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'It's really a myriad of different signals, not just the textbook': the complexities of diagnosing depression in gay men in general practice

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ABSTRACT

This paper reports on in-depth interviews with general practitioners (GPs) about their views and experiences of diagnosing depression in gay men – some of whom are living with HIV – and the broader social contexts in which such a diagnosis is located. This analysis is a key outcome of a collaboration between social researchers, primary healthcare researchers, GPs and community partners, to investigate the management of depression in gay men in primary care settings. As the qualitative component of this project, semi-structured in-depth interviews were conducted with 16 GPs with high caseloads of gay men, in three geographical settings in Australia: Sydney, Adelaide and a rural-coastal town. GPs considered the diagnosis and management of depression to be an integral part of primary care, especially in gay male patients. They had a heightened sense of

awareness that depression was common in the group of patients they were seeing. Central to diagnosing depression was the ongoing, long-term relationship GPs had with their gay male patients. GPs were vigilant and proactively inquired about depression, taking into account somatic, social and psychological indicators. In their approach to diagnosing depression, GPs considered not only the life circumstances of individual patients but also the broader social context of stigma related to homosexuality, and the effects that the HIV epidemic has had on individuals, especially on gay men who have been living with HIV for a long time.

Keywords: depression, gay men, primary health care

Background

This paper reports on in-depth interviews with general practitioners (GPs) about their views and experiences of diagnosing depression in gay men, some of whom are living with HIV. Gay men in Australia have been found to have a higher risk of depression than their heterosexual counterparts,^{1,2} and in a large sample of gay men, being homosexual or bisexual were major predictors of suicidality.³ Elevated levels of depression and other mental health issues among gay men have also been reported in the US,⁴ UK,⁵ and the Netherlands.⁶

Depressive symptoms are common among people with HIV, more common, in fact, than among people with other serious medical conditions.^{7,8} Reported prevalence rates vary widely, depending on patient demographics, disease state, treatment status, assessment strategies, and co-morbidities.⁹ In a sample of HIV-positive people recruited from clinics in Melbourne, 22% met the criteria for major depressive episode,¹⁰ and in a longitudinal cohort study of HIV-positive people in Australia, 20% reported a clinical diagnosis of depression.¹¹

The relationship between HIV and depression is complex, with both biomedical and psychosocial ramifications. Depression among people with HIV is associated with lower quality of life,¹² unemployment,¹³ higher sexual risk taking,¹ non-adherence to antiretroviral treatment,¹⁴⁻¹⁷ and disease progression.¹⁸⁻²⁰

It has been argued that the underdiagnosis of depression by GPs is a major health problem.²¹ However, the issue is more complex than simply GPs 'failing' to identify depression or 'missing' patients with depression. There is no uncontested agreement over the nature and labelling of 'depression' between GPs and psychiatrists on the one hand,²² and between GPs and patients on the other.²³

First of all, a distinction needs to be made between GPs recognising depressive symptoms in patients and making an explicit diagnosis of 'depression'.²⁴ GPs do recognise psychological symptoms but symptom patterns observed in patients do not always neatly fit into the disease categories of psychiatry, and patients do not always present with discrete conditions as defined and classified by psychiatry.²⁵ It has also been noted that GPs may, for medico-legal reasons, be circumspect in how they record information about psychological problems in patient notes.²⁶ The diagnosis of depression is also affected by demographic factors of patients and primary care settings.²⁷ For example, patients who saw their GPs more often were more likely to have psychological symptoms recognised by their GPs.²⁴

While GPs may recognise depressive symptoms, some patients may resist being labelled 'depressed'. Research has shown that in many contexts patients may feel embarrassed about being unable to cope or to formulate their problems clearly in their own minds, reluctant to seek help, or uncertain whether the doctor is the right person to confide in.²⁸⁻³⁰ Thus, in order to diagnose mental health problems, GPs need to tread a delicate balance between the need for trust in a patient-centred relationship and intruding too much.²⁶ If a patient presents with physical symptoms only, a diagnosis of depression may be unacceptable to them,²³ and what counts as 'depression' according to a standardised instrument may be perceived by patients as struggling to cope with job insecurity, poverty and social exclusion.³⁰

There are also methodological reasons for claims that GPs 'miss' depression. Such studies typically use standardised instruments to compare patient self-assessment and assessment of patients by GPs, or patient assessment according to a scale and GPs' clinical notes.^{22,27} However, patients who are identified as 'undiagnosed with depression' in a one-off survey can be identified later during clinical consultations, and patients who are identified in a survey as 'depressed' as a result of social problems and adverse life events can be 'clear' when followed up.³¹ Also, in in-depth qualitative interviews with GPs, 'knowledge in action', and clinical experience were identified as more important than 'scientific knowledge' and numbers on a standardised instrument.³²

