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Discourses of Depression of Australian General Practitioners Working With Gay Men

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Abstract

The data for this article are from a primary health care project on HIV and depression, in which the prevalence, nature, clinical management, and self-management of depression among homosexually active men attending high-HIV-caseload general practice clinics were investigated. One of the qualitative arms consisted of in-depth interviews with general practitioners (GPs) with high caseloads of gay men. The approach to discourse analysis was informed by Halliday’s systemic functional linguistics. GPs constructed three discourses of depression: engaging with psychiatric discourse, engaging with the patient’s world, and engaging with social structures. When GPs drew on the discourse of psychiatry, this discourse was positioned as only one possible construction of depression. This discourse was also contextualized in the social lives of gay men, and it was explicitly challenged and rejected. Engaging with their patients’ social world was considered vital for recognizing depression in gay men. Finally, the GPs’ construction of depression was inextricably linked to social disadvantage and marginalization. Depression is highly heterogeneous and constructed in terms of social relationships rather than as an independent entity that resides in the individual. There is a synergy between GPs’ constructions of depression and men’s experiences of depression, which differs from conventional medical views, and which enables GPs to be highly effective in dealing with the mental health issues of their gay patients.

Keywords

depression; gays and lesbians; HIV/AIDS; illness and disease, social construction; interviews, semistructured; language / linguistics; mental health and illness

In the psychiatric literature, the classification of depression abounds with adjectives; major, minor, clinical, subclinical, threshold, subthreshold, dysthymic, and recurrent brief depression classify depression according to severity and duration. Forms of depression that do not fit into any of these categories are grouped together as depressive disorder not otherwise specified. There are also terms such as seasonal, reactive, and masked depression, for example in a textbook widely used by Australian general practitioners (Murtagh, 2007, pp. 183-191); however, there is little agreement in the literature about the exact meaning of these categories.

According to the DSM-IV (American Psychiatric Association, 1994), major depression is defined as a constellation of symptoms: either depressive mood or loss of interest or pleasure, plus four of the following symptoms for at least two weeks: significant weight loss or weight gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or excessive guilt; diminished ability to concentrate; and recurrent thoughts of death or suicide. In practice, two individuals can be diagnosed with major depression but display a rather different combination of symptoms, and for very different reasons. Minor depression (dysthymic disorder) is defined as a very similar list of symptoms, but requires only a minimum of two symptoms for at least 2 years. Subthreshold, subclinical, minor, and recurrent brief depression are defined as having varying numbers of symptoms but fewer than major depression, and of varying length of duration. Subclinical depression is said to have clinically less distress than clinical depression (Pincus, Davis, & McQueen, 1999).

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From a theoretical perspective, the psychiatric concept of depression has been described as confused, “woolly,” and inadequate as a basis for formulating mental health problems. It has been argued that the exclusion of the social, economic, and political conditions that contribute to mental distress makes it too narrow for a full exploration of mental distress (Pilgrim & Bentall, 1999). It has also been argued that the DSM-IV (American Psychiatric Association, 1994) definition of depression is inadequate because there is no conceptual distinction between mental disorder as psychological dysfunction and nondisordered distress that arises out of a multitude of stressful social situations such as the loss of intimate relationships, the loss of a career, the inability to achieve life goals, and persistent serious social disadvantage. By defining depression in terms of symptomatology only, and by ignoring the contexts in which such symptoms arise, normal, nondisordered stress responses and individual pathology are conflated as mental disorder. The distinction between mental disorder and nondisordered distress is necessary, because optimal treatment needs to be based on a correct understanding of the condition to be treated (Horwitz 2007a, 2007b; Horwitz & Wakefield, 2007). In fact, patients seen in general practice often do not fit neatly into diagnostic categories, but frequently present after experiences such as relationship breakdowns or loss of employment, or they fall under “depressive disorder not otherwise specified” (Hickie, 1999; van Praag, 1990).

Another problem with depression as it is constructed by psychiatry is that it does not adequately reflect the spectrum of mental illness of patients from low-income populations (Katherndahl, Larme, Palmer, & Amodei, 2005) or among people from diverse cultural backgrounds (Cabassa, 2007; Karasz, 2005; Kokanovic, Dowrick, Butler, Herrman, & Gunn, 2008), and it says nothing about the gendered nature of depression of men (Cochran & Rabinowitz, 2000; Emslie, Ridge, Ziebland, & Hunt, 2006; Galassiński, 2008; Hirshbein, 2006; Johansson, Bengs, Danielsson, Lehti, & Hammarström, 2009; Oliffe, Robertson, Kelly, Roy, & Ogrodniczuk, 2010). It has therefore been suggested that a better approach to modeling depression would be grounded in the humanities (Dowrick, 2009), or an anthropological approach and a thick description (Geertz, 1975; Parker, 2005). In this article we provide such a thick description by exploring how general practitioners (GPs) with high caseloads of gay men, some of whom are living with HIV, make sense of depression in their clinical practice.

Gay men have a higher risk of depression than heterosexual men (Mao et al., 2008; Rogers et al., 2003). Among people with HIV, depressive symptoms are common; in fact, they are more common than among people with other serious illness (Colibazzi, Hsu, & Gilmer, 2006).

The relationship between HIV and depression is complex, and has biomedical and psychosocial aspects: depression is associated with disease progression (Leserman, 2003); nonadherence to antiretroviral treatment (Kleeberger et al., 2004); higher sexual risk taking (Rogers et al.); unemployment (Fogarty, Zablotska, Rawstorne, Prestage, & Kippax, 2007); and lower quality of life (Tate et al., 2003).

