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Title page

“Men just drink more than women. Women have friends to talk to” – gendered understandings of depression among healthcare professionals and their implications

* Jeppe Oute, Assistant Professor, RN, MA, PhD, Centre for Alcohol and Drug Research, Department of Psychology, Aarhus University, Jo.crf@psy.au.dk

Janis Tondora, Associate Professor, Psy.D., Yale Department of Psychiatry, Program for Recovery and Community Health

Stinne Glasdam, Associate Professor, RN, M.Sc., PhD, Integrative Health Research, Lund University

All authors have contributed to the paper. Jeppe Oute has done the majority of the writing whereas Tondora has provided useful input on the paper's introduction, methodology analysis, discussion and structure and Glasdam has contributed to all stages of the work process.

*Corresponding Author

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“Men just drink more than women. Women have friends to talk to” – gendered understandings of depression among healthcare professionals and their implications

Abstract

Little is known about how gendered understandings of patients can inform professionals’ discretionary actions and decisions to in- and exclude patients in clinical practice. Using Connell’s poststructuralist perspectives on gender as an analytic framework, this article aims to investigate how professionals’ articulations of depression are framed by signs of masculinity and femininity, and how these articulations inform service provision to patients with depression in clinical psychiatry. Building on interview data drawn from an ethnographic study, the article shows how the professionals’ articulations reflected a gender binary that framed how the feminized patients were often connected to psychiatric care while masculinized patients were referred to separate alcohol- or substance use treatment outside the psychiatric institution. The article discusses the societal and institutional conditionality of gendered understandings in psychiatry. In spite of several limitations, the article elucidates how professionals’ understandings might have wide-ranging implications for the accuracy of epidemiological research and policy, and how they reflect a power struggle between patients and professionals about the legitimate right to interpret patients’ conditions and efforts to manage their illness-related problems.

Introduction

Previous research has pointed out that substance-using patients with mental health problems are often bound up in a catch-22 situation. These patients are often denied access to care and treatment in psychiatric institutions due to their substance use issues while also being rejected in the alcohol and drug treatment systems due to their psychiatric problems (Davidson et al., 2008). It is argued that several systemic and interpersonal issues often frame exclusion of patients with complex and co-occurring problems. First, the very organization of psychiatric and drug and alcohol treatment systems contributes to the exclusion of substance-using patients from psychiatric treatment systems (Davidson & White, 2007; Hansen & Bjerger, 2017). Second, international research, including that from Scandinavia, elucidates how disenfranchising, stigmatizing and disempowering attitudes towards patients, professionals' unwillingness and inability to navigate complex systems, and poorly timed services within the welfare systems often obstruct such patients' access to care (Jacobsen, 2006; Ness, Borg, & Davidson, 2014; Oeye, Bjelland, Skorpen & Anderssen, 2009; Oute, 2017; Oute & Bjerger, 2017; Skorpen, Anderssen, Oeye & Bjelland, 2009). However, little is known about how gendered understandings of patients can inform professionals' discretionary actions and decisions to in- and exclude patients in clinical practice (Hansen & Bjerger, 2017; Ness et al., 2014). Building on data drawn from an ethnographic study that investigated involvement of patients and relatives in the context of treatment for depression, this article focuses on addressing this issue.

Background

It has been argued that depression is commonly portrayed using a uniform gender binary to explain differences between women and men (Emslie, Ridge, Ziebland & Hunt, 2006; 2007; Hill & Needham, 2013). However, recent research on gender differences in the context of

depression tends to rely on Connell's influential framework to develop more sophisticated approaches to conceptualizing differences between women and men in mental health.

Connell's work on masculinities (and femininities) relies on a rejection, not only of the idea that gender is founded in a biological essentialism, but also of the popular belief that the biological difference between the sexes is expressed as differences in behavioural and psychological characteristics in women and men (Connell, 2005; 2012). Connell and Messerschmidt (2005) argue that the dominant form of masculinity, hegemonic masculinity, is seen as the pattern of practice that allows men's dominance over women to continue. However, this form of masculinity is not assumed to be normal in the statistical sense as only a minority of men enact it. Rather, it reflects an articulation and embodiment of the currently most honoured way of being a man in a social context and this requires all other masculinities and femininities to position themselves in relation to it (Connell & Messerschmidt, 2005). As opposed to the dominant form of femininity called emphasized femininity, hegemonic masculinity has been associated with signs of being unemotional, independent, non-nurturing, aggressive, and dispassionate (Connell & Messerschmidt, 2005; Connell, 2012). In many societies, culturally dominant forms of masculinity also emphasise strength, stoicism and emotional control, in direct contrast with femininity, which is often characterised by vulnerability and emotional expression (Bourdieu, 2001; Emslie et al., 2007). However, masculinity has also been associated with heterosexuality, strength, independence, rationality, success, lust (hedonia), efficacy, stoicism, autonomy, potency and activity across Western industrialized societies which underpins that emphasized femininity is often viewed as the exact opposite (Connell & Messerschmidt, 2005; Connell, 2012). This is not to say that masculinity and femininity reflect two all-encompassing, static and binary identity categories of women and men. Rather, they provide a framework for understanding the relations between dominant and subordinate, and non-stereotypical, forms of femininity and