Diagnosing depression in HIV-positive people poses some unique challenges. Patients in whom depression is primary to HIV may or may not have had a previous history of depression. In patients in whom depression is secondary to HIV, depression may be the result of HIV infection or a side-effect of antiretroviral or other treatment.³³ Diagnosing major depression in people with HIV is also complicated by the fact that symptoms such as fatigue, sleep disturbance and weight loss may be indicative of both HIV infection and depression.³⁴

Methods

The data for this paper are from the Primary Health Care Project on HIV and Depression, a multi-method project with quantitative and qualitative arms. The aims of the overall project were, firstly, to describe, measure and compare depression among HIV-positive and HIV-negative gay men; secondly, to describe the ways in which depression is managed

by GPs and gay men themselves; and thirdly, to develop the research capacity and skills of GPs to assess and manage depression among gay men. The project is a unique collaboration between social researchers, primary healthcare researchers, GPs and community partners. This paper focuses on qualitative data, namely interviews with GPs.

Recruitment

Stage one of the study consisted of in-depth semi-structured interviews with primary care physicians who were trained and accredited to prescribe HIV medication. They were recruited from seven general practices that provide care to large numbers of gay men, including high caseloads of gay men living with HIV. Four practices were in inner Sydney (Australia's largest capital city), where a large number of gay men live and socialise. One practice was in inner Adelaide (one of Australia's smaller capital cities). It operates a programme for gay men living with or at risk of acquiring HIV. Two practices were located in a rural-coastal town. They provide care to the majority of gay men and people with HIV who live in that region.

To recruit GPs into the study, presentations were made at each practice and all GPs who can prescribe antiretroviral medication were invited via practice managers to schedule in time for an interview. Sixteen GPs agreed to be interviewed, 14 men and two women. They have been working in HIV medicine for between two and 24 years. Although the number of participants was relatively small, this sample represents a majority of the GP workforce in the three study locations who can prescribe antiretroviral medication.

Ethics approval was granted by the National Research and Evaluation Ethics Committee of the Royal Australian College of General Practitioners. The approval was ratified by the Human Research Ethics 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 semi-structured interviews in an open-ended, non-judgemental and conversational style.³⁵ Each interview lasted approximately one hour. An open-ended interviewing style was chosen to allow the 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 across interviews, an interview guide was developed by the project team and used to provide prompts in the interview. Interviews were audiorecorded and transcribed verbatim. To ensure confidentiality, all identifying information was removed from the transcripts or replaced with related but non-identifiable information.

Data analysis

Transcripts were firstly coded by the primary qualitative researcher and interviewer (CN), using NVivo software. Analysis was inductive and involved the identification of recurrent themes and concepts, including patterns and clustering of themes as well as commonalities and variation within themes. Analysis was iterative; as new concepts and themes emerged, earlier transcripts were re-examined and categories were refined. This allowed for empirically grounded findings to emerge from the transcripts, including unexpected findings, rather than being restricted to predetermined hypotheses.³⁶ Emerging themes were discussed, revised and refined among the project team. A second round of coding focusing specifically on 'diagnosing depression' was carried out by the first author (HK) to develop and refine subcategories. In order to provide a nuanced account of 'diagnosing depression', the analysis aimed to capture the range and diversity of views and experiences rather than to determine frequency.³⁷ The presentation of results in this paper focuses firstly on themes relating to the diagnosis of depression in gay men, followed by themes relating specifically to HIV-positive gay men.

Results

The GPs in this study took a broad view of 'depression'. It encompassed symptoms described in the psychiatric literature; however, GPs' understanding also took into account issues specific to the gender and sexuality of their male patients, such as overuse of alcohol and drugs, excessive work, ageing, body image, social isolation, and the loss of family and friendship networks.³⁸

GPs considered the diagnosis and management of depression to be an integral part of their work. Essential to diagnosing depression in gay men were the ongoing, long-term relationships GPs had with their patients, as well as GPs' awareness of issues relating to sexuality, living with HIV, and the broader context of the HIV epidemic.

Heightened awareness of depression

All GPs reported a heightened sense of awareness that depression was common in gay men, and they were vigilant regarding the possibility of depression in their gay patients. Events such as a forced change in work or relationships, a brush with the law, and financial problems were interpreted by GPs as possible warning signs. If patients mentioned any of these events, GPs followed up and inquired about depressive symptoms.

