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Depression Attributes Among White Non-Hispanic and Mexican-Origin Older Men

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Abstract

Objective—Depression is associated with poor quality of life, higher healthcare costs, and suicide. Older, especially minority, men suffer high rates of depression under-treatment. Illness attributes may influence depression under-treatment by shaping help-seeking and physician recognition in older and minority men. Improved understanding of depression attributes may help to close gaps in care for older men. The study aims are to describe the range and most frequent attributes of depression in a diverse sample of older men and to describe ethnic similarities and differences in depression attributes between white non-Hispanic and Mexican-origin older men.

Methods—In this qualitative study of white non-Hispanic and Mexican-origin older men who were recruited from outpatient primary care clinics in central California, 77 (47 white non-Hispanic and 30 Mexican-origin) men aged 60 and older who were identified as depressed and/or receiving depression treatment in the past year completed in-depth interviews covering their experiences of depression. Transcribed interviews were analyzed per established descriptive qualitative techniques.

Results—Twenty-one depression attributes were identified and 9 were present in at least 17% of the interviews. Men often attributed their depression to stressors such as grief/loss and spousal confiicts, feelings of moral failure, and poor health. Although there were similarities in depression attributes between the groups, we found several differences in the frequency of certain attributes.

Conclusion—Similarities and differences in depression attributes between Mexican-origin and white non-Hispanic older men suggest the confluence of various sociocultural factors. Awareness of the variety of ways that older men understand depression can help clinicians identify and engage them in depression treatment.

Keywords

Depression; attributes; older men; white non-Hispanic; Mexican-origin; qualitative

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INTRODUCTION

Clinical depression is a leading cause of disability in the United States[1] and commonly afflicts older adults.[2–4] Men in general have low rates of depression help-seeking and mental health service utilization.[5–7] Older men are less likely than older women to receive depression treatment, especially men from minority ethnic backgrounds.[7,8] Equally important, older men are at high risk for completed suicide, particularly whites and Latinos,[9] and depression remains a strong predictor of suicide.[10,11] Disparities in depression care persist, with high rates of undiagnosed and untreated clinical depression among older Latinos and men specifically.[5,12–15] In addition, studies have found that men are less likely than women to have their depression recognized by a primary care physician,[12,16] and minority patients are less likely to be screened and treated for depression than are white patients.[7,8] Latino older men have been found to have significantly lower rates of depression treatment than their white-non-Hispanic (WNH) counterparts.[15] Improving depression treatment among older men in general, and especially in those of minority backgrounds, is of public health significance if we are to reduce disparities and meet the needs of our increasingly ethnically diverse older adult population.[15] Part and parcel of advancing this public health goal is promoting patient-centered and socioculturally tailored services and interventions to improve management of late-life depression in men of underserved backgrounds.[13]

Previous research has identified important ethnic differences in conceptions and experiences of illness.[17–19] Ethnic differences in how individuals experience, explain, and express their distress (i.e., explanatory models) may contribute to patterns of help-seeking and to under-recognition and lack of depression treatment, particularly among ethnic minorities.[20–23] Illness attributes, and in this case depression attributes, have been found to be associated with health outcomes and quality of life.[24–27] Equally important, illness attributes provide insights into the barriers and facilitators of depression recognition, engagement, and treatment in older men.[28–30] However, we know little about depression attributes among ethnically diverse older men and how these attributes may be shaped by aging-related factors.

Taking as a departure the literature on illness explanatory models,[31–34] we focus on depression attributes among an ethnically diverse population of older men. To close the gap in our understanding of factors that shape older men's depression help-seeking and treatment engagement, this study's goal is to describe older men's explanations of the causes of their depression. The specific aims of this study are to describe the range and identify the most frequently perceived causes of depression in a sample of WNH and Mexican-origin (MO) older men and to describe the similarities and differences in perceived causes of depression between WNH and MO men. A better understanding of how older men view the causes or sources of their depression may aid clinicians in better recognizing depression in older men and more effectively engaging them in treatment.

METHODS

This study was part of a parent mixed-method, cross-sectional study (Men's Health and Aging Study) that identified barriers and facilitators of depression care in ethnically diverse older men (R01 MH080067). Study participants were recruited from primary care outpatient clinics in California's Central Valley, including clinics in a large academic medical center and its affiliated primary care network and in a safety-net, teaching county hospital (for additional parent study methods, see previously published data[15,35,36]). The study protocol was approved by the institutional review boards at both institutions. The authors are an interdisciplinary team that includes a medical sociologist, a medical anthropologist, and two geriatric psychiatrists who are health services researchers.