masculinity that both women and men may (or may not) articulate, embody and negotiate in daily practice at the institutional level (Connell, 2012). From this perspective, one cannot equate being a woman/man in biological terms (sex) and how people articulate and act in accordance with dominant ideals of femininity or masculinity (gender). Rather, the terms female/male refer to persons who, biologically speaking, can be identified as men or women whereas the terms feminized/masculinized refer to certain socially constructed gendered positions.

To put this framework into clinical context, binary views of the category of depression tend to dominate the field of mental health (Hill & Needham, 2013). According to the World Health Organization (WHO), at least two of the following core symptoms characterize unipolar depression: depressed mood, loss of interest and enjoyment and increased fatigue. Moreover, to classify a condition as depression, at least two other symptoms must be manifest, such as reduced concentration and attention, reduced self-esteem and self-confidence, ideas of guilt and unworthiness, bleak and pessimistic views of the future, ideas or acts of self-harm or suicide, disturbed sleep or diminished appetite (World Health Organization, 2014). Using this ICD or the DSM definition of depression, a body of gender studies has pointed out that depression is often viewed as the direct opposite of a relatively unwavering view of masculinity across Western societies (Seidler, Dawes, Rice, Oliffe & Dhillon, 2016; Zac, Simon, Jo, John & Haryana, 2017). As the ICD-10 is used to classify depression in Denmark, the formal signification of the category of depression bears resemblance to dominant forms femininity in Denmark (Oute & Huniche, 2017). However, research suggests that this tendency goes far beyond the formal classification of depression in clinical practice. In fact, epidemiological literature and policies for depression treatment tend to rely on a similar gender binary that rests on the idea that depression reflects deficient biological, psychological and/or social qualities in women (Ussher, 2010). Depression is

often portrayed as a condition constituted by fluctuating hormones, inadequate cognitive functions, or lack of ability to cope with personal problems. This essentialist idea leaves depression viewed as something caused by women being intrinsically irrational, weak, vulnerable and susceptible to critical life events such as childbirth (Ussher, 2010). In that sense, depression is commonly portrayed as a feminized condition (Creighton, Oliffe, Ogrodniczuk & Frank, 2017; Fullagar & O'Brien, 2014; Oliffe, Kelly, Bottorff, Johnson & Wong, 2011). Thus, the classification of depression in men tends to constitute the subordination or marginalization of men because depression as a category is connoted by a range of deficiencies in and around the person; i.e. lack of strength, efficacy, rationality, independence, resilience etc. (ibid.). This indicates why depression in men is often manifested by aggression, irritation, numbness, and focus on sexual capability and substance use, because these signs seem to be more congruent with dominant ideals of masculinity (Brownhill, Wilhelm, Barclay & Schmied, 2005; Ridge, Emslie & White, 2011).

Using the above framework, this article aims to investigate how professionals' articulations of depression are framed by signs of masculinity and femininity, and to address the question how these articulations inform service provision to patients with depression in clinical psychiatry. Thereby, we wish to critically examine how stereotypical gender binaries can underpin in- and exclusion processes of patients in daily practice. Furthermore, we will discuss how these practices can be socially conditioned, how they make sense for professionals within the context of psychiatric welfare institutions, and what implications such practices might have for patients and professionals.

Method

This gendered analysis of depression is part of a larger anthropological field study conducted in a provincial area of Denmark between 2011 and 2013. By means of a constructivist

fieldwork methodology called multisited ethnography (Marcus, 1998; Però, Shore & Wright, 2011), the field researcher followed the social transformation of notions of involvement across a family site, a clinical site and a political site (Hansen, 2016; Oute, Petersen & Huniche, 2015). At an early stage of the fieldwork in the clinical site, a dominant view of masculinity started to emerge. For instance, several psychiatric professionals gave accounts about how male spouses of their female patients with depression were particularly “*responsible*” or “*a good man*” because they involved themselves in the care of their partner. By contrast, staff members also argued that a husband of a female patient was not “*a real man*” because he had come out of the closet and identified himself as homosexual (Hansen, 2016). In line with similar findings from the same setting (Oute & Huniche, 2017), this example suggested that nurses held a heteronormative view of gender that framed how they saw the homosexual man’s masculinity as subordinate or marginalized (Hansen, 2016). This also implied that the staff tended to identify the field researcher as an impure “professional hybrid” because his background as a male mental health nurse and doctoral researcher placed him in between a feminized nursing position and a masculinized doctoral position (Hansen, 2016; Oute, 2017). For these reasons, professionals, primarily the nursing staff, only trusted the field researcher with restricted access to observe the formal meetings between professionals and patients (ibid.). The researcher’s socially contaminated position in the field led to the empirical materials for this gendered analysis consisting only of the professionals’ narratives about their meetings with and view of patients with depression (Hansen, 2016). Building on 45 qualitative interviews conducted during the fieldwork in the clinical site, this article investigates professionals’ articulations of depression.

