

ORIGINAL RESEARCH

Better Doctor-Patient Relationships Are Associated with Men Choosing More Active Depression Treatment

David Kealy, PhD, Simon M. Rice, PhD, Olivier Ferlatte, PhD, John S. Ogrodniczuk, PhD, and John L. Oliffe, PhD

Background: Men tend to have low rates of treatment uptake for depression. The quality of the relationship with their family physician may be a factor influencing attitudes toward treatment. The present study was developed to explore this issue in a nationally representative sample of Canadian men.

Methods: An online survey of 1000 Canadian men was conducted to inquire about men's relationship with their family physician and hypothetical treatment choices for depression. Main analyses were conducted among 819 men who indicated having a regular primary care physician.

Results: Two thirds of men with a family physician ($n = 534$; 65%) indicated they would pursue treatment if they were suffering from depression. Multinomial logistic regression, controlling for age, employment, education level, and current depressive symptoms indicated that positive perceptions of the patient-doctor relationship were associated with men being more likely to opt for pharmacotherapy ($n = 183$; odds ratio [OR], 1.06; $P < .001$), and individual psychotherapy ($n = 277$; OR, 1.04; $P < .001$), compared with a wait-and-see/no treatment approach ($n = 285$).

Conclusion: The quality of the doctor-patient relationship is an important element in helping men choose active treatment for depression. (J Am Board Fam Med 2019;32:13–19.)

Keywords: Canada, Depression, Doctor-Patient Relations, Family Physicians, Psychotherapy, Surveys and Questionnaires

One of the obstacles in addressing men's depression is their low uptake of treatment.¹ While reasons vary, traditional masculinity norms have consistently been identified as a limiting factor in men's uptake of treatment for depression.² An ideal of self reliance, for example, may equate acceptance of care with weakness, leading some men to prefer

waiting—without treatment—for their depression to subside. Primary care often represents men's first point of contact in the identification, diagnosis, and treatment of depression,³ and even persistent and treatment-resistant depression is frequently managed in primary care.⁴ Thus, family physicians are likely to play a critical role in helping men take an active approach to treating mental health problems.

Given the prevalence of depression and suicide among men,⁵ helping men to consider treatment for depression is an important public health priority. While several outreach and public messaging campaigns (eg, www.headsupguys.org; www.beyondblue.org.au; www.thecalmzone.net)^{6–8} have sought to change attitudes about depression among men—aimed at reducing stigma and promoting help seeking—men's direct experience with health care providers remains an important medium for encouraging treatment. Despite focused efforts to enhance management of depression in primary

This article was externally peer reviewed.

Submitted 6 November 2017; revised 13 June 2018; accepted 20 June 2018.

From the Department of Psychiatry, University of British Columbia, Vancouver, Canada (DK, JSO); The National Centre of Excellence in Youth Mental Health, Centre for Youth Mental Health, The University of Melbourne, Melbourne, Australia (SMR); School of Nursing, University of British Columbia, Vancouver (OF, JLO).

Funding: Funding for this study was provided by Movember Canada (Grant 11R18455). Movember Canada was not involved in study design, data collection, analysis, or interpretation.

Conflict of interest: none declared.

Corresponding author: David Kealy, PhD, Department of Psychiatry, University of British Columbia, #420-5950 University Blvd, Vancouver, BC, V6T 1Z3, Canada (E-mail: david.kealy@ubc.ca).

care, including education to family physicians, screening/detection strategies, and specialized consultation or collaboration with psychiatry, treatment rates for depression in primary care are less than optimal.³ While gender-based stigma may account for some of men's reluctance to accept treatment, other factors such as misinformation or concern about the experience of treatment or medication side effects may also be implicated.^{9–11} Moreover, the patient-doctor relationship itself may be a notable barrier to—or facilitator of—the uptake of depression treatment in primary care.¹²

The quality of the patient-doctor relationship may be a fundamental vehicle for the shaping of men's attitudes toward treating mental health difficulties. The depth of this relationship, reflecting continuity in care, openness, and sensitivity to the patient's needs, might contribute to feelings of acceptance toward mental health concerns and confidence in recommended treatments. While tentative feelings about the primary care experience may influence a man's hesitation regarding active treatment,^{9–10} a sense of being understood and cared for by his physician might incline him to consider pharmacotherapy or psychotherapy for depression.

