'For men only'

A mental health prompt list in primary care

Suzanne Brownhill, *BSW, MPH, is a PhD Candidate, School of Psychiatry, University of New South Wales.*
Kay Wilhelm, *MD, FRANZCP, is Associate Professor, School of Psychiatry, University of New South Wales.*
Gregory Eliovson, *BSc, MComm, was a research assistant, St Vincent's Hospital, Sydney, New South Wales.*
Merilyn Waterhouse, *BA, GradDipPsych, was a research assistant, St Vincent's Hospital, Sydney, New South Wales.*

BACKGROUND Barriers to detecting symptoms of depression in male patients in primary care include patients' reticence to self disclose and doctors' failing to ask questions that tap into their patient's emotional distress. Effective consultation is further hindered by time constraints, undifferentiated and nonspecific symptoms of depression, differing attribution of symptoms and expectations of the consultation, and low levels of mental health literacy. These issues, of particular relevance to men, informed the design of a screening instrument, the 'For Men Only' Prompt List (PL).
OBJECTIVE This article reports an evaluation by male patients and their general practitioners of the PL conducted in the context of primary care. The patients completed the PL in the waiting room and used it to raise issues during consultation. The instrument was evaluated using a short questionnaire completed by patients, a postal questionnaire by GPs, and field notes.
DISCUSSION The PL was useful for those patients who required prompting in raising issues surrounding depression. Those who already had a good relationship with their doctor, were at ease discussing issues without prompting, or had a specific physical problem to be treated, did not find it as useful. All practitioners found the PL provided extra information about their patients. It also helped them build rapport with patients and made their job of assessment easier. Doctors depend on patients to self disclose and patients depend on doctors to provide an accurate diagnosis. The PL addresses some of the barriers to identifying depressive symptoms in men, particularly in assisting male patients to 'open up' to their doctors.

A number of barriers to detection of depression in primary care have contributed to low detection rates. These include structural barriers such as the setting of the clinic,[1] and time constraints (perceived and actual long waiting times and short consultation) which can lead to focussed, task orientated enquiry and limit a broader psychosocial exploration. Interpersonal barriers to detecting depression include sex, age and socioeconomic bias, and differing expectations of the consultation between doctors and patients.[2] Differing attributions (where patients may construe their problems as 'physical' while the doctor may see them as 'psychological', or vice versa) may also hinder recognition of symptoms. Other complicating factors include alcohol abuse and where symptoms are 'hidden' (such as somatic presentations of emotional distress). These barriers are particularly salient for men whose delayed help seeking and reticence to self disclose may also be a reflection of low levels of mental health literacy (such as knowledge of mental health issues).[3]

'Hidden' symptoms

Low treatment rates for men have been linked to social norms of traditional masculinity that make help seeking more difficult for men. The belief that expressing the need for help, for men, is a 'sign of weakness'[4,5] characterised by difficulty relinquishing control,[6] has been known to inhibit expressiveness and lead to symptoms being avoided, denied, camouflaged or hidden.[7,8] Furthermore, doctors who maintain this same view of masculinity and help seeking in men are

more likely to overlook, deny or dismiss symptoms in men.[9,10]

Differing expectations of the consultation

Accurate assessment is impeded when doctors and patients approach the consultation with differing expectations.[11] For example, some doctors may attach greater importance to somatic symptoms, and prescribing drugs,[12] while some patients may be more oriented to emotional agendas and quality of life issues such as disruption of normal activities and relationships.[13] In other cases, patients may invite a prescription or a 'quick fix' to avoid any exploration of sensitive psychosocial issues that may be difficult to raise. In any case, doctors depend on patients to self disclose in order to fulfill their professional task[10,12] and patients depend on doctors to provide an accurate assessment[14] and to respond to issues raised.[2]

Mental health literacy

Patients' self disclosure and doctors' ability to detect depressive symptoms requires a level of mental health literacy. This has been defined as the knowledge and beliefs about mental disorders (including depression) which aid their recognition, management and prevention.[3] A recent Australian study assessing knowledge and beliefs about depression found a community wide lack of recognition of the symptoms of depression and limited understanding of the availability and effectiveness of standard treatments, in both depressed and nondepressed groups.[15] It remains unclear, however, whether levels of mental health literacy differ between men and women.