Depression and Discourse

There is no doubt that mental distress exists in many forms. What is contested, however, is the view that mental distress can be categorized as disorder in isolation from the illness experience of those who suffer from it, and from the social, cultural, political, and historical landscape in which labels are assigned to such experience. Categories and labels do matter, because the way in which a condition is perceived and constructed has consequences for diagnosis, treatment, and care.

It has been argued that psychiatric categories are not natural kinds similar to those in the natural sciences, but categories that have been constructed by professionals to describe and deal with emotional distress (Harper, 1996; Kirmayer, 2005; Zachar, 2001). There are no external referents to determine a mental condition in the way that physical conditions can be linked to a biological agent. Whether or not a mental state is a disease is partly a judgment based on values and assumptions about what counts as normal (Crowe, 2000; Dowrick, 2009). Moreover, the classification of mental disease has been in constant flux. Categories appear and disappear, boundaries between categories are redrawn, disorders are renamed and classified into new subtypes, and subtypes are arranged and rearranged into clusters. These processes are not necessarily based on scientific insights, but are embedded in socioeconomic change (Abbey & Garfinkel, 1991), political change (Skultans, 2003), changes in the perceived relationship between the individual and society (Armstrong, 1980), changes in the power relationships within the psychiatric profession (McPherson & Armstrong, 2006), and the introduction of new medications (Hirshbein, 2006; Skultans).

A discourse approach to depression makes the connection between the individual and the social. It acknowledges that depression is both a language and a lived experience, and therefore cannot be treated as an entity outside the discourses in which it is constructed (Massé, 2000). A discourse approach also acknowledges that psychiatric categories are almost entirely produced through language (Harper, 1995). The patient describes thoughts, feelings, and experiences to the clinician, and the clinician attaches a diagnostic label to the patient’s experiences. However, discourse is more than language use between
two individuals. Discourses are patterns of ways of representing experiences, phenomena, and social relationships. Discourses do not simply describe and reflect social reality as we see it, but play a crucial part in constructing this reality (Crowe, 2000; Kress & Hodge, 1993). Thus, from a discourse perspective, depression does not exist independently of the social, cultural, and political processes in which it is experienced, diagnosed, and treated.

Methods
The data for this article were drawn from a primary health care project on HIV and depression (Körner et al., 2008; Mao et al., 2008, 2009). It was a collaboration between social researchers, primary health care researchers, GPs, and community partners. The aims of the project were to investigate the prevalence, nature, clinical management, and self-management of depression among homosexually active men attending high-HIV-caseload general practice clinics. It was a multistage, multisite, mixed method study with three data collection stages—one quantitative and two qualitative.

The qualitative arm of the study comprised three surveys: patients self-completed a survey when they visited their GP; their GP completed a clinical assessment of that visit; and clinical data were extracted from clinical notes later on. Mao was the primary quantitative researcher and collected the quantitative data. The qualitative arms comprised in-depth interviews with GPs and with gay men who were depressed. In interviews with GPs, we explored their views and experiences of diagnosing and managing depression in gay men, some of whom were living with HIV. In interviews with gay men who were depressed, we explored their views and experiences of living with depression, their history of depression, their management and self-management of depression, and issues related to HIV and sexuality. Newman was the primary qualitative researcher and conducted these interviews. In this article we draw on the interviews with GPs. Kidd, Saltman, and Kippax were the chief investigators and responsible for the overall design and conduct of the project. As an associate investigator, Körner contributed to the design of the qualitative arms. As the only linguist on the team, she was responsible for the conceptual design of this article, analyzing the data, and writing the manuscript.

Recruitment
Primary care physicians who were trained and accredited to prescribe HIV medication were recruited from seven general practices that provided care for large numbers of gay men, including high caseloads of gay men living with HIV. Four practices were in inner Sydney (Australia’s largest state capital), where large numbers of gay men live and socialize. One practice was in Adelaide (one of Australia’s smaller state capitals); it operated a program for gay men living with or at risk of acquiring HIV. Two practices were located in a rural coastal town; they provided care for the majority of gay men and people with HIV who lived in the area.

GPs were invited via the managers of their practice to participate in an interview. They received $150 AUD to reimburse them for their time; this was less than the government schedule for one hour of their time. Sixteen GPs agreed, including 14 men and 2 women. They had been working in HIV medicine between 2 and 24 years, and often had long-standing relationships and regular contact with their gay patients. Some mentioned that they were gay themselves. Although the sample was relatively small, it represented a large number of the GP workforce who could prescribe antiretroviral medication in the three study locations.

Ethics approval was granted by the National Research and Evaluation Ethics Committee of the Royal Australian College of General Practitioners, and ratified by the Human Ethics Research Committees of The University of New South Wales and The University of Adelaide. Written consent was required for participation.

Data Collection
Data were collected through face-to-face semistructured interviews in an open-ended, nonjudgmental, conversational style (Minichiello, Aroni, & Hays, 2008). Interviews lasted about an hour. We chose open-ended interviews to allow GPs to explore in detail the complex issues they faced in their work with gay men. Interviews explored the diagnosis, treatment, and management of depression; aspects of depression related to HIV, gender, and sexuality; and reflections on practice. To provide consistency, an interview guide was developed by the project team. Interviews were audio recorded and transcribed verbatim. All identifying information was removed from the transcripts or replaced with related information that would not identify participants.

Data Analysis
Theoretical approach. Language is an intrinsic part of social life, dialectically interconnected with other elements of social life. Therefore, one way of doing social research is through a focus on language use (Fairclough, 2003). The approach to text analysis for this article was informed by Halliday’s systemic functional linguistics (SFL; Halliday, 1994). SFL makes the connection between the individual and the social. It acknowledges that no text, including depression scales, represents a reality that is neutral, but rather rests on particular assumptions and views a phenomenon through a particular lens; in the
case of depression, the lens of science and medicine (Fairclough, 1992).