Recruitment of Older Men

To generate a sample as representative as possible of depressed older men (treated and untreated) in this predominantly rural area, a two-step depression screening process was used to identify older men with a 1-year history of clinical depression and/or depression treatment.[15] Study criteria also included the following: (1) age 60 years or older, (2) Mexican origin or U.S.-born non-Hispanic whites, (3) nonpsychotic, (4) nondemented, and (5) noninstitutionalized. During a first phase of recruitment, men were approached at their scheduled primary care visit and asked to complete a brief sociodemographic form, which was a modified version of the Patient Health Questionnaire-revised[5,37] and a question on past year depression care use (i.e., "In the past 12 months, have you had any treatment such as medications or counseling for stress, depression, or problems with sleep, appetite, or energy?").[5]

Men who met initial study criteria were administered the Structured Clinical Interview for *Diagnostic and Statistical Manual of Mental Disorders, Third Edition Revised*, or SCID, major depression module to assess the occurrence of an episode of major depression in the past month and past year.[38] In addition, chronic depression was assessed based on the endorsement of three or more SCID items, including at least one of two core symptoms of major depression (i.e., anhedonia) on most days over the past 2 years. After completing this second phase of screening, it was determined whether men fully qualified for the study. Men who qualified were invited to participate in a follow-up interview at a place and time of their preference.

In-Depth Interviews with Older Men

Participants in the in-depth qualitative interview were each compensated $100. In-depth qualitative interviews were conducted with older men (in their homes or in the clinic) by trained qualitative researchers (Ph.D. or M.D.). All but four of the interviews with older men were conducted by the lead author who is bilingual/bicultural (ECAV), and the remaining interviews were conducted by one of the coauthors (LH). The interview guide for older men covered the following domains: conceptions of masculinity, depression explanatory model, family responses to illness, views of suicide, and help-seeking generally and in primary care. These a priori domains were informed by the study conceptual framework and aims (e.g., to identify barriers and facilitators of depression care in ethnically diverse older men).

Consistent with standard approaches in qualitative data collection through in-depth interviews, the interviewer had considerable latitude in conducting the interview, including the order in which interview domains were explored and the flexibility to ask follow-up clarifying questions.[39]

Interviews with men ranged from 1.5 to 2.5 hours and were conducted in Spanish or English per participant preference. All interviews were audiotaped, transcribed verbatim by three bilingual research staff, and deidentified. Spanish language interviews were also translated into English. The lead author (ECAV) reviewed translations for accuracy and quality. If issues were identified during the translation process, these were brought to the entire parent study team, which included other bilingual/ bicultural researchers, for discussion and resolution.

Data Analysis of In-Depth Interview Transcripts

Although 80 in-depth interviews were completed, only 77 (47 WNH and 30 MO) were deemed usable for qualitative analysis (3 were lost to technical issues). Computer-assisted data analysis (i.e., data management and coding) was conducted using NVIVO (QSR International, Melbourne, Australia) and involved multiple steps that included open-coding and constant comparison, following an accepted approach for descriptive qualitative studies.[38,40,41]

First, three researchers systematically read and coded the 77 interviews with older men for major topics: psychosocial and emotional distress, family, suicide, coping and self-management, formal help-seeking, masculinity, and substance use/abuse. These topics were both anticipated (based on the design and content of the interview guide) and emergent (based on initial open coding and discussion of whole transcripts by the research team). Depression attributes were one of the a priori themes operationalized in the “explanatory model” domain of the interview guide, and thus it was systematically explored during each interview with older men. The coded material included older men’s statements regarding their identified causes of their depression. Consistent with the principles of qualitative methods, data saturation was achieved on the theme of depression attributes across the sample of interviews.

In a second phase, interview material coded as “psychosocial and emotional distress” was further analyzed by the lead author who created a code book with attributes categories (e.g., physical decline, economic/financial strain, conflict with wives/ partners). This set of coding categories was discussed and agreed on by the entire team (LH, JCB, JU). A research staff and the lead author then independently and systematically recoded all interviews based on these agreed on categories of depression attributes. In addition, every fifth interview was independently coded by two other research staff to ensure good agreement and consensus throughout the coding process.

During a third phase of analysis, the lead author constructed a general matrix for the entire sample of interview transcripts that allowed the team to visualize the codes to examine the range of attributes and identify the most common attributes. Given that one of our goals was to compare depression attributes across WNH and MO older men, the lead author then

stratified the interview by ethnic group and constructed side-by-side matrices. This allowed the team to identify group patterns to establish similarities and differences between the two groups. All team members independently reviewed these results and through a consensus-building process discussed patterns and interpretation of the data.

