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Primary Care, Males, Masculinity, and Suicide : a Grounded Theory Study

John Thomas Casey
Portland State University

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PRIMARY CARE, MALES, MASCULINITY, AND SUICIDE:

A GROUNDED THEORY STUDY

by

JOHN THOMAS CASEY

A dissertation submitted in partial fulfillment of the
requirements for the degree of

DOCTOR OF PHILOSOPHY
in
SOCIAL WORK AND SOCIAL RESEARCH

Portland State University

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DISSERTATION APPROVAL

The abstract and dissertation of John Thomas Casey for the Doctor of Philosophy in Social Work and Social Research were presented May 7, 2009, and accepted by the dissertation committee and the doctoral program.

COMMITTEE APPROVALS:


Daniel Coleman, Chair

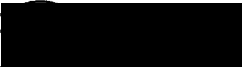

Pauline Jivane


Matt Modrcin


Vikki Vandiver


Mark Kaplan
Representative of the Office of Graduate Studies

DOCTORAL PROGRAM APPROVAL:


Daniel Coleman, Director,
Social Work and Social Research Ph.D.
Program

ABSTRACT

An abstract of the dissertation of John Thomas Casey for the Doctor of Philosophy in Social Work and Social Research presented May 7, 2009.

Title: Primary Care, Males, Masculinity, and Suicide:

A Grounded Theory Study

Suicide completion in the United States is a public health problem that claims over 30,000 lives annually. Most of these suicide victims are white males who die by firearm, and who typically are not taking antidepressant medication and are not involved in mental health treatment at the time of death. Depression is closely linked to suicide death, and treatment for depression is provided mainly within primary health care settings where most suicide decedents have been seen at some point in the year prior to their death. The rate of male depression is likely under-reported, partly due to gender-bias within primary care and also due to the lack of gender-specific assessment instruments and interventions.

This study was conducted to better understand primary care providers' experience of treating depressed males. A grounded theory approach explored the contradiction that males in the U.S. complete suicide four times as often as females, yet females are diagnosed with depression twice as often as males. This study is guided by the proposition that gender roles are socially constructed, and it is shown that common masculine gender-role stereotypes influence males' sense of self in ways

that can limit their ability to engage with others in times of need, and consequently increase their risk for depression and suicide. The influence of shame and violence on suicide completion involving males is also reviewed.

Semi-structured interviews were conducted with 16 primary care providers to elucidate their subjective experience of treating patients who present with complaints of depression and suicidal risk. Participants described two alternative ways of treating depression, one that adhered to the medical model review of systems, and one that focused on the patient-provider relationship. There is also within this study an outline of an approach to the treatment of depression and suicidal risk that involves more collaboration between primary care and mental health providers. It is suggested that further integration of those two disciplines/professions can be enhanced by the efforts of social workers because of their mental health training and expertise: related implications for social work practice are discussed.

DEDICATION

This dissertation is dedicated to Tim, whose spirit guided me on this academic journey, and whose long struggle inspired me when the path I followed was difficult. I offer this work in his honor with the hope that others may find within it some way to help illuminate their path or that of others when darkness intrudes.

ACKNOWLEDGMENTS

I wish to thank the members of my committee very much for their support and guidance throughout my dissertation work. Many thanks to Dan Coleman for his help as my advisor throughout my doctoral program, and for leading me through the dissertation process in his role as committee chair; thanks to Pauline Jivanjee for sharing her qualitative research expertise with me, and for challenging me to uphold the tenets of this approach; thanks to Mark Kaplan for introducing me to the field of suicidology, and for his generous availability as he mentored me in this area; thanks to Matt Modrcin for his inquisitiveness in the area of masculinity studies, and for encouraging me to formulate my own interpretations beyond those found in the literature; and thanks to Vikki Vandiver for bringing her wealth of research experience to the dialog regarding my dissertation, and for helping me develop it to meet doctoral level standards.

Many thanks to Michael Polen at The Kaiser Center for Health Research for graciously sponsoring this study, and for providing me with technical support to conduct it.

I also wish to thank my wife, Julie, along with Will, Mary and Amelia for their support and encouragement during this project. I am especially grateful to Julie for believing in my ability to do this work, and for her patience and tolerance during the last five years as my academic quest consumed much of my time and energy.

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Primary Care, Males, Masculinity, and Suicide:

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CHAPTER 1: INTRODUCTION

Introduction

The origin of this dissertation stems from the contradiction that females in the United States are diagnosed with depression twice as often as males, yet males complete suicide four times as often as females. That conundrum has intrigued and frustrated me throughout my 20 years of clinical social work practice in the areas of substance and psychiatric disorders. In my work as both a therapist and as a manager, I have on many occasions participated in peer review debriefings of completed suicides and have been struck by how they are often euphemistically referred to as “bad outcomes.” It has been my experience that those reviews invariably conclude both that the outcome was inevitable and that it is analogous to deaths due to other end-stage diseases, such as cancer or chronic heart disease. I reject that premise as being overly simplistic and an inadequate explanation of why some severely depressed individuals complete suicide while most do not. The notion that suicide is to be expected in some cases also does not account for the high rate of suicide deaths for males, or speak to how methods of suicide assessment and intervention might be improved.

It is proposed here that the higher rate of suicide completion among males reflects to some extent differences in males’ experience of depression, as compared to

females', and that males face certain barriers to getting help for their depression, which then increase both symptom severity and the risk of suicide. There is also the question of how to understand the lower rate of diagnosed depression in males, relative to females, especially given the disproportionately higher rate of suicide completion for males. My exploration of this area led me into the primary care arena which Regier, et al (1993) asserts has become the de facto mental health system in the United States. It has been reported that approximately 70% of all patient visits to primary care are related to psychosocial issues, and that primary care providers (PCPs) render approximately 50% of all behavioral healthcare services (Van Beek, et al, 2008). The prevalence rate of depression among primary care patients within the national Kaiser Permanente system has been reported to be roughly 8.4% (deSa and Price, 2007), and the estimated prevalence within other systems has variously been reported to be 4.8%-8.6% (Bertakis, et al., 2001) and 5%-10% (Goldman, Nielsen and Champion, 1999). Seelig and Katon (2008) suggest that those rates could actually be much higher, given that depressed patients may be misdiagnosed approximately 50% of the time, and they also report that the rate that primary care patients drop out of related treatment is as high as 40%.

The dissertation study reported here explores the PCP-patient relationship from the PCP perspective in an effort to better understand their experience of male patients who present with complaints of depression and/or suicidal ideation. Support for this study can be found in a recent study by Feldman and colleagues (2007) regarding the assessment of suicidality, which lists as one of its limitations the absence of data that

examines the quality of discussions that PCPs have with their patients concerning suicide. That phenomenon is explored in the present study through a grounded theory approach addressing the broader spectrum of discussions that PCPs have with patients when diagnosing and treating depression. The scope of the study also includes an overview of the complex reasons why males often delay or defer getting help when depressed, including negative bias within primary care settings.

The primary objective of this study, therefore, is to elucidate the essential elements of the interaction between PCPs and depressed male patients in an effort to facilitate the promotion of gender-specific strategies in primary care practice that can enhance the engagement and assessment of depressed males. An area of particular interest is the PCPs' style of assessment compared to how social workers approach that element of the clinical encounter, such as in my past experience as an emergency room social worker which routinely involved assessing depressed patients. This study, therefore, is influenced by the premise that social workers are specifically trained to assess broader environmental factors that impact individuals, such as gender role issues and violence within our culture. My current role as a manager of a crisis stabilization program situated within a health care setting, also both facilitated my access to PCPs and contributed to my interpretation of the interviews I conducted with them for this study.

In addition to my professional experiences in this area, my interest in conducting this study was also generated by my personal experience as a so-called suicide survivor. The initial phase of this study began approximately nine years after

the suicide death of one of my seven siblings. My ability to clearly foresee but not prevent that death has profoundly influenced every phase of my research, as well as many other areas of my life. Although it is contrary to my nature to divulge any personal information in an academic work, this intimate disclosure is intentionally made here in an attempt to locate my voice in the work and thereby enhance the rigor of this qualitative study (Tobin and Begley (2004)).

CHAPTER 2: LITERATURE REVIEW

To provide context for this study, the relevant literature concerning the epidemiology of suicide is reviewed below along with an exploration of the treatment of depression within primary care. An underlying premise throughout this study is that gender-roles and expectations are socially constructed, and this premise is introduced in this section within a discussion of help-seeking behaviors and masculinity issues.

Suicide Epidemiology

Within the broad category of mood/affective disorders, individuals with a major depressive disorder or a bipolar disorder (either Type I or II) have a 10-20% risk for suicide throughout the course of their illness (Moller, 2003; Tondo, Hennen, and Baldessarini, 2001, et al). It has also been found that the vast majority of suicides occur among individuals experiencing episodes of major depression (Coryell and Young, 2005), while some studies suggest that as many as 70% of suicide deaths are linked to cases of untreated depression (Lewis, 2001), with more than 65% of initial attempts resulting in completions (Rihmer, 2007). Other studies estimate that 90% of suicide victims have diagnoses of depression and/or alcohol abuse or dependence at the time of the suicide (Gaynes, et al, 2004). Alcohol use has been seen to be both a precipitating factor in the onset of mood disorders and a self-medicating response to mood disorders, particularly in the elderly (Blixen, McDougall, and Suen, 1997). Recent research suggests that there is a genetic component specific to the constellation of suicide, depression and alcohol dependence (Mitchell, Mitchell and Berk, 2000),

while a more general genetic risk for suicide has also been well established (Baldessarini and Hennen, 2004; Qin, Agerbo and Mortensen, 2002).

It is important to bear in mind when considering the overall rate of completed suicide that the decedents are predominately White males, regardless of age or any other variables. It is also striking to note the high relative ranking of suicide as a cause of death within various age groups, especially among the elderly and the young. For example, the highest rate of suicide among all age groups in the U.S. is in the age 65 and older category, and this has held constant since the uniform reporting of suicide deaths began in 1933 (Hosansky, 2006). It is the second leading cause of death for those in the 25-34 year-old age group, third for both the 10-14 and 15-24 year-old age groups, and fourth and fifth, respectively, for the 35-44 and 45-54 year-old age groups (Center for Disease Control [CDC], 2003). By an approximate ratio of 3:2, more suicides have been reported in the U.S. during the last 100 years than homicides (Institute of Medicine [IOM], 2002), and suicides occur in this country at nearly twice the rate of alcohol-related traffic fatalities (CDC, 2003). The actual number of deaths due to suicide is widely thought to be vastly underreported due to various factors, such as differences in coroners' methods of investigation into and reporting of suicides, as well as the potential for friends and family members to hide evidence of a suicide because of their fear of being stigmatized by the suicide (Burgess, et al, 2004; Jenkins, 2003; Neimeyer and Pfeiffer, 1994; Werth, 1998).

Consistent with CDC data, a comprehensive World Health Organization (WHO) overview of death rates in the U.S. within a wide range of ethnic groups

reveals rates in 2004 of 21.0 per 100,000 for White males (excluding Hispanic and Latino), 19.5 for American Indian or Alaska Natives, 9.0 for Black or African Americans, 8.6 for Hispanic or Latinos, and 7.9 for Asian or Pacific Islanders. By comparison, in that same report (WHO, 2006), there is a slight downward trend in the suicide death rate for all females over the same period of time, with a rate of 5.1 per 100,000 in 1950 as compared to 4.6 in 2004, with a high of 6.6 in 1970 and a low of 4.0 in 2000. There is no significant change in the death rates in the WHO report for White females and Black females during that same timeframe, with rates of 5.5 and 1.5, respectively, in 1950, and rates of 5.1 and 1.8, respectively, in 2004. Within the broader range of death rates for females in 2004 there was a rate of 6.2 for American Indian or Alaska Natives, 5.7 for White females (excluding Hispanic and Latino), 3.4 for Asian or Pacific Islanders, and 1.8 for both Black or African American, and Hispanic or Latino females.

Suicide is the eleventh leading cause of all deaths in the United States, claiming over 30,000 lives annually (CDC, 2003), making it a major public health problem (D'Orio and Garlow, 2004; Luoma and Pearson, 2002; Gaynes, et al, 2004). This problem is especially pronounced among White males in the U.S., who complete suicide approximately four times as often as females, and use firearms more often than not to do so (WHO, 2007). The WHO reports that the overall rate of suicide deaths in the U.S. has had little change during the last 50 years, with the highest rate found among males, ranging from 17.8 deaths per 100,000 residents in the population in 1950, to 17.7 in 2004, and only slight variations of 16.5 in 1960 and 20.4 in 1990 in

the intervening years. A comparison of the death rates for White males and Black males also shows little change within that same reporting period, with rates of 19.0 and 6.3, respectively, in 1950, and 19.6 and 9.0, respectively, in 2004 (WHO, 2006).

Treatment of Depression In Primary Care

Given that suicide is most closely associated with depression, it is important to consider the context for related interventions. Despite the data showing that males in the U.S. complete suicide approximately four times more often than females, it has also been found that the prevalence rate of major depressive disorder for women is roughly twice the rate for men, 9% and 4.7%, respectively (Ohayon, 2000, et al). Treatment of depression within the health care system is done mainly by PCPs rather than in the specialty care area of mental health (Van Voorhees, 2003), and there is evidence that many PCPs do not adequately address depressive disorders or other related diagnoses (Pincus, et al, 2001). Chan and colleagues (2006) report, for example, that major depressive disorder was identified by PCPs as a problem in the initial screening examination in only 30%-40% of depressed patients and, alarmingly, in only 9% of cases in which there was a co-morbid substance disorder.

It may be the case that some methods used to assess depression in males are not sensitive to male-specific characteristics of depression, such as increased alcohol use (Kuehn, 2006). Cochran and Rabinowitz (2003) suggest that "...undiagnosed and untreated depression in men may be one reason why many more men than women commit suicide" (p. 132). They also delineate a comprehensive depression assessment format that includes but expands upon DSM-IV criteria in areas of "masculine-

specific” symptoms, such as anger outbursts, and increased use of alcohol and other substances. In addition to the group of male suicide decedents whose depression was untreated, there very likely is another group of males who are not depressed but nonetheless complete suicide in an impulsive reaction to some type of life stressor, such as a sudden loss of job and home (Kaplan, M., personal communication, May, 2009).

Norman (2004) suggests that men’s depression is often masked by alcohol and drug abuse, while women may be more likely to report feelings of hopelessness and lack of confidence, in part reflecting their experience of gender oppression. More generally, she also finds that the prevalence rate for depression is culturally skewed by gender differences in help-seeking behaviors and the reporting of symptoms, with women in the U.S. more likely than men to ask for help and to be prescribed antidepressant medication. Cowling (2008) proposes that the prescription of those medications may involve a gender bias in that “Often the first line of assistance to women who are seeking help is to medicate them, without dealing with the dynamics of their emotions, perceptions, and cognitions” (p. 254). It is not clear from this area of the research if men are more likely than females to decline a recommendation to take antidepressants but this seems plausible, given the gender role expectations that interfere with males’ ability to seek help.

Help-seeking was also explored by Sleath and Rubin (2002) who found that females initiated a discussion regarding depression with their PCPs 62% of the time, while in the case of males it was the PCP who first raised that topic for discussion

67% of the time, and the patients were more than three times as likely to be counseled if the PCP was female rather than male. It has been reported in another study that patients being treated for anxiety were more likely to be counseled by female PCPs than by male PCPs, although this was not the case when patients were treated for depression (Chan, et al, 2006). These studies suggest that there is a reciprocal male gender-role expectation within primary care practice in which it may be out of character for many male patients to report feelings of depression, especially to a male PCP.

It has been shown that gender does play a role in the diagnosis of depression by PCPs, with females more likely to be diagnosed with depression than males, even when symptoms and severity are similar, as evidenced by high scores on the Beck Depression Inventory (BDI) for both genders (Bertakis, et al, 2001). In that same study, marital status did not influence the diagnosis of depression in males, but females were approximately five times more likely to be diagnosed with depression if they were divorced, separated, or widowed, as compared to those who had never married. These findings suggest that while the assessment of depression in females may be accurate within primary care, there appears to be a bias within primary care to not see males as being depressed, even when reliable instruments such as the BDI are used.

In their meta-analysis related to the treatment of depression within general medical settings, Goldman, Nielsen, and Champion (1999) report that 50% to 70% of patients who are depressed initially express somatic complaints rather than concerns

about depression. They also report that PCP skill deficits and negative attitudes regarding depression contribute to treatment barriers encountered by depressed patients, with the treatment provided falling short of best practice standards. In an effort to standardize a best practice model, both the federal government and the American Psychiatric Association published practice guidelines for the treatment of depression in primary care in 1993 (Stimmel, 2001). And even though the prescription of antidepressant medications increased 147% between 1990 and 1998 (Goldstein and Rosselli, 2003), antidepressants were prescribed by PCPs for less than only a third of markedly depressed patients (Goldman, Nielsen, and Champion, 1999). One variable that may contribute to under treating severely depressed primary care patients, particularly the elderly, is the reticence among some PCPs to ask about suicidal ideation due to liability concerns related to the identification of that problem or the fear that asking about suicidal ideation might encourage those thoughts (Schulberg, et al, 2004).

Accurately assessing depression and evaluating suicidal risk in the primary care setting is crucial, regardless of age or gender, given the finding in one study that among individuals reporting suicidal ideation, 87% had seen their PCP within the last year one or more times (Brook, et al, 2006). A qualitative study by Nirui and Chenoweth (1999) involving suicide survivors, though, suggests that suicide decedents had been uncomfortable confiding in their PCPs and/or not confident that their concerns would be received in a supportive manner or effectively dealt with. Other studies regarding medical necessity (Sabin and Daniels, 1994; Schwartz and

Weiner, 2003) speak to PCPs' challenges to see a high volume of patients while also keeping the cost and scope of care to a minimum, perhaps further limiting PCPs' responses to their patients' depression.

Risk Factors and PCP Interventions

In a study of primary care patients aged 19-93, Fischer, et al (2003) found that those in the 19-34 age range reported more acute symptoms of depression than others in the sample, and were more likely to have co-morbid alcohol abuse. They also found that PCPs referred those younger patients to mental health services three times more often than patients aged 75 and older, and that they rarely discussed suicidal risk with the older patients despite their relatively higher risk for suicide. More generally, Brook and colleagues (2006) found that common risk factors for suicidal ideation include being unmarried, having limited education, and being in the middle age group or younger; given the high rate of suicide completion among the elderly, one possible interpretation of this outcome is that the elderly are more likely to act on suicidal thoughts rather than ruminate about them.

Contrary to the findings in the study by Brook (2006), Kaplan, et al, (2007) found a positive association between higher levels of education and suicide in their study in which functional limitation was also identified as a significant predictor of suicide, along with physical illness, male gender, psychiatric condition, and military veteran status, suggesting a need for PCPs to have more training in the area of suicide detection and prevention. Turner, Lloyd, and Taylor (2006) provide support for a relationship between physical disability and both psychiatric and substance disorders,

with higher degrees of risk for males and younger individuals, while other studies have shown that chronic pain is a predictor of suicide, with deficits in problem solving skills as one of several related risk factors (Tang and Crane, 2006).

Unfortunately, the assessment of acute suicidal risk within primary care is not addressed in depth in either the depression guidelines or the research literature, and the knowledge and use of screening instruments that can identify that level of risk is quite limited, leaving PCPs with little ability to safely manage acutely suicidal patients (Gaynes, et al, 2004). There is also a dearth of studies that speak directly to the challenges inherent in the engagement of males in the diagnosis and treatment of depression within primary care. An exception is a pilot study by Smith and coauthors (2006), which offers a practical recommendation that a more general mental health screening be incorporated into routine physical exams, which they suggest would be an especially effective approach to engage males who, in particular, would otherwise be reticent to discuss their mental health concerns. Although it is not clear that this type of screening would contribute to a reduction in the completion of suicide, it would nonetheless have a positive impact on the primary care culture within which the dialog between PCPs and depressed males takes place, in that there could be an implied sense of permission for males to ask for help.

