Some Men Talk About Depression Differently

Older men should be encouraged to talk about changes in work, health, and family context.

BY ROXANNA GUILFORD-BLAKE

SAVANNAH, GA. — Older Mexican American and white non-Hispanic men are undertreated for depression, possibly because they talk about the depression experience differently from the way in which women do, preliminary findings from the Men's Health and Aging Study show.

MeHAS, funded by the National Institute for Mental Health (NIMH), examines barriers and facilitators to depression care for Mexican American and white non-Hispanic men aged 60 years and older in primary care. It explores how those men experience depression and considers the factors that impede or facilitate care.

Principal investigator Dr. Ladson Hinton of the University of California, Davis, and his colleagues presented preliminary findings at the annual meeting of the American Association for Geriatric Psychiatry.

The cross-sectional, mixed-method study, when complete, will comprise 96 Mexican American and white non-Hispanic subjects with recent depression. It also will include 48 of their primary care physicians.

Previous research has established that men are less likely than women to seek treatment. Depression is more prevalent in women, but men are less likely to seek treatment. "Women are more likely to be treated for depression; men are more likely to kill themselves," Dr. Hinton said. Older age and its attendant comorbidities can make identification of depression more challenging, he noted.

The four-part presentation drew on screening data from more than 190 men, 74 of whom were eligible for the study. Results from analyses of the first 36 qualitative interviews with eligible men also were presented. The study sample was drawn from a public hospital outpatient clinic and a university outpatient clinic. Future participants will be drawn from other settings.

All of the candidates undergo a brief screening. Eligible participants complete a quantitative interview, then undergo a qualitative interview that includes discussions about childhood, occupational history, migration, family, the experience of depression, health, views of aging, family and social responses to depression, suicide, formal care, and help-seeking attitudes.

Dr. Jürgen Unützer of the University of Washington, Seattle, and the University of California, Los Angeles, reviewed the data from the initial two-stage screening.

Nearly half (48%) of the eligible participants had suicidal thoughts in the previous year; 23% reported such thoughts in the previous month. A third (33%) reported the loss of a loved one in the previous year. Of the eligible participants, 72% rated their health as fair or poor. Nearly three-quarters (74%) received prescriptions for pain. In contrast, 46% received a prescription for depression; 15% received counseling or psychotherapy.

"We're confirming earlier research about particularly low rates of treatment among older men from ethic minority groups," he reported. Mexican Americans, especially those speaking Spanish, have the lowest rates of treatment.

Judith C. Barker, Ph.D., University of California, San Francisco, then discussed the extended interviews vis-à-vis notions of male roles and masculinity. Of the 74 men who were eligible for the study, 52 have participated in the qualitative interview. Dr. Barker presented on the first 36 interviews that have been transcribed and analyzed.

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These men perceived loss of productivity as a threat to identity—especially in terms of masculinity and male roles. The interviewees did not want to be a burden. She noted that the issue has come up in research related to other chronic conditions, but not to the same extent as when older men talk about depression.

She quoted one of the interviews: "A man's got to take care of the responsibilities, no matter what they are. You know what I mean? He can't be a burden on anybody. I started right away [after my marriage] taking care of me and my wife."

In the interviews, the men don't use "red flag" words, such as "blue" or "sad," Dr. Barker reported. They talk about productivity. She cites an interview in which a 60-year-old white non-Hispanic male said: "I never used to, but lately I have to ask for help sometimes. Physically, there's things you can't do. I used to do everything by myself. … It don't make me feel bad, but I don't like it. … You're not supposed to do that. You are supposed to do it on your own."

Because older men talk about depression differently from the way women do, clinicians might be less adept at recognizing depression—and its expressions—in them, she said. "Health care professionals need to expand their repertoires for detecting depression."

They should encourage older men to report and discuss changes in work, health, and family contexts and "assess the reported emotional impact of these changes for possible depression," said Dr. Barker. "Overall, the degree of distress wrought by these losses that the men were talking about was expressed similarly for both groups of men in a general sense."

Dr. Barker did identify some differences. Mexican American men linked these losses with impacts on the family more than white non-Hispanic men did. "Mexican men's concerns about the family versus [white non-Hispanic] men's more individualized issues are definitely consistent with a large and diverse literature on these population groups," indicating they are more familistic, she said.

Lack of productivity was linked to an inability to provide for or take care of family members. White non-Hispanic men, however, were more likely to directly link it to physical disability that affected them as individuals.

Ester Carolina Apesoa-Varano, Ph.D., of the University of California, Davis, then addressed family issues that emerged from the interviews.

Families play a dual role, both facilitating and serving as barriers to the treatment of depression. Drawing from the participants' accounts, she observed that men often perceive a lack of support for their depression.

"Families tend to normalize depression as a part of aging," she said. That can inhibit care seeking. They also can stigmatize depression, making men less willing to disclose their feelings and less likely to seek formal care, she added.

None of the presenters disclosed any conflicts. MeHAS is funded by the NIMH. ■

Poor Cognitive Function Linked to Brain Hormone Levels

BY MITCHEL L. ZOLER

ORLANDO — High blood levels of a brain natriuretic peptide were associated with poor cognitive function in a study of 950 community-dwelling, healthy, elderly adults.

"This is the first time this [association] has been shown," Dr. Lori B. Daniels said at the annual scientific sessions of the American Heart Association.

Elevated levels of natriuretic peptide mark the presence of a variety of disease states, especially heart failure, Dr. Daniels said. She suggested several mechanisms that might link production of natriuretic peptide to poor cognitive function, including reduced cardiac output that drops oxygen or nutrient supplies to the brain, atrial fibrillation that creates microemboli, microcirculation deficits that harm both the heart and brain, and genetic predisposition.

Another issue is "which comes first, cardiovascular disease or poor cognitive performance," said Dr. Daniels, a cardiologist at the University of California, San Diego.

Patients analyzed were enrolled in the Rancho Bernardo study in the early 1970s. Of the more than 5,000 community-dwelling adults in the study, 950 underwent a battery of cognitive function tests from 1997-1999 and had blood specimens drawn; they were the focus of the new analysis. The average age of the 950 participants was 77 years; 61% were women. Two-thirds were hypertensive, 4% were current smokers, 49% drank three or more alcoholic drinks per week, 41% were college graduates, 12% had diabetes, 6% had a history of stroke, and 20% a history of cardiovascular disease.

The researchers used three tests to evaluate cognitive function: The Mini-Mental State Exam (MMSE), which assessed cognitive features, including orientation, attention, calculation, and recall (a score of 24 or less indicated poor cognitive function); the Trail-Making Test B, which gauged executive function (a score of 132 seconds or more indicated poor function); and a category fluency test that asked participants to name as many animals as they could in 1 minute (a score of 12 or less indicated poor function).

Tests used to evaluate cognitive function included the MMSE and the Trail-Making Test B.

DR. DANIELS

MMSE results identified poor function in 7%, the trail-making test B identified poor function in 30%, and category fluency identified poor function in 15%.

Natriuretic peptide levels in the blood specimens were measured using a test that detects N-terminal pro-B-type natriuretic peptide (NT-proBNP). Natriuretic peptide measurements were considered low if the level was less than 450 pg/mL, and high if the level was 450 pg/mL or greater. Among the 950 participants, 79% had a low level and 21% had a high level.

People with high levels of NT-proBNP had significantly worse results in all three cognitive function tests, compared with those who had low levels.

The next step in exploring the link between natriuretic peptide and cognitive function should be a prospective study, Dr. Daniels said.

She received research support from Roche Diagnostics, which markets an NT-proBNP assay. ■