Men's views of antidepressant treatment for depression, and their implications for community pharmacy practice.

Introduction:

Community pharmacy as a profession, is striving to provide better support for people experiencing mental health problems such as depression [1]. Depression is the fifth leading cause of global disability accounting for 4.2% of global years lived with a disability [2]. It can worsen treatment outcomes for co-morbid conditions [3] and is a risk factor for heart disease [4, 5], suicide [6] and alcohol abuse [7].

Men with depression have worse mortality outcomes compared to women with depression [8, 9]. This is somewhat explained by differences in their navigation of depression. Some men mask symptoms [10] and engage in recovery hindering behaviors such as delayed help-seeking [11-13] and alcohol abuse [14]. Many men have poorer social-support networks, which has been linked to hindered mental health recovery [15]. Hegemonic masculinity is a concept that can partially explain these findings. It is a pattern of practices, mainly enacted by men, to demonstrate or protect one's masculine status [16]. In western societies stoicism, strength, control, and restricted emotionality are traits typically characteristic of hegemonic masculinity [17], and though men should not be seen as a homogenous group, the concept of hegemonic masculinity might help orientate healthcare professionals to relevant mental health phenomena such as self-stigmatisation in response to a threat to gender status [13, 18, 19]. For some men, reconstruction of one's masculinity is part of depression recovery [20]. However, hegemonic masculinity has nuanced meanings across different individuals, cultures, and contexts [21, 22].

Community pharmacists can support men treating depression, particularly those taking antidepressants. They routinely interact with these patients, have expertise to address medicine related issues and have good mental health literacy [23-25]. Optimally utilising community pharmacists could also alleviate pressures elsewhere in the healthcare system [1]. Yet men underutilise these professionals [26, 27], and there is little knowledge about what men taking antidepressants see as the role of the community pharmacist in their treatment journey, or how community pharmacists can best support them.

From non-gender specific knowledge it is known that antidepressant consultations by community pharmacists predominantly focus upon medication counselling, as opposed to psychosocial discussions [28]. Both community

pharmacists and patients consider the community pharmacist's contributions in depression care to be around medication safety and supply, and providing information, particularly around adverse drug reactions [23, 29]. Community pharmacists typically spend more time counselling patients who are newly prescribed antidepressants compared to those collecting antidepressant refills, and do not tend to proactively counsel these refill patients [24, 30, 31]. Yet antidepressant users desire community pharmacists to proactively provide follow-up care[32]. These patients want to capitalise on community pharmacist knowledge but can struggle to know what to ask[32]. A suggestion from patients taking antidepressants in a Canadian study was that the community pharmacist should initiate regular discussions so that important topics could be discussed naturally [24].

Good patient-community pharmacist relations, patient centred care and progressive patient trust can facilitate pharmacy depression interventions [33-36] and the perception of community pharmacy as a 'safe space' [33, 37]. Multifaceted pharmacy interventions for depression have been more successful than just educational interventions [38], although the results only demonstrated improved antidepressant adherence, not clinical outcomes. These studies predominantly recruited females, with a median of 70% female participants, therefore findings are not male specific. Interventions that are sensitive to men and action-focused could be more beneficial to men with depression [39, 40], yet it is unknown what this means for a community pharmacy context.

A better understanding of how community pharmacists can support men taking antidepressants is important because, although antidepressants are an effective option for treating major depression [41], there are barriers to their practical application. These include adverse drug reactions [42, 43], including male-specific complaints (e.g. erectile dysfunction), poor adherence [44-46], and stigma [42, 43, 47]. Understanding such phenomena has improved patient outcomes in depression [48-50].

Some antidepressant users question the bio-chemical explanations of their condition [48], and the validity of pharmacological treatment [51]. This results in the creation of a moral framework to legitimise their treatment choice and continuation [52]. Taking antidepressants can involve both a decision and meaning making process [53]. For example participants experience conflict over 'duty to be well' versus 'taking the easy way out'. How one feels about antidepressants can be a constant re-evaluation process [53]. There is limited knowledge about men's views of taking antidepressants. Studies suggest findings are similar to non-gender specific studies, although hegemonic masculinity is influential for some aspects [20, 54]. Some men felt taking antidepressants compromised hegemonic masculine traits such as control and autonomy [54]. These traits are especially valued by men [55, 56].