'Relationship difficulties, that often comes through. Difficulties with family interactions, with partner interactions, work interactions. They often come through as a presenting feature of a depression, actually. They're just not happy with whatever, with their life, basically. Whatever it might be. But those are features that come through quite strongly. And then when you fish it out, well then they may be losing interest in things. They may be not sleeping properly. They may be having a lot of anxiety as well. That's often associated with it. So there's a whole sort of constitution of, a whole lot of signs, I suppose.' (ADE_GP2)

Because they were aware that depression was common in gay men, some GPs did not wait for such events to occur or for their patients to raise issues themselves. In contrast to the research on the underdiagnosis of depression, the GPs in this study actively pursued the possibility of depression in their gay patients and inquired about depression as a matter of routine.

'I deliberately seek it out and I deliberately ask and I deliberately focus. And I deliberately and very commonly, well, I leave an open door policy to say that, "okay, if you're experiencing these particular feelings, I want to know about it". I leave the door open. How many come back and take up that offer? Quickly looking back when I knew I was going to be doing this [interview], I just did a quick survey of three consecutive days of consultations averaging 25 to 30 consultations a day. About a third of them I would have a discussion of depression in that consultation. So about a third. And that's not actively seeking, that's actually routine, what we would do.' (SYD_GP7)

Because GPs were highly sensitised to depression in gay men, they proactively probed beneath the surface, not necessarily accepting at face value the appearance that some gay men presented.

'I see a lot of lonely people. A lot of people who can't tell people about their depression. Not necessarily that they're lonely, as in socially isolated, but they can't reveal it because they just can't. And prising it out of them [is] sometimes difficult when they're used to saying all the right things.' (SYD_GP9)

Some GPs relied less on talk about events that may trigger depression, but routinely monitored their gay patients for physical signs that could be symptoms of depression.

'Because just from my own experience, depression is so incredibly common that we're thinking about it all the time. More particularly, I tend to weigh people regularly, so if you see any unexplained weight loss, that's a clue.' (SYD_GP6)

Central to this proactive inquiry about depression – the 'fishing it out', the 'prising it out' – was the ongoing, long-term relationship and the frequent contact GPs have with their gay male patients. In a similar fashion to that reported by Bushnell *et al*,²⁴ this enabled GPs to detect subtle changes in mood, behaviour or appearance early on.

'It's like, yesterday I was in the middle of seeing one chap, who's not HIV but [has a] definite risk of it because his partner is. And they broke up and he's a happy, easy going, good looking, everything you'd want him to be exec [executive] type. But I just said to him, "you don't look the same today, what's up?"', and then it was tears. Because he normally would not portray that. It was just, I think, lucky the fact that I could spot that he'd lost a bit of weight, he looked a bit drawn. But I think the average person would not see [it] in him.' (SYD_GP9)

The GPs in this study were also very much in touch with the effects of the HIV epidemic on the lives of individuals and on the gay community as a whole. One major theme here regarding depression in HIV-positive gay men was loss – loss of income, loss of careers, loss of relationships, loss of family, loss of social support, loss of future. Until the mid-1990s, HIV was a terminal illness and many gay men, both HIV-negative and positive, lost partners and numerous friends. This loss of social relationships, plus lack of support from families who did not accept a gay man's sexuality, were considered by GPs to be important factors for depression.

'I guess a lot of people too that have been positive for a while have lost most of their friends to HIV, and don't have any support from there either. I mean if they're lucky enough to have a partner that's good, but I guess some people have lost all their social support through illness and death. And that's an important factor.' (SYD_GP3)

For HIV-positive gay men, key events such as a positive diagnosis, the need to start antiretroviral therapy, treatment failure, an AIDS-defining illness, or a friend's AIDS-defining illness were identified by GPs as additional triggers that increased their vigilance and awareness of depression. This was especially the case for HIV-positive gay men who have been living with HIV for a long time, who had lost

well-paid jobs and careers and the social status that came with these careers, and who have been reliant on social security payments.

'So the other factor is socio-economic. Especially in this area [rural-coastal town], a lot of people moved here as their finality. They were going to die. They moved here either to do that or to do that eventually. Or they moved here to get away from what they perceived as an unhealthy scene in the city area, to prolong their life a bit longer. And many had accepted that this was their fate and so their asset base is very, very miserable. And I think anybody who has dire socio-economic circumstances finds life more miserable and depression is increased.' (RC_GP2)

In addition to the effects of socio-economic deprivation, GPs believed many gay men have struggled to come to terms with social isolation, both voluntary and unwanted, since their HIV diagnosis. These experiences contributed to the wide range of signals that GPs were alert to regarding the detection of depression in their gay patients.