SFL is profoundly concerned with the relationship between language and social processes, and its orientation to text analysis is concerned with the social character of texts (Halliday, 1994; Martin & Rose, 2003; Martin & White, 2005). As a theory of language, it is concerned with meaning rather than form. In SFL, language is viewed as a social rather than an individual phenomenon, a resource to make meaning rather than a container for preexisting meanings to be discovered. Furthermore, it postulates a close relationship between text and context: language forms are not arbitrary but are determined by and reflective of social relations. One fundamental aspect of SFL is the organization of meaning into three broad areas: construing experience, making sense of the world around us in terms of what is going on (experiential meaning); engaging with one another, enacting social roles and relationships (interpersonal meaning); and organizing meanings in a certain sequence so that they can be shared with others (textual meaning). These three meanings operate simultaneously when we use language.

**Linguistic analysis.** Text analysis is invariably selective and informed by theory. We always choose to answer certain questions about social events and practices and not others (Fairclough, 2003; Minichiello et al., 2008). First, the first author (Körner) read the transcripts and took notes to become familiar with the data (Braun & Clarke, 2006). Then initial codes were generated. These codes were data driven, and focused on those features of the interviews where the GPs described their approaches to identifying depression in their gay male patients and their views on the relationship between depression and living with HIV (Braun & Clarke; Minichiello et al.). Coding was informed by questions such as the following: How did the GPs describe depression? Did they use medical terminology, or did they describe depression in terms of social experiences? Did they talk about depression in abstract terms, or were patients mentioned in their descriptions? What were they looking for in depression that was specific to gay men and to HIV? What kind of contexts did they talk about when they described depression?

Next, a detailed textual analysis of the text extract identified was performed. This focused on two questions: What does the term depression mean in terms of what is going on (experiential meaning)? What intersubjective stance do participants take toward these meanings (interpersonal meaning)? Experiential meaning is concerned with content, the material and symbolic reality that is constructed through discourse; that is, the kinds of activities, events, participants, and circumstances involved. The linguistic resources to make these meanings are process types, participant roles, and lexical relations (Martin & Rose, 2003). Interpersonal meaning is concerned with a speaker’s attitude toward the propositions put forward. The linguistic resource for this is the system of engagement. It is grounded in Bakhtin’s notions of heteroglossia and dialogism (Bakhtin, 1981, 1986). In a dialogic view, language is intrinsically interactional and intertextual. The starting point is not the mind of the individual, but the individual in interdependence with others. Individuals make sense of their social world as heterogeneous, multivoiced realities, where meanings converge, diverge, or clash with each other. In a dialogic view of language, all utterances enter into relationships with alternative similar or contradictory utterances (White, 2000).

Under “engagement” are grouped together those linguistic resources that enable speakers to position themselves (i.e., engage with) with respect to alternative voices and positions that relate to the same communicative event. Are alternative positions acknowledged? Are they invited, or are they challenged, rejected, restrained? How does a speaker position himself intersubjectively in relation to alternative positions: in alignment/agreement, in disalignment/disagreement, or neutral? Engagement options are shown in Table 1.

While doing the linguistic analysis Körner wrote notes, recording reflections as analysis progressed. Finally, linguistic patterns were grouped into three broad interpretive categories (Minichiello et al., 2008): engaging with psychiatric discourse, engaging with the patient’s world, and engaging with social structures. These categories were determined on the basis of clusterings of lexicogrammatical choices; for example, what particular process

### Table 1. Semantics of Engagement: Engaging With Alternative Positions

<table>
<thead>
<tr>
<th>Engagement Options</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>No alternative positions are acknowledged.</td>
<td>Depression has biological causes.</td>
</tr>
<tr>
<td>Alternative positions are acknowledged and invited.</td>
<td>Depression can have biological causes.</td>
</tr>
<tr>
<td>Alternative positions are acknowledged but rejected or constrained.</td>
<td>Depression sometimes has biological causes.</td>
</tr>
<tr>
<td></td>
<td>It is possible that depression has biological causes.</td>
</tr>
<tr>
<td></td>
<td>It seems that depression has biological causes.</td>
</tr>
<tr>
<td></td>
<td>I think depression has biological causes.</td>
</tr>
<tr>
<td></td>
<td>Depression does not have biological causes.</td>
</tr>
<tr>
<td></td>
<td>Of course depression has biological causes.</td>
</tr>
<tr>
<td></td>
<td>Depression can have biological causes, but it is not clear.</td>
</tr>
</tbody>
</table>

Note. Examples are not from the corpus; for a complete overview, see Martin & White, 2005.
types and other lexical items occurred together? What choices from the engagement system occurred together? What other linguistic features were noteworthy? Finally, where relevant, the shifts of meanings throughout a text were examined.

**Results**

**Engaging With Psychiatric Discourse**

*Aligning with psychiatric discourse.* One construction of depression is very closely aligned with depression as it is constructed in the *DSM-IV* (American Psychiatric Association, 1994); that is, an independent entity made up of a constellation of decontextualized symptoms that are also constructed as independent entities: “It’s usually the symptoms that people present with. That collection of depressed mood, lethargy, insomnia, weight change, poor concentration. They’re the common presenting symptoms.”