Aims of the study:

To explore men's views around antidepressant treatment, including the influences of hegemonic masculinity, and consider their perceptions of community pharmacists' role in their antidepressant treatment. The secondary aim of this study is to consider what these findings mean for community pharmacy practice.

Method:

This study has a qualitative study design. It has been designed and reported in line with Standards for Reporting Qualitative Research (SRQR) guidelines [57]. The method for data collection was individual semi-structured, audio recorded interviews. There is an underlying assumption in this study that realities are multiple and socially constructed in line with a constructivist research paradigm.

A brief interview schedule was developed to address identified gaps in the literature. Key topics were around men's views of antidepressants, experiences of the community pharmacy, insights into unmet care needs and potential improvements (see appendix 1). The interview schedule was piloted prior to use. This involved internal testing with two researchers experienced in qualitative methods, and field-testing with three males, two of whom had past experience of taking antidepressants to treat depression. Based on the piloting some changes were made, for example the word 'intervention' was replaced with 'service' and a question was added to ensure a shared understanding between participants and interviewer on the definition of 'community pharmacist'. A standardised opening question was used to establish an understanding on participant's antidepressant history, and to ease participant into the interview.

Eligible participants were males, fluent in English, aged 18-65 years and prescribed antidepressants to treat depression, including those treating depression with anxiety. Males under 18 years were excluded since this age range has unique antidepressant prescribing guidance due to different pharmacokinetics and treatment risk [43]. Those over 65 years were excluded since depression in the elderly can be influenced by factors related to ageing [58]. Participants with diagnosed schizophrenia, psychosis or dementia were excluded.

Convenience sampling was used for recruitment. Recruitment (and interviews) occurred from August 2017-November 2018. Recruitment occurred via poster recruitment either at a United Kingdom (UK) University (two participants), or at five participating UK community pharmacies (three participants), or by the community pharmacists in these branches identifying and approaching eligible participants who presented in the pharmacy (nine participants). Recruitment discussions occurred in private areas. For all participants a subsequent

discussion was held with a researcher prior to participation to confirm they met inclusion criteria and they understood the study. Recruitment occurred till data saturation, which was determined when the last two interviews produced no new themes. Information power (see Malterud et al [59]) was also considered to 'sense check' if data saturation was likely to have occurred. Fourteen participants were recruited in total. A relatively small number of participants could reach data saturation because the study has a fairly narrow aim, and participants hold specific knowledge and experiences relevant for this aim. Fourteen participants seemed reasonable for data saturation to have occurred and passed the 'sense-check'. The ages of recruited participants ranged from 26-61 years old. The mean age was 49 years.

Interviews ranged from 39 -71 minutes. The mean duration was 56 minutes. All interviews were conducted by the same female researcher (SB) who was a qualified pharmacist. This researcher had received extensive training on interviewing prior to conducting the interviews. The participants were briefed that the interviewer was a pharmacist, however she was introduced to participants as a 'researcher'.

Interviews were transcribed verbatim, and analysed using thematic analysis (e.g. see Braun and Clarke 2006 [60]). NVivo12 was used for analysis. The codes were predominantly coded inductively, however 'hegemonic masculinity' was coded deductively. Initially, a long list of themes were developed by SB, who organised themes in the list into a candidate set of super-ordinate categories and sub-themes. A technique described by Ziebland and McPherson [61] facilitated this process (the one sheet of paper technique). Authors met to discuss coding and themes, and to explore alternative interpretations. The research team comprised of a community pharmacist, a social pharmacy professor, and a male researcher with personal experience of depression.

This qualitative study is part of a wider study about developing a complex intervention. Participants were aware about the nature of this study at the time of interview. Eight participants expressed interest in further involvement. These eight also partook in member checking, where the researcher invited further contributions on interviews and the preliminary analysis.

Ethics Approval:

UK Research Ethics Committee and University of Nottingham granted ethical approval [Ref: 17/EM/0264]. All participants signed a consent form and were offered a £10 voucher for participation. Pseudonyms were used. Participants agreed their confidentiality could be breached to access a professional (e.g. G.P) if the research team had safeguarding concerns.

Results:

Table 1 highlights participant demographics. Fourteen participants were recruited. Nine out of fourteen participants had used antidepressants for more than one year, five for less than one year, and of those five, three had prior episodes of depression treated with antidepressants. The men had a mix of employment and relationship status, yet were predominantly aged 40-60 years and Caucasian.