RESULTS

Description of the Sample

The screening process results are summarized in Figure 1 and elsewhere.[15] Of 108 qualified men, 80 agreed to qualitative interviews. Three interviews were lost to technical issues, leaving 77 interviews for analysis. Compared with the 28 men who qualified but did not complete the qualitative interview, the 80 men who completed the qualitative interviews were more likely ($p < 0.05$) to be WNH and not to report past-year depression treatment ($p < 0.10$) but not differ significantly ($p > 0.10$) in terms of the other characteristics. Most men, especially MO, were recruited from outpatient clinics in a safety-net hospital in the California Central Valley. The majority of the older men, particularly MO, were low income; were mostly unemployed or retired; had histories of blue-collar (i.e., truck driver), farm labor, and unskilled (i.e., seasonal farm worker) occupations; and resided with a spouse, partner, or other kin. Years of schooling varied among men: WNH men were more likely to have completed high school and have a technical degree or some college compared with their MO counterparts. Most MO men had histories of being uninsured or receiving minimal coverage through a county-based medical assistance program, whereas WNH men were more likely to have received medical insurance through their past employment or government (Medicare) programs (for sociodemographics, see Table 1).

Most Common Depression Attributes Identified by Older Men

Our analysis yielded a wide range of reported depression attributes. We found 21 categories of attributes (for a list of depression attributes, see Table 2). Of these 21 categories, 9 were most commonly invoked by men as a cause of their depression (for the most common attribution frequencies, see Table 3). The remaining 12 depression attribution categories were present in fewer than 15% of the interviews.

Topping the chart and mentioned by all men in our sample was experiencing financial, economic, and employment problems. Men viewed economic constraints and their inability to remain productive as a central source of their depressed mood. Following financial/economic/employment issues, over 50% of the men identified their declining health as having a detrimental effect on their mood. Men perceived this physical decline both as part of their aging bodies and/or the consequences of chronic illnesses, something they believed they could do little about. In third place with a frequency of 48%, men spoke about the death and the loss of those around them (not just family and friends but also pets) as causing their depression. Men typically described the loss of loved ones as unexpected, and they were unprepared to handle the ensuing grief. Following grief and loss, 46% of older men in our sample attributed their depressed mood to chronic or recurrent conflicts with children and extended family.

Less frequent yet still evident in the men's views (34%) were the conflicts they said to experience with wives and partners, which men thought to be responsible for their distress. Although often the men identified external sources as the culprits of their depression, at times they also reported internal ones. We found that 21% of the men identified "being morally weak," "being defected," or "an individual failure" as a source of emotional distress (Table 4). Following moral weakness/individual failure, a similar number of men (20%) attributed their depression to loneliness and isolation. Likewise, for 20% of the men, those who had others around such as family or partners, the burden of caregiving for others was perceived as causing their depressed mood. Finally, 17% of the men also referred to substance use, especially drinking alcohol, as a source of emotional distress. Although a number of these men disclosed having a history of substance use (e.g., alcohol, drugs), this attribution was less frequently invoked in men's accounts of their depression.

In short, we found that older men in our overall sample characterized the origins of their depression in complex ways and attributed it to a variety of external and internal causes. In particular, the intersection of biologic, psychological, and social factors evident in their changing bodies, roles, and relationships with others were described as overwhelming and disconcerting, so much so that many reported long or chronic periods of depression, even when having received depression treatment such as anti-depressant medications.

Ethnic Comparison of Depression Attributes in Older Men

In addition to describing the range and most commonly identified depression attributes in our sample, we sought to describe specific similarities and differences by ethnic group. Taking the analysis a step further, our cross-ethnic comparison of depression attributes revealed some expected and unexpected insights into the similarities and differences between WNH and MO older men (for cross-ethnic comparison of depression attributes, see Table 5).

Similarities Between WNH and MO Older Men—Both WNH and MO men overwhelmingly identified financial/economic problems as an important source of their depressed mood. Also, we found similar frequencies across the two groups regarding the identification of conflicts with their children and extended family and having a moral weakness/being an individual failure as reasons for feeling sad and disinterested. We found all three depression categories (financial/economic/employment issues, children and extended family conflicts, and moral weakness/individual failure) to be similarly present in the depression accounts of both ethnic groups (Table 5). The most striking similarity, and perhaps the most counterintuitive to extant knowledge, is the one related to the identification of children and extended family conflicts, something that is typically associated with minority, especially Latino, strong family orientations.

