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Abstract

High rates of both illicit drug use and depression are consistently reported among gay men. However, little is known about how beliefs about drug use shape clinical encounters between gay men and health professionals, and that in turn affect clinical communication and care, particularly in relation to depression. We compared 'doctor' and 'patient' beliefs about the role of illicit drug use in gay men's depression. Semi-structured interviews were conducted in August-December 2006 with 16 general medical practitioners working in seven 'gay-friendly' practices in Sydney, Adelaide and a rural-coastal city in New South Wales, and in February-May 2008 with 40 gay men with depression recruited through four Sydney and Adelaide practices. A thematic analysis of these two sets of interviews found that doctors expressed the beliefs that: *illicit drug use is related to depression in gay men; illicit drug use impedes effective diagnosis and treatment of depression in gay men;* and *illicit drug use increases the level of complexity involved in caring for gay men with depression*. Gay men expressed the beliefs that: *illicit drug use is closely related to depression; illicit drug use can be helpful in dealing with difficult experiences;* and *illicit drug use is just what you do as a gay man living in a big city*. Both groups believed drug use and depression were related but doctors emphasised the negative outcomes of drug use and interpreted these in relation to health. Gay men believed that drugs could have both negative and positive uses and differentiated between health and social outcomes. While the doctors articulated a pragmatic position on drug use, which is consistent with harm reduction principles, communication with gay male patients could be enhanced if both groups acknowledged their divergent views of illicit drugs and their potential role in mental health.

What is known about this topic

- Gay men report high rates of depressive disorders and illicit drug use.
- Open communication is essential to achieving quality health care.
- Diverse beliefs about depression are held by general practitioners (GPs) and patients, but less is known about beliefs concerning the relationship between drug use and depression.

What this paper adds

- Both GPs and gay men believe illicit drug use and depression are related.
- Some GPs worry patient drug use impairs the doctors' capacity to provide effective care, while some gay men value drug use as a means of coping with challenges and participating in gay community events.
- Doctor-patient communication could be further enhanced by recognising divergent beliefs about illicit drugs and their role in depression.

Introduction

The first of the five domains of the *Curriculum for Australian general practice* is focused on 'communication skills and the doctor-patient relationship' (RACGP, 2011). This reflects the primacy of communicative ideals such as openness, honesty and lack of judgement in contemporary thinking about how quality and equity can be achieved in primary health care settings (Ong et al., 1995). However, communication between doctors and patients is by no means uncomplicated, and can be significantly shaped by social and cultural 'beliefs' (Shaw, 2002, Johnson et al., 2005, Kokanovic et al., 2010). [Related terms include 'views', 'perceptions', 'concepts' and 'understandings' (Reutter et al., 2005, Pratt et al., 2009).] Sexual orientation has been commonly identified as an issue in this regard, with some clinicians feeling 'uncomfortable' about discussing sexual health issues with their non-heterosexual patients (Hinchliff et al., 2005), and gay and lesbian people reporting a reluctance to disclose sexual orientation in health care settings (Meckler et al., 2006).

As part of a larger study exploring vulnerabilities to depression among gay men attending general practices in Australia, we conducted interviews with doctors and patients about their experiences of the diagnosis and management of depression. In the course of these interviews, we noted that illicit drug use was described as an issue by both groups, but sometimes in quite different ways. Doctors often framed drug use as complicating their capacity to address the mental and other health care needs of gay men, while some gay men valued drug use as a means of coping with challenges and participating in the gay community. In this paper, we identify and compare the beliefs articulated by doctors and patients about the role of illicit drug use in gay men's depression, and consider how to address any divergent beliefs which may create barriers to achieving open communication and 'shared decision making' (Robertson et al., 2011) in this setting.