The diagnostic process

GPs were aware that depression could manifest in many different ways, and described putting together a diagnosis from physical, psychological and social indicators as well as through observation of a patient's presentation.

'And then of course all the things that go on when you are in a consultation with somebody, picking up on non-verbal cues, eye contact, their general demeanour.' (ADE_GP2)

Frequent minor health issues and chronic conditions often alerted GPs to investigate psychological well-being, even though not always in a direct manner if explicit questioning was perceived as inappropriate in the circumstances.

'It's the people who are constantly having minor health issues and you're trying to get them to realise, "well, do you think this is lifestyle related?". And I might skirt around the issue. And, you know, "has there ever been any depression or mental illness in your family?". Try and ask the questions that aren't so focused on them, if I perceive that it's going to be threatening. But it often takes those people a long time to acknowledge that they could be psychosomatic. So irritable bowel syndrome's another classic, I think that can often be a sign. Or skin conditions too, if people's eczema is flaring or their psoriasis is flaring. (...) So, I mean, it's really a myriad of different signals. It's not just the textbook. (SYD_GP8)

GPs also pointed to a discrepancy between 'classic' depression as described in textbooks, and depression in the psychosocial context of gay men's lives as they encountered it in their clinical work.

'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. You'll also hear the story of, as I've said, an agitated depression. So you'll hear the story of anxiety, anxiety-related symptoms. Very rarely a classic depression. And they're the things I pick up on.' (SYD_GP7)

Because of these different manifestations of depression in gay men, these GPs also think differently about how to go about the diagnosis of depression in this population. For example, GPs very rarely used standardised instruments to arrive at a diagnosis. They rather relied on their judgement and their experience, 'that intangible general practice thing', as one GP called it. Knowing a patient, and the ability to pick up on small changes were considered more important than numbers on a scale.

'It's the change rather than the actual, you know, administering. And on the other hand you sometimes give those handout things, like ticks, with the tick box ones. They 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)

Diagnosing depression was not a clear-cut matter but a multilayered process that GPs described as 'building a picture', or 'building a diagnosis'. This process included questions about a patient's life in general, aspects of a patient's social life, and inquiry into depressive symptoms. In this way, GPs were teasing apart whether moods or social problems were, indeed, moods or social problems or actually warranted the label 'depression'.

'And I probably make the dreadful mistake of usually starting a consult with, "how are things going?". And that may just make it very clear that, "look, things are fine". If that doesn't look like things are absolutely fine, I'll specifically say, "well, look, what's happening?". And that may be at work or at home or in the family or with the partner, whatever. And so you build a picture. If it's looking like someone's depressed I will then ask specific questions related to mood and all the symptoms that go with depression that people might, you know, how people are functioning,

how are they concentrating, what's their energy like. All of those other things which people don't necessarily directly connect with mood, to try and build a bigger picture of is this person actually depressed. Or are we just talking relationship problems and pissed off at work, or whatever.' (SYD_GP4)

Depression was perceived as a 'network of connections', and the clinician's task was to tease apart the various strands of this network in order to assess whether the label 'depression' was warranted, for example, in the case of gay men living with HIV.

'There's a network of connections (...) and at different stages of HIV how, how it links in with depression. Through acute HIV and then more advanced HIV, causing symptoms. So I guess it's trying to work out whether it's an adjustment disorder of depressed mood or dysthymia or major depression. Trying to make those distinctions. Or the role of drug and alcohol factors. And then more secondary causes like job loss or relationship breakdowns. And they're often, may or may not be tied in with HIV. So you're sort of trying to go for the diagnostic filter (...)'. (SYD_GP6)

Sexuality, stigma and depression

In their approach to diagnosing depression in gay men, GPs considered not only the symptoms and circumstances of individual patients but also the broader social context of stigma related to homosexuality. In their experience, depression was a particular issue for those gay men whose sexuality was not accepted by their families. The breakdown of social relationships and the ensuing lack of support often resulted in depression.

'One thing I've found quite common is, almost a bit of social outcasting. I've found that I've got quite a few patients that have, fall in the category of perhaps their sexual identity has been confused in the past. And they've got married and have children, and then they've leant more towards being gay and that's caused disaster because of misunderstandings and infidelity, and family break up. That's a pretty common thing. Then they go towards a gay partner and they've got no social supports, the social supports just evaporate and they can be quite isolated (...). So they've felt pressured into following certain lines of, like marriage, whatever, and it hasn't worked out. And there's just one disaster leading to another. And then they get quite, not only depressed but confused about what's happening. That's not an uncommon theme.' (ADE_GP2)

Some gay men had difficulties accepting their own sexuality, and this lack of self-acceptance also

alerted GPs to the possibility of depression in these men.