The present study was developed to examine whether men's willingness to consider treatment for depression would be associated with the quality of their relationship with their family physician. We hypothesized that, if presented a hypothetical scenario of suffering from depression and considering several treatment options, men would be more likely to choose an active treatment approach if they experienced a positive relationship with their family physician. Since opting for treatment may well be motivated by the severity of depressive symptoms, we sought to control for depressive symptom distress in examining the role of the patient-doctor relationship.

Methods

Participants

A cross-Canada online survey regarding men's mental health was conducted in April 2016, involving 1000 adult male respondents sourced from an online survey provider. Institutional ethics approval was obtained for the study. Respondents were screened for eligibility (>18 years of age, ability to read English) and stratification (reflecting 2011 census age and regional distribution). Participants'

average age was 49.6 years (SD, 14.6; range, 19–86 years). Most were employed ($n = 691$) or retired ($n = 226$), and educated beyond high school ($n = 850$).

Survey Variables

The survey was composed of questions regarding their experience of primary care, current depressive symptoms, and a limited number of demographic items. Respondents were asked 1) whether they had a family physician for regular/continuing care, and 2) about their hypothetical treatment preferences: "If you were depressed, which approach do you believe would be most helpful to you?" Four options were available for respondents to choose from: a) medication for 6 months, with possible side effects; b) individual psychotherapy; c) group psychotherapy; and d) no treatment/wait-and-see with a 40% chance of depression resolving.

The quality of men's relationship with their family physician was assessed using the overall score of the Patient-Doctor Depth-of-Relationship Scale (PDDRS).¹³ The PDDRS is an 8-item self-report measure of patients' perceptions of the depth and quality of their relationship with their physician. Reflecting a single factor, the PDDRS provides a total score based on items scored using a 5-point scale anchored by 0 (disagree) and 4 (totally agree). Sample items include, "This doctor really knows how I feel about things" and "This doctor really cares for me." Good psychometric properties have been reported for the PDDRS,¹³ and excellent internal consistency was observed in the present sample (Cronbach's $\alpha = 0.94$).

Current depressive symptoms were assessed using the Patient Health Questionnaire-9 (PHQ-9),¹⁴ a self-report measure that assesses the 9 key features of major depressive disorder. Respondents rate items relative to the preceding 2-week period, using a 4-point scale from 0 (not at all) to 3 (almost every day). The PHQ-9 is a well validated and commonly used measure of depression severity within both research and clinical practice (present sample Cronbach's $\alpha = 0.92$).

Analytic Approach

Statistical analyses were conducted using SPSS version 24 (SPSS, Inc. Chicago, IL). Preliminary analyses, using t -tests and ANCOVA, examined differences between men with and without a family physician. Subsequent analyses were restricted to

men who indicated having a regular family physician. Descriptive statistics were obtained to characterize this sample of respondents. Multinomial logistic regression was then used to examine men's inclination toward the aforementioned treatment choices for a hypothetical case of depression. The PHQ-9 total score was entered as a covariate to control for the potential influence of depressive symptom severity. Potential sociodemographic confounding variables were also entered, including age, employment status (yes/no), retirement status (yes/no), student status (yes/no), and level of education (postsecondary/no postsecondary). Given the possibility that continuous PHQ-9 scores might obscure findings regarding men who are actually depressed (a score of 10 or above most consistently indicates major depressive disorder),¹⁵ subanalyses using ANOVA and logistic regression were undertaken according to categories of depressive severity.¹⁴ Multinomial regressions were repeated for the following PHQ-9 cutoff scores: none-to-mild depression (<10), moderate depression (10–14), and moderately severe depression (>15). Sociodemographic covariates were included in these models, with the exception of retirement, student status, and education level due to insufficient cell sizes in the moderate and moderately severe groups.