Experientially, depression is constructed through the technical vocabulary of psychiatry and in nominal groups forming a part/whole taxonomy (Martin & Rose, 2003). Human participants are absent from this construction. Intersubjectively, the construction of depression as a taxonomy of symptoms is largely unproblematic and uncontested, but not entirely so. There is some acknowledgment that there can be alternative presentations (“It’s usually the symptoms that people present with.”). In the following extract, the construction is still aligned with the psychiatric discourse of depression as a constellation of symptoms, but it is less categorical:

I guess primarily it would be a change in mood. A lowered sense of mood from despondency to despair, to overt suicidal thinking or ideation. And then accompanied by a range of other things like feeling, successive feelings of guilt. Poor concentration, a sense of hopelessness, of helplessness. Sometimes accompanying vegetative symptoms like not eating well, losing weight, or excess weight gain. Or poor sleep, or loss of, and then loss of interest in things, lack of pleasure. . . . But I think the main core of it is a pervasive sense of lowered mood. And one that makes them feel that they’re feeling more than they should; more than what others around them are feeling. And it makes them stand apart.

Alternative views to the *DSM-IV* classification of depression (American Psychiatric Association [APA], 1994) are acknowledged through explicit and implicit modality (Halliday, 1994): “I guess,” “it would be,” “sometimes.” But then the participant changes tack, and the *DSM-IV* view (APA) is countered by an alternative view (“but I think”). However, the GP does not follow through with this shift, but reverts to the starting point of depression as low mood, but this starting point is now qualified. Human participants are introduced into this discourse, and the abstract technicality of low mood is recast as a construction of depression in which people have feelings. This construction of depression as people feeling “more than they should” and “more than others around them” resonates with the argument that a mental state can be considered a disease based on assumptions about socially sanctioned normal reactions (Crowe, 2000; Horwitz & Wakefield, 2007).

*Contextualizing psychiatric discourse.* Here, the psychiatric discourse of depression as a list of symptoms is enmeshed with gay men’s lives and living with HIV. It is also contextualized in the clinical interaction and the doctor–patient relationship:

Sleep disturbance, classically. Interest in activities, concentration, energy levels, outlook. . . . There may be events [for HIV-positive gay men] that are more likely to trigger it. . . . So we may actually be more sensitized in asking about those symptoms related to specific events [such as] a positive diagnosis, need to start therapy, death of a friend, first AIDS-defining illness, first AIDS-defining illness in a group of, in a social network, failure on a regimen.

Depression here is constructed as two taxonomies: First, a taxonomy of symptoms as in the *DSM-IV* (APA, 1994), and then a taxonomy of depression as the result of events related to HIV infection. What is important here is not only the technical terminology of psychiatry, but the way in which living with HIV is constructed. In everyday language, processes are worded congruently as verbs and participants as nouns (e.g., Joe’s friend died.) In scientific discourse, processes are reworded metaphorically as nouns (Halliday, 1994; e.g., death of a friend). Turning processes into things makes it possible to construct taxonomies of knowledge. In our case here, there is a taxonomy that incorporates classic psychiatric symptoms but also milestones in living with HIV infection; or, the other way round, milestones in living with HIV are constructed as indicators of depression. In the following extract a hybrid taxonomy of depression is constructed with one arm in psychiatry and one arm in the social life of the gay community:

I think there’s different types of depression. There’s endogenous and there’s reactive. And if reactive is postpartying which, like drug, postdrug depression, then there’s a lot of it. And it’s then seasonal. So I see depression, I see comorbid depression with
anxiety. And I see a lot of people who like, react to pressures, like people who break up or can’t cope with work.

This construction unfolds in three phases. First, there is a textbook-like statement about a common distinction of types of depression according to etiological and nonbiological causes. Although this distinction was removed from the DSM-III in 1980, it has remained in use (McPherson & Armstrong, 2006, p. 56). However, this distinction is not taken for granted, but intersubjectively positioned as only one possible alternative (“I think”). In the second phase, “reactive depression” is further classified into “postparty depression,” a kind of depression that is not acknowledged in the medical literature, and “seasonal depression.” Seasonal depression here, however, is not the seasonal depression of winter, as described in the textbook (Murtagh, 2007), but in this case refers to the major dance party season in Sydney’s gay community between December and March, the southern hemisphere summer. In the third phase, depression is contextualized in the clinical interaction with GPs and patients as human participants, and the processes constructing depression revolve around actions: depression is constructed as doing rather than being or feeling. Although this construction is grounded in the discourse of medicine, this discourse is neither taken for granted, nor is it rejected. It is rather complemented by a construction that is grounded in the GP’s experience, in the social life of Sydney’s gay community, and in the lives of gay men.

Challenging psychiatric discourse. In the next two extracts, the psychiatric discourse is rejected altogether, and depression is constructed through counterexpectancy (Martin & White, 2005), albeit in different ways: “Depression is, it’s only a word, okay? And I approach it in that way. It’s a simple word. It’s a concept.” Here, the construction of depression as an objective, independent, reified entity is challenged and replaced with an alternative—depression as a linguistic construct. There is an understanding that depression is not a natural category, and an understanding of the role of discourse in constructing depression, with implications for the GP and for clinical practice. In the next extract, the construction of depression according to the DSM-IV (APA, 1994) as the basis for diagnosing depression is countered three times: “I don’t subscribe to a formula. I don’t look at the DSM-IV. I’m familiar with it in a loose way, but I tend to just base it on history.” The depersonalized acontextual construction of depression in the DSM-IV (APA, 1994) is explicitly rejected. It is countered by a construction that invokes interaction between GP and patient, and thereby a collaborative discursive construction of depression. This position is explicitly grounded in the participant’s own subjectivity, thereby acknowledging that this position is not one that is universally shared.

In summary, when GPs engage with the discourse of psychiatry, depression is constructed as a hybrid that encompasses depression as a mental disorder without reference to the context in which symptoms arise. However, this construction is positioned as one possibility only, and an alternative construction of depression is offered; that is, depression as a reaction to social losses and social pressures, and depressive symptoms arising as a reaction to the many setbacks people living with HIV can experience in the course of living with a condition that can still have a terminal outcome. Finally, the construction of depression as decontextualized symptomatology is explicitly rejected as a possibility that does not apply, and replaced with an alternative construction. Taking a patient’s history allows the GP to attend to the contexts in which a patient experiences symptoms, and to distinguish between mental disorder and nondisordered responses to stressful social situations.