Recruitment of participants

The fieldwork in the clinical site was carried out at two hospitals’ outpatient clinics specializing in the treatment of people with affective disorders, and included five associated

open psychiatric units where there were, on average, twenty patients being treated (Oute et al., 2015). The professionals agreed *to narrate* the concrete ways they involved, and interacted with patients and relatives. All professionals were informed orally and in writing about the study before the interview and gave informed consent to participate. The informants consisted of 29 members of nursing staff, including specialized psychiatric nurses, staff nurses or nursing assistants. In addition, 10 medical doctors in postgraduate training or fully trained psychiatrists and 6 psychologists and social workers were included. There were 37 women and 8 men included, between 32 – 61 years of age. Based on age, occupation and sex of the informants, the sample predominantly consisted of white female, middle class professionals in midlife (Hansen, 2016).

Interview procedures

The interviews took place in conference rooms at two hospitals in a Danish region from October 2011 to November 2012. The interviews were guided by one narrative-invoking question: *Tell me about an exemplary experience you have had with a concrete patient, diagnosed with depression.* The aim was to elicit nuanced portrayals of what the professionals perceived as ‘good,’ ‘appropriate’, or ‘suitable’ patients with depression. In line with the constructivist methodology, this technique was used to produce insight into the common ways of describing and producing meanings that frame the social reality of daily treatment practice (Marcus, 1998; Però et al, 2011). The duration of the interviews was 45 – 60 minutes, with a variation from ten minutes to two hours. The interviews were recorded and transcribed verbatim.

Ethical considerations

In Denmark, the Danish National Committee on Health Research Ethics only assesses biomedical studies such as clinical trials or psychosurgery. In this sense, an approval from the Danish National Committee on Health Research Ethics was not a legal requirement, as the anthropological fieldwork is a form of inquiry rooted in the social sciences that, per se, is considered neither a trial nor a surgical procedure (Hoeyer, Dahlager, & Lynoe, 2005). In spite of mismatching legal and ethical requirements between biomedicine and anthropology (ibid.), the field researcher chose to inform the Committee about the study and let the committee conduct a formal assessment of the project before initiation of the fieldwork. Subsequently, the author received notice from the Committee that the Committee was not required to assess the project, as it was not subject to bioethical regulation due to its methodology and purpose. However, the field researcher was advised by the Committee to ensure ethically sound health research in order to safeguard vulnerable informants from potential harm and to ensure informed consent and confidentiality (Hansen, 2016). Therefore, the conduct of the field study was ethically regulated by the principles of the Codes for Nursing Research based on the Helsinki Declaration (Northern Nurses' Federation, 2003). In practice, the study adhered to the principles of situational research ethics that are considered the ethical code of conduct in anthropological fieldwork (Hoeyer et al., 2005; Oeye, Sorensen, & Glasdam, 2016). In accordance with the Act of Processing Personal Data, the study was also reported to, and approved by, the Danish Data Protection Agency, J.no. 2009-41-3391.

Analytic strategy

Connell (2012) has argued that health researchers can chose between several different approaches to gender analysis. It is argued that gendered articulations of depression could be analysed using a broad poststructuralist understanding of the notion of discourse despite the

fact that this approach often fails to take into account the daily workings of gender regimes at the institutional level (ibid.). This kind of gender analysis was chosen as it aligned with the theoretical standpoint of the methodology because it focused on written and spoken language as well as gestures, practices and all other symbolic systems (ibid.).

In order to examine how gendered understandings of depression were discursively shaped, the analysis focused on the structural positioning of masculinized and feminized patient subjects (Connell, 2012). We operationalized Connell's framework using the poststructuralist notion of discourse as laid out by Laclau and Mouffe (2001). Through this theoretical lens, discourse was understood as articulation. An articulation was defined as "*any practice establishing a relation among elements such that their identity is modified as a result of the articulatory practice*" (Laclau & Mouffe, 2001, p. 105). By using this definition analytically, it became clear how the informants' articulatory practices shaped the specific binary meanings of the patients' identities, and how opposing chains of equivalent symbols, words, and metaphors that were used by professionals to depict the patients' gender established these particular meanings (Laclau & Mouffe, 2001). In this way, it became clear how the informants' articulatory practice during the interviews ordered and described masculinized and feminized patient identities in relation to each other (Connell, 2012). Although being stabilized within their own chain of equivalence, the meanings of the patients' identities were seen as fluid and never fully closed because they could have been re-configured by their relations to the position(s) of competing gendered identities. In spite of the potential ambiguity of their articulations of the patients' identities, the professionals' discourse delineated a limited space of possibilities, which restricted the ways in which it was meaningful for professionals to deliver treatment and care (Laclau & Mouffe, 2001).