Results

The majority of respondents ($n = 819$; 82%), indicated having a regular family physician for continuing care. These men tended to be older (M , 51.41 years, SD , 14.38) than those without a family physician ($n = 179$; $M = 41.72$ years; $SD = 41.72$),

$t = 9.02$, $P < .001$ (2 participants did not respond to the question). Men without a family physician had higher levels of depression ($M = 5.29$; $SD = 5.78$) than those with a regular primary care provider, $t = 3.07$, $P < .002$. Further examination using ANCOVA found the difference in depressive symptoms to be nonsignificant after controlling for the influence of men's age. Remaining analyses were undertaken only among the subsample of men with a regular family physician. Table 1 presents demographic and descriptive data for these respondents overall and according to PHQ-9 depression categories.

Overall, two thirds of men with a family physician ($n = 534$; 65%) indicated an intent to pursue some form of treatment if they were suffering from depression. Nevertheless, 35% ($n = 285$) preferred a no-treatment/wait-and-see approach. Table 2 presents the results of the multinomial logistic regression analysis using this latter option as the reference category. A significant positive association was found between men's perceptions of the quality of their relationship with their family physician and inclinations toward pharmacotherapy and individual psychotherapy for depression, after controlling for age, employment and student status, educational background, and severity of depressive symptoms, the latter also significantly contributing to hypothetical preference for medication. While age approached significance (a trend toward younger men opting for medication and individual therapy), being a student emerged as a significant predictor of preferring individual psychotherapy. No significant predictors emerged regarding a hypothetical preference for group psychotherapy, al-

Table 1. Sociodemographic and Descriptive Data Regarding Canadian Men with a Regular Family Physician

	Overall, ($n = 819$)	PHQ-9 < 10, ($n = 669$)	PHQ-9 10 to 14, ($n = 74$)	PHQ-9 ≥ 15 , ($n = 76$)
	n (%)	n (%)	n (%)	n (%)
Employed	540 (65.9)	449 (67.1)	47 (63.5)	44 (57.9)
Retired	209 (25.5)	191 (28.6)	5 (6.8)	13 (17.1)
Student	33 (4)	18 (2.7)	7 (9.5)	8 (10.5)
Completed post-secondary education	695 (84.9)	573 (85.7)	59 (79.7)	63 (82.9)
	M (SD)	M (SD)	M (SD)	M (SD)
Age (y)	51.41 (14.38)	52.90 (15.00)	46.23 (12.25)	43.32 (15.10)
Depression (PHQ-9)	5.29 (5.78)	3.00 (2.75)	11.77 (1.36)	19.11 (3.60)
Patient-doctor relationship (PDDRS)	20.09 (7.89)	20.55 (7.79)	17.43 (7.24)	18.58 (8.75)

M , mean; PDDRS, Patient-Doctor Depth-of-Relationship Scale; PHQ-9, Patient Health Questionnaire-9; SD , standard deviation.

Table 2. Results of a Multinomial Logistic Regression Examining Men's Relationship with Their Family Physician and Hypothetical Choice of Treatment for Depression; Overall Sample of Men with a Family Physician (n = 819)