Differences Between WNH and MO Older Men—We found several differences across ethnic groups in terms of depressions attributes (Table 5). First, a higher percentage of MO men referred to their declining health compared with WNH men. This difference may be explained in terms of MO men's' concerns about their inability to physically sustain jobs in the context of their limited economic resources, not just for themselves but for their

extended families, and of more physically demanding jobs such as farm labor. In contrast, the WNH men for the most part could count on a more stable source of retirement income having had traditional working class jobs (e.g., truck driver, mechanic, clerical).

Second, another notable difference across WNH and MO men's perceptions of what causes their depression involved the couple conflicts attribution. In particular, WNH men referred to conflicts with wives and partners almost twice as much (40% compared with approximately 20%) as MO men did. WNH older men typically focused on their strained individual relationships with their wives or partners whom they attributed to their depression or said to worsen their depression. On the other hand, MO men were more likely to place their conflicts with their wives and partners in the context of their families (e.g., the woman's role as a mother) and their relationship with children and grandchildren.

Third, we found that over one-fourth of WNH older men perceived caregiving for others as causing them to feel depressed. In contrast, caregiving for others was not frequently mentioned by MO men. Instead, slightly under one-fourth of the MO men attributed their feelings of sadness and disinterest to loneliness and isolation from others. This may be due to WNH men taking on caregiver roles more often than MO men who are likely to see caregiving as the purview of women, especially older daughters.

DISCUSSION

Our findings highlight that older men viewed the causes of their depression in a wide range of circumstances and experiences, the most prominent ones including financial/economic/employment issues, health decline, grief/loss, and conflicts with children and/or spouses. The nine most common depression attributes men articulated paint a complex landscape of the interplay of sociocultural factors shaping the experience of emotional distress. These accounts of the causes of depression point to physical, social, and psychological changes due to aging (both in the biologic and social sense) that coalesce to threaten men's emotional well-being, and men's ability to cope with them over time seems especially adversely affected.

Overall, we found substantial overlap in how WNH and MO men made sense of their depression but also identified several important differences. Our cross-ethnic comparison showed similarities, although somewhat counterintuitive to current understandings, between WNH and MO men's views of the causes of their depression. These similarities involved financial/economic/employment issues, conflicts with children/extended family, and having a moral weakness/being an individual failure as depression attributes. Although these men may be separated by their ethnically imbued values and orientations, they are also united by dominant (hegemonic) ideas about manhood in the context of culturally (and generationally) defined norms about men's roles as workers and family providers.

Although similarities between the two groups were striking, so were the differences we found regarding attributes such as declining health for MO men versus grief/loss for WNH men. Although both groups invoked these as depression attributes, they did so to different degrees, with MO men identifying declining health as the second most common cause of

their emotional distress. For MO men, declining health was intrinsically related to their ability to remain economically productive workers, even in old age, given their typically poor backgrounds. This may be partly due to ethnicity (e.g., expectation to economically provide for nuclear and extended family) but could also be explained in terms of MO mens' poorer general health status or high prevalence of chronic illnesses or comorbid conditions such as type 2 diabetes, which have been linked to depressive symptoms.

It may also be the case that other factors such as differences in socioeconomic status and in the number of losses/deaths of close intimates and friends across these two groups accounts for this difference. Of equal note is the discrepancy in how frequently both groups of men invoked conflicts with wives/ partners as a depression attribution. WNH men were twice as likely to do so as their MO counterparts. This may be due to a combination of ethnic familial values, household structure, and residential patterns. In other words, it is possible that MO men are more focused on their relationship with children and grandchildren in that they continue to see themselves as providers for the "whole" family. Likewise, MO men may be more oriented toward seeing children and grandchildren as a reflection or symbolic representation of their own accomplishment or as an extension of themselves and their status. Thus, incongruences between their own expectations about what they would like their extended families to "look like" or "do" might more readily lead them to be in conflict with them and attribute their depression to them. Further, MO men may rely more readily on the nuclear and extended family (beyond their wife) for a variety of day-to-day activities, both because their wives may be unable to help (e.g., due to limited English proficiency) and because they are likely to reside in intergenerational households or have family in close geographic proximity with whom they interact more frequently. Again, this may create more opportunities for conflict and disagreements, which the MO men are likely to see as a cause of their low mood compared with the WNH men. Finally, it is striking that loneliness/ isolation was a common depression attribution for MO men only, whereas caregiving for others was so exclusively for the WNH men. This may be explained by MO men's strong family orientations, where they feel disillusioned by strained and disengaged relationships with children and spouses given their inability to fulfill the provider role. In contrast, for WNH men, caregiving might be experienced as a heavier burden given their more prominent roles in caring for wives and partners compared with MO men, who may leave that to other (e.g., women) kin to perform.