A recent study in which opinions about suicide were sought from individuals 16-24 years of age revealed that issues of fear and stigma dissuaded them from seeking help when in distress, and that they did not believe that crisis services would be confidential or helpful, based on their earlier experiences within their families

(Gilchrist and Sullivan, 2006). Along the same lines, there is a body of research that focuses more specifically on the area of masculinity and help seeking, such as a study of college age males by Good and Wood (1995) in which male gender-role conflict is defined as having a restriction-related component (emotional suppression), and an achievement-related component (quest for success). Males who score high in both of these areas, according to that study, may be more susceptible to depression, due to restricted emotionality, and less likely to seek help, due to fear of being seen as weak, than other men who score lower in these areas. There is also the possibility that there is within the various elements of the masculine gender role a greater propensity for violence which may have implications for both suicidal methods and completion.

Masculinity and Violence

Miller, et al, (2007) reports that 80% of all suicide deaths in the U.S. involve males and that 88% of male suicides involve the use of firearms. The use of firearms to complete suicide is the most common means of intentional death in the U.S., according to the CDC (2007), which also reports that this method accounted for approximately 48% of all suicide deaths in both the 15-24 and 45-54-year-old age groups, and 58% within the 55-64-year-old age group for the year 2004. A study by Joe, Marcus, and Kaplan (2007) explores the relationship between the completion of suicide by firearm and numerous variables, and finds that 78% of the decedents had not been taking antidepressant medication prior to their death and 84% had not been involved in mental health treatment, leading to their recommendation that PCPs discuss suicidal risk with their patients.

With the exception of impulsive suicides, the process of actually completing suicide generally involves a trajectory that begins with suicidal ideation which then leads to suicidal behavior in a process hastened by triggering events, typically in the form of some sort of loss such as job, relationship, health or functioning (Stillion and McDowell, cited in Flint, et al, 1998). Predicting suicide completion in the short-term versus the long-term has implications for the type and timing of intervention efforts, according to a study by Kaplan and colleagues (2006). These authors found that suicide decedents in a short-term risk group were more likely than those in a long-term risk group to have been White males acting impulsively and using firearms, and that the opportunity for effective crisis intervention services within the short-term risk groups was limited. It has been proposed that some individuals may have a predisposition to suicide, and then develop a life trajectory for suicide that is often influenced by a pattern of impulsive-aggressive behaviors related to early childhood traumas and neglect (Turecki, 2001). Cutcliffe, Joyce, and Cummins (2004) also speak to the notion of a suicide trajectory, and note that there are limited 'windows of opportunity' available to health care practitioners to intervene before the path to suicide inevitably leads to completion.

The Primary Care Setting

It is the intent of this dissertation study to contribute to efforts to interrupt the suicide trajectory by examining the arena in which patients are most likely to seek help for depression. One study found that the completion of suicide is rare, while also reporting that 10% of the sample in that study was actively suicidal, and that most

patients do not report suicidal intent to their PCPs (Schulberg, et al, 2005). Luoma and colleagues (2002) reviewed 40 studies conducted within the U.S., Europe, and Australia, to determine the rates of contact that suicide decedents had with either primary care or mental health services prior to their death, and they found a higher rate of contact in primary care. More specifically, they found higher rates of contact in primary care within one year (75%) and within one month (45%) prior to suicide completion, as compared to rates of 33% and 20%, respectively, for mental health services. Luoma and coauthors also report that females have higher rates of primary care contact prior to suicide completion, although only two of the 40 studies reviewed addressed gender within primary care. One can reasonably infer from the studies related to limitations in males' help seeking behaviors that males in the U.S. may be less likely than females to seek treatment in primary care for any type of complaint.

Given the high rate of contact that patients have with their PCPs prior to completing suicide, more comprehensive assessment of depression and suicidal ideation within the primary care population is essential, particularly for males, and the PCP-patient relationship is an important component of that assessment process. In their grounded theory study of treatment for depression within primary care, Baik and colleagues (2005) interviewed eight PCPs and found that the amount of time that the PCP spent with the patient was the most critical factor in the recognition of depression. Although that study breaks new ground through its use of interviews with primary care providers to explore diagnostic variables, it does not specifically address issues related to the construct of masculinity and help seeking behaviors, nor have any

other studies been found that examine these dynamics within the context of primary care practice.

However, there are studies that show that the quality of the communication between PCPs and patients plays an important role in the therapeutic relationship, with some common themes emerging that appear to influence the care that patients receive for their depression. Gender of both patient and PCP, for example, has been found to be related to patients' experiences working in partnerships with their PCPs, largely due to the more expressive presentation of females than males. The degree to which patients experience a sense of partnership with their PCP is greater for both male and female patients if the PCP is female, according to Hall and Roter (2002), who also note in their meta-analytic review of 7 observational studies that PCPs are more inclined to develop stronger partnerships with their female patients, than with male patients. In an essay outlining his ecological model of communication within patient-PCP encounters, Street (2002) also stresses the value of partnership between patient and PCP. He suggests that a sense of reciprocity may develop, typically when a female in either role freely shares information, especially when the problems being addressed involve difficulties with mood or other emotional issues.

The studies reviewed here speak to the limitations inherent in the treatment of depression within primary care, as compared to treatment within mental health, and there are also implications in the areas of patients' motivation for and acceptance of treatment. A study by Van Voorhees, et al, (2003), for instance, found that patients seen by mental health specialty care were more likely to engage in treatment, than

were patients treated for depression by their PCPs. That study also suggests that patients choosing to be seen in primary care may be less inclined to enter into a therapeutic alliance with their PCPs because the patients do not fully accept their need for treatment. It appears that unlike primary care patients who may see a PCP for various concerns including depression, patients seeking mental health treatment in specialty care tend to be more focused on that one problem area, which may help account for acuity differences, including suicidal risk, in the two arenas.

It is clear from the literature review above that White males in the U.S. in all age groups have a much higher rate of suicide completion than females, and that the method of completion typically involves the use of firearms. Variables that contribute to this high rate of suicide completion for White males include deficits in the area of help-seeking behaviors related to gender role expectations, and intervention limitations within primary care where most depressed males are assessed and treated.

CHAPTER 3: THEORY AND RESEARCH QUESTIONS

There is in this next chapter further support from masculinity studies for the notion that gender has been socially constructed in our culture in a manner that favors toughness in males and discourages the expression of any emotions that can be seen to suggest weakness. It will also be shown here how pervasive gender-role expectations contribute to males' propensity for violence, suicide completion and premature death due to other causes. Research questions for this study are then outlined within the context of an overview of grounded theory, along with the benefits of utilizing that approach in this work.

Masculinity Theory

In addition to the importance of motivation within the course of treatment for depression, the role of gender can also significantly influence the extent to which males are able to ask for help when they feel depressed and/or suicidal. An underlying premise of this study is that gender identity is a social construction that for many males impedes their ability and willingness to ask for help if in so doing their core sense of self is threatened. While there are gender-role expectations for both males and females that are consistent with the constructs of masculinity and femininity, respectively, there are elements of masculinity that may uniquely contribute to the high rate of suicide completion among males.

Given the consistently high rate of suicide completion among males in the U.S., it is important to turn here to the somewhat limited, but growing, area of men's studies to help place in context this increasingly predictable loss of life. Mahalik

(1999) has proposed that masculinity involves a socialization process in which a gender-role schema is taught to males at an early age in a very direct manner. He further postulates that the schema is quickly internalized and then reinforced throughout the life span via eight main scripts provided to males, which he has identified as the pursuit of success, power, emotional control, fearlessness, self-reliance, primacy of work, playboy, and disdain of homosexuals. That collection of scripts, or messages, comprises one definition of the primary/traditional masculine gender-role expectations, which are commonly maintained at the expense of males' emotional connection with themselves and with others.

Much of the current research in the study of men's issues is consistent with and expands upon the seminal model of masculinity developed by David and Brannon in 1976 (as cited by Abreu, et al, 2000; Levant, 1996; Mahalik, 1999; and Walker, Tokar, and Fischer, 2000; et al). That model proposed that males in Western cultures are socially conditioned to repress fears and feelings, both considered to be feminine, through the projection of aggressive behaviors that generate an image of toughness and success via four gender-role types characterized as "the sturdy oak, the big wheel, give 'em hell, and no sissy stuff." These gender-role personas are thought to be specific to males, and are likely to increase their risk of death by suicide in ways that are uniquely different than the risk factors for females.

The gender-role expectations to be strong and tough, for example, may both interfere with the ability of males to seek help, and contribute to their propensity to use violent methods when they feel unable to 'tough it out' when under duress.

There is in both the “sturdy oak” and the “no sissy stuff” personas a risk that males who embrace them may be disinclined to seek therapy and/or medication when depressed due to concerns that such actions might compromise their sense of masculinity. The risk for suicide may also be heightened for males whose sense of identity is strongly influenced by any of the four personas when that identity is threatened by significant losses, such as in the areas of income, relationship or health.

The influence of parents, peers, teachers and media contribute to the ongoing social construction of masculinity, which invariably leads many males to experiences of gender-role conflict or strain when their feelings or accomplishments are at odds with gender-role expectations (Mahalik, et al, 1998). Gender-role strain, according to Levant (1996), reflects the lack of a universal model of masculinity, which is elusive because the definition of an ideal gender-role for men varies somewhat according to factors such as class, age, sexual orientation, and race. This may best be exemplified by differences in how gay males and heterosexual males develop a sense of masculine identity within the context of our culture’s set of gender-role expectations. Men who feel conflicted about their inability to meet any given social definition of masculinity are more likely to be at risk of depression, substance abuse, and an inclination to act out in terms of anger and high-risk behaviors (Mahlik, 1999), all of which are variables that have been shown to be associated with suicide completion.

Regardless of the various ways in which males struggle with their experience of masculinity, there is support for the assertion that the basic elements of male gender-role expectations are commonly introduced at a very early and critical phase of

identity formation. Pollack (2006) suggests that boys are first taught to hide their emotions between the ages of 3 and 5 through a “boy code” that rewards toughness and relies on shame to enforce a prohibition against emotional expression or vulnerability, a condition he calls “gender straitjacketing.” Messages regarding strength and toughness are often communicated to males during childhood (“big boys don’t cry”), and reinforced through styles of play, such as organized sports, where boys are often encouraged to “shake it off” when injured, and literally applauded for continuing to play despite being injured. Children clearly understand that there are gender-specific differences in the cultural rules that regulate the expression of emotion, which contributes to the social intolerance for males who emote. In a newspaper article regarding the phenomenon of being an only child, for instance, a 9-year-old girl illustrates this understanding by noting that if she were to have a sibling, she would hope that it would be a brother because “girls are more sensitive, and if you hurt a boy’s feelings he wouldn’t get as upset” (Kelley, 2007).

The gender-role indoctrination of males continues beyond childhood in ways that further establish the social construction of what it takes “to be a man,” which invariably involves taking risks and not taking care of oneself. Movies are a popular means used to perpetuate this mainstream gender-role stereotype, ranging from a common plot device involving an adolescent boy who is declared to be “the man of the house” when the father is suddenly absent, to the daredevil astronauts glorified in book and movie form as having “the right stuff.” In stark contrast to the images of maleness portrayed in the movie *The Right Stuff*, Thomas Eagleton was forced to

withdraw from the vice-presidential ticket during the U.S. presidential primaries in 1972 because it was disclosed during the campaign that he had a history of depression that included both inpatient and ECT treatment. His withdrawal from that race was hastened by character attacks from the mainstream media, such as in editorials in the New York Times, Los Angeles Times and the Washington Post, calling for him to leave the race despite public opinion polls which showed that most of the public did not find him to be unfit for that office (Strout, 1995).

Consistent with the masculine image conveyed through sports and movies, the prevailing male gender-role, according to Moller-Leimkuhler (2003), reflects the value within Western culture for toughness in men through the characteristics of competitiveness, aggression, dominance, and independence, which often preclude the possibility of seeking help when it is needed. She proposes a gender model of male vulnerability instead of the traditional model of masculinity which places males at higher risk of both suicide and premature death, such as due to alcohol abuse, violence, and coronary heart disease. Although her vision for a new model of masculinity offers some hope for much needed changes in the experience of being male, her work and that of others reviewed above suggest that the risk of suicide can be greatly exacerbated by common gender-role expectations for males, especially among those who have a predisposition for depression.

Grounded Theory

Given that the completion of suicide precludes follow-up studies of subjects, suicide research is largely dominated by quantitative studies of epidemiology, along

with retrospective studies, such as psychological autopsies. In an effort to complement those efforts, the present study is situated within the context of primary care practice, where most cases of depression are treated. This study utilized a grounded theory approach to interpret the phenomenon involving the subjective experience that PCPs have in their routine assessment of patients who may be depressed and may also be at risk of suicide. A grounded theory study involving PCPs is pursued here because there are no known studies that offer insight into the role that the PCP-patient relationship plays in the effort to intervene in the pathway that many individuals take from depression to death.

Grounded theory arose from the field of sociology in the 1960s, and it involves the study of a phenomenon through an inductive process that results in the emergence of a relevant theory (Strauss & Corbin, 1990). It strives for an enhanced understanding of the human experience through a process designed “to explain a given social situation by identifying the core and subsidiary processes operating in it” (Baker, Wuest and Stern, 1992, p.1357). The essential elements of grounded theory include participant selection that reflects emerging hypotheses, simultaneous research processes, and a focus on the usefulness of the findings rather than the validity of the findings (Maggs-Rapport, 2000). Unlike quantitative studies, which test hypotheses that reflect research questions, grounded theory studies begin with the articulation of a research problem and related research questions, and then move into the process of data collection which ultimately yields a theory that is grounded in the data (Charmaz, 2006).

As conceptualized by Strauss & Corbin (1990), conducting a grounded theory study involves doing fieldwork to gather data, such as the PCP interviews in this study, and then simultaneously coding the data and testing theories that emerge from the data. Grounded theory was chosen for this study because my area of interest is PCPs' subjective experience of treating males for depression and suicidality, and the interpretative approach of this methodology can best capture the PCP perspective while also facilitating the construction of a related theory.

An important distinction regarding methods is offered by Caelli (2001) who notes that "*Methodology* refers to the philosophical framework that must be assimilated so that the researcher is clear about the assumptions of the particular approach, whereas *method* refers to the research technique and the procedure for carrying out the research" (p. 275, emphasis in original). Charmaz (2006) considers the methods of a grounded theory approach to be "a set of principles and practices, not as prescriptions or packages...[that can be thought of as] flexible guidelines, not methodological rules, recipes, and requirements" (p. 9). Her interpretation of grounded theory methods has guided both the design and execution of this study.

An advantage of utilizing grounded theory methods in this study is that the simultaneous construction and analysis of data throughout the study generated a theoretical basis for more fully understanding the PCP-patient relationship as it pertains to the treatment of depression (Charmaz, 2006). As a novice researcher it was also my experience that this approach best suited my analytical style, which in this case focused initially on the global question of "What happens when a depressed

patient sees his or her PCP?" which then led to more specific questions as outlined below.

Research Questions

Within the semi-structured interview format utilized in the study there was the flexibility to have some dialog with participants and ask different questions in any given interview, while also asking all participants a core group of questions. Prior to developing those interview questions I identified four conceptual research questions that I hoped to explore in order to address the research problem, which is that in the U.S. the rate of suicide completion is four times greater for males than it is for females, despite findings that indicate that females are diagnosed with depression twice as often as males. This study is situated within a primary care setting in an effort to learn how PCPs understand this research problem, and how their perspectives influence their clinical practice.

The first question had to do with the process of assessing patients who report or appear to have symptoms of depression. My experience as a clinician is to approach this task within the context of the patient's overall presentation, such as affect, and through their overall functioning, such as their ability to perform well in the areas of work, child care or school. The outcome of that evaluation typically leads me to recommend that the patient begin a course of individual or group therapy, and sometimes to also be seen for a medication consultation. I was curious, then, to learn to what extent PCPs rely on formal assessment instruments or clinical interviews to formulate a diagnosis and what treatments they were most likely to prescribe.

As a consequence of my review of the literature that is concerned with masculinity issues, the second question of interest to me involved masculinity dynamics, particularly deficits in help-seeking behaviors. While the literature review provided me with more context for the evolution of theory in this area of gender dynamics, the studies did not otherwise surprise me or speak to dilemmas facing males that I have not seen in clinical practice. So I was interested to hear how PCPs think about this area, given their different clinical training and focus, and to talk with them about what strategies they employ to facilitate effective engagement with their male patients.

Suicide prevention from a primary care perspective constituted the third question of interest. I found myself curious about how or if PCPs consider suicide to be a problem, as well as their sense of responsibility to address that possibility among their patients. More specifically, I was interested in their experience of initiating related interventions with their patients, and their relative sense of confidence versus competence in managing suicidal patients.

The phenomenon of being a PCP who is responsible for both medical and psychiatric disorders was the fourth question of interest to me. Other than as a patient who occasionally sees a PCP for some physical malady, I had no frame of reference for how the clinical practice of a PCP might be similar to or different than how mental health therapists treat patients for depression. There was also within this theme an interest in more global issues, such as time management and access to needed resources. It was otherwise my guess that developing questions to address these areas

of interest would likely provide some continuity throughout the interviews, but the richness of the responses would likely come as much from the unscripted queries.

These areas of inquiry are consistent with a defining characteristic of research questions from a grounded theory perspective, which is that they generally involve some type of action and process, and address interactional, organizational, or biographical dynamics (Strauss & Corbin, 1990). Those types of questions can be found within the scripted questions in the present study, which explore participants' relationships with depressed patients (interactional), the PCPs' various styles of managing the time pressures inherent in primary care practice (organizational), and the past experiences that PCPs have had in treating depressed/suicidal patients (biographical).

CHAPTER 4: METHODS

Design

This study utilized grounded theory methods to examine a crucial window of opportunity for intervention that occurs in primary care practice when a PCP meets with a depressed patient. The objective of this study was to explore the patient-provider relationship within the context of primary care providers' experiences in an attempt to identify variables that influence the process of assessing and treating depression and suicidality, particularly among males.

Two PCP/administrators were interviewed at the outset of the study to review with them the focus and structure of the study, and to get their input regarding the proposed questions for the PCP interviews. In addition to their input they also functioned as key informants who provided useful data that was later compared with data gathered from the PCP interviews in a process known as data triangulation (Maggs-Rapport, 2000). Examples of their input included a caution to be sensitive to the possibility that some PCPs might feel threatened by questions regarding their clinical practice or that some may have a personal history of depression, and they shared some of their experiences treating depressed patients. I also obtained other feedback regarding the study during presentations that I made at four monthly PCP staff meetings where an effort was made to recruit participants for the study.

Although efforts to recruit PCPs for focus groups that would have provided an opportunity to test questions for the individual interviews failed, mostly due to PCPs' time pressures, some impressions of PCPs were developed in the provider meetings

that helped inform the study and further triangulate the data (Berg, 2007). I noticed, for example, that many of the agenda items for those meetings were related to system pressures, such as quality management indicators and access issues. The scope of those expectations led me to question whether it was realistic for me to be able to find a sufficient number of PCPs who would be willing to participate in the study. There was only one PCP who volunteered for the study after hearing my presentation at a provider meeting and only one PCP who responded to a flyer that I had sent by e-mail attachment to a PCP distribution list. But I was able to develop an adequate sample by calling PCPs by phone, and interviews were subsequently conducted with PCPs at four Kaiser Permanente clinics. It was determined after 16 interviews that no new information was being gathered, indicating that the point of saturation had been reached (Charmaz, 2006), and no further interviews were pursued at that point.

The semi-structured interviews were conducted in an attempt to gain an understanding of any PCP-patient dynamics that, from a PCP perspective, may aid or hinder the assessment and treatment of depressed males. As with the interviews with the two PCP administrators, the 16 PCP interviews were recorded on audio tape to ensure that an accurate record of the data was established to enhance the credibility of the subsequent data analysis process. I then transcribed all of the transcripts and analyzed the resultant data in accordance with the data analysis framework of the research design, which involved open, axial, and selective coding.

An Investigator at The Center for Health Research (TCHR), located within the Kaiser Permanente Northwest Region, sponsored this study, and approval for the study

was granted by the TCHR Internal Review Board. Approval for the study was also obtained from the Human Subjects Research Review Committee at Portland State University in Portland, Oregon (see APPENDIX A).