Background

Men who have sex with men (MSM) can be a diverse population, but in Australia around two thirds of MSM self-identify as 'gay' (Smith et al., 2003), increasing to around 90% in metropolitan areas (Zablotska et al., 2011). Australian gay men are disproportionately affected by particular health issues, most notably HIV (NCHECR, 2010) and depression affects around 25% of gay men attending Australian GPs (Mao et al., 2008). High rates of depression among gay men have been attributed – at least in part – to social factors such as discrimination, homophobia and rejection (Mays & Cochran, 2001, Mao et al., 2009). Illicit drug use is common among gay men in Australia (Knox et al., 1999, Prestage et al., 2007a, Prestage et al., 2007b) as well as in other (comparable) parts of the world including the US and Europe (Bickelhaupt, 1995, Cochran et al., 2004, Bonell et al., 2008). Drug use is often represented as an accepted part of gay sociality (Slavin, 2004, Race, 2009). At the same time, this is sometimes recognised as 'problematic' from within gay communities (Holt, 2011), or interpreted as a form of 'self medication' in coping with negative experiences associated with disclosure of gayness or HIV infection (Robinson & Rempel, 2006, Semple et al., 2006). As in the general population, however, the relationship between 'co-morbid' drug use and depression in gay men is most appropriately understood as complex, layered and multirelational (Semple et al., 2002, Halkitis et al., 2005, Jané-Llopis & Matytsina, 2006, Holt, 2011).

A variety of beliefs about depression have been described in the literature from the perspectives of 'patients' (Brown et al., 2001, Kadam et al., 2001) and 'doctors' (Andersson et al., 2001, Körner et al., 2008). However, very few papers compare health professionals' and patients' beliefs about depression. GPs and their patients have been shown to share some beliefs about depression. These have included personal experiences of depression conflicting with biomedical explanations (Burroughs et al., 2006, Kokanovic et al., 2010), depression being 'justifiable' in some populations, and GPs' limitedd capacity to treat depression (Rogers et al., 2001, Burroughs et al., 2006).

Divergence in beliefs of doctors and patients about the 'self-management' of depression have also been identified, with some patients saying they simply want to 'get by' while doctors aimed to control or cure depression (Johnston et al., 2007). The limited research on beliefs about illicit drug use tends to focus separately on health professionals and people who use drugs, commonly concluding that clinicians have a lack of knowledge about how to respond to drug use as a health issue (e.g. Johnson et al., 2005, Kelleher & Cotter, 2009) and that drug users often believe clinicians hold negative views about them (e.g. Hindler et al., 1996). A Norwegian study found people who use drugs were more likely to emphasise 'positive aspects of illegal substance use' than GPs (Wynn et al., 2009: 227). Studies focusing on gay men's experiences of illicit drug use have also reported 'positive' [as well as 'negative'] beliefs, including the belief that illicit drugs can help to cope with life challenges and traumas (Jerome et al., 2009), enhance social interactions (Halkitis et al., 2005, Jerome et al., 2009), increase energy and ability to focus (Chartier et al., 2009), and improve sexual experiences (Semple et al., 2002, Halkitis et al., 2005, Chartier et al., 2009, Jerome et al., 2009).

General practice plays an important role within gay men's health in Australia, and there is increasing knowledge available about how Australian GPs diagnose and manage depression in gay men, as well as how gay men experience depression (Körner et al., 2008, Newman et al., 2008, Newman et al., 2009, Newman et al., 2010, Körner et al., 2011). However, very little is known about the role that beliefs play in shaping how gay men's health care is negotiated within general practice consultations. Our earlier research with general practitioners who provide care to gay men found that some Sydney GPs believed increasing crystal methamphetamine use among gay men had created new challenges for the clinical management of depression (Saltman et al., 2008). In order to ensure that healthcare providers can assist in reducing drug-related harms among gay men (Roche & Richard, 1991, Frei, 2010), while continuing to address the particular mental and other health care

vulnerabilities they may experience, it is particularly important that open communication about drug use is both aspired to and actively worked towards in general practice settings.

