Author’s response to reviews

Title: Family-centered depression treatment for older men in primary care: a qualitative study of stakeholder perspectives

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Author’s response to reviews:

Dear Dr. Tonkin-Crine,

We have made changes to the manuscript in response to the reviewer comments. We have listed each of the reviewer comments along with our responses and a summary of changes made in the manuscript. All changes in the manuscript have been made with track changes.

Matthew Manear, Ph.D. (Reviewer #1)

1. Abstract: In the methods section, the study would be more accurately described as a "cross-sectional qualitative descriptive study" as opposed to an interview study. Qualitative descriptive studies are a recognized qualitative design (see paper by Neergaard et al 2009, BMC Medical Research Methodology).

Response: We have changed the abstract as suggested by the reviewer.

2. Introduction: This is a very good introduction, however it should end with a clear statement about the research question or objective.
Response: The last sentence of the introduction has been revised to make clearer the goal of the study which was to elicit stakeholder perspectives on the acceptability and feasibility of a family-centered depression intervention.

3. Methods: There is only a minimal mention of the qualitative study design (in the analysis section). The authors should clearly mention early in the methods that they have conducted a qualitative descriptive study and justify why this is appropriate.

Response: We have now cited the suggested reference (i.e. Neergard et al, 2009) and have included the following sentence in the analysis section justifying the use of a qualitative descriptive approach: “Because the goal of the study was to generate knowledge that would directly and pragmatically inform intervention development and implementation, a descriptive qualitative approach was used.”

4. Methods: The authors mention discussing certain pre-determined topics during interviews, was there a conceptual framework guiding the data collection process? If not, how were these topics of discussion determined and by whom?

Response: We have added a sentence clarifying this issue: “These pre-determined topics were chosen by the research team to elicit in an open-ended fashion stakeholder general perspectives on the acceptability and feasibility of involving family in depression care, and to explore stakeholders perspectives on specific aspects of the research team’s anticipated intervention approach.”

5. Methods: It was not clear if interviews were conducted with both older men and their family members together or whether all interviews were conducted with a single person at a time.

Response: In the methods section we have clarified that the interviews were conducted separately.

6. Methods: Some additional details should be provided on the interviewers and members of the research team involved in the analysis, for instance whether they were health professionals or not or whether there was diversity in the analysis team with respect to cultural background (potentially important in this study).

Response: We have specified that the analysis was conducted by a team that is multi-cultural and multi-disciplinary.
7. **Results/Discussion:** The authors mention in their Methods and Limitations sections that they had a high representation of Latinos in their sample, yet did they notice any differences in perspectives between Latino participants compared with other participants? This is worth exploring as previous studies have shown differences in views on patient activation and shared decision making in Hispanic populations relative to other ethnic groups (e.g. Patel & Bakken 2010, DE Cortes et al 2013).

Response: We have included the following sentence in the limitations paragraph to address the issues of cross-ethnic differences: “In addition, our study was not designed to systematically compare the perspectives of Latinos and white non-Hispanics (or other ethnic/racial groups) but rather to identify themes that were broadly reflected in the sample and were relevant to development and implementation of a common intervention.”

8. **Results/Discussion:** The results seem to suggest that family members are not currently very involved in the care and treatment of the depressed older men, but is this in fact the case? Did family members discuss how they may already be supporting their husbands or fathers? If family involvement in this sample was low, this could be reported as a finding.

Response: This study was not designed to systematically assess the role of family members in older men’s depression care, but rather to explore stakeholders’ attitudes about their possible involvement. Prior work by our research team, cited in the introduction, documents a variety of family roles in older men’s depression care.

9. **Discussion:** The authors mention that clinicians should explore the preferences of older men regarding the involvement of families in their treatment and that for some men it could be better to explore family involvement only after some time has passed, such as mid-treatment. However, it is possible that some caregivers will also be at risk for experiencing stress and mental health problems given the burden of caring for their loved one, and ideally primary care clinicians should be concerned by the health of these caregivers. This possibility should be acknowledged by the authors, as it has implications for the content of guidelines for family involvement in depression care (i.e. need to care for the family and not solely the individual affected by depression).

Response: This is an important point and we have added this to the discussion: “Finally, clinicians should also consider and assess the impact of participation in older men’s depression care on family members themselves; it is possible, for example, that in some cases older men
may want to include family but this might not be in the best interests of the family member’s health or well-being.”

Bianca Brijnath, Ph.D. (Reviewer #2)

1. Findings are presented descriptively without illuminating their underlying rationales. For example, when exploring when men ought to be engaged about family-centred care, participants suggest often after treatment has commenced. Yet other family members, especially women, are often major catalysts for men initiating mental health-seeking to begin with. How is this apparent contradiction reconciled by participants?

Response: We agree with reviewer that the data suggest the need for flexibility in when men should be included in treatment (i.e. at the start or later) and this is noted in the discussion. This finding suggests that to have significant “reach” in this population, the timing of the delivery of the family-centered intervention (i.e. at the start of treatment or late) needs to be tailored to the preferences and needs of individual men.

2. Likewise, managing one's medications emerges as an important daily practice for preserving autonomy at a life-stage where many men experience a loss of identity and independence through retirement, infirmity, illness etc. Much more could be made in the findings and discussion about how medication management has therapeutic benefits beyond the material properties of the pills themselves.

Response: We now include the following sentence: “However, it is important to stress that men may also value independence in some aspects of depression self-management (e.g. taking medications) which may also serve to affirm their masculinity and to preserve their autonomy.”

3. Despite more than 50% of the sample being Latino and non-White, no cultural comparisons are made either in the findings or discussions across the cultural groups. I find this remarkable as considerable literature documents that there are different kinship arrangements and notions of family support across culturally diverse groups. The authors ought to make more of these comparisons in the analysis as it would add considerably more rigor to their work.

Response: While we agree with the reviewer that cross-ethnic differences may exist, it is beyond the scope of this study, which would likely need to be expanded to allow for systematic cross-ethnic comparison. We have now included a statement to this effect in the limitations section.
and a clarification of the overall goal of this study, which was to develop a common approach to intervention.

4. There is no discussion of gender vis-a-vis the feminization of care. From what I can tell from Table 1, 50% of the patient/carer sample were married. Again, reflecting the literature on the feminization of care, I would assume a portion of the children (25% of carers) were also women. This is a missed opportunity especially when paired with the cultural comparisons. Research shows that gender dynamics influence men's health-seeking as well as how involved they might wish women to be in their mental healthcare. There are also generational issues at play here - i.e., discussing sensitive topics (depression and sexual dysfunction) with daughters/children present in the room etc.

Response: We agree with the reviewer that feminization of care is an important point. We have added the following sentence to the discussion: “For older men, it is also worth noting that family helpers are most likely to be women (i.e. either wives or daughter/daughter-in-laws) and that this gender and generational differences may also influence the qualities and dynamics of provision of support.”

5. Finally, given the difficulties the researchers experienced recruiting the patient sample (~6% response rate), yet 80% response rate from their carers tells us something about the methodological challenges associated with this area of research. Again, this is an important contribution which ought to be more fully discussed in the limitations section.

Response: We agree that the recruitment challenges are an important point and these are now mentioned in the conclusion.