Reference: No treatment/wait-and-see (n = 285)	OR	95% CI	P
Medication, 6 months with possible side effects, (n = 183)			
Age	0.98	0.96, 1.00	.08
Employed	1.20	0.63, 2.27	.58
Retired	1.64	0.75, 3.60	.21
Student	2.80	0.78, 10.11	.12
Level of education	0.69	0.41, 1.15	.15
Depressive symptoms	1.06	1.03, 1.10	.001
Patient-doctor depth of relationship	1.06	1.03, 1.09	<.001
Individual psychotherapy (n = 277)			
Age	0.98	0.97, 1.00	.06
Employed	1.48	0.81, 2.70	.21
Retired	1.15	0.55, 2.40	.71
Student	4.92	1.54, 15.75	.007
Level of education	1.00	0.61, 1.65	.99
Depressive symptoms	0.98	0.95, 1.02	.42
Patient-doctor depth of relationship	1.04	1.02, 1.07	<.001
Group psychotherapy, (n = 74)			
Age	1.01	0.97, 1.03	.98
Employed	0.71	0.31, 1.65	.43
Retired	0.99	0.36, 2.75	.99
Student	2.05	0.33, 12.64	.44
Level of education	0.81	0.40, 1.63	.55
Depressive symptoms	1.01	0.96, 1.06	.78
Patient-doctor depth of relationship	1.03	1.00, 1.07	.09

CI, confidential interval; OR, odds ratio. Bold text indicates statistically significant values.

though the depth of the patient-doctor relationship approached significance.

Subanalyses revealed somewhat different patterns according to categories of depression using PHQ-9 cutoff scores. Men who scored below the cutoff for major depressive disorder (<10) rated their relationship with their family physician more positively than men with a moderate level of depression, $F(2,816) = 6.82$; $P = .001$. Multinomial regression (see Table 3) regarding the former group revealed that the strength of the patient-doctor relationship was a significant predictor of their hypothetical preference for treating depression with medication and/or individual psychotherapy, compared with no treatment or a wait-and-see approach. These associations were not observed among men with moderate depression, based on a PHQ-9 score between 10 and 14. Indeed, no predictors were significant in this model. Among men with moderately severe depression (≥ 15), however, the inclination to choose medication and individual psychotherapy over no treatment was significantly

related to the depth of their relationship with family physician.

Discussion

The present study sought to examine the relationship between men's experience of primary care—specifically, the quality of the patient-doctor relationship—and the hypothetical preference for 1 of 3 active treatment choices for depression, as opposed to a wait-and-see/no-treatment option. Overall, the degree to which men were likely to opt for pharmacotherapy or individual psychotherapy (compared with no treatment) was significantly associated with the depth of their relationship with their family physician. While the size of this effect was small, it was significant after controlling for severity of depressive symptoms as well as several potentially confounding sociodemographic variables. This finding underscores the value of the patient-doctor relationship in potentially facilitating men's uptake of active treatment for depres-

Table 3. Sub-Analyses of Men's Hypothetical Choice of Treatment for Depression, Multinomial Regression by Depressive Severity

	OR	95% CI	P
Severity of depression: None to mild, PHQ-9 < 10 (n = 669)			
Reference: No treatment/wait-and-see (n = 242)			
Medication, 6 months with possible side effects (n = 130)			
Patient-doctor depth of relationship	1.06*	1.03–1.09	<.001
Individual psychotherapy (n = 238)			
Patient-doctor depth of relationship	1.04*	1.02–1.07	.001
Group psychotherapy (n = 59)			
Patient-doctor depth of relationship	1.02*	0.98–1.06	.27
Severity of depression: moderate, PHQ-9 ≥ 10 (n = 74)			
Reference: No treatment/wait-and-see (n = 27)			
Medication, 6 months with possible side effects (n = 22)			
Patient-doctor depth of relationship	1.02 [†]	0.94–1.11	.63
Individual psychotherapy (n = 18)			
Patient-doctor depth of relationship	0.96 [†]	0.88–1.05	.41
Group psychotherapy (n = 7)			
Patient-doctor depth of relationship	1.11 [†]	0.97–1.26	.12
Severity of depression: moderately severe, PHQ-9 ≥ 15 (n = 76)			
Reference: No treatment/wait-and-see (n = 16)			
Medication, 6 months with possible side effects (n = 31)			
Patient-doctor depth of relationship	1.13 [†]	1.04–1.24	.005
Individual psychotherapy (n = 21)			
Patient-doctor depth of relationship	1.14 [†]	1.04–1.25	.008
Group psychotherapy (n = 8)			
Patient-doctor depth of relationship	1.08 [†]	0.97–1.21	.17

CI, confidential interval; OR, odds ratio; PHQ-9, Patient Health Questionnaire-9. Bold text indicates statistically significant values.