Sample

The sample was drawn through my contacts at my workplace, Kaiser Permanente in the Northwest Region, which is a component of a larger national health maintenance organization. Through my managerial position within the Department of Mental Health at Kaiser, I had access to the department chief and the assistant chief, both of whom work closely with primary care and were supportive of this study. Through those contacts, support for the study was obtained from the vice president/assistant medical director of primary care, who encouraged regional leaders within primary care to also support the study through PCP participation. Recruitment of participants for the study was further enhanced through contacts I have with a mental health therapist who is assigned to one of the primary care clinics. Those contacts helped make it possible for me to gain entrance to the PCP provider meetings and to access certain PCPs who might be willing to be interviewed, none of whom had I previously met.

This study involved a purposive sample, which allowed me to use my knowledge of primary care practice at Kaiser to select participants for the study and gather input in an area where little information has previously been developed (Berg, 2007). In order to ensure that a broad representation of PCPs were included in the study, attempts were made to include approximately even numbers of male and female

PCPs, along with a range of experience within both urban and suburban clinics (see Table 1 at the end of this chapter for PCP characteristics). After initially conducting interviews with several PCPs who volunteered for the study when contacted, additional study participants were then sought during the latter phase of the study through the process of theoretical sampling, which involves seeking additional subjects due to a lack of saturation in particular categories that emerge from the data (Charmaz, 2006). Examples in this study include seeking participants who either did or did not have access to a mental health therapist stationed in the primary care clinic, and those who either did or did not endorse the notion of having a sense of community with patients, both of which are elaborated on in the next section.

Data Collection

Most of the interviews were conducted in PCPs' offices either during the lunch hour when the primary care offices are closed or early in the morning. All interviews were recorded on audio tapes which were then labeled by participant number only, and locked in both a file cabinet and office to ensure that confidentiality is maintained. The duration of the interviews ranged from 30-60 minutes, with an approximate average of 40-45 minutes. All study participants were given a small array of chocolates at the conclusion of the interview in appreciation of their time, and those gifts (\$10 each) were purchased at my expense. Following a brief overview of the study, interviews began with general diagnostic questions, followed by questions more specific to how or if gender issues play a role in the course of depression or suicidal

ideation among males. Interview guide questions related to general diagnostic issues asked at the outset of the interviews included:

a.) In terms of a percentage of your caseload, how common is it for you to see patients who are depressed?

b.) To what extent do you find the use of the QPD (Quick PsychoDiagnostics electronic questionnaire, used within the Kaiser system), or the DSM to be useful in making a diagnosis of depression?

c.) How do you determine when the use of those tools is indicated, and approximately how often do you use those tools?

Interview questions related more specifically to gender issues included:

d.) What signs or symptoms do you typically see in your patients that indicate that they may be depressed, and are there gender differences in what symptoms you see?

e.) What differences or similarities do you usually see among depressed male patients, as compared to depressed female patients, in the way in which they report or talk with you about their symptoms?

f.) Are there differences related to patients' gender that you think may influence your approach to a discussion with them about their depression?

g.) How do you go about identifying risk factors for suicide among your patients, and does gender of the patient play a role in this process?

h.) How do you go about engaging depressed patients in discussions related to safety, such as removing guns from the home or other harm reduction measures, and do those discussions vary by gender?

i.) Within the context of your practice experience, how do you understand the finding that females are diagnosed with depression twice as often as males, yet males complete suicide four times as often as females?

j.) What thoughts do you have about suicide prevention from a primary care perspective?

Responses to the questions above during the initial interviews led to the development of questions explored in subsequent interviews, with a particular emphasis on related gender differences or similarities, such as:

k.) How do patients respond to recommendations for antidepressant medication, versus a recommendation for therapy or for both?

l.) Do you see gender differences in how patients respond to a discussion of a diagnosis of depression, as compared to how they accept or engage in the treatment plan?

m.) Are there particular engagement strategies that have been effective for you when talking with patients about depression or suicide?

n.) Are there differences related to how females identify depression as a problem, compared to how males identify depression as a problem?

Other questions developed during the course of the interviews were also asked that did not necessarily emphasize the role of gender, including:

o.) (After providing an example or two from previous interviews,) do you have a sense of community with any of your patients?

p.) Have you had the experience of seeing patients who report physical symptoms that you diagnose as depression, to which the patient has a negative reaction, such as 'you're saying its all in my head'?

q.) Are there cultural factors that influence your experience of assessing and treating depression?

Participants were also asked their thoughts about the role that alcohol or stigma plays in the diagnosis of depression, along with questions about their role as a provider and how they manage the time pressure in primary care. I used a transcription machine made available to me by the Regional Research Institute at Portland State University to transcribe the interview tapes. Short memos outlining my experience of each interview and key points were added at the end of transcripts in an effort to clarify the relevance of main concepts (Charmaz, 2006).

Data Analysis

Analysis of the data involved open, axial, and selective coding. Open coding is done in the initial coding process, and it involves "fracturing" the data into small bits as a way to identify similarities and differences. Axial coding is a process of developing connections among the various categories and sub-categories that emerge from open coding, while selective coding leads to a framework comprised of the core categories that support the grounded theory (Charmaz, 2006). In actual practice there may be an overlap between open and axial coding, such that one often moves from

one to the other or does both at the same time (Strauss and Corbin, 1990), although in my experience this was a mostly linear process.

Charmaz (2006) stresses the importance in the initial coding process of developing short codes that focus on actions, without being influenced by preconceived notions or categories, and doing this on a line-by-line basis. In adopting that approach, my sole objective in the open coding process was to identify groups of similar actions and then label them with code names of three words or less in length. The axial coding process then involved developing groups of codes that had some obvious overlapping properties, and then further consolidating those groups through the selective coding process. I used a qualitative software program known as Atlas.ti (Scientific Software Development, 2004) to code and analyze the data by working from the transcripts to develop simple codes initially and then moved through the creation of more complex codes to the eventual formation of key themes. There were some exceptions to that process which involved a few simple codes that captured important concepts without the need for further refinement, such as the “suicidal risk” code. The coding process is more specifically described below within the context of interview questions and related responses.

Codes

During the initial coding process certain actions caught my attention in several transcripts, leading to the formation of many simple codes, some of which will be outlined in detail here to illustrate the evolution of the data analysis process. Most of the study participants, for example, reported that it is common in their experience that

a depressed male patient's spouse will make a primary care appointment for the male patient who is reticent to do so. The related open code "make appointment" later was subsumed under the broader code "problem identification," which also included the simple codes "patient reports depression" and "PCP identifies depression;" (make appointment + patient reports depression + PCP identifies depression = Problem Identification). It was commonly reported by study participants that females are more inclined than males to identify depression as the reason for their visit to the PCP, while in the case of males it was more likely that their PCPs raised this as a possibility. Questions a and n, from the interview guide above, provided most of the data that led to the development of the problem identification code, while additional support for this code and others came from either follow-up questions or unsolicited input.

Questions d, e and p provided a basis for the simple codes "females report sadness" and "males report stress," which were then merged with other input into the "symptoms of depression" code. It was reported that males often complain to their PCPs about pressures and stress related to their jobs, with females being more likely to tell their PCPs that they feel sad or hopeless, helping lead the PCP to a diagnosis of depression in either case. Most of the PCPs also talked about the tendency for males to increase their use of alcohol when depressed, more so than females, which led to the simple code "males abuse alcohol." There was an obvious overlap of those two codes such that they were subsequently combined to form the more global code "depression assessment," code which included other diagnostic distinctions related to gender.

“Males are guarded” was a simple code that had to do with male gender-role stereotypes, such as the notion of toughness, which participants suggested is a common defense seen among depressed males. A review of the transcripts suggest that the typical feeling states associated with depression, including sadness and hopelessness, present a dilemma for males who adhere to the conventional definition of masculinity and its aura of invincibility. Input elicited from questions k and l contributed to the construction of this code, which was later expanded into the “males and masculinity” code to encompass other related male identity issues identified in the interviews. The propensity for males to attribute both their problems and their treatment to others, such as *“my wife thinks I’m depressed”* or *“my wife thinks the meds help,”* rather than to ask for help, led to the development of the “evades the problem” code, which was then captured within the broader “help-seeking behaviors” code.

Many study participants reported that males often isolate more when they are depressed, and this was noted in the open coding process via the “isolates when depressed” code. It may be that it is easier for males to isolate themselves when depressed, according to an observation made by one PCP who talked about men retreating into their shop or garage to work on projects, while females traditionally have more need to continue to manage childcare and/or household responsibilities. There was also input from many of the PCPs regarding the limited scope of support systems among male patients such that the “isolates when depressed” and “lacks support system” codes were later combined within the broader “males and isolation”

code. The codes related specifically to male gender challenges, “males and masculinity,” “males and isolation,” and “help-seeking behaviors,” had considerable and consistent overlap to the extent that they were incorporated within the broader concept of “masculinity issues.” The blending of these three codes into the “masculinity issues” code seems to best represent or capture a collection of characteristics that comprise a certain male profile commonly seen by study participants.

In addition to the codes reviewed above, there were other codes that were identified that are also influenced by gender issues. A code regarding “females and vulnerability” is related to their depiction by PCPs as being prone to the gender-role stereotype of being weaker than males in some respects, but also as caretakers who neglect their own needs in order to take care of children and spouses while often being overwhelmed by this role. “Relationship with patient” is a code that was developed in reference to how patients, males in particular, may become less influenced by gender-role stereotypes in discussions regarding depression over the course of a long history of seeing their PCP. In those types of relationships, 20 years or longer for some patients, it is reported that some males have also developed physical problems, such as arthritis, that makes it more difficult to maintain an identity based on toughness, and perhaps consequently more possible to talk about problems with mood and the purpose of life. Younger patients, it was reported, tend to have PCP relationships of much shorter duration, often due to frequent changes in jobs and health insurance, which are not as conducive to building levels of trust that can facilitate discussions of

sensitive topics such as those captured within the “suicidal risk” code.

“Stigmatization” was yet another code that was not addressed by questions from the interview guide but it was an area of difficulty for some male patients, according to some PCPs who saw it as a potential barrier in discussions related to depression.

Among these stand-alone codes there are some areas of overlap but generally not of sufficient degree to warrant any merging of these codes.

Two simple codes, “uses formal tools” and “relies on interview,” reflect participant input related to interview guide questions b and c, and they were merged into the “methods of assessment code.” Responses to question h in the interview guide resulted in the simple code “asks about means,” which was then expanded with other input to create the “guns/harm reduction code,” that is a measure of the participants’ level of assessment and intervention in this area. Question g in the interview guide led to the “asks about suicide” code which had some overlap with unsolicited input that addressed participants’ confidence in their ability to assess suicidal risk to the extent that the “comprehensive suicide assessment” code was developed. These two codes were subsequently combined within the “risk assessment and intervention” code which spans both assessment/intervention strategies and participants’ thoughts about their related abilities to effectively conduct this task.

Interview guide questions f, i and m generated responses that led to the simple codes, “expresses empathy, concern,” “sees more frequently,” and “normalizes problem,” which were later consolidated within the “engagement strategies” code. The simple codes “works extra hours” and “maintains standard schedule” were

merged into the “managing time pressures” code, and the “counsels patient” code was merged into the “PCP in therapist role” code. There was then a consolidation of the “engagement strategies,” “managing time pressures” and “PCP in therapist role” codes into the “engagement style” code which captures all facets of input regarding engagement of patients.

The “use of BHPs (behavioral health professionals)” code refers to the access that PCPs have to behavioral health professionals at one of the four clinics where interviews were conducted, and it was left as a simple code due to its limited but useful input. There was also one other simple code, “sense of community,” which was not seen to warrant refinement, and it is explored in more depth in the results section, below.

Table 1. Primary Care Provider Characteristics

Participant Number	Sex	Discipline	Clinic Setting	Years of Practice
*P. 1	Female	MD	Urban	13
*P. 2	Male	MD	Suburban	25
P. 3	Male	MD	Suburban	20
P. 4	Female	PA	Suburban	8
P. 5	Male	MD	Suburban	15
P. 6	Female	MD	Suburban	10
P. 7	Female	MD	Suburban	7
P. 8	Male	MD	Suburban	6
P. 9	Female	MD	Suburban	18
P. 10	Male	PA	Suburban	23
P. 11	Male	MD	Suburban	21
P. 12	Female	MD	Suburban	27
P. 13	Male	MD	Suburban	28
P. 14	Male	MD	Suburban	20
P. 15	Male	MD	Rural	29
P. 16	Female	MD	Rural	12
P. 17	Female	MD	Rural	10
P. 18	Male	MD	Suburban	19

****Note:** participants 1 & 2 are PCP/administrators who were interviewed regarding the structure and content of the study, including the proposed questions for the semi-structured interviews with PCPs. In their role as key informants, they contributed to the process of data triangulation which involved comparing their input with the transcripts from the 16 PCP interviews (P. 3 through P. 18).

CHAPTER 5: RESULTS

Various passages from the interview transcripts are reviewed in this next chapter in an effort to further delineate the codes that emerged during the data analysis process. Prior to this review, and unrelated to the codes, is a brief digression that depicts the sense of humanity that I serendipitously discovered within the reactions two of the PCPs had when their patients completed suicide. These short accounts helped underscore for me the importance of this work, as evidenced by the powerful impact that suicide deaths have on others who are close to suicide decedents.

While my personal experience of the utter horror of suicide helped draw me to this study, I did not solicit nor anticipate discovering similar feelings among the study participants, but some surprised me with their candor in this area. An open-ended question asked of participants at the end of each interview was whether there was anything else they wished to add or areas that I did not ask about that may be of use in the study. A few of the PCPs responded by talking about patient deaths due to suicide, and their related experience of helplessness and grief as they watched that process unfold. Selected passages are presented here because it is their poignant stories that give voice to the scope of the pain that is inherent in suicide completion, and it is the power of that voice that helped drive my passion for this study. In the passage below, for example, this participant paused and appeared to deliberate before then talking about a suicide death that appears to have exacted a considerable emotional toll which PCPs are not immune to.

...I, there's this one patient that comes to my mind but it's not a man. It was a lady that I saw, and it was in the first two years here, and she was depressed and I knew it. And I talked to her, I saw her... probably five or six times before she committed suicide. And each time I saw her I just, I tried to get it out of her, I tried to, you know, find out what it was that was, that was so bad for her, and how could we help, and she just never, she just never opened up, she never did...she would not, she would not do it...she was always real vague about, about what was happening. And then she did kill herself, and that just, that was very upsetting...And that's the only patient that I've had that I know of that committed suicide, that I knew was depressed, that, um, you know, just, we just couldn't do anything for her...Whew, oh, that was rough...Talking to her husband afterwards and he said he knew, and he couldn't, he couldn't make an impact on her [P. 16].

This next example also graphically illustrates how the horror of suicide can envelope others in what is perhaps the ultimate personal tragedy, the taking of one's own life. It also captures a sense of inevitability regarding the outcome that is common in my experience both within and outside of this study.

I have had two men that I am aware of in my 20-some years here who have committed suicide and one was...a wonderful man, a family, young family, I was seeing the family and the patient...was on antipsychotic medicine, being treated by this psychiatrist, and then one day while his wife was in the shower he just shot himself and...the psychiatrist and I were both horrified, it was just

an absolutely horrible, horrible, horrible outcome. And you know I, certainly there isn't anything I could have done differently [P. 12].

In addition to the primary objective of this study as outlined earlier, a secondary objective, developed through those accounts, is simply to help raise awareness among PCPs of the potential for suicide among their patients. While this next provider is most fortunate to have had such a long career without having had a patient complete suicide, it is noteworthy that that possibility does not appear to have been given much consideration.

...I've been in practice 30 years, I've never had a patient commit suicide, you know, of course, attempts but I've never had anybody do it...[but] probably it would be higher on my concern if I had had a personal experience but I have to admit I haven't put a lot of thought into it...[P. 15].

Through this study I hope to garner the attention of providers like the one above, if only briefly, to say that the subject of suicide is important and is one that warrants one's thoughtful consideration. I did not anticipate when I embarked on this academic journey that it would involve interviews with PCPs, but it is clear from their input that the level of consciousness regarding suicide spans a broad spectrum.

The 16 interviews, while conducted with a semi-structured interview guide, were varied and wide-ranging in content. Interviewees generally seemed at ease and very receptive to the questions asked of them regarding their clinical practice experience as well as their perspectives pertaining to broader system issues. The PCPs who participated in this study talked at length about their experience of assessing and

treating patients for depression, and managing patients with varying degrees of suicidal risk. There were two styles of addressing this problem area which study participants described as either relying mainly on the use of formal assessment instruments used during the standard-length office visit, or through longer in-depth clinical interviews in which more background information is gathered.

Study participants also identified several gender differences that may complicate the assessment process for males. Two key themes emerged through the data coding process and each were supported by several relevant subcategories. The first of these themes, *Gender Differences Within the Assessment Process*, is comprised of the following subcategories; *problem identification, depression assessment, suicidal risk, masculinity issues, stigma, and relationship with patient*. This theme is explored below through passages from relevant transcripts.

Gender Differences Within the Assessment Process

Problem Identification

In regard to the onset of depression, this first passage contrasts the openness and honesty typically seen by this PCP among female patients, with the concealment and withdrawal often seen among males. There is also in this example the suggestion that females have more connection with support systems than males do, and that the severity of symptoms can be greater in males because of delays in problem identification.

I think that women in general feel more open and honest and agree to talk about what is going on...a woman is so much more attuned to it, and I think it

is because she has got so much feedback from people around her telling you, your mood has changed, something's up, mom you're doing this, or wives and husbands are bickering back and forth, and women have a lot to take care of. Men do too, but women have kids and houses and jobs, and that's our culture now, so I think whereas a man can sometimes kind of withdraw and kind of hide things much more and for longer periods of time before the symptoms are real evident, to the point where they are problematic for those around them... [P. 4].

It was commonly reported in this study that in the case of married males it is their spouses who identify depression as a problem, which suggests that some males may externalize their depression. Some PCPs suggested that depressed males who do not have a spouse or a partner to help define the problem may have more difficulty accessing primary care for treatment than ones who do, such as is the case in this next example.

...if you ask them [men], do you think you are depressed, after a while going through the depression list, and they say, oh, I don't think so but my wife does...[P. 6].

In addition to the role that families can play in identifying depression among and for males, the transcript below demonstrates the difficulty that some males have in the area of asking for help. This next passage also raises the possibility that some males may have different levels of awareness of the problem than females which may limit males' ability to identify depression.

With my male patients...I get a phone call from their daughter or spouse saying so and so is depressed, you need to see him now...[but] I don't know though if it's so much that they're not aware of it, as much as that they won't talk about it...[P. 7].

This next PCP seems to suggest that while the female gender-role stereotype that allows for an ability to be vulnerable may facilitate early intervention, males may have much higher acuity of symptoms and risk due to male gender-role expectations that impede help-seeking behaviors.

...I think more women are more willing to be seen as depressed and get treatment for depression than men. Now, I think...a lot of men would have...a much higher threshold before they would be willing to be diagnosed and treated for depression in general...And I think more women are willing to have a lower threshold to say, I'm depressed...[P. 8].

This next PCP offers the clarification that within the area of healthcare it is not only that males commonly fail to identify depression as a problem but rather that many men don't take care of themselves in general. This is an important distinction in that it seems to speak to a broader multi-factorial perspective in which males may fail to identify depression as part of a pattern of avoiding healthcare.

... a lot of times men don't recognize that they're depressed until you point out that they have all the symptoms, but...men generally neglect their health in all sorts of ways, not just depression, it's often the wife that has them come in... [P. 14].

Depression Assessment

Several of the study participants talked about how easily female patients report feeling sad or depressed, while male patients commonly talk instead about being irritable or angry rather than being depressed. Study participants also suggested that males are more inclined to use alcohol to mitigate symptoms of depression, while females have more of a tendency to misuse pain medications and other prescription drugs. In this first example and in some that follow there appears to be the possibility of a PCP bias to see women as being depressed or as being more depressed than males, perhaps because women identify depression as a problem more often than men do. It is also the case in this first passage that the PCP talks about women having symptoms of depression that are consistent with the DSM, while that is not the case with the symptoms noted for men.