This study has several limitations. Interviews were conducted typically in a nonclinical setting by a nonclinical expert. Our sample size, although adequate for a qualitative study, does not allow for definitive generalizations to a larger group of older men. Our MO sample was smaller than the WNH sample, and, arguably, it is about the MO men that we understand the least when considering barriers and facilitators of depression care. Further, the MO sample was not diverse in terms of sociodemographic characteristics (the majority selected from a rural, poor, farm labor region), which limits any analysis of potential intragroup differences in the idioms of distress used by older MO men. Likewise, the MO sample size does not permit comparisons based on migration history or between U.S.-born Mexicans and those born in Mexico. Another important limitation relates to working with and analyzing translated material. Although our translations were performed by fully bilingual, non–U.S.-born Latino individuals, translations are always subject to individual

and sociocultural idiosyncrasies, especially given the diversity and heterogeneity among Latinos (including among Mexicans). Finally, our study is limited only to MO older men rather than Latino older men. Future research may focus on the complex interaction between aging, sociocultural background, and gender identity in other groups and test models emerging from this study to improve depression care for older men.

The results of this study may be useful for clinicians and researchers. In clinical practice, the types of depression attributes described in this study may influence how men experience and express their distress. Our description of the most common attributes may help clinicians recognize depression. Further, understanding how patients make sense of their depression can deepen clinicians' awareness of patient experience to facilitate a more trusting, empathic therapeutic relationship and align clinicians' care with patient-centered principles. Appreciation of depression attributes can reveal important stresses in patients' lives that can inform targeted intervention and referral to additional services. This study provides a foundation to develop future observational and interventional research focusing on the mechanisms by which the interplay of a variety of sociocultural factors influence depression care trajectories in older men. A dynamic process-oriented understanding of the mechanisms involved will advance a more nuanced theoretical model that can be tested across other populations and can more effectively inform clinical practice and supporting mental health services.

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References

1. U.S. Department of Health. Healthy People 2010. Government Printing Office; Washington, D.C: 2000.
2. Charney DS, Reynolds CF, Lewis L, et al. Depression and bipolar support alliance consensus statement on the unmet needs in diagnosis and treatment of mood disorders in late life. Arch Gen Psychiatry. 2003; 60:664–672. [PubMed: 12860770]
3. Unutzer J. Clinical practice: late-life depression. N Engl J Med. 2007; 357:2269–2276. [PubMed: 18046030]
4. Crystal S, Sambamoorthi U, Walkup JT, et al. Diagnosis and treatment of depression in the elderly Medicare population: predictors, disparities, and trends. J Am Geriatr Soc. 2003; 51:1718–1728. [PubMed: 14687349]
5. Unutzer J, Katon W, Williams JW, et al. Improving primary care for depression in late life: the design of a multicenter randomized trial. Med Care. 2001; 39:785–799. [PubMed: 11468498]
6. Hinton, L, Arean, PA. Epidemiology, assessment, and treatment of depression in older Latinos, in Depression in Latinos: Prevention, Assessment and Treatment (Issues in Children's and Families' Lives). Aguilar-Gaxiola, S, Gullotta, T, editors. New York, NY: Springer; 2008. 277–298.
7. Gonzalez HM, Vega WA, Williams DR, et al. Depression care in the United States: too little for too few. Arch Gen Psychiatry. 2010; 67:37–46. [PubMed: 20048221]
8. Alegria M, Chatterji P, Wells K, et al. Disparity in depression treatment among racial and ethnic minority populations in the United States. Psychiatr Serv. 2008; 59:1264–1272. [PubMed: 18971402]