144 *Table 1: Characteristics of Participants.*

Participant ID	Age (years)	Length of antidepressant treatment for current episode. (approx.)	Has participant used antidepressants before?	Prior episodes treated with antidepressants?	Ethnicity[++]	Employment status	Relationship status.	Sexuality
P1	59	8 months	No*	No *	White	Unemployed	Divorced /Single	Heterosexual
P2	58	20 years	Yes	No+	White	Unemployed	Divorced /Single	Heterosexual
P3	46	2.5 years	Yes	Yes	White	Unemployed	Divorced /unknown	Heterosexual
P4	61	11 months	Yes	Yes	White	Retired	Married	Heterosexual
P5	41	6-7 years	Yes	Yes	White	Unemployed	Divorced /unknown	Heterosexual
P6	40	11 months	Yes	Yes	White	Unknown-Paternity leave?	Married	Heterosexual
P7	41	10-15 years	Yes	No+	White	Employed	Unknown	Homosexual
P8	43	8-9 years	No	N/A	White	Employed	Married	Heterosexual
P9	59	6-7 years	No	N/A	White	Employed	Married	Heterosexual
P10	59	4-5 years	Yes	No+	White	Employed	Married	Heterosexual
P11	51	1-2 weeks	No	N/A	White	Unemployed	Single	Heterosexual
P12	60	4-5 months	Yes	Yes	White	Employed	Married	Heterosexual
P13	40	1.5 years	Yes	Yes	White	Self-employed	Married	Heterosexual
P14	26	2 years	No	N/A	White (Other)	Employed	Married	Heterosexual

145 * = Prior course prescribed but never started., + = 1 episode, but different antidepressants used. [++] = Ethnicity descriptors based on classifications from 18
146 ethnic groups recommended for use by England and Wales government [62].

Antidepressant's attributions to benefits.

All of the men in this study identified an improvement in their functioning when taking their current antidepressants.

> *P7:Those really dark, horrible, awful thoughts. I have considerably less when taking the medication.*

Yet some were uncertain as to what extent these improvements were attributable to antidepressants.

> *P1: I would like to think, and I'm sure it is, that the tablets must've been kicking in that gave me the motivation to go out and go running, but I don't know you see that's it. I don't know if it was.*

Most men tolerated this uncertainty. It however became problematic when they were considering stopping. Some men stopped antidepressants to ascertain if they could function without them.

> *Researcher: What was your reasoning for weaning yourself off?*
> *P10: Because I thought that… I'm not a great fan of taking medication that is not necessary and the only way to know if it is not necessary…*

Many men had unsuccessful withdrawal attempts. They spoke of suddenly feeling "flat" or "awful" and feeling they must restart antidepressants. They were then unsure how to explain their unsuccessful withdrawals, potentially attributing it to placebo effects. These experiences made men more cautious about stopping antidepressants, yet they still reported desiring to do so at some point.

> *P8: I never know if I can wean myself off or whether I should stay on the level I am on, but to me I have tried to reduce the amount before and I felt shaky and nervous, whether that is placebo effect or not I do not know.*

Some men sought a discussion with a healthcare professional to ascertain if the dose and/or continuation of antidepressants was appropriate. If they had not had such a review, this led to feelings such as being "lost in the system", "drifting along" or being on their own.

Views of community pharmacists' role influences engagement.

Medication supply was seen by participants as community pharmacists' key role in their depression treatment. Most accounts highlighted community pharmacists' dispensing role, and occasions when community pharmacists had taken an action to ensure participants had medicines, e.g. an emergency supply. There were some accounts of community pharmacists counselling and supporting participants, which in turn increased a participant's confidence in their treatment.

> *P11: (the pharmacist) said you will probably see some improvements after a few weeks […] If somebody encourages me, they say this will help you; people who know what they are talking about like the pharmacist and the doctor, I do listen to people.*

Yet mainly interactions with community pharmacists were sparse and most participants had not sought-out advice from community pharmacists.

> *P10: They are just basically a dispenser and it is usually the assistant that hands it out. The pharmacist you tend never to talk to.*
> *Researcher: Ah-huh.*
> *P10: I have never sought to talk to the pharmacist about it.*

These participants did not express dissatisfaction with community pharmacists' input in their treatment journey; most were not expecting more. Yet two participants who had a vocational association with the profession felt more support could have been offered from community pharmacists.