...women tend to be more depressed, feel worthless, feel guilty a lot; women feel guilty a lot. Men feel more anger, more dissatisfaction with themselves or their situation, either work or home, feel unaccomplished. But mainly angry and just very passive, they just don't want to do it anymore...[P. 6].

In this next passage the PCP talks about the different ways in which males and females tend to misuse substances when depressed, although neither manner of substance abuse is recognized in the DSM as a symptom of depression.

...[females] seem to speak more readily about sadness and hopelessness than my male patients do. My male patients seem to focus more on their physical symptoms...I find it difficult to remember a male patient who didn't have

some sort of substance issue who was depressed or didn't have some other psychiatric diagnosis, who wasn't in a situational depression without substance issues...[and for females] I think the alcohol and the substance abuse is much less prevalent, they tend to be, on the other hand, poly-pharmacy, so they have medications for irritable bowel, they have medications for sleep disturbance, they have medications for anxiety and so on, so that may be another form of substance seeking [P. 7].

It is the combination of gender-related differences in symptoms of depression and the way in which patients talk about their symptoms that is one of the more common experiences reported by PCPs in the area of gender differences, such as in the following passage..

I think that the depression does present itself in a little different way in men frequently, so that they don't have that sense of sadness and it is more the irritability or, um, yeah, fatigue or irritability. I think the women are more likely to say they're depressed and to be tearful and depressed mood...[P. 12].

This next PCP captures the experience, mentioned by other study participants, of how males' expression of anger when depressed can create a crisis in their primary relationships that contribute to them getting treatment for their depression.

...females tend to be a bit more emotional, weepy, they're much more explicit in detail and what it is that's bothering them...a lot of times with men their depression manifests as anger and irritability, um, a lot of those emotions that are difficult for their partners to live with. So anger, I think, is one of the more

prominent ones with men...[Men] don't call it depression...[they say] I'm stressed out, um, I can't sleep, you know, my job is on my nerves, so they'll describe a lot of the symptoms that go along with it rather than saying I'm depressed [P. 16].

The following passage suggests that females' acceptance of treatment is greater than that of males, and it also shows how PCPs' gender bias can limit their ability to gather important clinical information from patients.

...women, you know, seem to be more willing to accept the diagnosis of depression than men do...I would say that [substance abuse is] more prevalent in my male patients, that they are self-treating depression that way. I think it's less common in my female patients, and I think I probably have a little bit of a bias, that I tend to ask about it more consistently in my male patients, so I might pick it up better. I don't know that I ask about it enough in all of my female patients, I feel that I probably have a bias and I probably miss it a little bit in female patients [P. 17].

Suicidal Risk

While much progress has been in identifying various risk factors for suicide, much remains unknown about which at-risk patients will complete suicide. Within the context of gender differences, PCPs in the following passages speak to a range of factors that influence suicidal risk, including protective factors, gender-role stereotypes and age. In this first passage the PCP cites protective factors for females

and masculinity issues for males as significant variables in the assessment of suicidality, and it appears that this provider commonly explores this area with patients.

...a woman would tell me yeah I think about suicide but I would never do it because of my kids, where I don't hear that from a man...rarely do I really hear from a man, you know, that I would be leaving three children behind...and I think because it is something that is more shame-based [for men]. I think it is real hard to come out and be open, and I think oftentimes it is just easier to say, you know what, it would be easier for everybody if I was I just gone, they would get my insurance money...[P. 4].

In addition to a reference to masculinity issues that can contribute to suicidality for males, this next PCP observes that the physical connection that females have with their children serves as a protective factor for them. Although not directly stating this, the PCP also suggests here that females have an emotional bond with their children that is unique and incredibly powerful, and a particular protective factor that is foreign to males.

...I think that we're still decades behind...understanding what depression is and how it can manifest, and...think that the men have a much more (sighs), a much more view of themselves as being weak if they have that diagnosis. And that that can create a vicious cycle, I'm weak and I'm worthless, and therefore I'm just going to end it, um, and I think the women, even though their diagnosis is more frequent, I think they have a better social support, they're more willing to talk about it. They have the children that they've borne

that, I think, serves as a better tie to living, um, men, while they're fathers, don't have that physical connection with their children that women just have, because the fathers didn't bear the kids, and I think that can separate them a little bit from not hurting themselves for that reason. Um, I think men are just less likely to talk about it and less likely to be seen frequently even if their symptoms don't improve, that they're more likely to say, "The hell with it, you know, they didn't figure it out so, we're done" [P. 16].

This next passage reflects the reality of the higher rate of suicide completion among males, along with the challenges inherent in engaging males in discussing related risk factors.

More women talk about suicide, some are open, some of them maybe have tried in the past, some attempts. Men don't talk about that, they usually don't talk about, say, you know, I feel suicidal; only if you ask them ...but definitely I pay more attention to the ones that have risk factors no matter, especially men because they don't open up...I think it's much harder in men to figure what their likelihood of, you know, committing suicide or what it will be. And on the other hand, in women, you know, they may have ideation or attempts, you know, but they're not successful...[but] it has to do again with the ego, the women are supposed to be the weak ones, and the men, if I think about it I better do it for good because I don't want anybody's pity, you know, because I'm a man. Women can do that, can live with that every day of their lives, but I don't really want anyone to pity me...[P. 6].

There is in the last passage a suggestion of resignation that may be associated with suicidality among older patients, which speaks to the high rate of suicidal completion among elderly males.

...my older male patients are going through a very different approach to suicidal gestures than my younger male patients are...so a lot of my older male patients are so isolated and a suicidal gesture wouldn't get them anything...[P. 7].

Masculinity Issues

Early intervention in the treatment of any disorder, whether it is heart disease or breast cancer, is clearly associated with better outcomes both in terms of treatment efficacy and the ability of patients to live longer despite having a serious illness. The area of help-seeking is related to early intervention, and it is one of this study's three main concepts that are reflected in this next passage.

...we know for a lot of other medical conditions men tend to show up later along the course of the illness than women do. That is true of heart disease, hypertension, a lot of the usual chronic diseases that we take care of, diabetes...I think in general for a lot of things women tend to show up at early stages of the condition and more likely to sort of bring it up as possibilities; I think I may have heart disease, I think I may have diabetes, I think I may suffer from depression, or something like that...[P. 3].

Support for the notion that males tend to be more isolated in general can be found in this next passage, along with the observation that females tend to have a stronger sense of connection with other females.

...I think it's just the way women behave, is that, you know, women network more and they share the feelings and symptoms more among each other, so they will often talk about it more among their friends and family members and then, you know, somebody will suggest, you know, this doesn't sound right or maybe you are depressed; I know so and so who has that. So they have a...tendency to bounce this off of other people so that they sort of come in with that mind-set that something like that could be going on...[P. 3].

There is also in this next passage the assertion that there are gender-role expectations for males and females that are consistent across cultures, and that for males can be rather self-defeating.

Whereas men tend to keep to themselves about these kinds of things, and so, you know, you are not necessarily [going to] talk to your coworker, and say I think I'm depressed, I'm feeling tired; I mean, it is much less likely to happen, so they sort of stew about it for a lot longer, you know...Whereas women tend to sort of initiate that conversation with their peers and then come to that conclusion...I don't think it's necessarily [just] this culture, you know, in Chinese there is a proverb that says...men shed blood, not tears, is how it goes. There is in tears shed a commonality; the blood flows, the tears don't, is another way to put it...[P. 3].

This participant conveys a strong sense of respect for patients in this next example, along with strong clinical skills that also facilitate a comprehensive assessment with both males and females. There is also here the identification of shame and embarrassment as components of depression for males, likely reflecting the gender-role expectation for males to be tough and powerful.

I don't come out and ask [men] real frank questions, like, are you depressed. I try to be a little bit more subtle about it because sometimes it's offensive. Sometimes it's shameful and embarrassing for men...Males, it's a little bit harder, just because it can be reserved...and I wouldn't say macho, macho is not the word, but prideful....males don't talk about it and it's not as obvious and...men are just that strong, silent, stoic [gender]...[P. 4].

While anger can be seen as a defense against depression and a related sense of heightened vulnerability, increased isolation among depressed males may serve as a protection against intense emotions but therein is also the potential for increased suicidal risk in absence of treatment interventions, as outlined below.

[Men] are aware of the different emotions that they're feeling like the anger and wanting to isolate and that kind of stuff but they don't equate that, they don't understand that's depression [P. 16].

It is striking that the PCP in this next passage identifies a sense of failure as a common male reaction to the experience of feeling depressed, suggesting that this is somehow unmanly or shameful.

...[with depressed] male patients you have to kind of pry it out of them...[and then reassure them that] it's not a failure on their part or failure of their self or masculinity, um, that they need help with these problems [P. 17].

Stigmatization

The stigmatization of depression may be a factor in why some patients choose to seek help for depression in primary care rather than in the specialty area of mental health. This next passage attests to the toxic power of stigma and how, in the case of mental illness, that force can erode the very essence of an individual's sense of self.

[Men] feel the stigma still of the label of mental illness and that it's a character flaw or something wrong with their strength, that they're not able to deal with what life's dealt them so far. So I think for them I think it feels like a weakness...[P. 16].

The PCP's approach to this problem in the following example area appears to reflect a collaborative approach to treatment that is also sensitive to gender issues.

I think that with male patients, um, you know, I think you have to spend more time convincing them that they're not crazy, this is something that we can overcome...[P. 17].

There is in the last passage a recognition of the stigma associated with the diagnosis of depression, and the futility of making that diagnosis if the patient does not accept it.

There's a huge stigma, and if it's not going to lead to, if the diagnosis alone is not going to lead anywhere I'm not going to bother to make it...But if I'm

trying to sell them on a diagnosis, um, I want to tread carefully not to offend them and drive them away from the office [P. 8].

Relationship with Patient

Some PCPs report that it is not only the length of time that they spend with patients in any given clinic visit that helps facilitate discussions regarding depression, but also it is the relationships they develop with patients over time that influences this dialog, as shown in this next passage.

...I think what happens is that I've known these people a long time and they bring it [depression] up more often, so they get treated more...[P. 3].

Within the context of long term patient-provider relationships it appears from this next passage that some providers can more easily recognize increased symptoms among their patients because of their familiarity with them, and then are able to offer related feedback that patients are willing to accept because of their trust in the relationship.

Um, now that may be the benefit of a having a long-term relationship with folks, where, um, I've seen them through ups and downs, so I may have an intuition about how serious something is...if a person has gotten through three bad phases in 15 years and I can say, you're in a rut again, we're going to give you more medicine to get you through this rut, there's usually optimism and not fear. People having personal experiences of getting through things and then when I can be able to remind them of that it's pretty powerful [P. 5].

The PCP in this last passage also reports that gender differences among elderly patients seen over a long period of time may be less of a barrier to discussions related to depression than is the case among younger patients who do not have long-term patient-provider relationships.

I had in Salem, you know, older men patients who opened up to me because they knew me for so long, and most likely they would mention that I wouldn't tell anybody else but I know you for so many years, you know, this [depression] is what I think is going on... So I think after I have patients for awhile, for couple of years, that ratio disappears, it's like men and women equally come and say that they feel depressed. [P. 6].

Prominent among the key ideas within the theme explored above is that many males are reluctant to seek help from their PCPs in general or to ask for help with depression in particular. Males also tend to attribute their depression to physical complaints, increased irritability or anger, as compared to females who appear to be more likely to report feelings of sadness or hopelessness. Some study participants suggest that parenting children may be a stronger protective factor for females than it is for males in the area of suicidal risk, and that males are less inclined than females to report suicidal ideation. There is also within the first theme consistent reports from PCPs which suggest that males often evidence feelings of shame and embarrassment regarding their depression, perhaps as a consequence of the influence of gender-role expectations to be strong.

The second key theme identified in this study, *Style of Clinical Practice*, includes the subcategories; *methods of assessment, risk assessment, engagement style, sense of community and use of behavioral health professional*. Through the analysis of these subcategories it is apparent that the patient's experience of treatment is likely influenced by the provider's practice style, and it was found that there is considerable variability within that style. The presentation of data that follows begins with a focus on the assessment process and then expands to what I found to be important contextual elements of the patient-provider relationship regarding ways in which some PCPs think about suicidal risk and management.

Style of Clinical Practice

Methods of Assessment

Throughout the process of comparing and coding transcripts as the data were collected, the methods of assessment code was unique in the dichotomous organization of PCP responses that emerged. Participants either described assessing depression and suicidal risk through in-depth interviews that typically included questions regarding related family history, or they reported the use of questionnaires to gather data upon which a diagnosis could be ascertained. There is some natural overlap between the two approaches, given that both have a common grounding in the DSM criteria for depression. It is the subjective element of the patient-provider interaction that is of primary interest, because the interview format has more potential for PCPs' ability to engage with patients through their curiosity and interest and build a relationship. A related implication is that the clinical interview format involves the

patient and the PCP spending more time together, than is the case for the patient completing a questionnaire in the lobby, and that longer face-to-face interaction could mutually enhance the sense of patient-provider connection.

Several brief passages were chosen to illustrate the two very different ways that participants approach the assessment process. Frequent references are made here to a hand-held electronic mental health screening tool, the Quick PsychoDiagnostics Panel (QPD), available to all Kaiser PCPs in the Northwest Region, and it is referred to below variously as the QPD, the Shedler (who developed it), and the black box (which is a slang term for the QPD common to the primary care settings).

The first transcript in this section reveals a reliance on objective instruments to the extent that the question of suicidality is addressed through the patient's completion of a formal assessment questionnaire rather than by way of a discussion initiated by the PCP.

...[suicidality] is part of the screening, you know if you get to that point. The tools that I use most, is both the QPD, as well as the PHQ-9; both have the question... since I have been using the tools I don't even ask because the tools take care of it. I do the PHQ-9 because...it is just a series of questions that goes right to there and it is sort of like if you blink too hard you forget, you'll miss it, so it isn't like you sort of set it aside... they just answer like any other question [P. 3].

By comparison, the provider in this next example places a high priority on engaging patients in discussions related to symptoms of depression.

We have a black box, and often times it's not working, and by the time that I actually dig under the surface, I don't want to say hey, let me stop and go get this tool and have you fill out this questionnaire. Because it kind of breaks the stream of consciousness and kind of their openness and their honesty, and sometimes it's tough to get them started in that direction again, and if I get someone talking in that direction I certainly don't want to stop it...[P. 4].

It is fairly clear from this next passage that some providers have certain limitations in how the diagnosis of depression is conceptualized. This response is also rather curious in that the participant seems to rely on an instrument that is based on DSM criteria, yet also states that he does not follow those same criteria. It is also may be the case that what is being referenced is minor depression rather a major depressive disorder.

I have a very good medical assistant, that black box, she's astute enough that she'll sometimes tell a patient that they need to take that before I see them...I'm probably not good at following the [DSM] criteria to establish the diagnosis [of depression]...There's no question in my mind, whether you establish the diagnosis or not, formally, many of the medicines used for that diagnosis do good. So I tell people that I want them to be as happy and healthy as possible. And I know, there's a side of me that's embarrassed about that, that it's not being scientific...But, when I can get people happier and healthier, I feel that it's still an okay approach [P. 5].

The depth of skills and overall sense of compassion both seem rather limited in this next example. There may also be a reciprocal dynamic at play here involving deficits in help seeking behaviors on the part of male patients, and a subtle bias on the part of the PCP to not see male patients as being depressed.

Um, but a lot of times I'm sure that I don't pick up a lot of depression if a man comes in and, I don't know if they complain about it, because they usually don't complain about depression or irritability or things like [that], so I'm sure I don't pick up a lot of stuff like that ...[so] I usually do the QPD...I'm sort of depending on the QPD, it helps me a lot...the QPD is really helpful too because some people will say, you know I'm not sure if I'm depressed, and then...a lot of stuff comes out...The QPD is invaluable; I use it all the time...Any time they talk about having an emotional problem, any time there is depression or anxiety or anything I just whip it out...[P. 9].

The bias in this next passage is not at all subtle, and instead reflects an assumption that male patients are typically either dishonest or unaware of their own distress.

[regarding the use of the QPD,] I think it depends on the circumstance, that I find out, my experience has been that when it's guys I don't find it to be as helpful to me because I think guys lie when they are answering questions like this or don't have the same kind of self-perception, as opposed to women...But I think it's a good starting point [P. 11].

This next approach appears to typify a basic symptom related style of assessment that is devoid of a broader relational or situational context. Given that the Shedler is based on the DSM criteria, it not clear from this PCP's response why the symptom check-list is favored here over the Shedler.

Um, I use this (holds up a laminated card, which is on his desk) which is from the DSM, I think, for major depressive, versus a finding for minor depression, um, so, I use that pretty exclusively. The Shedler is sometimes when the patient is not a very good historian and it's kind of ambiguous...but I don't use it all that often [P. 14].

This next provider appears to have an appreciation for the context of the presenting problem, both historically and in the present, neither of which is captured by symptom check-lists.

[regarding the use of the QPD,] Uh, I don't find that as useful as my interview most of the time...I think that my interview is pretty accurate and I think family history and talking about what happened in childhood and how important that really is, as goofy as it sounds, you know, all that crap that happened within that clan does have a bearing on how you are...[P. 16].

Risk Assessment and Intervention

Assessing suicidal risk is a type of assessment that requires a wide range of sophisticated skills, and it is an area in which many participants questioned their own competence. Their candor about this came as a surprise to me, as did the deference accorded to me as a mental health professional by some due to my experience in this

area, both of which suggested that some of the participants would welcome some help in this area. Many of the PCPs interviewed for this study also indicated that they do not have a great deal of confidence in their ability to assess suicidal risk. And many of the study participants appeared to be uncomfortable exploring this area, and their clinical style was characterized by uncertainty and misinformation. All of these providers reported that they routinely see depressed patients and some of them are referred to mental health for further evaluation, but there is some potential for a lack of follow-through with the referral that could then potentiate the risk. There is, then, in the passages that follow a level of concern about this risk that is expressed by the participants. This next passage suggests that the question of risk invariably presents a dilemma for this PCP.

[in regard to assessing risk factors]...I have to think now about my patients who have attempted suicide or who have succeeded. I will say, um, I've done a piss poor job of that, I think... And I really don't feel like I am competent to make a determination if somebody made a gesture as a call for help, versus an attempt which was truly trying to kill themselves [P. 8].

This participant reports in the next passage a lack of expertise with suicidal patients as a simple statement of fact, and in the process suggests that there may also be a lack of confidence in the area of the patient-provider relationship.

...I'm out of my league with somebody who I think is, you know, really suicidal or whatever, because I'm certainly not an expert at dealing with people...[P. 11].

This next passage lacks the clarity of the previous one, in that this provider does not seem to have a good awareness of the extent of the gaps in the screening process outlined below, such as the lack of concern for suicidal risk among younger males.

For men, I think I'm probably not very good about assessing for suicide potential in the men, um, I worry about it more in some of the older men, um, the younger men, um, I think it's probably, when I see the younger people I'm maybe not as concerned about the younger men in most cases as being suicide potential...I do not typically ask about, um, weapons or guns in the household, and that may either be that I don't think about it or because it's I haven't, um, it doesn't come to me often enough that I feel like I need to do that routinely [P. 12].

Other responses from participants suggest a need for basic education in the area of suicide risk assessment, such as this next passage.

One of my patients who committed suicide, she hit everything. It was, if I had a list of all patients carrying a diagnosis that said who was at risk, she would have been at the bottom...she had a long history of treatment, in counseling, checking in, reporting in, doing well, looking good, you know, vivacious, engaging. Yeah; just, none that I would think of as indicators...Um, so, um, I'm not sure asking helps...So, I don't ask too often ... I don't know what the statistics are for overlap between depression and homicide and other violence,

but I've heard that as well. I probably ask more about those sorts of things with that concern than suicidality [P. 5].

It appears that while this next participant may be quick to refer high risk patients to mental health, there does not seem to be a high priority placed on identifying these cases in any consistent or comprehensive manner.

As far as the person that comes in and, you know, says something totally unrelated to being depressed or to the point of suicide and not picking up on the cue, I don't have any idea how often that happens but...I feel like I don't know a lot about it, um, and I have probably a low threshold to pass it off to somebody in mental health to take care of, on the one hand but on the other hand it's like I'm not looking for it a lot (laughs), you know [P.13].

The participant in this next example suggests both a lack of competence in assessing suicidal risk, and also a fairly low level of confidence in this area.