In order to understand the context of the professionals' articulations of the patients, the interview transcripts were read through after the fieldwork. The subsequent inductive

coding focused on identifying words, metaphors and passages which the interviewees used to describe the patients. This led to the construction of 15 preliminary codes. The coding process was performed in NVivo 9.0 software in order to support the transparency and coherence of the categorization and management of the relatively extensive data. Finally, the codes were clustered in three categories: (1) gender characteristics of the patient(s), (2) gendered reasons for the patients' depression, and (3) gendered effects of depression. The three categories accounted for equivalent signs that were consistently articulated in coherence with each other across the interviews (i.e. chains of equivalence) (Laclau & Mouffe, 2001). Despite the authors being aware of the theoretical possibility that the professionals might articulate competing depictions of their patients' gender and the relations between them, the analysis revealed that they held a uniform and stereotypical understanding of patients with depression. This became clear as each of the three categories reflected the different elements of a gendered binary. Using this somewhat closed binary, the professionals presented one subject position that reflected the identity of a feminized, normal and/or good patient with depression in contrast to another subject position; the identity of a masculinized, atypical and/or bad patient.

Results

The results are presented according to the articulation of the two gendered patient identities. The informants used descriptions of masculinized patients' identities to set the stage for the identity of feminized patients. Therefore, the professionals' articulations of the masculinized patient are presented before their portrayal of the feminized one.

The masculinized patient

Often, but not always, the professionals talked about biological men when they described masculinized patients. The representation of masculinized patients was characterized by the idea that s/he was a person for whom it was natural to isolate him/herself and solve his/her mental health problems alone.

Depressed men are often more self-destructive than women. Men are different. They withdraw and isolate themselves much more than women. (Female nurse, 44).

This idea became clear when the professionals characterized masculinized patients as inherently autonomous, hedonistic, active and self-reliant persons:

They feel that they should manage everything on their own. Well, the younger generation may have changed a bit. It might be genetic, but the upbringing means a lot, too. (Female nurse, 55).

The understanding of the essential characteristics and upbringing of the masculinized patients was used by the professionals to contextualize the reasons for the patient's condition. These reasons suggested that the patients' self-reliance and efforts to be actively managing their problems on their own had failed. This line of reasoning implied that the professionals gave the overarching explanation that the mental health condition was caused by loss of social position, status, and recognition following ruined professional career, divorce, infidelity, inability to provide, being fired, or bankruptcy:

Female doctor (49): *On my last shift, there was a farmer who was close to going bankrupt. He had thoughts about not wanting to live anymore. Sometimes, it is like, the wife says that enough is enough, and she wants to move out. This was the case then, and it gets easier for you [directed to the male researcher] to cross that line and try to commit suicide if you're socially threatened.*

Male interviewer (33): *You just said 'you'? Do you refer to men or do you mean 'you' as in both men and women?*

Female doctor (49): *Well, it is mostly you because it is the men who are threatened socially.*

The professionals articulated how the masculinized patients' condition was caused by a disruption of the patients' status and position. The professionals noted that the severity of the masculinized patient's condition was caused by her/his actions and efforts to solve her/his problems alone, by way of using alcohol or substances such as cocaine, benzodiazepines, cannabis or amphetamines or by trying to commit suicide:

Many male patients could be depressed. They self-medicate. However, it paves the way for problems with depressions. They can hit "rock bottom" or it can trigger a depression. Then.... they have chosen to drink. When they meet our system, we have to make you [directed at the male researcher] turn your back on the alcohol in order to see your psychiatric condition. Therefore, we demand that you have to be sober for a while in order to observe what is depression and what is alcohol. It may be difficult for a man to stay sober, you know. Well, men are more likely to drown their sorrows in alcohol [than women are]. (Female nurse, 46).