While numerous studies have sought to understand why depression in men is difficult to detect in primary care,[4] few studies have engaged men directly. Heifner[5] recruited a group of men to talk about their experience of depression and found that most had very defined traditional stereotypical gender role identities which influenced their help seeking behaviour. Another study, formative to this evaluation study, recruited a nonclinical group of young and older men to a series of focus groups.[5] The group discussions were designed to elicit 'new' information concerning men's experience of depression, ways of coping and help seeking.[2] The qualitative data were used both descriptively, and analysed using a grounded theory approach.[16,17] The results indicated a high level of mental health literacy in those men who identified in themselves, and observed in other men, all the commonly accepted symptoms of DSM-IV major depression.[18] In addition, they identified the need to withdraw, and an escalation and intensification of negative affect toward anger.[19] These two symptoms in men may easily be overlooked in consultation and thus remain 'hidden'.[7,8] Furthermore, the men also reported a tendency for male patients to wait for doctors to 'guess' the problem rather than actively self disclosing.[2]

In an attempt to narrow the expectation gap between doctor and male patient in the consultation process, the men were asked: 'What questions should general practitioners be asking to detect depressive symptoms in men?' The answer to this question and overall analysis of the qualitative data informed an instrument for use by male patients and practitioners in primary care to facilitate discussion on issues surrounding depression. The instrument, the 'For Men Only' Prompt List (PL), is the focus for this evaluation study.

The 'For Men Only' Prompt List

The front page of the PL asks questions that relate to perception of health, work and family satisfaction, social support, major life events, and issues the doctor needs to know and discuss (Figure 1). The first question asks the patient to rate his physical (poor/fair/good/excellent) and emotional health (lousy/not bad/pretty good/feeling great). Poor ratings of emotional health have been found to be predictive, while positive ratings of emotional health have been found to be protective, for the onset of depression.[20] The question: 'When was the last time you saw a doctor?' was designed to establish delayed help seeking and whether an emotional crisis had precipitated the visit. Emotional problems can manifest in physical problems due to delayed help seeking, common in men, at which point the problem is likely to be serious. The next question: 'Why are you seeing the doctor today?' was designed for the doctor to quickly identify the patient's perception of the visit. This enables the doctor to respond appropriately and 'in tune' with the patient thus building rapport.

Having the patient nominate his 'best' and 'worst' life events taps into any significant issues and acts as a cue for questions surrounding, eg. unresolved grief or loss, being retrenched from work, etc. 'Work' and 'family' have been found to be major sources of, and buffers against, depression for men.[2]

The last questions on the front page ask the patient to identify things the doctor needs to know about them and what they would like the doctor to discuss with them. These questions allow the patient to write down sensitive issues that may be difficult to articulate, and also encourages the patient to take an active, rather than passive, approach to the consultation process.

Twenty 'Yes/No' questions on the back page of the PL reflect issues articulated by men in relation to their experience of depression and coping (Figure 2). These questions also incorporate the commonly accepted symptoms of DSM-IV major depression[18] which include diminished interest, lethargy, and change in weight or sleep patterns. Additional questions focus on the need to withdraw and the escalation and intensification of negative effect.

The PL has been informed by men for men. It is in 'male friendly' form and language style, designed to facilitate discussion for men, and to make the doctor's job easier in detecting symptoms

for men only

Please fill in this form and hand it to your doctor at consultation. The answers you give are building blocks for you and your doctor to discuss health and related issues. Thank you!

HEALTH

How would you rate your **physical health?** (please circle)

Poor Fair Good Excellent

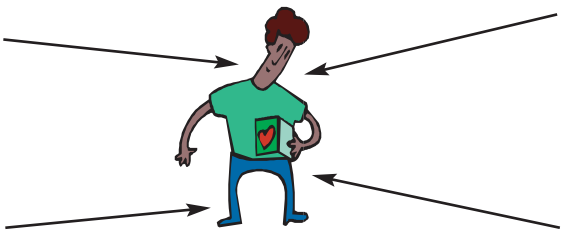
How would you rate your **emotional health?**

Lousy Not bad Pretty good Feeling great

When was the last time you saw a doctor?