9. Centers for Disease Control and Prevention. National Center for Injury Prevention and Control. [Accessed December 29, 2014] Suicide Facts at a Glance. 2012. Available at: http://www.cdc.gov/violenceprevention/pdf/Suicide-DataSheet-a.pdf
10. O'Connell H, Chin AV, Cunningham C, et al. Recent developments: suicide in older people. BMJ. 2004; 329:895–899. [PubMed: 15485967]
11. Conwell Y, Duberstein PR, Caine ED. Risk factors for suicide in later life. Biol Psychiatry. 2002; 52:193–204. [PubMed: 12182926]
12. Hinton L, Zweifach M, Oishi S, et al. Gender disparities in the treatment of late-life depression: qualitative and quantitative findings from the IMPACT trial. Am J Geriatr Psychiatry. 2006; 14:884–892. [PubMed: 17001028]
13. Givens JL, Houston TK, Van Voorhees BW, et al. Ethnicity and preferences for depression treatment. Gen Hosp Psychiatry. 2007; 29:182–191. [PubMed: 17484934]
14. Vega WA, Rodriguez MA, Ang A. Addressing stigma of depression in Latino primary care patients. Gen Hosp Psychiatry. 2010; 32:182–191. [PubMed: 20302993]
15. Hinton L, Apesoa-Varano EC, González HM, et al. Falling through the cracks: gaps in depression treatment among older Mexican-origin and white men. Int J Geriatr Psychiatry. 2012; 27:1283–1290. [PubMed: 22383214]
16. Apesoa-Varano EC, Hinton L, Barker JC, et al. Clinician approaches and strategies for engaging older men in depression care. Am J Geriatr Psychiatry. 2010; 18:586–595. [PubMed: 20220598]
17. Angel RJ, Thoits P. The impact of culture on the cognitive structure of illness. Cult Med Psychiatry. 1987; 11:465–493. [PubMed: 3319427]
18. Baer RD, Weller SC, de Alba Garcia JG, et al. A cross-cultural approach to the study of the folk illness nervios. Cult Med Psychiatry. 2003; 27:315–337. [PubMed: 14510097]
19. Biafora F. Cross-cultural perspectives on illness and wellness: implications for depression. J Soc Distress Homeless. 1995; 4:105–129.
20. Duddu V, Isaac MK, Chaturvedi SK. Somatization, somatosensory amplification, attribution styles and illness behaviour: a review. Int Rev Psychiatry. 2006; 18:25–33. [PubMed: 16451877]
21. Eisenman DP, Meredith LS, Rhodes H, et al. PTSD in Latino patients: illness beliefs, treatment preferences, and implications for care. J Gen Intern Med. 2008; 23:1386–1392. [PubMed: 18587619]
22. Cooper AE, Corrigan PW, Watson AC. Mental illness stigma and care seeking. J Nerv Ment Dis. 2003; 191:339–341. [PubMed: 12819554]
23. Rubel AJ. The study of Latino folk illnesses. Med Anthropol. 1993; 15:209–213. [PubMed: 8326839]
24. Brown C, Dunbar-Jacob J, Palenchar DR, et al. Primary care patients' personal illness models for depression: a preliminary investigation. Fam Pract. 2001; 18:314–320. [PubMed: 11356741]
25. Yeung A, Chang D, Gresham RL Jr, et al. Illness beliefs of depressed Chinese American patients in primary care. J Nerv Ment Dis. 2004; 192:324–327. [PubMed: 15060408]
26. Mechanic D, Mcalpine D, Rosenfield S, et al. Effects of illness attribution and depression on the quality of life among persons with serious mental illness. Soc Sci Med. 1994; 39:155–164. [PubMed: 8066494]
27. Rief W, Nanke A, Emmerich J, et al. Causal illness attributions in somatoform disorders: associations with comorbidity and illness behavior. J Psychosom Res. 2004; 57:367–371. [PubMed: 15518672]
28. Helman CG. Communication in primary care: the role of patient and practitioner explanatory models. Soc Sci Med. 1985; 20:923–931. [PubMed: 4012368]
29. Good, B. Explanatory models and care-seeking: a critical account. In: McHugh, S, Vallis, TM, editors. Illness Behavior: A Multidisciplinary Model. New York, NY: Springer; 1986. 161–172.
30. Okello E, Neema S. Explanatory models and help-seeking behavior: pathways to psychiatric care among patients admitted for depression in Mulago Hospital, Kampala, Uganda. Qual Health Res. 2007; 17:14–25. [PubMed: 17170240]