The masculinized patient was portrayed as someone who 'has chosen to drink' and 'self-medicate' rather than submitting him/herself to the care of the professionals or to other social communities. Thus, in the eyes of the professionals, masculinized patients were seen as guilty of causing and worsening their psychiatric condition. Moreover, s/he was also presented as being responsible for rebuffing psychiatric treatment given that the patient's use of alcohol and substances was considered an active way of trying to remedy their problems in solitude. Consequently, the professionals chose to classify masculinized patients as 'agitated' and/or 'atypical'. That category referred to the professionals' way of arguing that masculinized patients "*often become more ill [than normal depressed people]*" and "*often become psychotic*". Despite requiring long periods of sobriety before making treatment accessible, the

professionals argued that it took longer for these patients to seek out and get treatment due to their masculinized attitudes. By contrast, a feminized patient with “*normal*” depression was regarded as a patient who willingly and quickly sought out professional help for his/her problems; i.e. someone who complied with the professionals’ diagnosis and treatment recommendations:

Men often find it difficult to recognize. Maybe, they are more ill [than women are]. Sometimes they can behave differently than women. It means that they are concealing their symptoms, and if they are doing an MDI test [Major Depression Inventory] they choose fewer symptoms than they have. Therefore, they fabricate more [than women do]. Moreover, they are more irritable. Many of them have physical symptoms. Their depression is expressed through headaches and palpitations, which they view as something physical to begin with. [...]. It is called somatizing. Moreover, perhaps, they are bit more agitated, and restless. A little manic and a little passive [aggressive]. (Female nurse, 44).

As such, masculinized patients were often described as irresponsible and, at times, dishonest patients, who were difficult for the professionals to care for given that “*they are concealing their symptoms*” and trying to solve their problems autonomously rather than relying on the professionals’ expertise. In this respect, the professionals often portrayed masculinized patients as unable, or unwilling, to accept their mental health condition and reveal themselves to the professionals. In keeping with this pathologising view, the patients were described as irritable, passive- aggressive, irresponsible, somatizing, sexualizing, and/or in denial.

Female psychiatrist (51): *Well, she was a nice woman. She had a diminished sense of humor, but we did not know her mood or if she always was such a peevish old woman. She seemed more cranky than depressed. Moreover, she was certainly not shamefaced.*

Male interviewer (33): *And does this make you question that she had a depression?*

Female psychiatrist (51): *Yes, you would think so but she had an agitated depression.*

Male interviewer (33): *But, you previously mentioned that she also had a personality disorder?*

Female psychiatrist (51): *Yes, due to her restlessness. She was never pleased, and not respectful, repressed and compliant like depressed [patients] normally are.*

By contrast to the view of a feminized patient with “normal” depression, the masculinized patients with atypical depression were, commonly, classified as someone being “*abusive*” or having a “*personality disorder*” [borderline, antisocial]. To some extent, this classification mirrored a sense of frustration among the professionals. As compared to a ‘good patient’ with depression who submitted to, and validated, their professional identity, the professionals articulated that the masculinized patients questioned their skills and expertise by not automatically accepting, appreciating, or complying with their perspectives and recommendations.

Hence, masculinized patients were depicted as deviant deviants. They were agitated, and volitional substance-using patients who did not recognize the social order of the patient-professional institution because they did not accept or comply with the offered treatment.

This understanding led to a tendency to blame the patient for actively choosing to maintain or even worsen his/her condition. While often hoping to normalize the patient’s condition, this, then, justified the professionals’ discretionary actions to neglect the patients’ suffering and experience of depression and to exclude them from psychiatric treatment by requiring them to first achieve abstinence:

Male interviewer (33): *Are you saying that you do not recognize depression in men [at the E.D. or outpatient clinic] because they are classified as alcohol abusers?*

Female nurse (45): *No, they tell us that they think that they are depressed but they have chosen to drink. [...]. Then we say that you have to stop drinking and get enrolled at the alcohol treatment clinic. You just have to turn up there. However, if you are drinking three bottles of red wine and half a bottle of schnapps each day, you are not going to [turn up].*

Therefore, masculinized patients were often referred to the municipal alcohol or substance use treatment system rather than psychiatric care despite the fact that the professionals often were aware that the masculinized patient expressed that they felt depressed and wanted help.

The feminized patient

In most cases, the professionals talked about women, in the biological sense, when they articulated feminized patients with depression. The feminized patients were characterized as weak, melancholic, perfectionistic, sensitive and vulnerable:

She must be able to get a hold of herself. It might be the masculine approach—that you have to pull yourself together. [...] So, I am weak when I get depression. Well, then I would not be a real man or ... Well, I don't know. Women are vulnerable, so it's more natural to have depression. (Female nurse, 44).

The feminized patients' identity was articulated by depicting them as naturally weak, dependent and vulnerable (i.e. lacking resilience). According to the professionals, these traits emerged, at times, as an overly caring attitude and constant vigilance towards the person's children, partner and others. This formed the logical context for the professionals' ways of explaining the reasons for these patients' condition. In contrast to the masculinized patients' condition, the professionals' consistently described the causes of the feminized patients' normal depression as rooted in social circumstances around, rather than in, the individual:

She has been under a lot of strain in relation to being afraid of losing her partner.

She has also been burdened by poor working conditions. (Female nurse, 46).