Methods

For the original study, seven general practices with large numbers of gay male patients and high caseloads of people living with HIV in Sydney, Adelaide and a rural-coastal city in New South Wales agreed to take part. GPs at the practices were informed about the study through flyers and presentations, and interviews were scheduled through practice managers. In-depth interviews with 16 GPs (14 men, two women) were conducted in August-December 2006. The GPs had worked in HIV medicine and gay men's health between two and 24 years. GPs were not asked to disclose their age, sexuality or HIV status. The second phase of data collection was a survey of male patients attending participating practices. A subset was invited for interview if they had: 1) agreed to be contacted; 2) identified themselves as 'currently suffering from depression' at the time of the survey; 3) measured above 4 on the PHQ9 self-screening tool for depressive disorders included in the survey (Mao et al., 2008); and; 4) identified as gay, homosexual, queer or bisexual. Forty interviews were conducted in February-May 2008 with 26 men in Sydney and 14 in Adelaide. Seventeen interviewees disclosed that they were HIV-positive, so slightly less than half. Ages ranged from 20 to 73 years and almost half were in their forties. 90% were Australian born and had Anglo-Celtic backgrounds. Fulltime employment was reported by 21 men and part-time by 7, with a wide range of incomes; 5 were unemployed, and 8 received a disability support pension. The age, HIV status and allocated pseudonym of each participant are noted under the interview extracts.

In line with the aims of the original study, the core interview questions explored the experiences of both doctors and patients in the diagnosis and management of depression, particularly in general practice settings, and additional questions explored broader issues relating to HIV, gender and

sexuality. The first stage of the original analysis involved identification of recurrent themes from the de-identified interview transcripts with NVivo 8 software (Bazeley, 2007) according to the principles of thematic analysis (Braun & Clarke, 2006). As is a recognised strength of qualitative research, 'emergent' findings are often identified during the course of analysis. In this study, illicit drug use was identified as a theme in both sets of interviews, but this was not central enough to our original study aims to warrant a more detailed analysis. Therefore, we have taken the opportunity of receiving additional funding from *beyondblue: the national depression initative*, to conduct a more focused, secondary analysis of the particular role that drug use plays in our study data. Two papers have been produced from the quantitative data, including one that clarifies the role of alcohol and other drug (AOD) use in major depression (Holt et al., Published online first), and one that describes concordance between 'doctor' and 'patient' assessments of major depression (Bryant et al., in press). In the qualitative component, we found that the data on illicit drug use were not broad enough to permit an in-depth appraisal of variations and divergences *within* each of the participant groups. However, the data were very well suited to an examination of recurrent patterns in the beliefs of doctors and patients, including any variations and divergences *between* the two groups.

Ethical approval for both phases was granted by the Royal Australian College of General Practitioners Human Research Ethics Committees and ratified by ethics committees of participating universities. Written consent was obtained from all participants.

Findings

Doctors' beliefs

The first belief from the GP interviews was that *illicit drug use is related to depression in gay men*. Drug use was one of a range of factors included in the diagnostic repertoire for detecting depression in this population. The GPs articulated what they call a 'pragmatic' position toward drug use, where

they acknowledge and respond to the harms that may result from drug use without being (at least explicitly) judgemental about that use. As one Sydney GP put it, detecting depression in gay men requires being 'very conscious about low self esteem ... Recreational drug use. At risk behaviours' [SYD_GP11]. Other GPs described more complex relationships between alcohol and other drug use and depression among gay men:

> [W]ith men generally there's probably alcohol issues. With gay men, in particular, probably also drug and alcohol issues. And I think depression sort of feeds [into that] in a number of different ways. It could be a form of self medication to deal with depression. Or it could be taking the chemicals and becoming depressed as a result of that' [SYD_GP10].

Gay men were described as a distinct group in these accounts, with implicit comparisons to heterosexual men. Drug use becomes one of a series of illustrative statements that these doctors use to characterize gay men as a 'coherent' patient population but also – importantly – to identify particular vulnerabilities believed to deserve special attention in general practice.