*Odds ratios adjusted for age, employment, retirement, student status, and level of education.

[†]Odds ratios adjusted for age and employment.

sion. Thus, while strategies to mitigate stigma and adherence to traditional masculinity norms remain important, attention should be devoted to encouraging and facilitating the continuity of men's engagement in primary care.

One sociodemographic variable emerged as significant: being a student. Attention to mental health among postsecondary students has increasingly come into focus through awareness campaigns, peer support programs, and campus counseling services.¹⁶ Men involved in postsecondary studies may thus feel less stigma about mental health issues, and may have greater access to knowledge about the treatment of depression.

Interestingly, further analysis of our sample revealed that the association between the patient-doctor relationship and treatment preference did not hold for men with current depression in the moderate range. This was in contrast to those without major depression and those with more severe

depression. It may be that different mechanisms are involved in this relationship between these groups. Nondepressed men may readily imagine opting for treatment based on trust in their physician, when they are not facing the actual burden of symptoms or concerns related to psychotherapy or medication side effects. For men who are actually depressed, the connection with their doctor may carry less weight among a number of factors in their contemplation of an active versus wait-and-see approach. Those with severe depression, however, may especially rely on a secure and trusting relationship with their physician as they face potentially greater comorbidity and risk, and more complex treatment. Alternatively, the nonsignificant finding regarding the patient-doctor relationship among men in the moderately depressed category could be due to the relatively small number of men in this category. It is possible that a smaller effect size—relative to those with severe depression—of the association

between the patient-doctor relationship and treatment uptake may not have been detected due to reduced statistical power. Given the simplicity of our survey and the relatively fewer men in these severity categories, further research is needed to examine these possibilities.

While specialized intervention, such as motivational interviewing, may assist family physicians in promoting treatment adherence,¹⁷ key interpersonal/relational qualities such as empathy, compassion, and genuineness can help men to feel accepted, understood, and encouraged about the prospective value of treatment. As the authors of a review of depression in primary care note: “a caring and attentive FP is likely to be highly therapeutic—hardly a surprise, but worth exploiting in a systematic fashion.”³ The depth of the patient-doctor relationship extends beyond a particular consultation, encompassing treatment of the “whole patient” and the total relationship developed between physician and patient over time.^{18,19} While maintaining such a relationship may come naturally to many family physicians, concerted attention to men’s experience of the relationship may help to enhance empathy and address potential “alliance ruptures.” Borrowed from the psychotherapy literature, alliance ruptures—tension or deterioration of the working relationship—can often be repaired through sensitive inquiry and responsive negotiation.²⁰ Doing so may contribute to a stronger and deeper patient-doctor relationship in the long run.

Several limitations to the present study must be noted. First, the cross-sectional nature of the data precludes inferences regarding causality and raises the possibility of shared method variance. The number of potential confounding variables was also limited. The scenario of being depressed and contemplating treatment was hypothetical; we did not ask which treatment had been selected by men who were indeed depressed, and the options were presented in a forced choice format that precluded the selection of multiple approaches. Men contemplating actual treatment would likely have more nuanced options, and may choose differently compared with a hypothetical scenario. Finally, the Canadian context of the survey—where universal health care obviates financial concerns about many treatments and services (though psychotherapy is only consistently covered when provided by psychiatrists)—may not generalize to other countries. These limitations point to a need for further research con-

cerning men’s connections with their primary-care providers in the context of their mental health needs. While more needs to be learned about the nuances of the patient-doctor relationship among men—particularly among those who are reluctant to seek help for mental health problems—the present study provides support for the quality of this relationship as a vital element in the battle against men’s depression.