The professionals attributed the depression to a disruption of the patient's position as being responsible for the emotional work in their family life and/or their social position at work. The idea was that the condition was caused by loss of value in relation to being a primary caregiver (emotional sensitivity) or functioning as being a good colleague (vigilance). This was exemplified by how the patient had a depression following a divorce; children leaving the home; a partner being unfaithful, or coming out of the closet and being excluded from her/his work community.

In this medically dominated context, it was meaningful for the professionals to classify the feminized patients with depression as normal, honest, open, socially oriented and responsible:

Men just drink more than women. Women have friends to talk to, they are better [than men] at expressing their feelings. (Female nurse, 45).

In contrast to the masculinized patients, the feminized patients' condition was depicted as being not nearly as severe because the feminized patients were presented as more able and willing to talk to family, friends and/or professionals about their thoughts and feelings in order to change their problematic situation. As such, the professionals articulated the feminized patient as someone wanting to receive help from the professionals and one who would tacitly accept the conditions under which the help was provided. In other words, the feminized patients were viewed as good, respectful patients who complied with the institutionalized order of psychiatric treatment.

Taken together, the professionals' understanding of the feminized and good patients was juxtaposed by their portrayal of the masculinized and bad patients. In this sense, the professionals' articulations reflected a gender binary that was used to explain the mental health conditions of the two identity categories of good and bad patients and their responses

to depression. These explanations lead to either “sympathizing with” or “blaming” the ‘good’ and ‘bad’ patients, respectively. This overarching categorization framed how the professionals then in- or excluded the patients in or from psychiatric treatment. While the feminized patients were regularly connected to psychiatric care, the masculinized patients were referred elsewhere for separate alcohol or substance use treatment in the municipality outside the regional psychiatric institution. In effect, the good patients were, then, more likely to be formally diagnosed with depression than those considered bad patients despite the fact that all of the patients initially sought out professional help for depression.

Discussion

The results show how professionals’ gendered understanding of patients with depression reflects a well-known binary, used to classify and manage patients, as it underpins their interpretation of the patients’ condition. In light of this, it is pivotal to discuss and reflect on how such gendered understanding and day-to-day clinical decisions can also be seen as reflections of some of the values related to the professionals’ own social positions (Järvinen & Mik-Meyer, 2005) and/or the institutional workings of the psychiatric welfare system.

In Denmark, there is a tendency towards utilizing a feminized view of normalcy in the public sector, including the healthcare system (Mouritsen, 2015). This view reflects a widespread form of hetero-normativity that refers to the institutionalized norms that good people should identify with in terms of heterosexual gender roles and relations whereas those patients, who do not, are considered deviant or bad (Hansen, 2016). This form of normativity, then, reflects a subtle, constitutive premise for the healthcare professionals’ discourses about how good and bad patients ought to conduct themselves. In this sense, the professionals’ heteronormative articulations about gender and depression echo a feminized, middle class view of normality.

This is known to lead to an inherent lack of responsiveness to patients who are perceived to fall outside this norm as they have unique needs and employ other strategies for managing life problems than those who fit the feminized, middle class norm (Mouritsen, 2015). However, the professionals' reliance on this understanding cannot be seen as a conscious definition or act. By using Bourdieu's distinction of taste as a lens to reflect on the professionals' understanding, their views can be seen as reflections of their structural class position in Danish society. Instead of being fully recognized and intentional, these norms could be subtly manifested "behind the back" of the professionals. This suggests that the professionals' socially conditioned, but not determined, views of normality shape their take on social reality in general (Bourdieu, 1993;1996). Perhaps more importantly, these conditioned views also frame professionals' uniform articulation of the relations between gendered patient subjects which subsequently can have a tremendous impact on the in- and exclusion of patients. This implies that the feminized view of normality tends to prompt professionals' decision to diagnose some patients with normal depression and others with atypical depression and alcohol and substance abuse, respectively. These classifications, then, underpin which patients are offered treatment and care within the psychiatric system by the professionals, and which patients are dispatched to the municipal drug and alcohol treatment system. In this sense, the feminized middle class normativity contributes to a system of care where professionals keep the 'good' patients that fit into their idea of normal reaction patterns and response strategies for depression inside the system, while those deemed as bad and deviant patients are referred outside. In this way, the normativity that was articulated in the interviews has a reinforcing and perpetuating effect on the traditional understanding of patients with depression in the psychiatric field (Bourdieu, 1993).

This result shows that professionals articulate a binary understanding of deviance (depression): a patient belonging to a psychiatric clinic is, per se, understood as ill, and a

patient can manage illness such as depression in a normal or deviant way (Foucault, 1994). Thus, the professionals' ways of classifying feminized patients as normal and masculinized patients as deviant can be seen as a form of institutionalization of deviance (Berger & Luckmann, 1991). The offer/denial of treatment, then, mirrors a process of social control on behalf of the patients: on the one hand, this occurs by including good patients in the symbolic realm of treatment through therapy. This implies that good patients are often considered as helpless, respectful, compliant, calm and dependent; i.e. patients who acknowledge the professionals' expertise and position by identifying with the classifications and complying with professionals' demands. On the other hand, deviant patients are excluded - i.e. symbolically annihilated - if they do not identify with the diagnosis and the psychiatric treatment strategy and implicitly reject the social order within the psychiatric institutions (Berger & Luckmann, 1991). In this sense, the masculinized patients' responses to depression disturb the professionals' feminized values for the right way of living with and managing the illness.