I don't have, um, I probably don't do a very good job of that, have a systematic way, I usually just flat out ask them, you know, have you had any suicidal thoughts... I don't really know what other doctors do but I think they do a better job than me in really checking it out...I just sort of drop it and move on...I would think most of the doctors in this clinic feel very comfortable, I certainly feel comfortable, I don't know that I, you know, pick up on it [suicidality] and treat it right but I feel like I know what I'm doing whether I do or not [P. 15].

Two crucial components of any competent risk assessment address the areas of suicidal intent and means, and for men in particular this has to do with access to firearms. The PCP's report in the following passage suggests strong skills in engagement and risk assessment, coupled with a focus on risk reduction.

...once they [men] have gotten down to the nitty gritty of, yeah I feel awful, and, yeah I have thought about this or that...then I'll say, you know, I'm concerned that you have guns in the house and I'd like you to get rid of those. And oftentimes they will, and I don't know that they always do...But often it's somebody who is pretty profoundly depressed and they know it, and they, you know, they have kind of played with the idea of, I could shoot myself and this would be all over with. They are pretty good about it, at least they tell me if they are thinking about it...sometimes when I see them they still look like they are in bad shape, and I'll say, I want to review the guns [P. 4].

There is in the next transcript both a routine question in the physical exam regarding firearm availability and, curiously, a more selective examination of firearm availability for depressed patients.

...one thing that there is in the social history that you do for any physical, that's one of my questions about, do you have guns at home and do you keep them locked, you know...Then, for depressed patients, um, I don't always, I mean if they're just depressed, you know, they are contemplative, like, okay, I'll try this pill, you know, see how I feel, they're hopeful that they're going to feel better. And I ask them, if they have no intention, or no ideation, no suicidal

ideation, um, or death thoughts, I most likely don't ask them if they have guns because I don't think the risk is there [P. 6].

This next provider also appears to have a rather selective manner when asking depressed patients about firearms, and there is a certain sense of resignation in the observation that there are many patients who have guns and will not part with them.

But assessing suicidality in a primary care setting is incredibly difficult because it is one of three or four problems which you have to try to address in under 20 minutes... when I ask about suicide risk, I will ask them about things like guns in the house or usually I just ask in general about plans. I mean, part of the problem too is that I have a lot of my patients live out in the country, and so trying to tell them you can't have guns in the house, well everybody does; they're not going to agree to that...[P. 8].

The response from this PCP in the following passage was unusual and difficult to understand within the context of the comments from other study participants who do seem to accept varying degrees of responsibility for making some attempt to explore this area.

[asking about removing guns from the home,] Um, only in jest. I have not really discussed that with them, I usually, a few of the people that I've talked to I've called (social worker)...And I think they're probably going into it more than I am, I'm not sure that they want to hear that from me, I'm not like a law enforcement kind of person [P. 10].

As is the case with many of the other passages here, the PCP below speaks very frankly with patients about suicidal intent and means, and also addresses appropriate harm reduction measures.

...I'm not one to beat around the bush and when the time is right I'll flat out ask, and, do you have plans, and have you tried before and, you know, are you giving things away and selling off stuff...And I will talk to them directly about firearms or ask them if I can call their wife or whatever, you know, try to find ways to make sure that they're safe and then give them the hotline number and mental health number and stuff like that...[P. 11].

This next provider does not discriminate when asking about firearms and appears to have a unique appreciation within this sample for the heightened risk of harm that is associated with substance use.

...I'll come right out and ask them, are you thinking of hurting yourself, have you ever thought of hurting yourself, have you ever hurt yourself or tried to, um, so that's a pretty standard question for everybody. Um, I'll ask about firearms in the home and impulsivity, you know, do you have thoughts, just even for a second (snaps fingers), that you don't want to be here, and, um, you know, ask about their family history of depression or suicide. I'll ask them if when they're drinking or when they're high, do you feel more suicidal at that time or more likely...I'll just ask if you're thinking of hurting yourself or killing yourself...If they answer that they have guns in the home I ask them to lock it up if it's not locked up...[P. 16].

Unlike the last passage, what is described by this next PCP is another example of how a decision to ask about means depends on the answers the patient provides to other questions, rather than routinely asking every patient about firearms in the home.

...I usually ask them, um, you know, thoughts, plans, ideas, um, sometimes if I feel that they're going to react to that or I'm not sure that I'll get a truthful answer I'll, you know, phrase it in the sense of, you know, sometimes patients feel so down they wish they were dead or, you know, do you have any thoughts like that. Um, and then depending on the answers to those questions, you know, are there issues, um, pills, guns, you know, things like that...[and if there are guns,] Usually I would try to see what, um, other family members, significant other, somebody else who's interacting with that person and I'll try to enlist, you know, their input or support for that...[P. 17].

Engagement Style

Managing time pressures in the primary care setting is explored here as one component of PCPs' overall engagement style, and there was generally very little middle ground in how this was discussed. Providers generally seemed to either work extra hours so that they could spend more time with patients, or they consistently worked to limit office visits to the standard 15-20 minute length. A correlation between conducting comprehensive assessment interviews, and spending more time with patients is noted, as is a correlation between the use of assessment instruments, and shorter office visits. The descriptions presented here reflect the high priority that some of the participants place on the time that they spend with patients, in contrast

with a clinical style of practice in which that is not the case. With this next participant the patient is clearly the priority regardless of the time pressures, involving choices that reflect a broader philosophy of practice.

...[I] just try to not to feel, not to make them feel that you're rushed...I've been doing this long enough to where I don't care whether I leave late or not, which is different than the way a lot of people feel and so they will rush through their patients. I'll rush through my charting and I will rush through my lunch, but I try not to rush through my patients...[so that I can] enter an exam room casually and truly not be in a hurry and, more than just taking two breaths before you enter, it's actually more the philosophy you have for your overall work schedule...[P. 10].

The provider below speaks to a personal philosophy of treatment which places a high value on the art of listening to patients, rather taking a more directive approach, apparently without much regard for the amount of time that this requires.

I take longer with patients than most people and I'm pretty, um, pretty interactive, really try hard to listen and then spend more time with them...So I think the majority of people feel very listened to and I think that makes a difference...I work a half FTE...and then I just tend to work longer days. So for example I've had a relatively easy morning in terms of seeing people but I haven't done my notes yet...I think that some people really look at their schedule and say, um, okay, I've got 15 minutes for this patient or 20 minutes for this patient, I don't do that, I never look at how much time, I just go in, I

look at what the problem is and, you know, I usually listen...I just try to go through the problems. So my philosophy is...not necessarily solve but to try to grasp the problems that are brought that day to end up with some sort of a result or a, you know, movement forward...and in most cases that happens and so I pretty much don't care what the timing is or how long it takes, it's more do you reach completion or where you want to be with that particular issue [P. 12].

Again, what follows below is a clear example of a participant who has chosen to be fully present for patients regardless of the consequential trade-offs, which in this case includes working from home throughout the week in order to complete chart notes.

(sighs, then laughs) You know, that's really not something that I consciously worry about because at the end of the day it all tends to balance out some way or another...I spend a lot of time with my patients and I think my time on the computer probably suffers and my time on paperwork will suffer as a result, so most of that is done after hours and in the evening and weekend. So, I don't think the patients suffer from a lack of face-to-face time [P. 16].

What is lacking in this next passage, as well as in the ones above, is any expression of resentment about the sacrifices that this PCPs chooses to make so that more time can be spent with patients in the exam room.

...it's hard, I think, although I think that no matter what happens with the time pressures, you know, for the most part the time in the room is the quality and

the bread and butter of what we do, so it's the other stuff here at the desk that becomes, it's more mundane or more, where you don't get everything done, um, or you save it for the next day, you come in on your day off to make up. So hopefully, you know, when you're in the exam room the patients are still the parts that you enjoy and that you can still take the time with [P. 17].

Other providers, such as the one below, take a different approach to the length of the office visit, such as the PCP below who limits the time spent with patients, and seems somewhat conflicted about that.

And I'm a little more selfish or protective of myself, maybe not in a volitional way but I've just built those little fence things in and can maybe sense the patient wants to talk a little more and I use some kind of phrase or something to cut it off, I mean I reach for the door and try to use my people skills the best that I can but I'm aware that with unlimited time I can be more up to my patients or, you know, if I wanted to stay...but there's a tension, I think about it quite a bit, it bothers me [P. 15].

This next PCP strives to maintain the standard office visit schedule, even when addressing high risk problem areas.

But assessing suicidality in a primary care setting is incredibly difficult because it is one of three or four problems which you have to try to address in under 20 minutes [P. 8].

The PCP in this last passage appears to manage the time pressures in primary care practice by being very selective about which potential problem areas merit attention during routine physical exams.

I mean, it is like, gun violence, is another issue; Should that be part of every physical? Do you have a gun? Is it locked? Sure, I mean, that's fine, but at some point you have to say how much can you sort of squeeze into an exam... There are lots of things that I don't screen for... because there is just so much time you have... There are good screening tools for a lot of different things but if you put them all together in one sitting... you would be there all day... [P. 3].

Sense of Community

The experience of having a sense of community with one's patients was an unexpected concept that emerged during the early course of the PCP interviews, and it was yet another area in which participants either strongly resonated with the concept or rejected it as foreign to their clinical style of practice. Within the context of the PCP interviews, having a sense of community with patients refers to the experience of having a reciprocal interest or background with a subset of a provider's broader caseload. A consistent observation among those providers who endorsed the experience of having a sense of community with their patients was that there was no hesitation in their response to being asked about this, suggesting that they have an awareness of this element of their patient-provider interactions. It is also noted that in the passages below that describe some PCPs' experiences of this concept are

participants who typically work extra hours so that they can spend more time with their patients, suggesting that these providers may have a bond with their patients that is unique.

This particular concept originated in an interview with a provider who is from another country, and has a subset of her provider panel that is comprised of patients from that same country. She reports that she and these patients converse in their native language, and she says that some of these patients talk with her about their mental health concerns, such as depression and anxiety. It is the connection through their shared homeland and language that brings those patients to her rather than to speak in English with other providers, she says, and it is through that sense of community that she is for them sometimes both a counselor and a PCP.

Unless it's a good rapport with the doctor and they feel confident that they can use the doctor not just for medical things, you know, treat this, this, and that, but also as a counselor. And what I found here in this area there is a large [foreign] community, and I come from [that foreign country] so I speak fluent [that foreign language], and I've got some [of those foreign] patients, and I feel like, at least for a couple of them, they have anxiety and depression, and I feel like I'm their counselor also. They won't go to talk in English to the mental health provider [P.6].

In the course of analyzing the data in the example above, it was found that that participant response was similar to but different than a previously developed code, Relationship with Patient. That led to the development of the new code, Sense of

Community, and to a related question asked in the remainder of the interviews, within the context of theoretical sampling as defined by Glaser (1992; as cited by Coyne, 1997). When a PCP in a subsequent interview was asked about having a sense of community with his patients, he talked about the difficulty inherent in developing trust within the PCP-patient relationship when patients do not have the perception of a shared background. He also stressed in the passage below the importance of maintaining a safe environment in his practice, and how as a gay provider he has developed a sense of community with several gay male patients.

So I think it's a lot more difficult to develop a trusting relationship with a patient if you're not from, if they don't perceive you as from the same background, you know, and that really depends on, you know, how much I'm willing to self-disclose with them. So, for instance, I have a contingent of Black gay men who see me regularly and it is a very, very, very safe environment...[and] Young gay people from traditional cultures almost invariably when they first come to see me feel like they need to be treated for depression and anxiety, and most of them don't stay on antidepressants, most of them come out and they realize that all their depression and anxiety was about the fact that they were depressed and anxious about coming out...[P. 8].

In this next passage a male provider talks about how his informal manner of dress and speech helps him develop relationships with blue collar male patients in a way that facilitates discussions regarding depression and related treatment options.

I seem to have more new diagnoses of depression in men for some reason, I think, I just get the feeling that...they're more willing to open up to me...I think the group that probably connects with me the most is, with my persona, would be, because I don't dress real fancy, I generally look like an average guy who just finished changing his flat tire, and so I think I'm able to connect with some of these...male blue collar workers, that others can't ...And I actually feel that I'm connecting, I feel that I'm basically just a middle class worker who just happens to be in the health care field [P. 10].

In speaking to his sense of connection with his patients, the PCP below reveals his sense of self and his understanding of how that influences his relationships with his patients.

Well, I think overall in terms of who I am as a person that I came from very humble means growing up and I've had to work real hard to get what I have. It's the old, you know, 20 miles each way uphill to get to school and all that kind of stuff, and so I think that comes across in who I am. And I have a lot of guys in particular who come to see me just because I don't get offended by their off-color language or they can just tell me how they feel, and I'm not judgmental, I don't have to put on airs, I can give it right back to them. That leads to a certain comfort level for certain patients, 99% of that is males, that they might not get elsewhere, or at least it seems that they appreciate that from me, which is why they stick with me. I have guys that have been seeing me for over 20 years, that are just like that forever and ever, so I would say that if you

want to call it a blue collar or being able to relate to anyone but I think that particular group of especially male patients for some reason I've got a bunch of them [P. 11].

Although gender concordance was a common feature of having a sense of community with one's patients for some of the PCPs, there were exceptions to this, such as this report from a provider in the following passage who feels that his strongest connection is with female patients.

I think that I have a tendency to be the practitioner that women come to, you know, of the men around because I, this was partially by feedback from, like the social worker, you know, would see that somewhere, I left more room for people to emote...I think I might have a little bit more difficult time getting into a man's mind, kind of set, than some people because I probably have a bit of a man and woman's mindset about stuff. I don't think I have a categorization in my brain about, you know, women are this way and men are that way...I think it's just more a sense that women are more inclined to come in and start talking about stuff [and I] probably have a predisposition to seeing female patients when there aren't female practitioners here [P. 13].

This next provider indicates that her core values and beliefs form the basis for the philosophy that define her identity as a PCP and guides her work with all patients regardless of gender.

I think my sense of community is more, more about humanity, you know, because I don't have a wide diversity of patients, we connect more on a level

of, well, you know, we're all, we're all God's children, and my faith is a large part of my life and my practice, um, and that part of my faith spills over to my practice, treating everyone as a human being who deserves to be respected.

And I feel like I probably embody that and that they know that, um, I feel like I have a very good relationship with most of my patients, and I tend to be very direct, I don't pussyfoot and I don't sugar-coat a lot of stuff, so I'll just, you know, be very frank and blunt, [but] kindly so [P. 16].

The shared sense of class described by male PCPs in previous examples is also evident in the way in which this next PCP defines her identity as a working mother who connects with patients in similar situations.

I'm a young working woman with a family and I do obstetrical care, so kind of my, you know, bond that I feel would be with, you know, the young families, the babies, the young moms, you know, they're raising their kids, the kids come into the practice, so that's probably, kind of, how I identify myself [P. 17].

A key idea discovered within the second theme identified in this study is that study participants report using either an assessment instrument such as the QPD or an in-depth clinical interview to formulate a diagnosis of depression but not both. There was a wide spectrum of skill level in how PCPs described their style of assessing suicidal risk, ranging from comprehensive approaches that include reducing access to firearms, to more cursory reviews that are conducted somewhat randomly. Study participants' reports differed in whether they adhere to the standard 15-20 minute

office visit or spend extra time with their patients, and also differed in whether they report having a sense of community with their patients or not.

CHAPTER 6: DISCUSSION

Summary

This study was conducted within four primary care clinics situated in the Northwest Region of Kaiser Permanente, which is part of a health maintenance organization (HMO) that reports the prevalence of depression in its national system to be approximately 8.4% (deSa and Price, 2007). In that same study it was also found that there are gaps in the assessment and treatment of depression in primary care, which suggests that the actual rate of depression could be higher within this HMO. The main objective of this study was to gain an understanding of the patient-provider relationship from the PCPs' perspective within the context of clinical practice as it pertains to treating patients for depression, and managing suicidal risk. Given that the assessment and treatment of depression is done mainly by PCPs in primary care settings, it was also my hope that the outcome of the study would help identify possible ways to enhance provider engagement with males who are depressed or at risk for suicide.

The participants in this study all seemed fairly cognizant of the notion that males may have some deficits in help-seeking behaviors which typically have some negative consequences for them, including a reticence to access basic health care or engage in treatment for depression. I found that there was among the PCPs varying levels of awareness of and sensitivity to this self-defeating dilemma facing many male patients, and it appears that it is the PCP's philosophy of treatment that most clearly influences how they respond to it. Many of the study participants also spoke to their

experience of the contrast between the reluctance of males to see themselves as depressed, and the relative ease with which females report their depression to their PCPs.

One of two key themes developed in the study, *Gender Differences Within the Assessment Process* helps to explain the role of gender within the lower rate of diagnosed depression and the higher rate of suicide completion that is reported for males, as compared to females. Study participants commonly reported that there are various gender-role dynamics that complicate the assessment and treatment of depression and suicidality among male patients. For example, the concept of problem identification is an area that PCPs talked about as a particularly difficult challenge for males. There is in this concept not only the influence of gender-role dynamics inherent in the process of seeking help for the treatment of depression, but there is also the actual process through which the formulation of depression as a problem is derived and accepted by male patients.

The patient-provider relationship is made even more complex by the PCP's *Style of Clinical Practice*, which essentially has to do with an overall philosophy of treatment, and it is the other key theme identified in this study. While it gradually became apparent to me early in the study that I was hearing from study participants about two different styles of clinical practice, it was the following comment that helped me the most in understanding a crucial distinction between the two, "...I'm out of my league with somebody who I think is, you know, really suicidal or whatever, because I'm certainly not an expert at dealing with people... [P. 11]." I inferred upon

later reflection that an implication of this statement is that this PCP's sense of identity involves being an expert in the area of physical systems and illnesses, rather than in the area of relationships per se. This is very different than my experience as a social worker who has a sense of professional identity that requires being an expert in the area of relationships. That PCP's statement helped me to recognize that some PCPs approached the area of depression from an illness model, while others explored the problem of depression more within their relationship with the patient and within the patient's relationships with others. The grounded theory that subsequently evolved from this study, Relationship-Based Medicine (RBM), is proposed here as a type of primary care practice that is pragmatically and philosophically different than the more traditional medical model style that has a primary focus on a wellness-illness continuum.

Sense of Community

In addition to spending more time with patients and relying more on in-depth clinical interviews rather than on the use of formal assessment instruments, a key component of RBM is the ability to foster and maintain a sense of community with one's patients. A study by Baik and co-authors (2005) found that PCPs diagnose depression sooner and more accurately when they spend the time it takes to get to know their patients and when they have an emotional connection with them. PCPs' experiences described in the present study were consistent with their conclusion, and led to the development of the *Sense of Community* code and also the *Managing Time Pressure* code, which speaks to the longer amount of time that some study participants

choose to spend with their patients. Subsequent to the coding of data for this study, I discovered that a sense of community theory base had been developed in 1976 by McMillan and Chavis who then presented it along with a related questionnaire in 1986 (McMillan, 1996).

In his review of the theory, McMillan (1996) expands upon and renames the four elements of the sense of community, while also outlining the original elements beginning with: Membership, which makes it possible to “create the form of emotional safety that encourages self-disclosure and intimacy” (p. 315); Influence, “The salient element of influence is the development of trust” (p. 318); Integration of Needs, which speaks to “the community’s function to integrate members’ needs and resources” (p. 320); and, Shared Emotional Connection, which posits that “Shared emotional connection equals contact plus high quality interaction” (p. 322). The four elements that define that theory also describe the manner in which some of the PCPs in the present study work with their patients to create a sense of community that promotes healthy lifestyles through relationships of the type illustrated by McMillan.

The validity of the sense of community theory was explored by Peterson and colleagues (2008) who developed an 8-item Brief Sense of Community Scale (BSCS) and demonstrated through factor analysis robust empirical support for both the BSCS and the four elements of the theory that comprise its underlying construct. Empirical support for an Italian version of the sense of community scale has also been demonstrated through factor analysis that supports the validity of the original theory (Tartaglia, 2006).