'Some of us have an easy road with our gayness, do you know what I mean? Like, it's not an issue mainly because our family and friends have always been supportive about it or you have the intelligence or the life experience to accept yourself for being that way. And therefore it's not an issue and you move through life, you know. But a lot of men have a very rough ride with that. They hate themselves for being gay. They're never comfortable with the fact that they are gay, and that in itself can contribute to their depression.' (SYD_GP5)

Several of the GPs in this study also believed that major events in the lives of gay men were often not properly acknowledged, and were trivialised by mainstream society.

'The thing with gay men, there's a slight difference ... a lot of their major life events are not considered major life events by their colleagues or their families. So things that make gay men depressed or more vulnerable to depression are usually minimalised by their workplace or again if, relationship breakdowns, all those sorts of things are always sort of minimised.' (SYD_GP1)

For HIV-positive gay men, GPs had a keen sense of the added burden that HIV could add to the many layers of exclusion already experienced by gay men.

'But I guess the thing is that, you know, dealing with HIV is one problem. Dealing with gayness is another one. So that might be an added issue for our male HIV-positive patients. That there is stigma on the basis of their HIV. There's also stigma on the basis of their, their gayness, that they have a rough ride with this world. There may be a long history of self-esteem issues born out of their willingness to accept themselves as a gay man, problems around that.' (SYD_GP5)

Discussion

The GPs in this study were highly sensitised to depression in gay men and expressed a keen vigilance for detecting depression in this population. In arriving at a diagnosis they considered physical, psychological and social indicators of depression and their patients' individual circumstances, as well as the stigma related to homosexuality and HIV.

It has been suggested that in GP consultations where the main focus is on physical problems, psychological problems are identified only as a subtext.²² In contrast, for the GPs in this study,

depression was almost always on the agenda, especially when patients presented with chronic or unexplained physical conditions.

It has also been suggested that difficulties in self-disclosure, shyness and embarrassment prevent patients from raising psychological problems with their GPs.²⁸ The GPs in this study were aware of these barriers and had strategies to overcome them by raising the topic of depression when they thought it was warranted, or by making it part of their routine. Direct questioning alleviates patients' fear about taking up the doctor's time and doubt about whether the GP is the right person to discuss personal problems with.²⁹ Continuity of care was essential here; the GPs knew their patients and their social and psychological functioning very well.²⁴ An element that is perhaps significant here is that a large number of the GPs in this study were gay men themselves, which may facilitate open communication with their gay male patients.

Interestingly, no GP mentioned that a lack of time prevented them from raising the topic of depression with their patients when they thought it was warranted. For some GPs it was a matter of routine.

The GPs in this study had unique strengths that enabled them to detect depression: a high degree of awareness that depression was very common in the group of patients they were seeing; a strong commitment to proactively pursue the issue with their patients; and a longstanding relationship with many of their patients. They also had a very clear understanding of the extent to which depression was related to personal and social challenges, and the multiple sources of disadvantage that their patients suffered. They readily made the connection between physical conditions, emotional problems, and the socio-economic difficulties that some patients experienced.^{10,30,38}

It has been argued that patients in general practice rarely report the typical symptoms described on diagnostic instruments such as DSM-IV (*The Diagnostic and Statistical Manual of Mental Disorders*),³⁹ or ICD-10 (International Classification of Diseases),⁴⁰ but that patients often present with non-specific problems such as aches and pains.²⁵ Most GPs in this study distinguished between the 'classic depression' of textbooks and what they actually encountered in their practices on a day-to-day basis. They very rarely relied on standardised instruments but relied on their clinical experience and their knowledge of their patients as grounds for diagnosing depression. 'Tacit knowledge' was considered more useful than standardised instruments,³² and uncertainty was not necessarily framed as a negative element but was an acknowledgement of the complexity that GPs faced in their clinical work, including a broad contextual view of the patient.²⁶

Conclusion

There are aspects of HIV primary care that make it amenable to developing a best-practice model of diagnosing and managing depression. This group of practitioners has been shown to be highly perceptive of depression as it relates to gender, sexuality and HIV infection in gay men, which informs their approach to diagnosing depression.³⁸ However, there are limitations to what the perceptions of GPs can teach us about how the depression of gay men is diagnosed and managed. Further data analysis from this study will explore the views and experiences of gay men themselves. The findings from both study arms will contribute to developing a training package for HIV-medication-prescribing GPs on the management of depression in gay men, as well as a web-based module for the self-management of depression aimed at gay men.

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CONFLICTS OF INTEREST

None.

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