To see this article online, please go to: <http://jabfm.org/content/32/1/13.full>.

References

1. Mackenzie CS, Reynolds K, Cairney J, Streiner DL, Sareen J. Disorder-specific mental health service use for mood and anxiety disorders: Associations with age, sex, and psychiatric comorbidity. *Depress Anxiety* 2012;29:234–42.
2. Seidler ZE, Dawes AJ, Rice SM, Oliffe JL, Dhillon MH. The role of masculinity in men’s help-seeking for depression: A systematic review. *Clin Psychol Rev* 2016;49:106–18.
3. Craven MA, Bland R. Depression in primary care: Current and future challenges. *Can J Psychiatry* 2013;58:442–8.
4. Schwenk TL, Evans DL, Laden SK, Lewis L. Treatment outcome and physician-patient communication in primary care patients with chronic, recurrent depression. *Am J Psychiatry* 2004;161:1892–901.
5. Ogrodniczuk JS, Oliffe JL. Men and depression. *Can Fam Physician* 2011;57:153–5.
6. Ogrodniczuk J, Oliffe J, Beharry J. HeadsUpGuys: Canadian online resource for men with depression. *Can Fam Physician* 2018;64:93–4.
7. Jorm AF, Christensen H, Griffiths KM. Changes in depression awareness and attitudes in Australia: The impact of Beyondblue: The National Depression Initiative. *Aust N Z J Psychiatry* 2006;40:42–6.
8. Stansfield J, Sargent P. Community whole-system approaches. In: Duffy D, Ryan T, eds. *New approaches to preventing suicide: A manual for practitioners*. London, UK: Jessica Kingsley; 2004.
9. Rochlen AB, Paterniti DA, Epstein RM, Duberstein P, Willeford L, Kravitz RL. Barriers in diagnosing and treating men with depression: A focus group report. *Am J Mens Health* 2010;4:167–75.
10. Saver BG, Van-Nguyen V, Keppel G, Doescher MP. A qualitative study of depression in primary care: Missed opportunities for diagnosis and education. *J Am Board Fam Med* 2007;20:28–35.
11. Scholz B, Crabb S, Wittert GA. “Males don’t wanna bring anything up to their doctor”: Men’s discourses of depression. *Qual Health Res* 2017;27:727–37.
12. Kravitz RL, Paterniti DA, Epstein RM, et al. Relational barriers to depression help-seeking in primary care. *Patient Educ Couns* 2011;82:207–13.

13. Ridd MJ, Lewis G, Peters TJ, Salisbury C. Patient-Doctor Depth-of-Relationship Scale: Development and validation. *Ann Fam Med* 2011;9:538–45.
14. Kroenke K, Spitzer RL, Williams JB. The PHQ-9. *J Gen Int Med* 2001;16:606–13.
15. Moriarty AS, Gilbody S, McMillan D, Manea L. Screening and case finding for major depressive disorder using the Patient Health Questionnaire (PHQ-9): A meta-analysis. *Gen Hosp Psychiatry* 2015;37:567–76.
16. Prince JP. University student counseling and mental health in the United States: Trends and challenges. *Ment Health Prev* 2015;3:5–10.
17. Keeley RD, Burke BL, Brody D, et al. Training to use motivational interviewing techniques for depression: A cluster randomized trial. *J Am Board Fam Med* 2014;27:621–36.
18. Branch WT. Treating the whole patient: Passing time-honoured skills for building doctor-patient relationships on to generations of doctors. *Med Educ* 2014;48:67–74.
19. Ridd M, Shaw A, Lewis G, Salisbury C. The patient-doctor relationship: A synthesis of the qualitative literature on patients' perspectives. *Br J Gen Pract* 2009;59:116–33.
20. Safran JD, Muran JC, Eubanks-Carter C. Repairing alliance ruptures. *Psychother* 2011;48:80–7.