Engaging With the Patient’s World

Engaging with their patients’ world and experiences was considered vital for diagnosing and managing depression in gay men. As one participant put it, “You are an absolute idiot if you are a doctor and if you don’t think about what your patients are thinking.” In this construction, experiential meanings revolve around human participants and their actions. Interpersonal meanings revolve around dialogue: the GPs in dialogue with their patients, and patients in dialogue with partners and friends.

There is a clear distinction here between depression as it is constructed by the DSM-IV (APA, 1994) and depression as GPs encounter it in their practices with gay men. In their approach to diagnosing depression, GPs do not look for or ask about symptoms of classic depression, but talk to patients about actions and events in gay men’s lives that are usually not seen as being associated with depression.

Depression constructed as action.

Well, anything to do with the law. . . . Anything to do with relationship breakdowns. Moving home, so whether that’s forced upon them by financial issues or whether it’s forced upon them by relationship breakdown. . . . And of course death. If anyone who is close to them dies, whether it be a dog, all the way through to their spouse or partner, mother, father, sister. . . . Issues with alcohol or other drug abuse. A drink driving charge, for instance, that may be the tip that all is not right. And then I suppose change. Change of workplace. So change is usually a signal that maybe things are not right.

In this construction, there is no reference at all to mood, affect, or a person’s inner state. Depression is constructed
entirely as actions and events in a broad range of human activity: doing certain things or acting in certain ways that are outside socially and legally accepted norms. Moreover, it is constructed as actions and events in which others play a role as well, and as events that can be forced on a man by others, events over which he has little or no control. In the next extract, depression is also constructed with a focus on action, but action in particular areas of gay men’s social and sexual lives:

In all gay men loss of sexual function is a major threat to their well-being in life! [laughter] . . . And you know, sometimes it’s just that older gay men have really unrealistic expectations, and they think they’re supposed to be performing like porn [pornography] stars when they’re in their sixties. And that can often be a sign of depression, too, I think, in that they’re depressed because their image of themselves is changing. . . . Often it’s drug taking in positive and nonpositive gay men. Drug taking, alcohol. Binging on drugs, binging on alcohol, binging on sex. Worrying about meaning in their life. Because a lot of gay men get their meaning around their sexual behavior. When anything disturbs that, it’s very threatening to their identity.

Depression constructed as actions and events in gay men’s social and sexual lives has a positive and a negative orientation: doing things, and not being able to do things. However, depression is not simply “doing” sex and drugs. It is rather doing these things to excess, beyond socially accepted norms. Similarly, the inability to act in a certain manner is not simply an inability to perform sexually, but an inability to attain the ideal of seemingly unlimited sexual performance.

In the last example in this section, depression is constructed as living and coping with the medical and social ramifications of HIV infection which, in turn, has ramifications for acting in other areas of life:

Oh, look it’s just everything. They’re having trouble taking their pills. It may be that they’re depressed. If they’re having [trouble] with relationships. It’s the whole gamut of normal activities which are affected more. . . . And what’s actually going on is this person isn’t coping with something, and may not have even thought that they’re depressed.

Whereas that may be what’s really going on.

Although there can be a biological relationship between HIV infection and depression, and between some antiretroviral drugs and depression, here the relationship between HIV and depression is constructed entirely in social terms, and the experiential meanings are entirely grounded in events in HIV-positive gay men’s lives rather than in mood states. Depression is experienced by HIV-positive gay men as not coping with the demands of managing HIV infection and, as a result, not coping with everyday activities and social relationships.

In summary, when GPs engage with their patients’ experiences, depression is constructed as actions and events in the external world rather than the internal world of affect or mood. Furthermore, none of the actions and events described by the GPs come anywhere close to the symptomatology described in the DSM-IV (APA, 1994). The psychiatric discourse of depression as low mood or loss of pleasure is not even acknowledged as an alternative; it plays no role in this construction. However, the alternative construction of depression as action is not presented as categorical, but as one possible alternative (e.g., “I suppose,” “usually,” “maybe,” “sometimes,” “often,” “I think”). It is presented as an alternative to the psychiatric discourse as it applies in a particular context. At the same time, depression is only one possible explanation for these actions, not the only one. Thus, depression is contextualized: first in gay men’s lives, and second in the GPs’ interpretations of whether certain actions and experiences warrant the label depression.

Depression constructed in dialogue. External voices are also introduced into GPs’ accounts of depression: the patient’s voice, and the voices of patients’ friends and partners. Thus, depression is not an independent entity that is located in an individual, but something that is experienced in social relationships and diagnosed in social interaction:

And often, I think, well, with gay male patients you’re asking a lot of questions about their drug taking and their going out. And often that naturally leads to questions about their mood and those sorts of things. So there’s a difference in gay men, in that you tend to do that. Which gives you the entrée into talking about depression, as well.

In this construction, the clinical interaction and the GP’s voice are explicitly integrated into the construction of depression, and it is the GP’s voice that initiates dialogue about depression. Initially, dialogue between doctor and patient is about doing rather than feeling, and the kinds of activities under discussion are aspects of urban gay men’s social lives: going out and taking recreational drugs as part of their socializing. However, dialogue about these activities is not a substitute for dialogue about feeling and mood; rather, it precedes interaction about mood and feeling. Thus, depression as a mood state is constructed as inextricably enmeshed with gay men’s actions in their social lives. In the following extract, additional voices are integrated into the clinical consultation about depression:
They often describe themselves as “moody.” . . . You know, friends are concerned they’re not going out, those sorts of things. . . . And often told by friends or partner that they’re moody. They don’t often say “depressed,” they often say “moody.” “I’m very moody.” So that’s kind of the classic, the classic entrée, and then you start the discussion from there about depression diagnosis.