Why are you seeing the doctor today?

Who are the **main people** in your life at present (family, mates)? [please write their names on the arrows]



Who is your **main support person?**

What have been your **best** and **worst life events?**

WORK

Are you **employed?** Yes ☐ No ☐

What is your usual **occupation?**

Years in your present job:

How **satisfied** are you at **work?**

Not at all Not very Fairly Very

FAMILY

Do you have a **partner?**
If so, how is the relationship working for you?

It's not Could be better Working well

Do you have **kids?**
If so, how is your relationship with him/her/them working for you?

It's not Could be better Working well

Are you having any **major problems** at home? If yes, please state:

Are there any other things that the **doctor needs to know** about you?

What would **you** like the doctor to **discuss with you?**

Please tick the boxes over the page ü

Figure 1. The 'For Men Only' Prompt List

Your name: **Age:**

Take 'in the past month' as a guide, but some of these issues may be over a longer time period.	**YES NO** [Please tick ü]
Is **work getting on top of you?**	☐ ☐
Are you **coping with the demands of family life?**	☐ ☐
Have you had **less interest or pleasure** in doing things?	☐ ☐
Do you use **recreational drugs or alcohol** to **boost your mood** or **self-confidence?**	☐ ☐
If yes, is your **use of drugs or alcohol becoming a problem** for you and/or your relationships?	☐ ☐
Has anyone commented that you're not your 'normal' self?	☐ ☐
Have you been **wanting to be on your own, more than usual?**	☐ ☐
Have you been **more angry, resentful, critical, or aggressive** towards other people or animals?	☐ ☐
Do things easily trigger you to **explode** with anger or frustration?	☐ ☐
Have you been doing things that are '**out of character**'?	☐ ☐
Have you been thinking that things are **becoming increasingly out of your control?**	☐ ☐
Have you been **taking risks** that might **injure yourself or others?**	☐ ☐
Have your **sleeping patterns changed** for the **worse?**	☐ ☐
Have you been having **more 'aches and pains'** than usual?	☐ ☐
Has your **interest in sex decreased?**	☐ ☐
Have you been **lacking energy** or just **couldn't be bothered?**	☐ ☐
Have your eating habits changed for the worse?	☐ ☐
Have you been **thinking a lot about regrets or sad events** in the past?	☐ ☐
Have you been **feeling down, depressed or hopeless?**	☐ ☐

Please hand to the doctor

Figure 2. Prompt List 'Yes/No' questions

of depression in men. The PL also acts as a practical exercise or 'something for men to do' while waiting to be seen by their doctor.[5] This article reports the pre-test and evaluation of the PL in the context of primary care.

Method

Recruitment

General practitioners who had been involved in earlier research with the authors were asked to allow access to male patients in their waiting rooms. The five practices' receptionists played a vital role in recruiting male patients into the study. A large poster was displayed in the GPs' waiting rooms and receptionists directed the men's attention to it. The male patients were invited to participate in the evaluation. For most, the response was positive – some older men declined (because they did not have their reading glasses) even though they were interested. The completed forms were placed in the patient's file for the doctor to view during the consultation.

Evaluation

The evaluation of the PL was conducted using a self report (for men), a postal questionnaire (for GPs) and field notes of the interviewer. The patient feedback questionnaire was completed postconsultation and the GPs' feedback form mailed back shortly thereafter. To ensure minimal intrusion in terms of time taken, the GPs' form required minimal work (ticking boxes, adding comments) and a reply paid envelope was provided.

Self report questionnaire

A short questionnaire was completed by patients immediately after the consultation. The first question sought patient perception of whether the doctor had asked the 'right' questions to pick up symptoms of depression, and if not, what else needed to be asked; and whether the patient had told the doctor about bothersome issues. They were also asked whether the form was 'useful' in raising issues (why/why not?) and whether patients would change anything about the form (if yes, what changes?). Space was provided to allow these men to make additional comments about their personal experience of depression, coping or help seeking beyond the scope of the set questions.

