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Who gets involved with what? A discourse analysis of gender and caregiving in everyday family life with depression

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Abstract

The recent process of deinstitutionalization of the psychiatric treatment system, in both Denmark and other European countries, has relied heavily on the involvement in treatment and recovery of cohabitant relatives of diagnosed people. However, political objectives regarding depression and involvement rely on a limited body of knowledge about people's ways of managing illness-related problems in everyday life. Drawing on a discursive notion of gender laid out by Raewyn Connell, the aim of the article is to elucidate how the involvement of relatives is guided by an extra-individual rationale about gender and caregiving, and how this gendered discourse might frame different challenges and burdens, depending on the gender of the diagnosed person and the cohabitant relative. Drawn from a larger, multisited field study on involvement processes in Danish psychiatry, the article is based on field notes and 21 interviews with seven heterosexual couples. The analysis shows that gender works as a decisive premise for the division of caregiving labour among the couples, and clarifies how the couples' gendered institution is disrupted after the onset of depression. The article argues that gender-blind involvement strategies could produce divergent treatment outcomes and varying social effects in relation to couples' everyday family lives.

Keywords: Involvement, caregiving, gender, discourse, ethnography, interviews

Introduction

During our conversation, Jasper made it clear that he had not noticed the illness before the diagnosis was made in 2009, in spite of the fact that Linda had felt ill since she was bullied by her boss in 2001. Jasper said that he had not observed Linda's recurrent depressed condition,

but that Linda's strength and mood varied from day to day. I might have seemed surprised, but remained silent. Linda explained that Jasper had neither participated in conversations with psychiatric professionals nor with social workers, because she did not want to worry him. Thus, she had brought her mother and sister along to the initial psychiatric sessions. Jasper seemed surprised when Linda explained this, but he emphasized that he did bring her some clothes when he received the call from Linda's mother that Linda had been admitted (First visit, March 2012, Jasper and Linda, both 42 years of age)

This field note is from a field study on the involvement of relatives in Danish psychiatry, in which involvement processes were ethnographically explored among seven heterosexual couples, in which one adult had been diagnosed with depression. The above excerpt indicates that the husband of a diagnosed woman had not been involved with the emotional care and treatment of his wife's depression over the course of eight years. Because the wife did not want to worry her husband, she instead invited other relatives to be involved with the management of her illness, treatment and care. The initial conversation with this couple, further visits, and field work in the homes of the other six families highlighted the fact that the husbands of wives diagnosed with depression were not engaged to any great extent with care and treatment, nor did they have an in-depth understanding of their wife's illness and emotional state. By comparison, the wives of husbands diagnosed with depression were largely responsible for understanding and managing their spouses' illness. In this article, we analyze how gendered positions in the family underpin the organization of the couple's different areas of obligation and engagement in the management of problems in everyday life with depression. We argue that psychiatric notions and practices of involvement need to take into account the fact that ways of handling depression in families are gendered.

Background

In recent years, the involvement of cohabitant relatives has become a pivotal element of political and professional initiatives to reduce societal costs associated with the prevention and treatment of mental illnesses, such as depression (National Institute for Health and Clinical Excellence (NICE), 2009). The process of deinstitutionalization of psychiatric treatment, in Denmark and other European countries, relies heavily on the involvement of cohabitant relatives and others of significance, with a view to optimizing recovery processes and preventing relapse (Hoof, 2011; Oute, Huniche, Nielsen, & Petersen, 2015). These political objectives regarding involvement and depression often rely on a limited body of knowledge about couples' ways of managing illness-related problems in their everyday lives (NICE, 2009; Umberson & Montez, 2010). Given that approximately two thirds of any population diagnosed with depression are known to be women (NICE, 2009; Umberson & Montez, 2010), and given the political objectives to reduce societal costs, in conjunction with subsequent clinical efforts to involve relatives, gender-blind involvement strategies could well produce divergent treatment outcomes and varying social effects in relation to couples' everyday family lives.

In previous qualitative health research, the involvement of relatives in the context of depression has predominantly been narratively explored. Based on a narrow range of informants, selected on the basis of the illness characteristics of the diagnosed person and their partner, involvement has been framed as an individual concern. Within this field, little attention has been paid to the broader sociological understanding and effects of gender. Instead, these studies have tended to focus on the psychosocial characteristics of

the actors' social identity that works as a premise for daily role-play and relatives' ways of managing illness-related problems throughout the illness trajectory (Hansen, Jakobsen, Rossen, & Buus, 2011). Despite the fact that several social scientists have proposed that depression and other mental conditions should be considered as social phenomena, the broader social and moral context for depression and involvement has been left largely unexplored (Hansen, Jakobsen, Rossen, & Buus, 2011).