First the patient’s voice is introduced into the GP’s account, describing feelings in the patient’s terms; however, there are also the voices of friends interacting with the patient, as recounted by the patient to the GP; integrated into this account. This interaction between patient and friends focuses on actions and feelings, the interaction between a gay man’s external social life and his inner emotional life. However, in contrast to depression as excessive action in gay men’s social and sexual lives, here depression is constructed as not enough action in a gay man’s social life.

In the last example, depression as it is encountered in dialogue with gay men is constructed overtly in opposition to the classic depression of the DSM-IV (APA, 1994):

And then I ask them to explain what they perceive. If they’ve used the word “depression,” then I ask them what they mean. And you’ll hear many different answers. I actively explore self-worth, self-image, ability to relate and deal with friends, colleagues, peers around them. . . . You’ll very rarely get a classic depression. And that is of poor appetite, weight loss, feelings of inferiority, feelings of decreased self-worth, poor sleep patterns. Those classic symptoms of depression, you’ll never hear that. You will hear the story of agitation, anxiety. You will hear the story of a masked depression. In other words, life of the party, things are going fantastic, but you chip away at that mask, and there’s a depression underneath that.

This construction unfolds in three phases, and alternatives are both acknowledged and rejected. In the first phase, the patient’s meaning of depression is invited into the clinical interaction as a starting point for the following interaction between doctor and patient. This is followed by an overt rejection of the psychiatric discourse of depression as an alternative that does not apply (“you’ll never hear that”). In the third phase, depression is again constructed from the patient’s experience, the patient’s story as recounted by the GP; however, this story is, again, just one alternative, one that is replaced by more dialogue, which reconstructs the patient’s focus on doing (“life of the party,” “things are going fantastic”) in medical terms as “masked depression.”

In summary, depression here is highly contextualized. It is contextualized in the lives of gay men and in the clinical interaction. When symptoms of depression are mentioned, they are constructed as reactions to change and loss: change of body image, loss of sexual performance, loss of identity, loss of purpose, loss of meaning of life, the inability to cope with change and loss. When symptoms are mentioned, it is in discussion about the contexts in which gay men experience these symptoms. Depression as it is constructed here can be a nondisordered reaction to losses; however, certain actions and reactions can also be an indication of mental dysfunction. Whether it is the one or the other can only be explored in dialogue with the patient.

Engaging With Social Structures

Depression is constructed as inextricably linked with social and economic forces that work on men and over which they have little or no control. This interrelationship is presented as a highly complex web in which depression is intertwined with various forms of social disadvantage, and it is not always possible to disentangle depression from social disadvantage, and how depression and social disadvantage relate to men, gay men, and HIV-positive men.

One prominent theme here is the interrelationship between long-term living with HIV, unemployment, and social disadvantage. Linguistically, the focus is on explaining depression: why and how. Broadly speaking, in this construction depression is not the cause for external problems; that is, men become depressed and then become unable to work, but they become depressed because they are unemployed, socioeconomically disadvantaged, and socially isolated, usually because they have been living with HIV for a long time:

I think you guys [researchers] really need to push the employment/unemployment thing. Because a lot of the patients we see have been given a diagnosis of depression, yeah? And it’s all tied up with their HIV. In fact, it’s got fuck-all to do with their HIV; it’s all to do with the fact they’re unemployed. They have social isolation. And it’s no different to the depression that’s seen in unemployment in general, you know? . . . You’ve got people who haven’t been employed for the last twelve years, fifteen years, and people don’t understand why they’re depressed. It’s like, hello! . . . “Oh, it must be the HIV.” Well actually, it’s not. But we’ve tried to do that as a, as a “total health” thing, yeah? That employment is a part of health. And working is a part of health. And it actually gives you a lot of positives apart from just financial.
The relationship between HIV and depression as it is constructed in biomedicine is explicitly challenged and rejected, and replaced with a relationship between unemployment and depression as it is encountered in general practice with HIV-positive gay men. Important here is the logical relationship between these two entities: gay men with HIV become depressed because they have been unemployed, often for long periods of time. This construction is the opposite of the construction in which men become unable to work because they are depressed (Galasiński, 2008). The construction of depression as the result of long-term unemployment counters pharmaceutical and psychotherapeutic treatments, and replaces them with an alternative management strategy in which employment is a part of mental health. In the following extract, two more elements are integrated into the construction of depression in relation to unemployment:

I think probably if someone is unemployed for a long time, their self-esteem kind of suffers. They don’t have a sense of worth, often. I think there’s still probably discrimination in the workplace with HIV, so I think that can impact on people, as well. But I guess if someone’s chronically unemployed, well then, yeah, I think that’s not much good for self-esteem.

For men who are depressed because of long-term unemployment there is an affective element integrated into the consequential relationship between unemployment and depression: a lack of work forecloses a sense of worth. For HIV-positive gay men who have work, depression is constructed in terms of discrimination because of their sexual orientation and their HIV status. In this construction, mood states do not simply reside in an individual, but they arise out of an individual’s interaction with his social environment and what is valued in that environment, fitting into certain social norms. Discrimination as a cause of depression is at the core of the following extract:

I see a lot of guys who are depressed who had in the past, you know, like sexual abuse. Or this sort of thing, where something was happening and they weren’t believed, or they were told, “That’s stupid.” Or they can’t say what they want to say because they’re so used to hiding their gay, being gay or HIV [positive]. Or both. I see a lot of isolated men who live in the suburbs. Not your traditional gay stereotype. Yes, they’re in minority, there’s not many of them. But they say, “Oh no, I can’t tell anyone I’m HIV out there. There’s no way. Country.” They come in from distant suburbs and different cities to come and see you, because they can’t, they feel it’s a small town.