The second belief evident in the GP accounts was that *illicit drug use impedes effective diagnosis and treatment of depression in gay men*. Many GPs described frustration about effectively distinguishing clinical symptoms of depression from 'negative by-products' of drug use:

> I think, being gay, I just find a lot of men are used to like hiding themselves because they're, when they were closeted they're used to like projecting a certain image of themselves ... [And a] lot of people I think cover their sadness or their depression ... through drugs, which make it even harder just to delve into it ... And on questioning I think a lot of people drink and take drugs, and then when they're in that withdrawal phase it can bring out the depressions ... [Or t]hey can say they were depressed but it's three days after a dance party and they've taken lots of drugs. And then a week later on reviewing them they're not depressed. [SYD_GP9]

Drug use becomes troubling here in view of the multiplicity of its potential meanings. For example, in an interview with one of the Adelaide GPs, gay men were described as 'more likely, able to identify [depression] as an issue and come forward, and accept treatment or discuss it... [However,] substance abuse possibly gets in the way ... And I [dare] say it happens more often than what's actually disclosed.' The belief that gay men may be secretive about illicit drug use was consistently noted as a perceived barrier to accurately detecting or treating depression.

The third belief evident was that *illicit drug use increases the level of complexity involved in caring for gay men with depression*. This belief builds on the first two but extends them into broader concerns about the capacity of general practice to respond to drug-related health issues:

> [D]ealing with addiction and substance abuse, I feel less comfortable with. I don't feel I have the expertise to deal with that, so I tend to send them [to a mental health support service] for that. But depression ... I will take on myself. [SYDGP_5]
>
> I won't name names, but I send ... a lot of these [gay men with drug use issues], to a certain psychiatrist. And he said, "Don't send me any more!" [laughter] Because he's fed up with them. And I would be too, I guess. They're the ones I can't deal with. [SYDGP_9]

This particular group of GPs accepted that many of their gay male patients take illicit drugs. The problems they describe are therefore not related to judging or condoning drug use but to the GPs' self-doubt about knowing when or how to intervene in 'problematic' drug use. The second quotation is indicative of the discomfort that these doctors express regarding co-morbid depression and drug use in gay men; the laughter may be a device to diffuse tension or normalise the discussion of a troubling or sensitive topic (e.g. Gronnerod, 2004). This discomfort seems to arise from the desire to address the potential harms of drug use without damaging the trust between these GPs and their gay male patients. As one Sydney GP put it: '[it's] sometimes a difficult path to tread between saying, "Yeah, well it's good that you're feeling good about yourself and your lifestyle. But you might

consider reducing this [drug use]"' [SYD_GP11]. Some GPs had concluded that the issue of drug use added a level of complexity to their general practice responsibilities which might 'exceed' their capacity to provide sustained levels of appropriate care to this population.

Gay men's beliefs

The first of the beliefs in the gay men's interviews was that *illicit drug use is closely related to depression*. This belief is very similar to the first of the doctors' beliefs, but involved less hypothesising about this being an issue or experience specific to gay men:

> Serious depression, I started experiencing around the age of twenty five ... [It was a] combination of, I guess, drug use and lack of identity. I didn't know who I was, why I was, what was my place in the gay scene ... But I also used drugs and alcohol to suppress that. So for a while I was in denial about my depression. [Anthony 43, HIV negative]
>
> I don't think I was drinking like a maniac or drugging like a maniac. It was a very slow, insidious kind of thing. But you know, it certainly had some impact. And I think because I've always suffered from depression, you know, the impact that drugs and alcohol have, it was just more of the same. I didn't really ever see a change in me. [Ethan 40, HIV negative]

Illicit drugs were variously positioned in these accounts as either worsening or masking the experience of depression, and sometimes as reducing the capacity of individuals to develop insights about or seek assistance for their depression. Despite this diversity in how drugs and depression were seen to relate to and shape each other, the belief that they *were* related in some critical way formed a central and repeated narrative in how many of these gay men recounted their lives.

The second belief evident in the 'patient' interviews was that *illicit drug use can be helpful in dealing with difficult experiences*. As Gabriel [44, HIV negative] put it: 'the only reason I'm here today is probably because for twenty years I took lots of drugs and drank lots of alcohol, and had a big party.'