In a qualitative study of university students that explored the role of membership within their student community, their neighborhoods and other group affiliations, such as churches, it was reported that their experience of identification with those groups significantly predicated their overall psychological sense of community (Obst and White, 2005). Similar outcomes regarding the relationship between having the experience of membership and having a psychological sense of community have been found in mixed methods studies (Brodsky and Marx, 2001; Zaff and Devlin, 1998). Efforts to maintain a sense of community for Kaiser patients is evident within the Kaiser nomenclature's focus on the *members* of the HMO, rather than making reference to members as *patients*. Other examples of this distinction include the Membership Services desks in all of the clinic lobbies, instead of a help desk or patient services; Member Concerns, instead of patient complaints; and phone calls regarding appointments being answered by Membership Intake Specialists (MIS) staff who also greet members when they check in for appointments.

While visiting various clinics to interview PCPs for this study, it was part of my experience to observe Kaiser members gathered in waiting rooms prior to their appointments, and it was apparent that their sense of community as members spans a wide spectrum. While most members had little or no interaction with each other, many others with a common connection, such as mothers with young children visiting with other moms while waiting to see family practice PCPs, seemed to spend more time visiting with one another. Other examples included Kaiser members who evidenced familiarity with MIS staff and nurses in other areas, such as physical

therapy and internal medicine, perhaps through ongoing treatment for chronic conditions.

As a group model HMO, Kaiser Permanente is comprised of two components, the physician corporation known locally as Northwest Permanente, and the HMO to which it provides capitated medical services, known as the Kaiser Foundation Health Plan (McFarland, 2001). As a Health Plan employee, I had the experience of being granted access to the PCP community, first to give presentations about this study at all-provider meetings (involving PCPs, NPs, PAs and RNs) for the purpose of recruiting study participants, and then later to PCP offices to conduct the interviews. Three of the four provider meetings that I attended began at 8:00am and had approximately 15-25 attendees, and I arrived prior to the attendees. Although the formal sense of community theory was unknown to me at that time, it is now obvious to me, through my observation of the socializing that occurred prior to the beginning of those meetings and in the discussions in the meetings before my presentations, that that theory base aptly captures the PCPs' sense of connection as members of the PCP/HMO community. The sense of PCP identity seen in the conference rooms was also discussed in interviews by PCPs who described their experience with patients in "the room" (the exam room), but none capture the essential elements of sense of community theory among PCPs and patients as vividly as the following passage:

...the nice thing about primary care is that you do get to know people and you can get to know them pretty well, pretty quickly because wearing that white coat when you walk into a room there's this automatic kind of, I trust you, to a

degree, and I mean just because of what I represent with that white coat, and I can open up and I can tell you things that I couldn't tell other people. That's a huge privilege and a huge responsibility as well [P. 4].

Obst and White (2005) posit that "community can simply be seen as a set of people with some kind of shared element, which can vary widely from a situation, such as living in a particular place, to some kind of interest, beliefs or values" (p.127). The shared element in the passage above involves a physical exam as a type of situation in which patient and PCP have a mutual interest in improving the patient's health in a collaborative process that can be enhanced by an element of trust within the patient-PCP relationship. Other study participants more specifically described having a shared background with some of their patients in the areas of religious faith, sexual orientation, hobbies and homeland; all of which reflect the simple notion that "Sense of community refers to the fundamental human phenomenon of collective experience" (Peterson, Speer and McMillan, 2007, p. 62).

Zaff and Devlin (1998) explore the area of psychological sense of community in their mixed method study of an elderly population who live in a particular housing development that is comprised of high-rise buildings and garden apartments. They report that the residents of the garden apartments have a greater sense of community than the residents of the high-rise apartments, especially in the area of having a sense of membership. Brodsky and Marx (2001) broaden the scope of psychological sense of community research beyond "territorially defined" (p. 161) communities, such as housing complexes, neighborhoods and towns. Their mixed method study of an

education and job-training center for low-income women operated by a group of nuns found support for two levels of psychological sense of community. They assert that psychological sense of community can operate on multiple levels simultaneously, such as within the sub-community of students at the training center, and between that sub-community and the macro-community at the center which includes the nuns and other staff.

There are then three levels of sense of community identified through this study; between patients and PCPs, among PCPs within the primary care community, and among patients as Kaiser members. Perhaps the weakest sense of community level here is among patients as members of the Kaiser HMO, while a stronger case can be made for the theory among PCPs within the primary care community. Both of those examples are limited by the brevity of my observations, however, but the data presented above from the PCP interview transcripts clearly demonstrate the relevance of the theory within the patient-provider relationship dynamics addressed in this study. Even with that limitation, it is proposed that those three levels of sense of community between the HMO members and their PCPs exist, and that there is an overlap among those levels; further studies involving both members and PCPs could bear this out.

As noted in the transcripts, males, unlike females, generally do not seem to have a sense of community within which there is the experience of safety and support that is conducive to talking about emotions in general or getting help for depression in particular. Although there are some limited examples of males making efforts to develop a sense of community through participation in various groups, such as the

Christian-based Promise Keepers. In his review of that movement, Niebuhr (1997) notes that “the Promise Keepers appear to have tapped a deep desire among men for a sense of community,” suggesting that there is a yearning for connection among some males but few easily accessible outlets for it. More closely related to the present study is the work of Reddin and Sonn (2003) who studied the sense of community among participants involved in men’s groups. They found that many of the males joined these groups at a time of great loss or crisis in their lives, and they propose that that theory provides a framework within the safety of the group for those males to reconstruct their experience of masculinity such that they reclaim identities that had previously been lost or compromised.

Male Socialization

Levant (1992) outlines a process of male socialization that “produces men adept at the skills of provision and protection, such as problem-solving, assertiveness, staying calm under fire, and providing for others, but lacking the abilities to know their own emotional life and to be empathic with others” (p. 397). That process occurs within a broader cultural context which often generates many treatment barriers for depressed males, including a “discomfort with emotional expression or self-disclosure, fear of dependency or vulnerability, and need to maintain control and power” (Perlick and Manning, 2007, p. 401). Swan (2008) observes from a feminist perspective that there is a “white, middle-class masculine anxiety about the widespread outpouring of emotions... [that reflects] a fear of the contagion of femininity... [which possibly] arises from a contemporary understanding of a more porous boundary between self

and other” (p. 101). The differentiation between self and other is greatly complicated by gender, according to Gilligan (1982), who has “argued that women see themselves and the world in terms of connectedness and are threatened by isolation, whereas men see the world in terms of autonomy and are threatened by intimacy” (cited by Perlick and Manning, 2007, p. 395).

The influence of gender on sense of self and other as outlined by Gilligan can be seen as a source of conflict between the two distinctly different male and female cultures. Barry (2007) suggests that “In addition to deconstructing the construct of culture, clinicians should consider deconstructing male gender. For example, clinicians may informally or formally assess dimension of ‘maleness’” (p. 355). It is also apparent that there needs to be a new language of maleness in order to effectively assess and treat depressed males, both in the manner that males’ emotions are labeled and in males’ ability to communicate their emotions to others (Kaplan, M. and Modrcin, M., personal communication, April, 2009). The transcripts from the present study suggest that the language of the RBM approach speaks more broadly to patients’ experience of depression, rather than the medical model language that speaks more specifically to the patients’ symptoms of depression.

Alexithymia, which has been defined simply as the “inability to put emotions into words,” (Levant, et al, 2003, p. 92), has been explored in numerous quantitative studies regarding its relationship to intimacy for males (Fischer and Good, 1997), and within various cultures (Le, Berenbaum, and Raghavan, 2002; Levant, et al, 2003). Limitations in verbal expression are common among boys and young men, according

to McQueen and Henwood (2002), who postulate that "...the high rate of completed suicide in young men who have no contact with mental health services suggest that there are ways in which the articulation of distress by young men are constrained" (p. 1506). Levant (1992) provides a model to help males develop a new "vocabulary for emotions, particularly the vulnerable ones, such as hurt, sadness, disappointment, rejection, abandonment, and fear, as well as the tender ones, such as warmth, affection, closeness, and appreciation" (p. 389). That approach may have some utility for PCPs, who are well situated to use their influence as experts to help provide patients with a language that more directly conveys the experience of emotion. The ability of males to learn that language, however, may be limited by the tendency for some males to rigidly define their sense of identity in terms of dominance and competence.

An anecdote involving language as a measure of competence is offered at the outset of a study by Smith and Wilhelm (2004), and it suggests the possibility that shame may be a consequence of diminished competence, particularly for males. The story involves a 6-year-old boy who regales his fellow travelers aboard a train with his recently acquired ability to read, which he gleefully demonstrates by reading aloud the road signs along the route and proclaiming to his companions that he can read. As the train leaves the U.S. the boy falls asleep and later awakens as the train nears its Canadian destination, but at that point the road signs are all in French and the boy has a look of panic as he guesses that his sleep has somehow robbed him of his ability to read. Despite many reassurances to the contrary, the boy is inconsolable and on the

return trip to his home does not read aloud a single road sign. Prominent in that poignant tale that I appreciate as a male is a seminal event in which a young boy experiences a sense of failure that was very public, which seemed to call into question his sense of identity as one who could read.

While the boy on the train does not yet appear to have developed the language he needed to express to others his distress about the road signs, he does communicate through his silence the depth of his upset. That story is also somewhat analogous to the sense of shame often associated with the experience of losing one's job, which is happening at an alarming rate in the midst of the current global economic crisis that has now reached epic proportions. The notion that males' sense of identity is influenced by their perception of competence in their jobs is supported by Draughn's quantitative study (1984) in this area. She reports that there is a positive relationship between the perception of competence among middle-aged men in regard to their jobs, and their perception of competence as husbands, and she also reports that income is an important factor for men in their perception of competence in their jobs. Some of the PCPs interviewed for the present study suggest that many male patients define their sense of competence in terms of their ability to function well in their jobs, and are frustrated when they experience a decrease in that functioning. That measure of competence within the workplace may help to explain the tendency for some men to reject the notion of depression because it is inconsistent with the construct of maleness that places a high value on success and being a so-called real man.

Reubens (2003) posits that males often "...think they're not 'real' (i.e., strong, materially providing) men if they pursue low-income careers or cry or ask for a hug, or exhibit other behavior identified with the rejected mother and not modeled by father, the identification object of choice" (p. 44). She also proposes that the social construction of gender is especially traumatic for young boys because it requires them to disidentify with their mothers, and that shame often masks that trauma, which can later negatively affect their level of competence in careers and marriage. Connor (2001) contends that shame for females is driven by alienation, such as in being ashamed of their bodies, while the male experience of shame is fueled by self-disgust. He also asserts that "jeopardy is at the heart of maleness" (p. 224), and then rather provocatively suggests that male shame has a related heroic quality that is glorified by male-dominated religions, such that "Christianity is so irresistible as a religion, because its central image, the crucified Christ, is one of shaming and suffering, rather than power and triumph" (p. 224).

Some of the PCPs in this study suggested that shame is often a barrier to help-seeking for males seen in primary care, and that a common defense against shame among depressed males is to deny or minimize the problem. Hook and Andrews (2005) used a questionnaire to study the role that shame-proneness has in the non-disclosure of symptoms and experiences related to depression among a sample comprised of individual who were either in therapy or recently had been. They report that "...shame was by far the most frequently endorsed reason for non-disclosure and there were similar rates for those currently and no longer in therapy, 76% and 69%,

respectively” (p. 431). Although their sample of 85 had approximately twice as many females as males and the role of gender was not explored, their results are consistent with similar studies and clearly attest to the power of shame as a barrier to help-seeking, which is an area of particular difficulty for males.

Gender differences was an area of focus in a quantitative study by Efthim and colleagues (2001), who explored the relationships between gender-role stress and three variables, including shame-proneness. They report that while there is a positive relationship for females between conforming to gender-role expectations and shame-proneness, the experience of gender-role stress for males is more complex, generating shame-proneness along with an inclination toward externalization and guilt. Benetti-McQuoid and Bursik (2005) also conducted a quantitative study that explores guilt and shame within the context of gender roles, but they approach gender socialization from an aschematic model in which various masculine or feminine traits define gender role. Among feminine, masculine, androgynous, and undifferentiated gender roles, they report that individuals with a feminine gender role orientation experience more shame-proneness and more guilt-proneness than those ascribing to other gender roles, regardless of their actual sex.

The various studies cited above suggest that males often have experiences of toxic shame at very early ages, which may increase their risk of impairment in overall functioning and perhaps also constitute a risk factor for depression and suicide. There may also be class differences within our culture that exacerbate gender-role stress for males and also heighten the related experience of shame. McQueen and Henwood

(2002), for example, assert that males in Western society are "...part of a dominant masculine power structure which nevertheless does not privilege all men. Thus particular subject positions within discourses are privileged, for example males as rational, competitive agents...[but whose] experience of emotions is prohibited by fear of intimidation and violence" (p. 1506). In their review of the feminist literature they also conclude that "The traditional western view of masculinity and its associated attributes of rationality, agency, and lack of emotion has fragmented. This, together with the disappearance of the work-based domain of masculine experience, has defined...the experience of being male as problematic" (pp. 1495-1496).

It is my formulation that the most problematic element of the masculine experience is a fusion of shame and violence that appears to occur for some males under certain circumstances, leading in extreme cases to either suicide completion or to murder-suicide combinations. However, I was surprised to find in my interviews with PCPs such a broad spectrum in the areas of shame and access to firearms, both of which I consider to be crucial in the assessment of suicidality, especially among males. It appeared that while some male patients may have deficits in their ability to talk about their depression, some PCPs seem to lack a language with which to explore suicidality and safety. Various attempts to create a new language of maleness have been made by Robert Bly (1990) and others, but the expression of emotions by males is still more commonly accomplished in American culture through acts of violence (Easton, Neavins, and Mandel, 2007).

In his phenomenological essay regarding his experience of shame as a male, Connor (2001) says that he is “ashamed of being a man...I am ashamed most of all of the violence that is inseparable from being a man. We boys and men grow up in an atmosphere and expectation of violence” (p. 213). During a recent 26-day span of time beginning on March 10th, 2009, through April 4th, 2009, in an extreme example, seven men in the U.S. shot and killed a total of 41 adults and seven children in groups ranging in size from 3-13. Four of those men completed suicide after shooting others, one was shot and killed by police officers, and two survived, resulting in a total of 53 lives lost, with 10 family members of the men and seven police officers among the dead. Two of the shootings involved family members, one of the shootings was a failed attempt to shoot a family member, and three of the shootings involved impending or recent job loss (In last month, 2009). With three of these shootings related to employment issues and three related to family matters, only one of these shootings, involving a man with a criminal history whose victims were police officers, can be seen as random. Perhaps for some of these men the experience of diminished competence in the areas of employment and family relationships in conjunction with consequent shameful feelings contributed to the violence that ultimately included for most of the men their suicide deaths.

One of these men was a Vietnamese immigrant who had recently lost his job, and he also reportedly felt frustrated by his limited ability to speak English. His 13 victims were fellow immigrants who were killed at the American Civic Association where he had until recently been involved in English classes and other immigration

services along with some of the victims. He is otherwise described in news accounts as a 41-year-old individual who lived with his parents and a sibling, and a gun enthusiast who frequented firing ranges on a regular basis (Fernandez and Hernandez, 2009; Rivera and Schweber, 2009). Durkheim's work (1951) suggests that this man's actions may reflect the state of anomy which involves "anger and all the emotions customarily associated with disappointment... [which can lead to] suicides which are preceded by a murder; a man kills himself after having killed someone else whom he accuses of having ruined his life" (pp. 284-285).

A more contemporary and more comprehensive context for the rage that led to this man's homicidal/suicidal actions can be found in the work done by Willis and Porche (2006) in the area of health disparities' affect on marginalized men. They define marginalized men as those who have been "...peripheralized on the basis of their identities, associations, experiences, and environment. Via the complex process of marginalization, these men...are removed in varying degrees from the powerful white, Euro-American, heterosexual, able-bodied, economically privileged, male center of society" (p. 428). Not only had this 41-year-old immigrant been marginalized economically and culturally, he likely had some experience of shame associated with his alienation, and the use of firearms had been incorporated into his lifestyle. Certainly the murder of others just prior to suicide completion is uncommon, compared to the more predictable rate of suicide not preceded by murders, although the recent spate of murder-suicide is alarming and merits further study.

Despite the extent of the carnage within the shooting sprees outlined above, there was virtually no subsequent discussion in the mainstream press or in political circles of concerns related to firearm safety. Throughout my interviews of PCPs for this study I found the area of firearm safety to be rather polarized, with study participants either exploring this area with their patients on a regular basis, or to avoid it altogether. It is clear in the literature, and intuitively, that the rate of male suicide completion in the U.S. is so much higher than the rate for females because men use more lethal, i.e., violent, methods, that being firearms. There is, then, a quality of violence that is inherent in suicide completion regardless of whether that involves a single act or also involves the murder of others. The relationship between violence and shame has been well established, including in work by Emery (2004) who observes that “Shame is the silent force that frays the bonds of interconnectedness... Shame is the antithesis to dignity...Cumulative shame becomes intolerable exclusion, fueling, in turn, reactive rage that seeks redemption through revenge...Shame is the force that gives violence meaning” (p. 230). Within those brief comments is one level of understanding of how one disenfranchised individual became so disconnected from himself and others that he was able to murder 13 others and himself.

Through his study of incarcerated males, Gilligan (2003) has found that males’ propensity for violence is relative to their capacity for love for and empathy with others, which he suggests depends on an ability to love oneself. He also speaks to the relationship between shame and violence in his impression that “...shame means the lack or deficiency of self-love. There are only two possible sources for love of the

self—from oneself and from others...And when the self is not loved, by itself or by another, it dies” (pp. 1153-1154). How any given individual experiences deficits in the area of love of the self will likely vary considerably, depending on global measures of connectedness and functioning, among other variables. It may be the case that the risk for suicide completion for depressed males is highest among those individuals who have low levels of love of self, high levels of shame, and are of a culture in which firearms and/or violence has been a prominent feature of their experience of masculinity.

My impression of the primary care arena during this study was that both the setting and the professionalism of the PCPs create a sense of safety for patients, which to some extent can help alleviate patients’ shame related to depression. It is also my impression that the area of shame as it pertains to males’ sense of self warrants further study, particularly within the context of affect regulation and gender-role expectations. Shame as a consequence of gender-role strain has been explored at length by Mahalik and colleagues (1998) who assert that “...when males do not live up to masculine gender ideals, they experience feelings of shame and anxiety due to both the discrepancy between their real self-concept and this ideal self-concept and the negative reactions of social forces around them” (p. 248).

Ferguson and Crowley (1997) suggest that shame and guilt overlap to the extent that they need to be assessed jointly despite their respective unique characteristics. They also note that “...shame is seen by many in the literature as a dejection-based emotion in which the person feels bad about the entire ‘self’ and

desires to hide from further scrutiny, whereas guilt is seen as an agitated state” (p. 426). Given the propensity for males to isolate and/or experience increased agitation when depressed, a mixed-methods study is therefore proposed in which depressed males’ subjective experience of shame and guilt is explored through qualitative methods, along with the use of an instrument to address this area from a quantitative perspective, such as the Test of Self-Conscious Affect-Modified (TOSC-M) recommended by Ferguson and Crowley (1997).

Gender Influences Within Primary Care

As described earlier in this work, traditional masculine gender-role stereotypes influence males’ sense of self in ways that can limit their ability to engage with others in times of need, and consequently increase their risk of suicide during times of loss, crisis or depression. There may also be a reciprocal bias within primary care that reinforces the higher rate of depression diagnosed among females, as compared to males. A parallel can be drawn between gender differences inherent in interventions for depression, and interventions for coronary heart disease (CHD). In her review of the literature, for example, Emslie (2005) found several studies that support the notion that patients and health care providers alike consider CHD to be a “man’s disease,” due to its higher rate of occurrence among males and the related research focus on males. That gender bias is seen as a leading factor in females’ reluctance to seek help for symptoms of CHD, to the extent that symptom severity is typically higher for females at the time of initial intervention than that of males (Lockyer and Bury, 2002).