Although this construction engages with patients’ experiences, these experiences are located within social structures and forces that work against gay men and over which they have little or no control. Social isolation here is not simply the result of living with HIV, being unemployed, poor, and socially isolated, but stems from the norms and values of hegemonic masculinity that are espoused by gay men’s social environment. Linguistically, depression is constructed as values that are foreclosed for these men: not being listened to, not being believed, not being accepted, not being respected. Depression is constructed entirely as social exclusion. In the following extract, depression is also constructed in relation to HIV; however, in a different way:

The common theme that I seem to come across is, particularly in men who have lived with this for the last twenty years, or certainly fifteen, twenty years. And it’s an overwhelming sense of loss. It’s a sense of, “I was told I was going to die fifteen years ago, and I’m still here. And now I’m living in poverty. And I gave up my career because of this. And I’ve not been able to have a relationship. And I’m quite lonely and isolated.” These are the things that I seem to see quite frequently with HIV. . . . Does anything stand out in particular? I’d have to say poverty and living in isolation, lack of ability to form relationships. They stand out.

Here the GP engages with gay men’s experience in the broader context of the HIV epidemic and long-term survival with HIV: loss of career, loss of income, loss of relationships. Depression is constructed entirely in terms of external actions and events, and decisions about living with HIV. It is also located in biomedical progress and reduced mortality because of antiretroviral drugs. There is no reference to depressed mood or loss of pleasure. When pleasure is missing in patients’ lives it is not because of their internal state, but because they have no money for pleasurable things.

In the final extract in this section, the GP tries to untangle the various strands that make up depression for HIV-positive gay men:

With long-term HIV and depression you’re dealing [with] many issues. You’re dealing, one, with the actual depression itself and the effect that depression is actually having on day-to-day activities. You’re dealing with, if that’s full-on depression where people cannot physically work, you’re dealing with economic disadvantage then, of inability to actually find a roof over your head, to actually get some tucker [food] on your table.
You’ve got financial poverty entrenched in that as well, and that creates real barriers to actually successful outcome on treatment options. You’ve got issues then of relationships, of family, interpersonal relationships, and how all that impacts on [the] ability to accept the diagnosis of HIV and make the most of moving on with the actual treatments that we’ve got.

The linguistic feature foregrounded in this construction is the grading of entities and processes that are inherently nongradable (Martin & White, 2005). By sharpening the boundaries around depression as a category (“the actual depression itself,” “full-on depression”), mental disorder is delineated against social and economic stress (“actually find a roof over your head,” “to actually get some tucker on your table”). These sharpened categories are set in a relationship with available management strategies (“real barriers,” “actual treatment options”). The boundaries between mental disorder and nondisordered response to stressful social conditions can be fuzzy, and extreme stress without any prospect of relief can lead to a breakdown of internal mechanism and turn into mental disorder (Horwitz 2007a, 2007b). This is evident in the GP’s distinction between the “actual depression itself” and “full-on depression,” and the stressful social and economic circumstances in which depressive symptoms manifest for gay men with long-term HIV infection. If depression is part mental health problem and part socio-economic problem, successful treatment will have to deal with depression on both fronts.

There are some features common to all extracts in this construction. First, the construction of depression is grounded entirely in the GPs’ experience rather than in the discourse of psychiatry. This discourse does not even figure in this construction, not even as a possible alternative. Where there is reference to a patient’s internal state, there is a direct connection with social structures. Thus, mood states are grounded in social disadvantage and marginalization. Second, where experiential meanings revolve around action, doing relates to dealing with the necessities of survival rather than seeking pleasure. Where meanings revolve around being, gay men are described in social terms: being unemployed, being poor, being socially isolated, having a sense of loss. This is in stark contrast with the psychiatric description of depression as being sad, being tearful, being withdrawn. Third, interpersonal meanings foreground values that deny, challenge, and reject alternative positions that do not apply. For gay men with HIV, meanings revolve around security and social acceptance, full and active participation in all aspects of social and economic life that are foreclosed for them. For GPs, meanings revolve around the psychiatric discourse of depression as an individualized mood state, which is replaced with the alternative of depression as social exclusion.

From a sociological perspective, three major sources of stress can be identified: low socioeconomic status and subordinate interpersonal positions; the loss, absence, or weakness of social ties; a lack of purpose in life, and the inability to achieve desired social goals (Horwitz, 2007a; Horwitz & Wakefield, 2007). GPs’ constructions of depression are seamlessly intertwined with all of these stressors, and gay men who have been living with HIV often suffer from multiple stressors over long periods of time with little prospect of relief. Thus, contextual circumstances are constructed as an explanation for why and how gay men experience profound misery. Even though GPs use the term depression, there is no reference to mental disorder or individual pathology. Irrespective of whether depression is constructed as mental pathology or nondisordered response, it is constructed as intense distress and suffering that needs to be relieved.

**Discussion and Conclusion**

Any illness, but especially chronic illness and illness associated with stigma, is not only a medical phenomenon but also a social and cultural phenomenon (Little, 1998; Little, Jordens, & Sayers, 2003; Treichler, 1988). Therefore, depression cannot be understood independent of the discourses that construct depression and what it means for specific cultural groups (Galasiński, 2008; Massé, 2000). Attention to the linguistic form of GPs’ constructions of depression presents depression as a highly heterogeneous, interdependent and intersubjective entity in which medical and sociocultural strands are firmly intertwined. Depression is constructed as interdependence between mood states and actions, between mood states and social structures such as unemployment and sexual discrimination. It is also constructed as interdependent with the doctor–patient relationship, with available treatments and management strategies, and with the HIV epidemic as it has unfolded in Australia in the last 25 years.