31. Cabassa LJ, Hansen MC, Palinkas LA, et al. Azucar y nervios: explanatory models and treatment experiences of Hispanics with diabetes and depression. Soc Sci Med. 2008; 66:2413–2424. [PubMed: 18339466]
32. Good, BJ. Illness representations in medical anthropology: a reading of the field. In: Good, BJ, editor. Medicine, Rationality, and Experience: An Anthropological Perspective. Cambridge, UK: Cambridge University Press; 1990. 25–64.
33. Kleinman, A, Good, B. Culture and Depression: Studies in the Anthropology and Cross-Cultural Psychiatry of Affect and Disorder. Vol. 16. Berkeley, CA: University of California Press; 1985.
34. Kleinman, A. Rethinking Psychiatry: From Cultural Category to Personal Experience. New York, NY: Simon and Schuster; 2008.
35. Dwight Johnson M, Apesoa-Varano C, Hay J, et al. Depression treatment preferences of older white and Mexican origin men. Gen Hosp Psychiatry. 2013; 35:59–65. [PubMed: 23141027]
36. Hinton L, Apesoa-Varano EC, Unützer J, et al. A descriptive qualitative study of the roles of family members in older men's depression treatment from the perspectives of older men and primary care providers [Epub ahead of print August 11, 2014]. Int J Geriatr Psychiatry.
37. Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: validity of a two-item depression screener. Med Care. 2003; 41:1284–1292. [PubMed: 14583691]
38. First MB, Spitzer RL, Gibbon M, et al. The structured clinical interview for DSM-III-R personality disorders (SCID-II), Part I: Description. J Person Disord. 1995; 9:83–91.
39. Britten N. Qualitative research: qualitative interviews in medical research. BMJ. 1995; 311:251–253. [PubMed: 7627048]
40. Chenail RJ. How to conduct clinical qualitative research on the patient's experience. Qual Rep. 2011; 16:1173–1190.
41. Merriam, SB. Qualitative Research: A Guide to Design and Implementation: Revised and Expanded from Qualitative Research and Case Study Applications in Education. San Francisco, CA: Jossey-Bass; 2009.

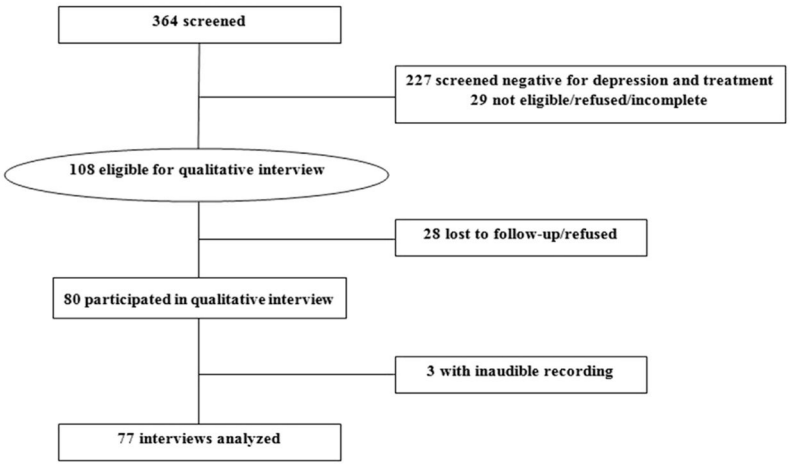

FIGURE 1.
Flowchart of recruitment of older men with 1-year depression and/or depression treatment.

TABLE 1

Sociodemographic and Clinical Characteristics of Older Men

Characteristic	N (%)
Sex	
Male	77 (100)
Female	0 (0)
Age[a]	
60–64 years	39 (51)
>64 years	38 (49)
Race/ethnicity	
NHW	47 (61)
MO	30 (39)
Education	
None	3 (4)
Grades 1–6	11 (14)
Grades 7–11	15 (20)
Grade 12 or GED	21 (27)
College 1–3 years	15 (20)
College 4 years or more	8 (10)
Graduate degree	4 (5)
Marital status	
Married	46 (60)
Divorced, separated, widowed cohabitating	31 (40)
Self-reported health	
Good to excellent	27 (35)
Fair	30 (39)
Poor	20 (26)
Language of interview	
English	60 (78)
Spanish	17 (22)
Clinical depression	
Past year clinical depression	60 (78)
No past year clinical depression	17 (22)
Clinical depression treatment	
Past year depression treatment	46 (60)
No past year depression treatment	31 (40)
Recruitment site	
Academic medical center clinics	33 (43)
County hospital clinics	44 (57)
Income	
<$10,000	22 (28)
$10,000–$25,000	29 (38)

Characteristic	N (%)
$26,000–$50,000	13 (17)
$51,000–$75,000	3 (4)
$76,000–$100,000	6 (8)
>$100,000	3 (4)
No answer	1 (1)
Employment	
Retired	63 (82)
Unemployed but seeking work	3 (4)
Employed part/full time	11 (14)

[a]Age range: 60–80 years; median: 64 years.