GP postal questionnaire

The GPs' postal questionnaire sought feedback on whether using the PL helped doctors to build rapport, elicit extra information from patients, clarify understanding of patients' current emotional state, and provide any new information about patients' environment (relationships/support system/work satisfaction/home life). Other questions invited GPs to comment on any problems they had with the PL, to make suggestions on improvement, and to recall any comments received from their patients regarding the PL.

Field notes

Field notes were collected detailing observations of the interview process with the patients, and are included in the Results section.

Results

The men

Seventy-four men participated in this study. Their mean age was 50.3 (SD: 19.02) years. Information derived from the PL provides a profile of male attendees. The majority rated their physical health as 'good' (52.3%). Ratings of 'fair', 'excellent' and 'poor' were 30.8%, 9.2% and 7.7% respectively. The majority rated their emotional health as 'pretty good' (58.5%). The next most common rating was 'feeling great' (20.0%), then 'not bad' (15.4%) and 'lousy' (6.2%). Most of the men were employed (63.1%), with an average 11.1 (SD: 13.6) years spent in their present job; 75.6% were 'fairly' or 'very satisfied' at work. Of the men who had a partner (77.8%), most (82.2%) reported their relationship was 'working well'. Most (67.2%) of the men reported having children and, of those, most (82.5%) reported their relationship with their children was 'working well'. Most nominated major life events related to work, family/relationships and health, and almost all (91.2%) of the men reported they were 'coping with the demands of family life'.

General practitioners

Fourteen GPs (10 women, 4 men) participated in this study, representing five sites in the inner west and eastern suburbs of Sydney (NSW). Even after follow up, only eight of the participating GPs returned their questionnaires, a response rate of 57%. Those eight GPs (6 women, 2 men) have been in general practice for an average of 24.7 (SD: 5.1) years.

Usefulness of the PL

Patient responses

Sixty percent of male patients found the PL useful in raising issues with their doctor. Patient responses are outlined in Table 1.

While only 60% of patients reported the PL useful, qualitative data shed light on patients who did not find the PL useful. These were men who already had a good relationship with their doctor (the doctor knows me/knows my history), or were positive about the doctor's consultation style (the doctor knows what to ask; at ease talking with the doctor). Other reasons given by patients for not (finding the PL useful) centred around the consultation being straightforward (having a specific problem to raise, eg. skin, blood test, 'sugar levels'), about commonsense issues or where there were no psychosocial issues worth raising (not having a need, or not having issues or problems to raise, not being applicable, or not affected by symptoms of depression).

Field notes provided additional evaluative information from comments made by the men. For example, the comments: 'The doctor can read the body signals of the patient' illustrates and reinforces the potential 'guesswork' component to the consultation process.[5] Another patient com-

Table 1. Patient responses to the PL

He now knows some issues about me and he might be able to help me.
Prompted discussion that would not have been raised otherwise.
Reminder, check list, thought beforehand about issues to be raised.
I felt obliged to mention current issues that otherwise I would probably have ignored.
It clarified for myself and my doctor what was needed.
To ensure I spoke openly about the way I have been feeling lately.
I probably wouldn't have raised specific queries with the doctor had I not been prompted.
Questions regarding the 'best/worst' things in life prompted discussion.
It was a good source of information about myself so the doctor could create friendly conversation.
The form supplies all the necessary questions that you would like to be asked.
Opens the 'emotional floodgates' to coin a phrase. Would promote honesty and reflection but in a nonconfrontational way.