Many men described productive or beneficial roles that drug use played in helping them to negotiate and even 'survive' challenging experiences in their lives, including an HIV diagnosis:

> It was all within the year. I seroconverted ... Mum died ... [and] my employer disallowing my benefits for my back [injury] … I became addicted to crystal at that time ... I would just sit at home and play computer games for hours on end or surf the net. Or just anything not to think about what was going on. I suspect all of those things led to that gradual decline of isolation and depression. [Jean-Paul 49, HIV positive]

> And then the day I was diagnosed I went and I shot up for the very first time. The day I was diagnosed. And that led down a really bad garden path ... And I thought I was dealing with my status … [But] I was just covering it up with something else, basically. Something really superficial. [Jake 32, HIV positive]

The gay men we interviewed in this study recognised both positive and negative roles for drugs in relation to depression, including, in these examples, as a way of coping with an HIV diagnosis, even if that strategy was also described retrospectively as 'superficial'. This suggests that while gay men's beliefs about illicit drugs are by no means straightforwardly celebratory, they did involve a more complex and diverse layering of meanings than was apparent in the doctors' beliefs.

The third and final belief expressed here was that *illicit drug use is just what you do as a gay man living in a big city*. Only men living in Sydney articulated this belief, positing their urban environment as creating the conditions (and being partially responsible) for their drug use practices. For example: 'before I moved to Sydney I'd probably had about four ecstasies in my life. Since I've been in Sydney, I've probably had about thirty. It goes with the territory' [Vincent 40, HIV negative]. These men also make conceptual links between depression and 'gay spaces' for drug use:

> I've been very moderate ... maybe three times a year, generally only one ecstasy pill ... But who knows? Maybe I wouldn't have this mild depression, if I hadn't ... But it's been fun. I

> remember my party experiences as being a release from life and life's stresses ... They're uniquely part of the gay lifestyle. And the ... one sort of area where the community comes together, in some way. [Keith 47, HIV negative]
>
> I think [depression is] a big problem and I think that in the gay community – this is just a guess – but I think it has a lot to do with drug use. Particularly amphetamines ... I certainly have seen in two of my friends a complete breakdown from amphetamine abuse, where they were unable ... to string a sentence together any longer. Unable to make rational thought. What a disaster ... But I think the depression ... is a feature of this drug abuse in the gay community. Definitely. [Nicholas 46, HIV positive]

Underlying both of these examples is concern about whether drug culture assists or hinders some gay men in managing the mental and emotional stresses of contemporary life. These interpretations of drug use are intimately connected with concepts of place, or more specifically to ways of belonging to (or participating in) gay community. Recent research in cultural geography and queer/gender studies suggests that the 'politics of belonging' are central to the formation of alternative sexual identities in advanced liberal societies such as contemporary Australia (eg. Gorman-Murray et al., 2008). It is interesting, therefore, to note that these men conceptualise drugs as contributing to that sense of belonging in contradictory ways: for some, drugs are a 'disaster', while for others, they are an essential component of 'coming together' as a community.

Discussion

While our analysis did not find that either doctors or patients made an explicit attempt to posit a direct, linear relationship between drug use and depression, both groups articulated a recurrent belief that drug use and depression *are related* in complex ways among gay men. However, beliefs about the implications of these relationships diverged between the two groups. The GPs articulated a 'pragmatic' position regarding the level of drug use among their gay male patients that is

consistent with a harm reduction approach, but they also worried about how drug use affects gay men's mental health and the GPs' capacity to diagnose and treat depression in the context of illicit drug use. The gay men, in contrast, believed illicit drugs could have both negative and positive uses and tended to make sense of drugs in relation to the broader context in which their social and sexual lives were embedded. Whilst it may not be unexpected for doctors and patients to hold different beliefs about contentious issues such as illicit drug use, our findings remind us just how significantly communication in clinical settings can be shaped by social and cultural differences.