A study by Patel and colleagues (2004) also found that females do not seek treatment for cardiac problems as quickly as males do, and that they are more likely than males to be seen by medical providers as having a psychological problem than one of a cardiac nature. It is possible that patients' gender may similarly influence the extent to which PCPs diagnose depression among their patients. In a study of gender bias in the diagnosis of depression within primary care, for example, Bertakis, et al, (2001) report that approximately 60% of the patients seen by PCPs are female, and the accuracy of this diagnosis improves as visits to the clinic increases. Their study also asserts, however, that "Even with equal exposure, female patients with depressive symptoms are more likely than males with similar symptoms to be diagnosed as depressed" (p. 695).

In his grounded theory study regarding the subjective experience of depression, Karp (1993) more generally found that many of the participants in that study initially understood their distress to be a reflection of situational problems rather than an illness involving an imbalance in brain chemistry. He goes on to suggest that initiating a course of antidepressant medication requires of patients an acceptance of the medical model definition of the problem, and the related construction of both a new theory regarding the problem's origin and a new sense of self as a person with a mental illness. And it is Karp's contention that that process of redefining realities is supported by the medical model because of the common perception that physicians have the ultimate expertise to make decisions in the assessment and treatment of illnesses that affect the body and the mind.

Sanders (2007) suggests that the medical model can contribute to the stigma inherent within mental illness through its reliance on the DSM, which he notes included until 1973 the disorder of homosexuality. While there may be merit to the points raised by Karp and Sanders, it may also be the case that the medical model offers a conceptualization of depression as a physical problem rather than as one of individual weakness or moral failing. The tendency for males in the present study to attribute the definition of the problem to others, such as *my wife thinks I'm depressed*, may be in part a rejection of an illness identity associated with the medical model, one that threatens the very essence of the concept of masculinity, with its elements of stoicism and toughness.

This study is influenced by the proposition that gender roles are socially constructed, mainly through a constant barrage of messages within mainstream media that perpetuate gender role stereotypes and expectations, such as in movies, popular music, advertising and television. Some study participants suggest that females may consequently be more willing to accept a diagnosis of depression because the social construction of gender allows females to seek and accept help more easily than males. The gender of patients and providers has also been the focus of some studies that have explored the degree of partnership or connection within the patient-provider relationship. It appears from the examples above, however, that a sense of shared background can help facilitate the experience of connection within the patient-provider relationship for the provider, regardless of gender concordance. This observation provides a contrast to other studies that conclude that patients respond

more favorably to female providers, especially when the patient is also female (Hall and Roter, 2002; Sleath and Rubin, 2002; Street, 2002).

Relationship-Based Medicine and the Medical Model

The sense of mutual connection within the patient-provider relationship forms the basis of RBM which is supported by the two main themes that emerged from the data generated by this study, *Style of Clinical Practice* and *Gender Differences Within the Assessment Process*. Those themes in combination delineate an approach to primary care practice that can be seen both as an alternative to the more traditional medical model, and as a model that can enhance the assessment and treatment of depression and suicidality. In addition to the concept of having a sense of community with one's patients, RBM has at its core the commitment to create the time and emotional space needed to facilitate long-term relationships with patients, despite the usual time pressures in primary care practice.

Although there is a natural overlap between the two models, given that both involve the provision of medical care to patients through a patient-provider relationship, often of long term duration, it is the mutual sense of community with patients that most clearly differentiates RBM from the medical model. A second distinguishing feature of the RBM focus is the practice of conducting in-depth clinical interviews to comprehensively assess the areas of depression and suicidality, rather than using standardized assessment instruments. Support for the proposed RBM model can be found in the work of Scott, et al (2008), who developed a model that fosters healing relationships within primary care practice. Among other variables,

they found that both patients and PCPs had a stronger sense of the healing process when they had an experience of mutual connection, and when PCPs were able to spend sufficient time to develop long-term relationships with patients. Miller and colleagues (2003) identified attributes that facilitate healing relationships, which they say include trust, closeness and emotional engagement within the patient-provider relationship. In a similar manner, Brody's review of patient-centered care (2006) is predicated on the premise that the quality of the PCP-patient relationship comprises the core of family practice, a distinction that he says is unique among all other areas of medical specialty.

Within the sense of community identified by many of the participants in the present study, it appears that the RBM model, more so than the standard medical model, allows for the opportunity for PCPs to connect more with males in times of great distress. It may also be the case that there may be more potential to treat depressed males in primary care because there is less stigma attached to that setting, as compared to being seen through the department of mental health. This study suggests that RBM offers more opportunity to engage males in primary care treatment than the medical model, although the medical model is staunchly defended by many, including Lamberts and Hofmans-Okkes (1996) who assert that "The medical model is strong, stable, and generally acknowledged as a cornerstone of modern society" (p. 179). When compared with psychological and environmental models, it has also been suggested that the medical model may have some advantages as an etiological

paradigm that may account for reduction in stigma while also facilitating help-seeking behaviors (Goldstein and Rosselli, 2003).

Limitations of the medical model, however, include its reductionistic focus on the linear process of assessing symptoms, diagnosing disorders and prescribing treatments from a logical positivist perspective that limits subjectivity and engagement (Freeth, 2007). Boyle (2006) suggests that developing alternatives to the medical model is a daunting challenge given its ideological power, yet she maintains that the biopsychosocial model is one example of an attempt that failed because of its roots in biological influences, despite its attempt to focus on psychosocial factors. The development of an emotional bond between PCPs and patients is a strength of the biopsychosocial model according to Biederman and co-authors (2005), but they suggest that this approach should be used selectively due in part to the time pressures associated with managed care practice.

In addition to an emotional bond between PCPs and patients that may be stronger in the RBM model than in the medical model, the reliance on instruments by medical model PCPs is another fundamental difference between the two approaches. The use of the QPD, which relies solely on symptoms listed in the DSM, was more commonly endorsed by medical model (MM) PCPs, as compared to RBM PCPs who were more inclined to assess depression and suicidality through their relationships with patients. Regardless, PCPs of both persuasions commonly expressed a lack of confidence in their ability to adequately assess suicidality among their patients, ranging from those who appeared to have very good skills in this area despite their

disclaimers to the contrary, to those who either did not pursue this level of assessment or made little attempt to do so. The outcome of this study otherwise basically reflects two very different approaches to the assessment and treatment of depression and suicidality. Although there is some overlap, my impression is that RBM and MM styles of practice are mostly polar opposites, and there is no indication that a convergence of those approaches is likely unless some type of formal structure to support it is developed.

There are also indications that there are gaps in the ability within both approaches to effectively and safely manage depressed patients with higher acuity and higher risk for suicide. It is noteworthy that one of the four clinics in which the PCP interviews took place was one of three clinics in the local Kaiser region that has a behavioral health provider (BHP) located in the primary care setting. At that particular clinic some of the participants talked about how they rely on the BHP for help with depressed patients seen to be at higher risk for suicide than other patients more easily managed on antidepressant medications. The BHP there provides rapid access to psychiatric assessment and brief intervention, which is a level of care that is separate from that provided by the Emergency Psychiatric Services (EPS) team in the emergency department that intervenes in cases of acute suicidality. The PCPs at that particular clinic who refer patients to the BHP, regardless of their own philosophical approach to treatment, indicate that their fairly high level of confidence in their ability to treat depression is due in part to that level of support for the more challenging cases. At the other clinics where there is no BHP available to the PCPs it was more likely the

case that those PCPs tend to refer more complex patients to the mental health department.

Although the PCPs at the other three clinics where interviews were conducted also have access to EPS services, it seems from their input that they have the sense that neither their training nor their experience equips them with the skills to effectively treat acute depression and suicidality. Seelig and Katon (2003) speak to this bind in their observation that the “Perceived usefulness of obtaining mental health specialty consultation impacts primary care physician reliance upon these potential colleagues and ultimately likely plays a role in whether patients receive appropriate, effective treatment”(p. 455). Their point would seem to suggest that providing primary care with enhanced resources from the department of mental health merits consideration.

In addressing the limitations of the medical model more broadly from the perspective of social work practice, Kane (1982) concurs that “Integration—not polarization—of health and social services is sorely needed” (p. 315). Most of the Kaiser mental health therapists in the NW Region are licensed clinical social workers, so it would be largely through the field of social work that an integration of mental health and primary care practice could be effected. There are several social workers at Kaiser, for example, who are currently participating in a redesign process involving mental health and primary care, and that effort includes a focus on enhanced integration of the two departments. Implementation of any plan that involves further integration will likely result in having more social workers collaborating more directly with PCPs in the process of treating patients who are depressed and at risk for suicide.

Strengths and Limitations

An important area of strength in the present study is that it adds a new perspective to the limited area of qualitative suicide research, and complements the relatively expansive body of quantitative research that is concerned with epidemiology and assessment instruments. A limitation of qualitative studies in general is that sampling procedure variations among otherwise similar studies can contribute to generalizability limitations (Scheibe, et al, 2003). The lack of a random sample of subjects is a limitation of this study, and it is also the case that the outcome of this study may not be representative of the experiences that PCPs have with depressed males in other hospital systems in other regions of the country. However, the intent of the study was to richly describe the study participants and to be transparent about data analysis and synthesis processes, so that each reader can assess the usefulness and relevance of the findings in their context.

In his contribution to the ongoing debate regarding qualitative research and generalizability, Sharp (1998) states that generalization involves the basic “claim that what is found to be the case in some samples is typical of the population from which the sample is drawn” (p. 786). He cites Robson (1993) in differentiating statistical generalization, which is demonstrated through probability statistics, from non-statistical empirical generalization, which involves either replicating previous studies in some fashion, or using other knowledge or theories to make a case that unique characteristics of a given sample can also be found in the target population. According to that definition of empirical generalization, the present study is

strengthened by comparing the essential features of the sense of community theory with the medical model to support the construction of the RBM model. It is also my impression that the sample in this study is broadly typical of PCPs working in larger primary care settings, given that study participants report various concerns widely addressed in the literature, such as time pressures.

Morse (1999) makes the case that the selection of small, purposefully selected samples facilitates, rather than hinders, the generalizability of qualitative research in which she says that participants are “selected purposefully for the contribution to the emerging theory...[which] ensures that the theory is comprehensive, complete, saturated, and accounts for negative cases” (p. 5). That was true of the present study which reflects a wide range of variability of clinical practice that one could reasonably expect to find in other HMO settings. Although there is potential for a self-selection bias within this or any grounded theory study, the risk is lessened through the reliance on a basic tenet of grounded theory, which is that the sample was chosen for the purpose of constructing a theory, not to represent a population (Charmaz, 2006). In pursuit of that goal, related presentations were given to groups of PCPs, as mentioned above, and recruitment flyers developed from the confidentiality form for the study were distributed (see Attachment A.), but most of the PCPs agreed to participate during phone conversations I initiated rather than responding to the flyers.

The inductive process of data analysis that served as a guide for the present study is consistent with the original iteration of grounded theory and with the methodology’s call for a simple design that allows for the gradual emergence of the

examined phenomenon's essence (Duchscher & Morgan, 2004), about which little is known (Strauss & Corbin, 1990). A limitation of this study is that the local Kaiser administration granted permission to conduct the study with the stipulation that I have only one contact with study participants, that being the PCP interview. This condition precluded my ability to conduct one element of data triangulation, member checking, in which participants are contacted after the initial collection of data to either confirm the accuracy of those data or to collect additional data (Charmaz, 2006). Although Horsburgh (2003) argues that because researchers and participants may have different agendas for the interview, there may be limited value in validating individual interviews as a way of providing validation for the broader study. Her specific assertion is that while participants may have an interest in validating their particular situation, researchers are more focused on a comprehensive synthesis and analysis of the data that has been gathered. Others have suggested that participant disclosure may actually be heightened by a single contact interview (Dickson-Swift, James and Liamputtong, 2007), and that may have been a factor in the present study during which I experienced surprisingly high candor among the PCPs.

Triangulation of data did occur, however, through two interviews with key informants, PCP/administrators, who provided useful feedback regarding the scope of the study and the initial set of questions proposed for it. My presentations at PCP provider meetings also provided a useful context for the culture within which the study was situated, along with some general feedback about the study and the interview questions. There was otherwise for me a parallel process throughout the course of the

study which involved not only my study of help-seeking behaviors and the participants' sense of community, but also my personal struggle with those dynamics as a researcher. The sense of community that I had with my small number of fellow doctoral students during the highly structured two years of coursework at the outset of our academic program quickly dissipated in the subsequent two-year period during which the present study was developed, conducted and analyzed. That estrangement along with my own deficits in the area of help-seeking behaviors led to a lack of investigator triangulation, such as having other student researchers code data.

It is possible, however, to have one person code all of the data generated by a qualitative study in a manner that enhances rather than compromises the outcome of the study. A recent grounded theory study regarding the experience of having depression, for example, involved a data collection strategy in which the principal researcher conducted all of the participant interviews, and then transcribed and coded all of the data (Feely, Sines and Long, 2007). The authors of that study, citing McCann and Clark (2003), also assert that "Such personal immersion in the transcribing process ensured that the researcher was absorbed fully in the research process; in so far as any individual can place him or herself within the world reality of another." Similarly, in a recent grounded theory study regarding the experiences of health researchers it was found that most of the participants were of the opinion that the process of data analysis began with their own transcription of the data (Dickson-Swift, James and Liamputtong, 2007). Both examples mentioned here are consistent with my experience of transcribing and coding data as a way in which I could fully

absorb the content and nuances of the interview transcripts, thus enhancing my ability to interpret the data. I also found my clinical social work skills to be an asset in the study, as that background helped me to engage participants in the interviews and gain their trust, which is especially important in qualitative research.

Taber (2000) prefaces his report of a grounded theory study regarding science education with the observation that “research to generate grounded theory deliberately avoids initially defining the research focus too tightly. Rather, the researcher enters the research context with a concern, or area of interest, that is felt to be worthy of study” (p. 473). My concern and interest related to the serious problem of suicide has been influenced by both professional and personal experiences. It was with considerable hesitation that I located myself within the context of my research by disclosing in this review my experience of the suicide death of a family member, but this was done in accordance with the chosen methodology and it is seen as another important strength of this study. Tobin and Begley (2004), in particular, suggest that methodological rigor can be enhanced in qualitative research through adherence to the notion of goodness, which includes the element of the researcher’s voice as it addresses participants and the examined phenomenon throughout the study. Citing Webb (1992), Horsburgh (2003), in a similar manner, asserts that qualitative rigor can be enhanced through reflexivity, which integrates the researcher’s relevant personal experience in the research.

Given my experiences with a sibling in crisis, my personal perspective was a strong and positive influence throughout the process of data collection and analysis

because I could appreciate some of the dilemmas facing depressed males being treated by PCPs. My personal history also helped me appreciate as a researcher the pain and shock some study participants described when they encountered suicide deaths in their practice. Despite my sense of closeness to that grief, theirs and mine, I was nonetheless able to manage bias in this area by maintaining a balance between my family history, and the curiosity, neutrality and objectivity that is inherent in both my clinical style and in grounded theory methods. By not disclosing my personal history to study participants, I also minimized the potential for bias within my interviews of PCPs as far as their response to me was concerned. The disclosure of my family history within this dissertation can otherwise be seen as my attempt to provide a particular frame of reference in a manner that is both overt and transparent, to help others determine the usefulness of this study.

CHAPTER 7: CONCLUSIONS

Conclusions

I found many of the perspectives expressed by study participants to be consistent with my experiences of assessing suicidal risk in settings that include a hospital emergency room, in-patient psychiatric units, out-patient treatment programs and within courses of individual therapy. Yet it would seem that the primary care arena offers patients a uniquely different frame of reference for this level of assessment than those other settings where evaluation of suicidal risk could be more commonly expected to occur. In regard to intervention opportunities, a study of patients' experiences within different types of patient-provider relationships may be useful in terms of understanding where and with whom they are more likely to feel safe and cared for to the extent that they can discuss suicidality and engage in harm reduction planning. A related outcome of this study suggests that PCPs whose style of clinical practice is consistent with the RBM approach may have an enhanced ability to engage patients in the process of treating depression and suicidality. That possibility could be further explored through quantitative studies that test the RBM model through the use of instruments such as patient satisfaction surveys that address related patient-provider relationship dynamics.

Many of the PCPs reported that some males may lack an awareness of their depression, particularly during the early phase of the disorder. This could be another important area to explore in a study involving patients because if a lack of awareness of the problem contributes to a delay in seeking treatment, a case could be made for

PCPs to provide patients with more information concerning depression, such as making related hand-outs more available during the office visit. It was also found that PCPs in general would likely benefit from additional support from mental health providers, which suggests that the treatment of depression and suicidality by PCPs can be improved through further integration of mental health services within the primary care setting. Strong support can be found for this proposal in a study that was released after the coding of data for the present study was completed. That study, involving the Grand Valley Health Plan in Michigan, found that collocating mental health therapists within primary care led to a 54% decrease in psychiatric hospitalization (Van Beek, et al, 2008).

A similar level of collaboration can be found within the RESPECT model (Re-Engineering Systems for Primary Care Treatment), which is comprised of a blend of care management services, an enhanced PCP-mental health provider partnership, and PCP education in the areas of depression management, including assessing suicidal ideation, intent and means, such as firearms (Dietrich, et al, 2004; Oxman, Dietrich and Williams, 2002). In noting that physical complaints account for approximately 75% of PCP visits for depressed patients, Blount and colleagues (2007) also suggest that accurate diagnosis and appropriate treatment are best accomplished through a multidisciplinary approach in the primary care setting. Citing the benefits of collocated care, they report that the information exchange between BHPs and PCPs greatly improves the treatment of depression, and they indicate that this model is

especially well suited for those patients who otherwise decline care from mental health providers due to issues of stigma.

Stigma and gender-roles are both socially constructed, and both pose barriers to health care that may be insurmountable for some males. Nolan and Badger (2005) propose that “The stigma that surrounds emotional, psychological and mental health problems can frame people’s reactions to their illness, and influence whether they seek help, whether they accept or reject advice and whether they adhere to a prescribed regimen” (p. 152). Stigmatization of mental illness is an issue that was repeatedly mentioned by participants in the present study, and it is also an area that I have become acutely sensitive to through my experiences over many years of working with individuals who have severe and persistent mental illness. It is from that perspective that I recognize and appreciate the need for providers to devote the time it takes to develop a collaborative approach with patients to help them with their struggles. Masculinity issues and stigma may be mitigated to some extent by promoting the message to patients, males in particular, that depression is a health problem or disorder, much the same as diabetes, which requires certain changes in lifestyle in order to successfully treat.

Goldstein and Rosselli (2003) report that “...research has shown that controllable illnesses provoke greater stigmatization and that depression is seen as a controllable illness” (p. 554). However, several participants in this study suggested that there is often less stigma associated with treatment for depression when it is sought in the primary care setting rather than in the mental health department.

Primary care may be a relatively safe place for many depressed patients due to a range of factors, including the discomfort that some patients have in being identified by others as a mental health patient, the opportunity for patients to discuss symptoms of depression with PCPs along with various other physical maladies, and the characterization of depression as a medical rather than a psychiatric problem. Many depressed patients in general appear willing to accept treatment from PCPs “...because they do not believe they are receiving ‘psychiatric care.’ Being treated by a PCP, but not receiving psychiatric care, may be reassuring to many patients because it does not threaten their sense of autonomy and ‘moral goodness’” (Van Voorhees, et al, 2003, p. 998).

Taking a broader view, Courtenay (2000) asserts that there are pervasive gender-biases embedded in our culture and within the research community to recognize depression as more of a problem among females than males, a misperception that he asserts is perpetuated by the medical community, where “Depression provides one example of how the health care system contributes to the social construction of disease” (p. 1396). His observation that males are taught to take risks with their bodies rather than to take care of them leads him to conclude that “men’s own unwillingness to seek help contributes to the social construction of their invulnerability to depression” (p. 1396). Collocating BHPs within primary care, along with more emphasis on the RBM model offers a framework, and some hope, for males to have the opportunity and support to construct a new model of self-care that promotes healing and in the process helps reduce suicidal risk for depressed patients.