> *P14: It just would have felt nice that someone would have concerned themselves with me […] It seemed like a very closed interaction.*

Some reflected how not understanding the role of the community pharmacist stopped them from discussing concerns because they were not aware of the option. This was confounded by how they were feeling in their depressed state, being inclined to keep things in, particularly when they had not previously established a clinical relationship with the community pharmacist.

> *P6: It would be really difficult to convince me to have a chat with the pharmacist. Partly because I did not understand their role, partly because of the mind-set at that point in time. I*

guess I have always had a good relationship with my G.P and I did not with my pharmacist back then.

The physical environment and staff resources were also barriers to sensitive discussions.

P13: There is a till and you talk to someone and everyone's there […] you can't really say anything discreetly […] also I would want to know that they have the time. If I can see that there is 10 people in the queue I am not going to feel like I can have a 10 minute conversation with them.

If community pharmacists proactively suggested interactions it was felt this could facilitate engagement, yet participants would need to know community pharmacists had appropriate expertise, resources, and that interacting with the community pharmacists was in line with collaborative care. One participant (P2) linked interacting with community pharmacists as "going behind the G.P's back" believing instead their role in the U.K's National Health Service (NHS) model of care system was to supply medication. Alternatively another participant (P4) referenced how the pharmacy was being advertised as a healthcare resource to utilise and used that as a justification for engagement.

Reflection of support and information needs.

Participants spoke about needs to normalise taking antidepressants. This could be done by the pharmacist's communication styles.

P13: I think they can help by almost not reacting, certainly not reacting negatively, and treating you normally and cheerfully, I guess those sorts of approaches means it is not made a big thing of it normalises it a little bit.

It could also be done through the information provided, for example participants wanted to know if their dose was high or low, and therefore what this said about their condition. They also wanted to understand any adverse drug reactions that would be likely based on their dose, and support on how to interpret information from the Patient Information Leaflet and the internet based on their dose.

P8: An awareness of the side effects would've been more useful. I was not aware how clouded my mind would become when I was in a high dosage, that might of been a bit more useful.

Participants felt the accessibility of the community pharmacists, and their knowledge and skill set, meant they could help them with these medication support and information needs. Participants also reflected upon struggles with coming off antidepressants, and mismatched expectations of treatment duration, some initially viewing it as a ‘quick fix'.

Participants were asked about service ideas or support pharmacies could offer. Most struggled to suggest developed ideas. Predominantly, ideas focused around improving healthcare access such as hosting psychological therapy services, or peer support groups at the pharmacy. Alternatively community pharmacists could organise patient’s access to these services. The reasoning behind why these ideas were suggested was linked to how easily extra steps to engagement became barriers.

P14: I was signposted to a counselling service or a therapy service, and I had to phone them, book an appointment, where as if a doctor or a pharmacist has the opportunity to just do that for me then it would have joined it up better.
Researcher: So what was the issue with you having to speak to them and call up?
P14: You are looking for excuses not to do things.

There was a desire for community pharmacists to be another point of contact, being able to triage men who are struggling, and this was linked to reflections that asking for help could be difficult. Some mentioned gender sensitive training or services, as there was an awareness that men could perceive threats to masculinity due to depression. However, equally men did not want to be patronised or stereotyped.

Hegemonic masculinity and taking antidepressants.

Antidepressants causing benefits was, for some, an assertion that they had not solved their depression themselves. For them it symbolised a weakness, failure, madness, or dependence upon something.

P13: You feel you need something just to get by, I think it feels like a failure.

These feelings could be problematic with ones masculinity.

P10: Maybe it is a male thing about the perceived strength… I do not need this because I am a male.

Yet taking antidepressants could be seen as a logical approach, symbolic of taking ownership to solve problems. One participant symbolised his masculinity by positioning men not taking prescribed antidepressants as not being masculine.

P3: I was going to say 'a big…big girls blouse' well yes stop being a big girls blouse, and basically pull your finger out and take it.

Influences of masculinity could cause challenges in healthcare interactions. When P9 is asked about his views about being approached by the community pharmacist to discuss medication he perceives a potential threat to his masculinity.

P9: I don't know. I honestly could not say because is there a maybe a little bit of stigma attached 'oh this bloke has got antidepressants'.