There are several limitations to our study. Our analysis cannot offer insight into the causes of depression or drug use, nor how the different types of depression and drug use are distinguished and understood. Since investigating drug use was secondary to the original aims of the study, the depth and diversity of views provided on this issue are somewhat restricted. This suggests there is scope for a more in-depth investigation of the meanings ascribed to illicit drug use among gay men and their doctors. We also did not have enough diversity available in this data to make any conclusions about how HIV status might figure in the relationships between illicit drug use, mental health and identity. While we interviewed GPs and patients in two Australian cities, we do not want to speculate about the role of 'place' in shaping these accounts. We did not ask the doctors about their own sexual identity and we did not evaluate whether doctors' sexuality affected their own beliefs about drug use or depression in gay men. Similarly, as only a few female doctors or those from non-Anglo-Australian backgrounds were interviewed, we cannot comment on the role of gender or ethnicity in GPs' views. Finally, the beliefs identified may be specific to the social and political context of the particular parts of contemporary Australia in which this research was conducted.

However, we did find these data suitable for identifying some of the areas in which the beliefs of these doctors and patients converged and diverged. If a shared understanding of the diversity of beliefs brought to a clinical encounter can foster more effective doctor-patient communication (Ong et al., 1995), this suggests that recognising and responding to beliefs can contribute to building a more genuinely 'shared' approach to the clinical encounter than the contemporary rhetoric on 'decision making' typically acknowledges (Robertson et al., 2011). GPs may be better placed to encourage gay men to deal with problematic drug use and its effects if they are prepared to discuss men's motivations for drug use, including beliefs about drugs as pleasurable or useful. This may require an explicit acknowledgement of difference and disagreement about these meanings. Both policy-makers and researchers have called for a greater focus on pleasure in order to make drug education and interventions more effective (e.g. Holt & Treloar, 2008, Bunton & Coveney, 2011), arguing that ignoring the pleasure-based motivations for using drugs makes it difficult to create education strategies that drug users take seriously. Our findings contribute further weight to this argument and suggest that a shared understanding between doctors and patients that drugs may be inscribed with both positive and negative meanings could, for gay men, add additional legitimacy, trust and confidence to their clinical encounters with GPs. This may in turn lead to a more genuinely shared approach to making clinical decisions, including those relating to the diagnosis and management of depression.

A small amount of previous research has examined clinicians' beliefs about people who use drugs, most commonly identifying negative views and a lack of knowledge about needs and responses (e.g. Hindler et al., 1996, Johnson et al., 2005, Kelleher & Cotter, 2009). In contrast, the GPs we interviewed described drug use as a common and almost 'ordinary' feature of gay men's health care, even if they express some ambivalence about their own capacity to address this in relation to mental health. Supporting GPs in building their confidence and willingness to address drug use may

therefore be one of the most important steps in enhancing doctor-patient communication in this setting. In particular, we suggest that the 'tipping point' at which GPs come to believe they must seek specialist support from outside general practice should be discussed more openly between gay men and their doctors. It is possible that the doctors we interviewed identified drug use as an issue of note because it may be more easy to conceptually isolate as a 'treatable problem' than the various social, economic and medical stressors in everyday life – including the continuing marginalisation of gay men – which can lead to and complicate management of depression. This possibility points to the ongoing importance of primary health and other care professionals receiving support and training in the appropriate care of gay, lesbian, bisexual and transgender people (McNair & Hegarty, 2010).

Conclusion

Both doctors and patients can learn from each other regarding their respective understandings of illicit drug use and related issues, and doctors may find it useful to open up conversations that explicitly acknowledge divergent views about drug use while remaining sensitive to and focused on the mental health needs of individual patients. Policy-makers could provide better support to GPs, particularly at the point when GPs begin to believe that the drug use reported by their gay male patients will 'exceed' their professional capacity to provide effective care. This is consistent with the move by the Australian National Health and Hospitals Reform Commission to better integrate mental health and other allied support services within general practice settings (NHHRC, 2010). Finding new ways to support doctor-patient communication between GPs and their gay male patients will ensure that opportunities to respond to problematic drug use are not missed and that drug use does not compromise the diagnosis and management of depression in this often vulnerable population.

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