Table 2. GP responses to the PL

Great
The language and layout was good. Easy to fill out, easy to get info.
The question about 'main people' was very revealing in most cases.
Valuable in new, unfamiliar patients.
The prompt list helped bring to mind new issues about patients that I've been treating for years.

mented that he had previously endured three months of depression and felt that the PL 'would have helped the doctor' diagnose his depression. He reported not wishing to ask for help, nor to see a doctor during his depression despite losing 18 kgs over the period. Another issue raised was the patient's familiarity with their doctor (if you know your doctor well then the form plays no major part other than letting the doctor pick up depression symptoms). Important issues were more likely to be raised if the doctor was seen as easy to talk to or having an easygoing style. Another comment, that people can easily lie about the answers on the PL, reinforces the view that men may under report lifestyle habits rather than 'look bad'.[5] Time constraint on the consultation process was also raised.

GP responses

All GPs reported the PL provided extra information and 71% reported it clarified information about their patients. Most GPs (86%) found it useful in building rapport with their patients and 71% reported that using the PL made their job easier. Supportive comments from GPs are outlined in Table 2.

Two problems were raised by GPs: The PL is yet 'another' form to complete and too many responses on the back page can be daunting for the GP (even though the PL was not designed to be completed by GPs), and it is another issue to field in limited time (even though the PL was designed to save GPs time in identifying important issues). Despite these comments, the GPs requested copies of the PL to use with risk taking behaviours common to men.

Discussion

Task orientated short consultations in general practice (based on fee-for-service) pose barriers to detection of depression in men. Despite this, recent research has demonstrated that the first two minutes are important to set the scene for the consultation.[21] It is, therefore, important for doctors to engage men in a short space of time while at the same time providing a safe, nonthreatening environment for men to raise and respond to important issues.[5] Men have their own barriers underpinned by the belief that expressing emotion or problems, or exposing their vulnerabilities is a 'sign of weakness'[2,5] so that the provision of task orientated tools to facilitate this process may prove invaluable.

The comments by male patients and their doctors emphasise the importance of effective communication on both sides. In this regard, the PL was designed to assist doctors to ask questions relevant to men, and to assist men to self disclose. All GPs reported that the PL provided new information about their patients, and most of the patients found it useful in 'opening up'. They 'opened up' about issues that they may not otherwise have raised with their doctors. The PL may be beneficial overall, but is likely to be of most benefit where there is less familiarity and interpersonal ease between the doctor and the patient.

The PL may be considered useful as part of the move to a more patient centred approach to health care delivery.[22] It provides the opportunity for men to take responsibility for their health by giving information to their GPs in a structured, nonthreatening format thus exposing sensitive issues that would normally have remained 'hidden'. The PL has the potential to increase the mental health literacy of men by raising their awareness of such issues and by providing access to a screening instrument for such purpose. It also appears to narrow the gap of differing expectations of the consultation by providing a focal point for discussion in line with a collaborative approach where patients are more proactive and informed. While the PL covers symptoms of major depression, the aim is to promote a clinical conversation about depression and possible precipitants and associated risky behaviours.

Changes to the PL

The aim of this pre-test was to allow a sample of male patients (for whom the instrument was designed), to have some

input into its utility. The most consistent comment from male patients was about the ambiguity of two Yes/No questions that sought answers that related to 'change' in behaviour, eg.: 'Have you been sleeping less, or more, than usual?' and 'Has your interest in sex decreased or increased?' These questions were aimed to elicit any 'change' in behaviour, but have been misconstrued by users as 'either/or' answers therefore not fitting the Yes/No answer options. The GPs also suggested that the same questions be reworded to avoid ambiguity and the two questions have been modified accordingly (Figure 1).

Limitations

The patients and doctors in this study may have been particularly vigilant in focussing on and talking about issues surrounding depression. Despite this, the GPs found out more information about their male patients, and male patients offered additional information that would otherwise not have been forthcoming.

Conclusion

We set out to pre-test and evaluate a screening instrument informed and designed by men for men to overcome some of the barriers in detecting depression in men in primary care. The PL has been found to break down some of those barriers, particularly in guiding GPs to ask questions relevant to men's experience and expression of depression, and by assisting male patients to 'open up'. The positive responses from this small sample suggest implementation of the PL on a larger scale. This includes modification of the PL for other groups including women, adolescents and cross cultural studies in primary care.