The sociologist Mills argued that the difficulties that an individual experiences, including medical problems, are almost always interconnected with structures in society and experienced in the context of broader social problems. From this perspective, interactions in general practice are micro-level encounters that occur in the context of macro-level structures in society (Mills, 1959/2000). A fundamental feature of medical discourse, however, is precisely the exclusion of social context (Waitzkin, 1991, p. 26), and the dichotomizing of the doctor–patient interaction into the voice of medicine, which is concerned with technical issues such as laboratory tests, and the voice of the lifeworld, which is concerned with everyday,
nontechnical issues such as work and relationships (Mishler, 1984). One problem with this formulation is that neither the voice of medicine nor the voice of the lifeworld are monolithic, homogenous voices, but each voice can integrate the other voice into itself without necessarily creating conflict (Körner, 2010).

Microlinguistic analysis based on a metafunctional model of language (Halliday, 1994) provides a more nuanced account of depression, as it is concerned not only with what speakers say about a certain phenomenon but also how they say it and how they position themselves intersubjectively toward what they say. The definition of depression as a mental disorder according to the DSM-IV (APA, 1994) is intersubjectively positioned as but one possible construction of depression. Rhetorically, this opens up the discourse to possible alternative constructions in which depression is positioned as the lived experience of gay men, and mood states are constructed in the context of social marginalization and social exclusion. The definition of depression as a mental disorder is also intersubjectively positioned as an alternative that is invoked and directly rejected as an alternative that does not readily apply in general practice, or countered and replaced with an alternative position that is grounded in GPs’ experience. The construction of depression as a mental disorder is countered and replaced with the patients’ world, but also with GPs’ experience in general practice with gay men.

Discourse is both reflective and constitutive of social phenomena. A discourse perspective of depression reflects GPs’ reality in the clinic. At the same time, it is constitutive of GPs’ practices as they bring their patients’ lifeworld into the clinical interaction. This is enacted by GPs proactively inquiring about their gay patients’ social and sexual relationships, their working and social lives, their alcohol and recreational drug consumption, and their sexual risk practices. Exploring their patients’ experiences is integral to GPs’ understandings of depression (Körner et al., 2008; Ziółkowska, 2009).

It has been argued that we need a new, broader approach to depression as a socially and culturally mediated phenomenon (e.g., Cooper, 2004; Fabrega, 2005; Kirmayer, 2005). It has also been argued that we need to understand depressive symptoms in the contexts in which they arise, to distinguish between mental disorder as internal dysfunction and nondisordered responses to stressful social situations (Horwitz 2007a, 2007b; Horwitz & Wakefield, 2007). Depression as it was constructed and understood by the GPs in this study is highly heterogeneous. It encompasses the medical model of mental dysfunction and an understanding of depression as the experience of intense distress in the context of living with a highly stigmatized terminal illness, in an environment of persistent social disadvantage and with little hope of relief. There is an implicit understanding that the boundaries between social distress and individual pathology are not always fixed and clear, but can be fluid and indeterminate. This position acknowledges that distress which arises as a result of a problematic social environment can be a health issue without pathologizing it as mental dysfunction, and without dismissing it or trivializing it. Nondisordered distress can have profound consequences for a person’s mental well-being.

Rather than depression as mental illness, the GPs in this study worked with an understanding of depression in a mental health framework. Mental health is not the mere absence of illness, but includes social and emotional well-being. With this hybrid construction of depression, the management of the condition requires multipronged approaches that can include biomedical and psychological intervention, and referrals to mental health and social services. It can also include interventions such as the “total health thing” described by one of the participants, in which employment is seen as a part of health, and assisting patients to get back into the workforce is seen as an essential component of health care.

There is a synergy between GPs’ construction of depression in this study and qualitative studies of men’s experiences of depression, which differ quite significantly from medical definitions of depression. For men, depression is often experienced as loss of control, powerlessness, the inability to cope, loss of status, and loss of meeting social expectations (Emslie et al., 2006; Galasiński, 2008; Heffner, 1997), and men often enact depression outwardly in substance abuse and high-risk behavior (Cochran & Rabinowitz, 2000; Kilmartin, 2005). There is also a synergy between gay men and their doctors in the sense that for HIV-positive gay men, their doctor is an important source of emotional support (Fogarty et al., 2003), which puts GPs in a good position to deal with nondisordered distress as part of health care.

These findings contribute to our understanding of the discursive construction of depression and form part of the broader study of the social construction of health, including mental health. However, the study also developed some more concrete applications. During the final stages of our analysis we worked closely with our collaborating partners to inform them of our key findings, and to find ways to translate those findings into practice. Much of this was focused on informing the education and training programs for GPs who work with gay men through the Australasian Society for HIV Medicine. One output was particularly connected to the analysis presented here: an online module for the self-management of depression for gay men developed with the Clinical Research Unit for Anxiety and Depression based at St Vincent’s Hospital in the School of Psychiatry at The University of New South Wales. The module comprised six lessons on overcoming
depression and a fact sheet on managing sexual side effects. The latter was a direct outcome from our other work on the importance of this issue for gay men (Mao et al., 2009). The module consists of a series of comic strip images and associated text that follows the story of a gay man and his two best friends as he deals with feelings of depression. We worked closely with the module design team by advising on the language and concepts employed in the script, to ensure that the module rang true to the discourses that were emerging in the GPs’ and gay men’s interviews. This is just one example of how discourse analysis can help to illuminate our understanding of depression in both scholarly and applied dimensions.

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Note
1. Participants here is a semantic category that explains in the most general way how phenomena are represented as linguistic structures (Halliday, 1994, pp. 108-109); it does not refer to research participants.

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