TABLE 2

List of All Depression Attribution Categories

Inability to cope with situations	Financial/economic/employment issues	Loss and grief of family, friends, and/or pets
Moral weakness/individual failure	Children and extended family conflicts	Negative neighborhood and physical environment
Declining health	Declining intimacy	Old age
Craziness	Couple conflicts	Antidepressants
Loneliness	Life problems	Genetics/heredity
Lack of access to healthcare	Substance abuse	Caregiving for others
Discrimination and prejudice (not just ethnic)	Retirement and inactivity	Threats to masculinity

TABLE 3

Most Common Depression Attributes Identified by Older Men

Attributes	Frequency (%) (N = 77)
Financial/economic/employment issues	77 (100)
Declining health	40 (52)
Grief and loss	37 (48)
Children and extended family conflicts	35 (46)
Couple conflicts	26 (34)
Moral weakness/individual failure	16 (21)
Loneliness and isolation	15 (20)
Caregiving for others	15 (20)
Substance use	13 (17)

TABLE 4

Illustrative Quotes of the Most Common Depression Attribution Categories

Depression Attribution Category	Illustrative Quote
Financial/ economic/ employment issues	"When you get older, and you lose your job, you ain't got no way to make no more money. You are too old to do anything now. You get depressed because you can't do nothing about it [getting old and not making money]. That's what I think now is at the bottom of it." (WNH)
Declining health	"Because as you get older, so does your body. A person can go out and mow a lawn right now. I can't do that. I'm too old. My legs are killing me, and my back just kills me. I can't go out trout fishing anymore. You feel useless. You can't do something you did before. There are pains that you never thought you'd ever have. …I'm not kidding you. …I feel down and [depressed]." (MO)
Grief and loss	"Just my dog died, and finding out a lot more about my wife, all the stuff that she has to do to stay alive. My buddy died. Another best friend died. …it just seemed like… people were dying. Things were happening and I wasn't ready for it…." (WNH)
Children and extended family conflicts	"[I got depressed because….] my step-daughter used to tell me, 'you just want to control everything.' That's not the case. I don't want to control everything, but I don't like drug addicts coming to my home, I don't like idiots coming to my home, whether they are drug addicts or not… I got three grand babies, 2, 3 and 7, that I've got to consider when idiots come to my house…." (WNH)
Couple conflicts	"She's [wife] negative. So I say, 'sometimes I'd like to do some of these things.' 'Well, I don't know.' I don't have that partner to go with me, but I should be able to go myself. But she gets a little jealous. She started ragging on me… I would like to take her with me to some of these things. It's a disagreement [every time] and it gets me [down]." (MO)
Morally weak and individual failure	"…Especially older men because the older you get, the more serious depression sets in. …Some men work around that [obstacles and problems] and they find ways. I had tried, God knows I tried. Yeah, I'm a failure …It's like a strong person will always keep getting up. A weak person will just lay there and stay there." (WNH)
Loneliness and isolation	"Yeah, because out where I live, it's not like people [come] by all of the time. And I kind of like that, though. But as you get older, and I don't know whether you need more attention, but you feel lonely. …But as I get older, the drive into town may be so much longer." (MO)
Caregiving for others	"It gets [me] down… I worry about that [caring for his ill wife] because she can't do nothing. She can't hardly get up and go around anymore. …I start getting angry…she can't walk. Basically that is the way she is going to be for the rest of her life. So, that gets me down. I just get angry, depressed… I'm the caregiver." (WNH)
Substance use	"…if I were to say it was the reason [to be depressed], it would be the fact that my wife and I were drinking. And that would make me depressed, and I could get more depressed by drinking. …Because she would drink, I would be worried about her, and then my escape was to drink also. I would only drink beer, but I would drink sometimes a lot of beer." (MO)

TABLE 5

Ethnic Comparison of Most Common Depression Attributes Identified by Older Men

Attributes of WNH Men (N = 47)	Frequency (%)	Attributes of MO Men (N = 30)	Frequency (%)
Financial/economic/employment issues[a]	47 (100)	Financial/economic/employment issues[a]	30 (100)
Grief and loss	24 (51)	Declining health	19 (63)
Children and extended family conflicts[a]	22 (47)	Children and extended family conflicts[a]	13 (43)
Declining health	21 (45)	Grief and loss	13 (43)
Couple conflicts	19 (40)	Couple conflicts	7 (23)
Caregiving for others	12 (26)	Loneliness and isolation	7 (23)
Moral weakness/individual failure[a]	11 (23)	Moral weakness/individual failure[a]	5 (17)

[a]Similarities between WNH and MO men's depression attributes.