Some men were not used to opening up about their feelings. This caused barriers to discussions around depression treatment and concerns.

Researcher: Linked to your concerns [about taking antidepressants], were those concerns you felt that you could ask as a question?
P6: To the pharmacist?
Researcher: To anyone.
P6: Yeah.... no.
Researcher: Ah-huh.
P6: Definitely.
Researcher: Can you describe why that was?
P6: I suspect it was partly a gender thing, although I do not want to generalise too much. I did feel quite isolated as a man and that men do not really talk about it.

Influence of cognitive state upon healthcare interactions.

At the point of first being prescribed antidepressants, the men spoke of being focused on obtaining a solution to their depression. Underlying this focus was a desperation; a feeling they had no choice but to seek treatment. The men explained that their impaired cognitive state hindered approaches such as gathering information, deliberation, or exploring concerns relating to antidepressants.

Researcher: You have not used them before, was there any concerns about taking them?

P5: I did not even think about it.

Researcher: Did not think about it. Ah-huh.

P5: Because I did not… I did not feel normal at all.

Exploring concerns could also be seen as counterintuitive to obtaining a solution.

P2: I think I was of a state where I was like just give me something. I am not going to start quibbling.

One participant presented an analogy to illustrate difficulties in mind-set when one has impaired mental health. He suggests that, when depressed, one may not make rational, engaged choices; yet when in a healthier mind one may have more purposeful engagement with treatment once that treatment has shown to facilitate recovery.

P3: Well when you are depressed it is a bit like being dehydrated the last thing you want to do is drink water when you are dehydrated, but then when you start drinking the water you get the taste for it and then you force it down, eventually start to get thirsty and you want to drink water and then obviously become rehydrated again, it is kind of similar.

Participants also spoke of frustration when their initial strategy to take the antidepressants did not result in quick recovery. This led to feelings of being alone, frustration with the prescriber, the manufacturers of the medicine, and disbelief in the treatment strategy. Few felt able to express these concerns, instead presenting a front.

P12: The thing with antidepressants is they're not quick enough…Every time they said to me 'are you going to kill yourself?' So I thought I'll say no but it's a bit of a cop-out because you go around the corner and you think, God I feel awful today. I really feel horrible today, and I'll wait till everybody's gone to work and then I'll do what I do.

Discussion:

This is the first study to explore the community pharmacist's role in antidepressant treatment from the perspective of men with depression. There is seemingly a disconnect between what participants in this study view as the community pharmacist's role within their care, and what the professional body for pharmacy visualises the community pharmacist's role to be. Professional bodies advocate for a greater role for community pharmacists in mental health [1]. Yet the findings of this study showed most participants viewed the community pharmacist's role to be around safely dispensing their medication, and accounts of the community pharmacist's involvement in their care were sparse; a finding also found in studies looking at both genders [63, 64]. Participants did not express dissatisfaction with this, except two participants who had a vocational association with the profession.

To understand this disconnect, and how it might be changed, key themes are discussed. The first being men's cognitive state when first prescribed antidepressants. This study is the first study to give salient voice to men's reflections on how their condition impaired their gathering of information, and a decision making process, when starting antidepressants. The men were focused upon obtaining a solution to their depression. They were unlikely to have given cognitive space to explore concerns or beliefs, and were not seeking to deliberate and gather information. In some cases such an approach was likened to being a barrier to obtaining a solution [starting and/or obtaining antidepressants]. Depression can hinder ones decision making ability, particularly by impairing deliberation and appreciation of information [65]. Many men suffering from depression present to healthcare professionals at the point of desperation and despair [10]. This pattern has been linked to hegemonic masculinity, where men advocate stoicism or solving depression themselves first, and delay help-seeking until a point of despair [13, 66]. Despair as a phenomenon has been connected to impaired engagement and information gathering in patients with mental illness [67]. Participants also spoke about how they were inclined to keep concerns in check, and were not used to discussing their mental health. Previous studies have found that men may be less articulate than women when depressed [14, 68, 69].

Yet this study did find that the men, when reflecting, highlighted unmet information and support needs. Key initial support and information needs were predominantly around normalising the condition and contextualising their treatment. Other studies have shown men can self-stigmatise for taking antidepressants [70, 71] and may undergo a meaning making process, involving cognitive realignment on what it means to take antidepressants. This study supports this finding and adds that participants can go through a meaning making process upon what

their prescribed dose means in terms of their depression, and how it relates to others.