Similar patterns have also been identified across community psychiatry, forensic psychiatry and general psychiatric settings in the Danish welfare system (Jacobsen, 2006; Oute & Bjerger, 2017; Ringer & Holen, 2015; Sørensen, 2006). Equally important, similar processes have also been identified across related systems in other Western industrialized societies throughout the last fifty years (Goffman, 2007; Miller & Rose, 1986; Rowe, Lawless, Thomsen, & Davidson, 2011). This large body of research underscores the fact that welfare systems generally reproduce social order and class relations. However, this article adds nuances to this literature by shedding more light on how the workings of psychiatric institutions tend to stabilize stereotypical gender relations in contemporary Western societies.

However, this discussion could give the faulty impression that the in- and exclusion of psychiatric patients are pre-determined by societal (gender) and institutional structures alone,

but there are other influences that contribute to these processes. The inclusion of patients willing to comply and the exclusion of non-compliant, drug-using patients can also be seen as creaming. The concept of creaming refers to the process of favouring (good) patients who have a perceived greater chance of benefitting from treatment services. The concept encompasses the idea that street level representatives of the system sympathize with and favour those patients who are perceived to be more likely to gain from professional treatment due to the overall goal of optimizing the positive effects for help seeking citizens in welfare institutions (Lipsky, 2010). Creaming can also put into perspective why professionals exclude bad patients from treatment. Given that the frontline professionals' management of patients is also framed by political requirements for good practice and cost-effective treatment (Lipsky, 2010), creaming could be seen as a utilitarian strategy, used intentionally by the professionals. Good patients who enjoy "good" outcomes reflect positively on the professionals' practice whereas non-conforming, less successful patients may reflect negatively. The exclusion of those who are considered bad patients can thus be seen as an attempt to decrease the risk of poor outcomes and to prioritize limited resources (e.g. time, manpower, etc.) to support those good patients who are considered a "better bet" for their time and money. These results and discussions add nuances to the dual diagnosis literature. International studies show that the exclusion of persons with co-occurring mental health and substance use problems is often due to stigmatization, judgmental attitudes, inaccurate diagnosis, lack of individualized help, and poorly timed services (Hansen & Bjerger, 2017; Ness et al., 2014). On the one hand, this article adds to the literature as professionals' way of in- and excluding feminized and masculinized patients based on a gender binary, which reflects a subtle barrier that can obstruct, or entirely prevent, substance-using patients' access to care and support at the interpersonal treatment level. On the other hand, the process of creaming also offers some systemic explanation as to why professionals may actively and

legitimately choose to exclude bad patients from treatment. This exclusion may reflect their attempts to uphold their professional legitimacy and optimize outcomes as psychiatric treatment practices are, currently, informed by neoliberal austerity politics where limited resources should be prioritized for those patients seen as most likely to benefit (Oute et al., 2015; Thomas, 2016). However, it also raises several new issues.

First, the results and discussion suggest that the statistical distribution of men and women with depression may not tell the full story, given the tendency for overrepresentation of compliant patients among those provided a depression diagnosis and accepted into psychiatric care. This, then, calls into question not only the context dependency of the classification of psychiatric conditions, but also the accuracy of the distribution of biological women and men with depression in policies and epidemiological studies as previously pointed out by Ussher (2010).

Second, the gender binary that was identified among the professionals is highly problematic for patients with depression, as the binary tends to place the patients in a difficult double bind situation. The double bind is characterized by the fact that the person can neither opt to leave the situation (as they desire and need help for their distress) nor challenge the recommendations of the professional for fear of being punished or dismissed for doing so (Bateson, 1972). As pointed out in similar Scandinavian research, the implicit threat (of not being provided with help) puts into perspective how patients feel pressured to conform to the category of a good, weak and childlike help-seeker who submits to being dependent on the professionals and compliant with their recommendations (Glasdam & Oeye, 2014; Oeye et al., 2009; Oute & Bjerge, 2017; Skorpen et al., 2009).