As intended, this study has captured the essence of a phenomenon which in this case involves a particular style of clinical practice that is facilitated by PCPs' sense of community with their patients and other variables, which then led to the development of the RBM model through the data analysis process. An unintended outcome of the study is the enhanced understanding I now have of my brother's suicide death. It is abundantly clear to me that he did not have a sense of community among his seven siblings while growing up, and then only a semblance of one as an adult. The onset of his history of multiple psychiatric hospitalizations did not begin until his early 40s, shortly after the death of our mother with whom he had a strong connection and through whom he was able to maintain the limited sense of community he had with his family of origin. At the time of his death he had several of the classic risk factors for suicide, including psychiatric disorder, a previous suicide attempt, alcohol dependence and the demographic distinction of being a single, 50-year-old White male recently disabled by his illness to the extent that he could no longer function in his job. It also appears obvious to me that the death of our mother was a catastrophic loss that essentially launched him on a suicide trajectory from which he could not be deterred, likely due in part to the absence of having any sense of community with others.

This case example drawn from my personal experience illustrates the multifactorial nature that is common to suicide completion, and also highlights the importance of emotional connection that is central to interpersonal resilience and overall functioning. There is also compelling support in this case for the notion of a

suicide trajectory which in its clarity appears to paradoxically blur the distinction between acute versus chronic suicidal risk, such that in retrospect my brother can be seen to have been chronically at an acute level of suicidal risk in the years following our mother's death. It would seem to follow that suicidal risk of that depth and duration would require a comprehensive range of interventions from many different sources, including family and treatment providers, although extensive efforts were made in those areas in his situation to no avail. I am otherwise left with the impression that this level of suicidal risk is not well managed by either primary care or mental health providers working independently of each other in a silo fashion of treatment.

Regardless of the numerous nuances, similarities and differences depicted in the various passages outlined in this work, however, it is of the utmost importance to state unequivocally that a strong commitment to and passion for the provision of high quality patient care was the single most obvious and universal attribute among the participants in the study. Albeit approached in different ways, it was very clear throughout the interview process that the PCPs in this study are very dedicated to taking care of their patients, despite the ongoing challenge of dealing with competing system demands. And even though some providers expressed a lack of confidence in their assessment skills, there were exemplars that illustrate how to assess suicidal risk, such as the following passage which includes the crucial area of asking about means and developing related safety plans, especially regarding guns:

...I usually ask them, um, you know, thoughts, plans, ideas, um, sometimes if I feel that they're going to react to that or I'm not sure that I'll get a truthful answer I'll, you know, phrase it in the sense of, you know, sometimes patients feel so down they wish they were dead or, you know, do you have any thoughts like that. Um, and then depending on the answers to those questions, you know, are there issues, um, pills, guns, you know, things like that... [and if there are guns,] Usually I would try to see what, um, other family members, significant other, somebody else who's interacting with that person and I'll try to enlist, you know, their input or support for that... [P. 17].

Schulberg and colleagues (2004) assert that educational programs designed to teach PCPs how to conduct comprehensive suicide assessments “need to be further refined so as to be gender-specific and must be repeated periodically if they are to be effective” (p. 343). In addition to gender differences that make it difficult for males to seek help for depression, it has also been reported that there is virtually no difference between medication and psychotherapy in the treatment of depression (Bortolotti, et al, 2008; deSa and Price, 2007), with cognitive behavioral therapy and interpersonal psychotherapy being the most effective approaches (Nemeroff, 2008)..

Regardless of treatment modality, the present study demonstrates that the influence of the spouse/significant-other plays a prominent role in initiating treatment interventions for depressed males. And while there are many influences that play some role in suicide completion, such as stigma, masculinity issues and the very nature of psychiatric illness, the decades-long loss of over 30,000 lives on an annual

basis reflects the inadequacy of the prevailing treatment paradigm and makes a case for a new treatment model.

There is within this study an outline of an approach to the treatment of depression and suicidal risk that involves more collaboration between primary care and mental health departments that is augmented by more focus on the basics, including more time with patients and more emphasis on the patient-provider relationship. A case can also be made for routine depression screening within primary care, along with routine questions about firearms and related safety measures; both of which were practiced inconsistently by providers in this study. Perhaps a more comprehensive approach to this problem may be more possible within the current political climate which appears to be shifting in a direction that could lead to some type of national health care, along with recently enacted mental health parity legislation, that may support more acceptance and treatment of psychiatric disorders.

It is otherwise important to acknowledge that there is a certain universal durability that characterizes the process of suicide, as captured by Clayton and Auster (2008) who note that “There are many risk factors associated with an outcome of suicide, although in any individual patient, it is impossible to predict. Individuals of all races, creeds, incomes, and educational levels die by suicide. There is no typical victim” (p. 16). Their succinct summary of why there has been little change in the rate of suicide death in the U.S. during the last 50 years is offered here with some humility amidst the recognition that RBM is not likely to have much impact on that loss of life. But it is nonetheless my assertion that my conceptualization of RBM reflects an actual

style of primary care practice that exists, and that it is one that appears to reflect more of a personal philosophical approach to caring for patients than any generic training or organizational influence.

Training PCPs in the RBM style may be possible but it would need to involve a shift from the language of the medical model, with its terms such as symptoms and illness, to the richness of RBM, with its primary focus on the emotional experience of patients. Boyle (2006) suggests that in order to develop any alternative to the medical model it would be necessary "...to abandon all medical language when talking about emotional distress and disturbing behavior, because there is a very straight and very short line from medical language to medical thinking [but] we live in a culture linguistically dominated by medical models" (pp. 192-193). Support for RBM can be found in a grounded theory study conducted by Baik and coauthors (2005) involving an exploration of PCPs' experience of treating depressed patients. They report, for example, that PCPs who "...are comfortable with emotions tend to ask patients psychosocial (perceived as personal) questions that can lead to a more timely recognition of depression, suggesting that clinician education about symptoms of depression alone would not likely lead to recognition of depression" (p. 36). A distinguishing feature of the participants in the present study who are seen to have an RBM style of practice is their intuitive sense of the patients' emotional experience, which may yield more useful clinical information than a basic review of systems, common to the more traditional medical model.

Although the RBM approach has not yet been empirically tested, the data from this study suggest that both patient and provider benefit from the focus on the patient-provider relationship inherent in this style of practice. Despite it being more time consuming than the medical model approach, the depth of the clinical interview common to RBM may also help PCPs more quickly and more fully identify depression among male patients. The time pressures within primary care practice are both legitimate and significant, as noted in the present study and elsewhere (Rock and Cooper, 2000). Braddock and Snyder (2005) propose that both PCPs and healthcare organizations have an ethical responsibility to ensure that patients receive sufficient quality of time in the clinical encounter, rather than quantity of time, to provide a reasonable and adequate level of care. That objective appears to have created a dilemma for some participants in this study, which seems to have been resolved to some extent by a choice or an inclination to focus either on the patient-PCP relationship or on a more objective review of systems. My impression and hope is that the field of social work can, in either case, help further bridge the gap between medicine and mental health.

Implications for Social Work in Primary Care

Integrating mental health care within primary care may not be a priority for some healthcare systems, but it is possible for social workers to present a rationale for it and then influence the development and implementation process, such as was the case in my workplace. Although the location of therapists within primary care at Kaiser in the Northwest Region is limited to just a few clinics at present, it is an

example of how social work can assert a position and a presence within healthcare. This is in contrast to the concern expressed by Samantrai (1998) that social workers have increasingly been reduced to gatekeepers as "...managed healthcare has substantially transformed mental health delivery systems and redefined the roles and tasks of social workers" (p. 160). On a much grander scale she also asserts that social workers have the skills and the responsibility to influence the political process necessary to develop universal healthcare for all Americans.

While Samantrai makes a compelling case for social workers to embrace political activism, there is also the reality that the primary care culture is very well established and access to it is limited. During my participant recruitment presentations at PCP provider meetings I was very conscious as a social worker of being an outsider, and of the status difference within that arena, but it was ultimately my use of social work skills that allowed me to address that group. I was also aware of the range of reactions that the PCPs had to an overview of a study involving a topic that is not often discussed in primary care, including among some the suggestion of discomfort or disinterest regarding suicide that is commonly found in the broader culture.

Social work has an otherwise well established history of integration with primary care practice, as Badger and co-authors (1997) report, in part because "The Health Maintenance Organization Act of 1973 (P.L. 93-222) mandated integrated social work mental health services in health maintenance organizations (HMOs) because social work and related professions were thought vital to obtaining the HMO goals of health maintenance and promotion" (p. 23). My experience of working

within healthcare settings for the past 18 years, however, is that social work is well represented in more traditional areas, such as discharge planning on inpatient units and within advocacy efforts for basic services for those in need, rather than in actual mental health interventions.

It is also my observation that social workers comprise the majority of treatment teams working in hospital-based mental health and addiction treatment programs. But there are those who have nonetheless called for even higher levels of integration, such as Almgren (1998) who proclaims that "...primary care practice settings demand the integration of both the health and mental health aspects of patient care in ways that defy the fragmenting biases of specialized practice, whether within medicine or within social work" (p. 234). I agree with that formulation and accept that challenge with the hope that mental health care will become more fully integrated with primary care under the auspices of social work so that the psychiatrically complex, and perhaps ambivalent patients, can be more successfully engaged in treatment.

Person-In-Environment

The field of social work, through its person in environment (PIE) framework, provides a perspective through which either suicide completion or murder-suicide could be examined to better understand the context in which those actions occur. Karls and co-authors (1997) describe PIE as a four-factor system that is designed to facilitate social work assessment and intervention regarding difficulties in an individual's functioning and environment within the context of mental and physical health challenges. That approach may be useful in the case of an individual seen to be

at high risk for suicide, and may have some utility when used retrospectively, such as in the situation involving the Vietnamese immigrant individual mentioned earlier.

Although, a concern about cultural bias is expressed by Kemp (2001) who notes that “The generic nature of many social work discussions of person-environment relationships...contain assumptions about people and environments that reflect dominant cultural experiences and hence systematically obscure the experiences and perspectives of nondominant groups, such as women and people of color” (p. 10).

Given that many depressed males can be seen as having deficits in the language of emotion, it is perhaps as important to understand their experience of alexithymia inherent in their culture, whatever that may be, as it is to understand the environment that fosters it. Karls and Wandrei (1992) suggest that while the use of the PIE approach will not replace the DSM in terms of diagnosing psychiatric disorders such as depression, it “will allow social workers to systematically conceptualize and describe clients’ problems in the language of social work” (p. 85), thus enhancing the opportunity for social work intervention. There is also support for the ability of social work to provide primary care practice with a unique perspective of mental health issues within their contention that “Much of social work’s contribution to the helping profession centers on the strengths and resources a client brings to a problem situation. Social work as a profession has diligently resisted a medical, disease-oriented model for describing and classifying client problems” (p. 81).

Beyond PIE, social work research also has a strong focus on the voice of the client. In her review of service design and delivery for the elderly, Powell (2007), for

example, explores the contribution of social work both within that client population, and within the area of social research and related multi-disciplinary interventions. She asserts the position that social work is well positioned to help elderly individuals have more voice in the change process through their participation in qualitative studies that focus on their needs and challenges. Powell also notes that while those methodologies are “not unique to social work research, such methods can be distinctive or characteristic of research that is committed to listening and making explicit the voice or lived experience of those involved in the research process” (p. 113). The voice of depressed males is not well represented in the literature, which may in some respects mirror the deficits in the language of emotion that characterize the social construction of their gender-role expectations. Within that vein, Levant, et, al (2003) assert that “one of the central premises of the social constructionist perspectives on gender is that there is no invariant masculinity (in the case of men) but rather there are ‘masculinities’ that vary according to the social context” (p. 92).

Context, as one of my mentors is fond of saying, is everything. The context of the present study is that males in the U.S., usually rather silently, take their own lives at a rate that I assert would evoke an outcry for immediate intervention if it posed a threat to others. But since it does not, I accept a sense of responsibility as a social worker and as a suicide survivor to advocate for the voice of depressed males to be heard, unfettered by the force of gender-role constrictions. I also accept and embrace in that endeavor what Bloom and colleagues (1991) outline as the six languages of social work, which involve a fluency in the voice of “the client, the abstract language

of the theorist, the empirical and often quantitative language of the researcher, the categorical language of the information scientist, the technological terminology or jargon...as used by helping professionals, and the preferential language that conveys values” (p. 530).

As a final note, I wish to honor the all too often unheard voice of males who struggle with the strain of gender-role expectations and related experiences of depression, much of which is related to a poverty of language that reflects a toxic social construction of gender. And just as there is a particular language common to primary care medicine, such as terms related to organs and procedures, there is also a language that is common to mental illness and suicide. After the suicide death of her son, who was a gifted physician despite having a bipolar disorder, Sommer-Rotenberg (1998), for example, takes exception to the expression “committed suicide,” which is commonly used in reference to a death due to suicide. She speaks to the pejorative nature of that term by noting that “The only acts we ‘commit’ are heinous ones: adultery, a felony, some kind of crime” (p. 239), and she challenges physicians to “send a powerful message to colleagues, patients and society at large by using neutral and compassionate language when they refer to suicide” (p. 240). Influenced by the clarity and passion of her position, I have now modified my language and have modeled it for PCPs and others by using terms such as “suicide completion” and “suicide decedents,” with the hope that others too may begin to shift their use of language in this area so that we can begin to lessen the stigma and shame that is so

often associated with depression and suicide.

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APPENDIX A

I. Project Title & Prospectus

Males, Masculinity, and Suicide: A Primary Care Perspective

The completion of suicide in the United States is a public health problem that claims over 30,000 lives annually. Females are diagnosed with depression twice as often as males, yet males complete suicide four times as often as females. Given that suicide is most closely associated with depression, it is important to consider the context for related interventions. It is likely the case that the rate of male depression is under-reported, mainly due to a lack of gender-specific assessment instruments, and to gender-bias within primary care where most cases of depression are treated. The proposed qualitative study will explore the experience that primary care physicians (PCPs) have of male patients who present with complaints of depression and/or suicidal ideation, in an effort to better understand how to more effectively implement early intervention strategies.

A phenomenological methodology involving interviews with PCPs will examine a crucial window of opportunity for intervention that occurs in primary care practice when a PCP meets with a depressed male patient. The central research question in the proposed study will ask subjects to discuss their experience of treating males who appear to be depressed. Follow-up questions will be asked by the researcher either to enhance the clarity of the subjects' responses, or to elicit more

depth in the content of the interview. It is hoped that through an interpretation of the patient-PCP relationship within the area of masculinity and its role in men's experience of depression, themes will emerge that will add to the literature new insights in the areas of early intervention and best practice models. A strength of the proposed study is that it will add a new perspective to the limited area of qualitative suicide research, and will complement the relatively expansive body of quantitative research that is concerned with assessment instruments.

II. Exemption Claim for Waiver of Review

The researcher proposes to conduct individual interviews with PCPs, which will be recorded via audio tape and later transcribed. An expedited review will be requested based upon this study meeting the following criteria:

6. Collection of data from voice, video, digital, or image recordings made for research purposes.
7. Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

III. Subject Recruitment

Consistent with the qualitative design notion of saturation, the proposed study will involve a sample of a size that will be determined by the point at which no new information is being gathered from subjects, but most likely in the 10-20 range. The sample will be drawn by the researcher through his contacts at his workplace, Kaiser Permanente in the Northwest Region, which is a component of a larger national health maintenance organization. Subjects in the study will be primary care physicians at Kaiser who will be recruited via flyers and e-mail announcements of the study that will be posted on physician e-mail distribution lists. There will be no discrimination within this purposive sample in regard to age, gender, ethnic background, sexual orientation, or other variables.

IV. Informed Consent

The researcher will review with subjects the scope of informed consent prior to the commencement of the interview and before the tape recorder is activated. A copy of the informed consent form is labeled Appendix A in section IX of this application.

V. First-Person Scenario

I received in my mailbox at the clinic a flyer which was seeking primary care physicians who would be willing to participate in a study that involved being interviewed about treating depressed males. After some consideration, I contacted the

researcher who briefly discussed the study with me, and I then scheduled a one-hour interview with the researcher. The researcher came to my office at the appointed time, further explained the study to me and answered my questions about it, reviewed confidentiality protocols with me, and then conducted the interview, which was audio taped. At the conclusion of the interview, the researcher debriefed the interview with me and answered the remaining questions that I had.

VI. Potential Risks and Safeguards

The interviews will be scheduled at the subjects' convenience in the subjects' offices, so that the study does not pose an inconvenience to the subjects. Consistent with the chosen methodology of the study, the narrative interviews will be fairly open-ended, yet focused on the subjects' experiences with a particular patient population, and consequently the level of discomfort experienced by the subjects' is expected to be minimal, as is the risk in general. The potential benefit to the subjects is that both the interview and the outcome of the study will help increase subjects' awareness of gender issues that influence the patient-PCP relationship within the area of depressed males being treated in the primary care setting. The researcher will be available to subjects in the unlikely event that there is a need for an additional meeting for the purpose of debriefing or addressing any upset.

VII. Potential Benefits

Subjects will be offered gift cards with a nominal value to be used at a local coffee vendor in recognition of the time that they have set aside for the interview. It is the hope of the study otherwise that subjects will benefit from the study in terms of strategies to more effectively engage and treat males who are depressed, especially during the early phase of depressive disorders, thereby reducing suicidal risk.

VIII. Records & Distribution

In addition to having subjects review and sign the informed consent form, all audio tapes and handwritten notes will be labeled by a randomly chosen subject number only, and locked in both a file cabinet and an office at Kaiser for a minimum of one year to ensure that confidentiality is maintained.

IX. Appendices

Appendix A

Informed Consent Letter/Statement

To All Primary Care Physicians:

Thank you for your interest in the study of depressed male patients, known as: Males, Masculinity, and Suicide: A Primary Care Perspective. If you agree to participate in the study, you would be agreeing to participate in a one-hour interview

which will address gender-issue dilemmas that may influence the treatment of depressed males. Your participation in the study would mean that you would be willing to have the interview tape recorded so that the interview can be analyzed by the researcher and two of the researchers' fellow graduate students who will assist the researcher in the study as peer reviewers. You would also be giving permission to the research team to keep a record of your answers to these questions, so that your answers can be part of the study. Your confidentiality will be protected at all times, and your name will not be disclosed at any point, for any reason. You do not have to participate in this study if you do not want to do that.

Please feel free to ask any questions that you have about the study now or at any point during the study. You may also ask questions about this study at the Portland State University Human Subjects Research Review Committee Office of Research and Sponsored Projects, P.O. Box 751, Portland, OR 97207; (503) 725-4288, FAX: (503) 725-3416, or at the Web Site: <http://www.gsr.pdx.edu/>. Please sign below if you have read this disclosure statement and agree to participate in this study; you will be given a copy of this statement.

Signature

Witness

Date

Date

Human Subjects Research Review Committee

Post Office Box 751
Portland, Oregon 97207-0751

503-725-4288 tel
503-725-3416 fax
hsrrc@lists.pdx.edu

January 22, 2008

To: John Casey

From: Nancy Koroloff, HSRRC Chair

Re: Approval of your application titled, "Males, Masculinity, and Suicide: A Primary Care Perspective" (HSRRC Proposal # 07385).

Dear John,

In accordance with your request, the Human Subjects Research Review Committee has reviewed your proposal referenced above for compliance with DHHS policies and regulations covering the protection of human subjects. The committee is satisfied that your provisions for protecting the rights and welfare of all subjects participating in the research are adequate, and your project is approved. Please note the following requirements:

Changes to Protocol: Any changes in the proposed study, whether to procedures, survey instruments, consent forms or cover letters, must be outlined and submitted to the Chair of the HSRRC immediately. The proposed changes cannot be implemented before they have been reviewed and approved by the Committee.

Continuing Review: This approval will expire on January 22, 2009. It is the investigator's responsibility to ensure that a Continuing Review Report (available in ORSP) of the status of the project is submitted to the HSRRC two months before the expiration date, and that approval of the study is kept current.

Adverse Reactions: If any adverse reactions occur as a result of this study, you are required to notify the Chair of the HSRRC immediately. If the problem is serious, approval may be withdrawn pending an investigation by the Committee.

Completion of Study: Please notify the Chair of the Human Subjects Research Review Committee (campus mail code ORSP) as soon as your research has been completed. Study records, including protocols and signed consent forms for each participant, must be kept by the investigator in a secure location for three years following completion of the study.

If you have questions or concerns, please contact the HSRRC in the Office of Research and Sponsored Projects (ORSP), (503) 725-4288, 6th Floor, Unitus Building, 4th & Lincoln.

Cc: Daniel Coleman