Another key finding, also shown in mixed-sex studies [72], was the struggle the participants expressed with knowing when to stop antidepressants. This finding is linked to uncertainty on the extent antidepressants were causing noticed benefits, and initial unrealistic views of treatment duration. These initial unrealistic views could go unchallenged as men, due to their cognitive state, were not seeking to verify beliefs.

Men spoke about barriers to community pharmacy interactions. Some barriers found in this study have already been shown in other literature, such as the physical set up of a pharmacy causing privacy concerns [36] which was linked to stigma, and concern of antidepressants signifying meaning to others.

An interesting finding was the need for participants to know as a requisite for engagement, that they were interacting within the community pharmacists' scope of practice and competency, and as part of the wider NHS strategy of care. This makes the finding that participants saw the role of the community pharmacists predominantly as a supplier of medicines all the more pertinent, creating a barrier for unsolicited engagement. Particularly concerning was that participants could liken turning to community pharmacists for advice as "going behind the G.P's back".

Implications for Community Pharmacy Practice:

Some men may be unlikely to proactively engage with the community pharmacist in discussions around depression and treatments. Such an approach is not in line with their recovery strategy. Instead pharmacy could consider ways to facilitate engagement. Men could be educated that discussions around antidepressants, and wider holistic care is within community pharmacists' scope of practice and expertise.

It may be particularly important for pharmacy as a profession to seek ways to implement closer collaborative care with other mental health providers. In the UK community pharmacy access to a patient's clinical records is restricted. They can access a patient's NHS Summary Care Record, yet the accessible information is clinically limited [73], and collaborative working models between community pharmacists remains minimal [73] a finding also found in other countries [74, 75]. Researchers have recommended that community pharmacy interventions incorporate strategies to link with prescribers [63, 76]. This current study strengthens this recommendation, but also further expands on it; both the collaborative system, and patients understanding of it need improving. Relevant healthcare professionals should help patients understand collaborative care behaviour, and improve patient's perception of a community pharmacists' role within a collaborative care model.

Community pharmacists should encourage patients to explore their concerns and beliefs. This is particularly important since patient beliefs around antidepressants influence adherence [77]. Community pharmacists may need to help participants normalise their condition and treatment. This may include giving information on dose ranges and if their dose is normal. Community pharmacists should ensure patients are aware of potential side effects of antidepressants when newly starting, or when having a dose change. Literature shows minimal evidence of negative impact of such discussions [78]. Community pharmacists could reiterate that antidepressants should not be considered as a "quick fix", and ask monitoring questions throughout treatment, particularly as some men feel "lost in the system" when stabilised on the medication. In particular this study found a need for staggered support over time, and that is where the accessibility of community pharmacists could be particularly useful, a finding supported by other literature [79, 80]. Some participants had unsuccessful attempts at stopping antidepressants and attributed this to placebo effects. An awareness that patients can hold such views could help pharmacy practice. Particularly as it is possible such experiences could be linked to withdrawal symptoms, which can vary in severity and duration between patients [81]. Patients should be educated on withdrawal and managed appropriately.

While this study did not assess adherence it is worth noting all the men were currently taking their antidepressants and either felt antidepressants improved their mood, or perceived a need to be on antidepressants. Literature has shown that perceived need for antidepressants can increase adherence, although only if this outweighs concern on the medication[82]. Overall it is important for community pharmacists to explore patient's views on antidepressant need, highlight the potential benefits of the medication, while also exploring any concerns as highlighted above.

These findings come from male participants, but not all findings are gender specific. It seems that antidepressants could challenge masculinity, yet not all men will experience this. Care should be taken not to patronise or stereotype men as this could be detrimental [40, 83]. Community pharmacists should also be aware that men when depressed may put on a front, as a strategy to keep concerns in check, and this could be a barrier to communication.

Translation of these recommendations into routine practice will need careful planning and support from leaders of the profession as some barriers such as time [23, 29, 84], lack of pharmacists confidence in talking to those with depression [84-87], and lack of collaboration with physicians [23, 84] need addressing at both an individual and organizational level [76].

Limitations of study:

This was a small scale study. Based on the last two interviews producing no new themes it can be said data saturation was reached, however participants are predominantly Caucasians aged 40-60 years. Therefore it is not clear how generalizable results are. Further studies focusing on different ethnicities, and those aged 18-25 years would be beneficial.