Third, the professionals' ways of managing non-compliant and autonomous patients bear resemblance to a historical power struggle about the true understanding of the patient in Danish and Scandinavian psychiatry in the sense that they mirror a social struggle between

antagonistic articulations about recognition, status and privilege between professionals and patients (Oute, 2017). On the one hand, the traditional hierarchical nature of the professional-patient relationship provides professionals with the proficient and ethical legitimacy to exercise control over important decisions that directly influence the patients' treatment and their lives. On the other hand, their traditional management of masculinized patients stands in stark contrast to the recovery-oriented approach to clinical practice that is being politically celebrated and clinically advocated globally, in part for its potential to provide more coherent services and bridge mental health and addiction services (Davidson & White, 2007; Harper & Speed, 2014; Ness et al., 2014). As this overall approach focuses on supporting the self-activated, autonomous, and challenging patients, it centres its attention on the person's voice and perspective rather than focusing only on the professionals' legitimacy, expertise and knowledge (Deegan, 1996; 2002). An adoption of such a person-centred approach in clinical practice would however grant legitimacy and position to masculinized patients who do not necessarily fit the norms and values held by the professionals and it has significant implications for the professional identity of psychiatric treatment professionals. Within a person-centred approach, professionals might experience the patient with more masculinized and empowered responses to the experience of mental illness as someone who would potentially invalidate their clinical expertise and identity (Deegan, 1996; 2002). In this sense, the above double bind reflects a situation where professionals' ways of placing patients in a juxtaposition could be a way of resisting, or entirely blocking, a person-centred approach to care for masculinized persons with mental health problems and dual diagnosis in order to uphold professional status and maintain social order (Fullagar & O'Brien, 2012; Oute, 2017). The reflection of this power struggle could give some explanation as to why the psychiatric professionals actively reserve the legitimate right to misinterpret, and refuse to support masculinized patients' and other empowered mental health service-users' active responses

and efforts to manage their illness related problems, at least in part, due to their gendered views of depression.

Fourth, the professionals' articulations suggest that, primarily, male patients often manage their depression using masculinized responses such as avoidance (e.g. drinking alcohol or substance use) and externalization following a 'build up' of distress (e.g. becoming aggressive or attempting suicide) (Brownhill et al., 2005; Creighton et al., 2017).

Subsequently, the analysis elucidates how psychiatric professionals often fail, or even refuse, to interpret patients' masculinized responses to depression as a gendered manifestation of the experience of depression. In this sense, the article contributes to a deeper understanding of the social and institutional processes that can underpin professionals' assessment for depression, and how they can entirely miss, or at least downplay the significance of, symptoms such as irritability, substance use, self-harm or suicidal ideation in, primarily male, patients with depression. The professionals' decisions to exclude masculinized help-seeking patients could then add to the 'build up' of negative emotions and increased externalization among such individuals. In this sense, the article begs to question if, or to what extent, the stereotypical, gendered understandings of depression can potentially compound the distress of certain patients who seek support only to be rebuffed and feel further alienated from a treatment system, they experience as neither sensitive nor responsive to their needs. Given the high rates of suicide among male patients with depression (ibid.), this is an important area for future inquiry because males are more likely to present with the masculinized types of experiences of and responses to depression that professionals, apparently, find more difficult to manage in daily practice.

Limitations

The results of this study must be considered in the context of several limitations. First, there will always be differences between what people do *in situ*, *in actu*, and how they talk about their practices. As indicated above, ethnographic observations of meetings between professionals and patients could have added important nuances about the history of the field, the practical impact of health care policies on day-to-day practice, and the complexity of making clinical classifications and treatment decisions (Bourdieu, 1993; Järvinen & Mik-Meyer, 2005).

Second, a richer ethnographic data or a purposefully selected sample could have furthered the insights drawn from this analysis by shedding light on the intersections between sex, gender, sexuality, education, class, race, ethnicity and/or age (Creighton et al., 2017; Hansen, 2016).

Third, the binary gender stereotypes reflected in the narratives from the clinical site call for a more sophisticated analysis of relations and interactions between the plurality of other and perhaps more subordinate or even marginalized gendered subjectivities (Connell, 2012). As previously argued, such dynamics could have been articulated among, for example, younger nurses, male nurses, female doctors, male patients with depression, and masculinized relatives in other settings even though such processes did not emerge clearly during the fieldwork in the clinical site (Hansen, 2016; Oute et al, 2015).

Conclusion

The article shows how psychiatric professionals articulated a binary gendered view of depression that could frame the in- and exclusion of feminized and masculinized patients in daily practice, respectively. In doing so, it showed why, mostly, women were more likely to be diagnosed with depression and connected to psychiatric care, while masculinized patients were more often diagnosed with atypical depression, personality disorder and/ or alcohol- and

drug addiction disorders, and subsequently excluded from psychiatric care and referred to drug- or alcohol treatment. Against this backdrop, the article discussed the societal and institutional conditionality of a gendered understanding of depression. In spite of several limitations, the discussion illustrated how professionals' understandings might have wide-ranging implications for the statistical accuracy of epidemiological research and policy, the delivery of psychiatric services, the experience of patients in care, and clinical outcomes in the treatment of depression.

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