers often report feeling that their views or opinions are ignored during physician visits. Our study suggests that more research is needed to discover the best way of engaging and working with family members to facilitate diagnosis and effective depression care for older adults, particularly older adults who are at high risk for having a missed diagnosis or ineffective treatment, such as older men and minorities.

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References

1. Institute of Medicine CoQoHCiA. Crossing the Quality Chasm: A New Health System for the 21st Century. Washington DC: 2001.
2. Unutzer J, Bruce ML. The elderly. *Mental Health Services Research* 2002;4(4):245–7. [PubMed: 12558011]
3. Bruce ML, Ten Have TR, Reynolds CF Jr, Katz II, Schulberg HC, Mulsant BH, et al. Reducing suicidal ideation and depressive symptoms in depressed older primary care patients: A randomized controlled trial. *Journal of the American Medical Association* 2004;291(9):1081–91.
4. Croghan TW, Schoenbaum M, Sherbourne CD, Koegel P. A framework to improve the quality of treatment for depression in primary care. *Psychiatr Serv* 2006;57(5):623–30. [PubMed: 16675754]
5. Hinton L, Zweifach M, Oishi S, Unutzer J. Gender disparities in the treatment of late-life depression: qualitative and quantitative findings from the IMPACT trial. *Am J Geriatr Psychiatry* 2006;14:884–892. [PubMed: 17001028]
6. Schmutte T, O'Connell M, Weiland M, Lawless S, Davidson L. Stemming the tide of suicide in older white men: A call to action. *American Journal of Men's Health* 2008;3(3):189–200.

7. Arean PA, Ayalon L. Assessment and treatment of depressed older adults in primary care. *Clinical Psychology: Science and Practice* 2005;12(3):321–35.
8. Good GE, Wood PK. Male gender role conflict, depression, and help seeking: Do college men face double jeopardy? *Journal of Counseling & Development* 1995;74:70–5.
9. Magovcevic M, Addis ME. Linking gender-role conflict to nonnormative and self-stigmatizing perceptions of alcohol abuse and depression. *Psychology of Men & Masculinity* 2005;6(2):127–36.
10. Neighbors HW. Improving the mental health of Black Americans: lessons from the community mental health movement. *The Milbank Quarterly* 1987;65(2):348–80. [PubMed: 3330178]
11. Kessler RC, Brown RL, Broman CL. Sex differences in psychiatric help-seeking: Evidence from four large-scale surveys. *J Health Soc Behav* 1981;22:49–64. [PubMed: 7240706]
12. Husaini BA, Moore ST, Cain VA. Psychiatric symptoms and help-seeking behavior among the elderly: An analysis of racial and gender differences. *Journal of Gerontological Social Work* 1994;21(3-4):177–95.
13. Addis ME, Mahalik JR. Men, masculinity, and the contexts of help seeking. *Am Psychol* 2003;58(1): 5–14. [PubMed: 12674814]
14. Nutting PA, Rost K, Dickinson M, Werner JJ, Dickinson P, Smith JL, et al. Barriers to initiating depression treatment in primary care practice. *J Gen Intern Med* 2002;17:103–11. [PubMed: 11841525]
15. Henke RM, Chou AF, Chanin JC, Zides AB, Scholle SH. Physician attitude toward depression care interventions: implications for implementation of quality improvement initiatives. *Implementation Science* 2008;3(40):1–10. [PubMed: 18179688]
16. Burroughs H, Lovell K, Morley M, Baldwin R, Burns A, Chew-Graham C. ‘Justifiable depression’: how primary care professionals and patients view late-life depression? a qualitative study. *Fam Pract* 2006:1–9.
17. Callahan CM, Hendrie HC, Tierney W. Documentation and evaluation of cognitive impairment in elderly primary care patients. *Ann Intern Med* 1995;122:422–9. [PubMed: 7856990]
18. Carney PA, Rhodes LA, Eliassen S, Badger LW, Rand EH, Neiswender C, et al. Variations in approaching the diagnosis of depression: a guided focus group study. *The Journal of Family Practice* 1998;46(1):73–82. [PubMed: 9451373]
19. Kaufman, S. In-depth interviewing.. In: Gubrium, J.; Sankar, A., editors. *Qualitative Methods in Aging Research*. Sage Publications; 1994. p. 123-36.
20. Oishi S, Shoai R, Katon W, Callahan C, Unutzer J, Arean P, et al. Impacting late life depression: integrating a depression intervention into primary care. *Psychiatr Q* 2003;74(75-89)
21. Coffey, A.; Atkinson, P. *Making Sense of Qualitative Data*. Sage Publications; Thousand Oaks, CA: 1996.
22. Tai-Seale M, Bramson R, Drukker D, Hurwicz M, Ory M, Tai-Seale T, et al. Understanding primary care physicians’ propensity to assess elderly patients for depression using interaction and survey data. *Med Care* 2005;43(12):1217–24. [PubMed: 16299433]