Ethical issues

Approval for the pre-test and evaluation was granted from the University of New South Wales Ethics Secretariat. Patients were given a Statement of Information that explained the study and those willing to participate in the study gave their informed consent. General practitioners were offered additional copies of the PL for use with future male patients.

Acknowledgments

We thank the patients and GPs who participated in the study, and Dr George Burkitt for helpful comments on the draft PL. This study was supported by a NHMRC Grant No. 993208.

Conflict of interest: none declared.

Further reading

Morgan H. Depression in men. Aust Fam Physician 2001; 30(30):206–217.

References

1. Burkitt G. Barriers to men consulting. Clinical Skills in Men's Health Conference. Newcastle, New South Wales, 1999.
2. Brownhill S, Wilhelm K, Barclay L, Parker G. Detecting depression in men: A matter of guesswork. International Journal of Men's Health 2002; 1(3):259–280.
3. Jorm A, Korten A E, Jacomb PA, Christensen H, Rodgers B, Pollitt P. Mental health literacy: A survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Med J Aust 1997; 166:182–186.
4. Moller-Leimkuhler A. Barriers to help seeking by men: A review of sociocultural and clinical literature with particular reference to depression. J Affect Dis 2002; 71:1–9.
5. Heifner C. The male experience of depression. Perspect Psychiatr Care 1997; 33(2):10–18.
6. Tudiver F, Talbot Y. Why don't men seek help? Family physicians' perspectives on help seeking behaviour in men. J Fam Pract 1999; 48(1):47–52.
7. Warren L. Male intolerance of depression: A review with implications for psychotherapy. Clin Psychol Rev 1983; 3(2):147–156.
8. Pollack W. The tortures of job: Diagnosing and treating hidden depression in older men. J Geriatr Psychiatry 1999; 32(2):195–222.
9. Ross S, Moffat K, McConnachie A, Gordon J, Wilson P. Sex and attitude: A randomised vignette study of the management of depression by general practitioners. Br J Genl Pract 1999; 49(438):17–21.
10. Salmon P, Peters S, Stanley I. Patients' perceptions of medical explanations for somatisation disorders: Qualitative analysis. Br Med J 1999; 318:372–376.
11. Anstett R. The difficult patient and the physician-patient relationship. J Fam Pract 1980; 11:281–286.
12. Arborelius E, Timpka T. Comparison of patients' and doctors' comments on video recorded consultations. Scand J Prim Health Care 1991; 9(2):71–77.
13. Campion P, Butler N M, Cox AD. Principle agendas of doctors and patients in general practice consultations. Fam Pract 1992; 9(2):181–190.
14. Ong L, de Haes J C J M, Hoose A M, Lammes F B. Doctor-patient communication: A review of the literature. Soc Sci Med 1995; 40:903–918.
15. Goldney R, Fisher L J, Wilson D H. Mental health literacy: An impediment to the optimum treatment of major depression in the community. J Affect Dis 2001; 64:277–284.
16. Glaser B, Strauss A L. The Discovery of Grounded Theory: Strategies for qualitative research. London: Weidenfeld & Nicolson, 1967.
17. Strauss A, Corben J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2nd edn. Newbury Park, California: Sage Publications, 1998.
18. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders. IV edn. Washington, DC: American Psychiatric Association, 1995.
19. Brownhill S, Wilhelm K, Barclay L, The 'big build': Men's experience and expression of depression. (in preparation).
20. Hoff R, Bruce M L, Kasl S V, Jacobs S C. Subjective ratings of emotional health as a risk factor for major depression in a community sample. Br J Psychiatry 1997; 170(2):167–172.
21. Pollack K, Grime J. Patients' perceptions of entitlement to time in general practice consultations for depression: Qualitative study. Br Med J 2002; 325:687–690.
22. Clark N, Gong M. Management of chronic disease by practitioners and patients: Are we teaching the wrong things? Br Med J 2000; 320:572–575.

AFP

Correspondence

Suzanne Brownhill
Caritas Centre
299 Forbes Street
Darlinghurst, NSW 2010
Email: sbrownhill@stvincents.com.au