The researcher was female and a pharmacist which could have influenced the responses the men gave. Also most participants were recruited by a community pharmacist and this again could have influenced responses men gave on topics of community pharmacy. Yet care was given to create rapport and encourage the men to give full responses, which may have addressed this.

Another issue from recruitment via the community pharmacist is that pharmacists may have recruited those they knew. However the pharmacist recruiters confirmed they recruited a mix of participants they knew, and those they did not. Also having varied recruitment routes (e.g. posters) could have decreased this potential bias risk.

Most men gave reflective accounts, and this could be subject to recall bias. This study also reported participants' perceptions for how community pharmacists could improve their care and these may not be beneficial in practice. Some men suggested intervention ideas, yet ideas presented lacked depth and/or explanation of active components. This is expected since the method in this study facilitates gathering of ideas, but not a systematic and rigorous approach for intervention development, and results should be interpreted within this context. Further work around developing gender sensitive pharmacy services using appropriate methods would be useful.

Conclusion:

Some men, particularly those that adhere to hegemonic masculinity may not seek out consultations with community pharmacists around their condition or treatment. It is known hegemonic masculinity can delay men seeking treatment until a point of desperation. This study finds that in this state, they are not giving cognitive space to explore their information needs nor their underlying views around antidepressants. Most men had not sought advice from the community pharmacist. Medication supply was seen as the principal role of the community pharmacist in their care.

It would be beneficial for community pharmacists to create opportunities for men to engage in conversations around their antidepressants and wider support. If men view such interactions as within community pharmacists' scope of practice and expertise, part of a collaborative healthcare system, and not threatening to their masculinity, then these engagements are more likely to be acceptable to men. Such interactions can be beneficial at first prescription and also throughout treatment, and discontinuation.

Appendix.

Appendix 1: Interview guide used in semi-structured interviews.

Purpose of question	Question	Question Path:
Opening/ Introductory question:	How long have you been taking your (current) antidepressant?	
Second:	Was this the first time you used antidepressant medication?	
General questions:	When you had your new prescription, did you remember having any concerns?	
Follow up/Probe:	What were they, can you describe further? What specifically concerned you? Etc. Or if 'no' – ask about did they remember having a need for further information?	
General questions:	Did you ask any questions? (or if relevant:) speak about these concerns?	If relevant
Follow up/Probe:	Who did you ask/speak to? What influenced your decision to ask this person?	If 'yes'
General questions:	Did you have any concerns that could be easily asked as a question?	
Follow up/Probe:	Can you give examples/What were they, can you describe further? What specifically makes them easy to ask? Etc.	
General questions:	Did you have any concerns that were not easily asked as a question?	If 'yes'
General questions:	Can you describe further? What are the challenges to ask these in a question form? What makes them not easily asked as a question?	
General questions:	When you had your new prescription, did you remember having any need for further support?	

Follow up/Probe:	Can you give example? Etc.	
General questions:	So you have taken your antidepressant medication for xxx long. Knowing what you know now, what would be the most important question you think someone should ask about when they are newly starting antidepressant medication?	
Follow up:	Can you explain further?	
General questions:	Again, knowing what you know now, what would be important advice you think someone should be given when they are newly starting antidepressant medication?	
Follow up:	Can you explain further?	
	And finally, knowing what you know now, what would be important support someone should be given when they are newly starting antidepressant medication?	
Clarification/Expanding question	Is there anything you want to add or expand upon before I move onto new topic?	
Blurb: A focus of this research is understanding how community pharmacy can improve the support they offer to patients. In this study I'm focusing upon men with depression. Before asking question establish a shared understanding with participant on what 'community pharmacy' means.		

NB: Ask if patient needs/wants a break here (be after approx. 30mins of interviewing)

Introductory Question:	You mentioned xxx support needed. Can community pharmacy help with providing this support?	(If relevant)
Follow up:	How might pharmacy help to provide this for support men treating depression?	
Direct Question:	What services could pharmacy deliver to better support men treating depression?	
Follow up:	Can you give further detail on that? Can you explain further?	(If relevant)
Direct Question:	Previously we spoke about xxx concerns, information needs and support. What current needs in relation to your condition, and treating your condition are not being met?	(If relevant)
Direct Question:	Can pharmacy help meet these needs?	(If relevant)

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