What remains somewhat unaccounted for in the literature that intersects depression and caregiving is the reciprocity of societal ideals, values and depression, which in turn frames how the diagnosed individual's, relative's or family's condition is experienced and can be managed (Busfield, 2000; Kleinman, 1995). The kinds of values and ideals that are often not taken into account in these studies have been highlighted in the historical work of French sociologist Ehrenberg, who showed that depressed individuals can be seen as subjects of a contemporary condition that is framed by the very signs and symbols that contradict (negate) neoliberal ideals of autonomy, capacity to act, and responsibility (Ehrenberg, 2010). Ehrenberg's work highlighted that these moral premises constitute individuals classified as depressed in contemporary society, but it also puts into perspective why such individuals are considered to be a persons in need of care. Despite the fact that Ehrenberg's work does not show how these moral premises actually function at an institutional level, his work established a framework that puts into perspective how and why relatives often feel obliged to involve themselves in the caregiving labour; i.e. the practical management of illness-related problems and the regulation of emotions and feelings linked to depression, with a view to normalizing the diagnosed individual (Karp, 2001; Oute et al., 2015; Oute, Petersen, & Huniche, 2016; Umberson & Montez, 2010). However, the study of the social origins of depression, by psychologists Brown and Harris (2011), who established that serious, provoking events play a significant role in the development of depression in women, did not include such a moral framework. Their study highlighted that women who lacked an intimate relationship were more likely to develop depression than those with supportive partners, thus indicating that having a partner could be seen as a protective factor (Brown & Harris, 2011). In a highly recognized study on mental illness, involvement, and caregiver burden (Karp, 2001), the sociologist Karp depicts how relatives experience their obligation towards their partner in different ways and how families manage emotional and practical problems in their everyday life after the onset of illness. Karp's work suggests that the boundaries of relatives' obligation to care depend on the nature of the relationship and the strength of social ties among the diagnosed individuals and their relatives (Karp, 2001). But, as Karp notes, the gendered context that structures the ways families experience depression, their ways of managing and the burdens that ensue from the division of practical and emotional obligations of care are still largely unexplored (Karp, 2001).

This article on caregiving adds to the literature on the involvement of relatives in the context of depression. Drawing on previous research on gender and depression, the purpose of this article is to elucidate the following research questions: How is the involvement of relatives guided by an already-present discourse about gender, and how might this gendered rationale (discourse or understanding) frame different challenges and burdens, depending on the gender of the diagnosed person and the cohabitant relative? How could the involvement of relatives facilitate recovery in individuals diagnosed with depression?

Gender, discourse and depression

In order to analyze the gendered context of depression and how it constitutes caregiving, we need to consider how gender is conceptualized and structured discursively. In an article on the relation between gender and health, the influential Australian sociologist Raewyn Connell (2012) addresses the limitations and inadequacies of the common categorical understanding of gender as something static and unproblematic that orders identity categories of women and men. Such identity categories are highly prevalent in policy and health research; for example, in epidemiological research, where it is consistently reported that women experience higher rates of depression than men (Ussher, 2010). The logic of this categorical understanding of gender is founded in a biological essentialism that renders a popular belief that the biological difference between the sexes is expressed as differences in psychological characteristics and behaviour; a belief that has been decisively refuted by multiple gender scholars (Connell, 2012; Kumar & Gupta, 2014). Australian health psychologist Ussher (2010) emphasizes that epidemiological findings are constituted by “realist epistemology” and a discourse of medical naturalism that frames an understanding of depression as a “*naturally occurring pathology within the woman*” (Ussher, 2010, p. 9). However, in American sociologists Hill and Needham’s (Hill & Needham, 2013) review of the link between gender and mental health, little or inconsistent empirical support was found for the proposition that depression is a functionally equivalent indicator of misery and that women often respond to stressful conditions by developing affective disorders.

Thus, multiple gender scholars argue that more sophisticated approaches to gender ought to be reflected in health research, because this categorical understanding offers neither “*a way of conceptualizing the dynamics of gender*” nor an analytical strategy for shedding light on how gender orders are constructed and challenged (Connell, 2012, p. 1676). Connell proposes that the health studies on gender must focus on how gender meanings are discursively shaped, by drawing on a broad understanding of discourse that includes language, practices and all other symbolic systems. From this position, Connell argues that: “*The commonsense dichotomy of masculine and feminine is an effect of discourse, constructed by the way we talk, create images or texts, present ourselves, even how we conduct our research. Gender identities are not expressions of an inner truth but are subject positions in discourse*” (Connell, 2012, p. 1676). The structural positioning of masculinized and feminized subjects is construed as an effect of the coherence of elements of a discourse; a discourse that both constitutes the characteristics of the subject and places it in a binary relation to other subjects. As such, a dominant (hegemonic) discourse of gender frames the continuing patterns of reciprocity of gendered subjects’ interactions. These interactions take place within social institutions, such as marital institutions and family life. Such discourse has been identified in heterosexual, middleclass couples all across Scandinavia: Whereas men are commonly obliged to provide for the household and manage practical matters (e.g., lawn mowing or repairing things in the house), women are seen as carrying the primary responsibility for housework, childcare and care for the family’s emotional wellbeing in general (Magnusson, 2008; Stefansen, Smette, & Strandbu, 2016). Drawing on the notion of a gender regime, Connell (2012) then proceeds to argue that such a relational understanding of gender can nuance the understanding of reciprocity and interaction among gendered subjects at the institutional level. This, then, provides a framework for making clear how hegemonic discourses about gender could be disturbed by subordinated forms of femininity and masculinity and challenged by

alternative and non-stereotypical ways of dividing labour in everyday life (Connell & Messerschmidt, 2005; Magnusson, 2008; Stefansen, Smette, & Strandbu, 2016).

To understand the link between gender and depression, it is essential to consider the World Health Organization (WHO) classification of unipolar depression as it is used in a Danish context. According to the WHO, unipolar depression is characterized by at least two of the following core symptoms: Depressed mood, loss of interest and enjoyment and increased fatigability. 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. The minimum duration of an episode is two weeks (World Health Organization, 1996). Drawing on this understanding and/or its American equivalent (the DSM-4/5), a range of international studies have emphasized that the categorization of depression in Western, industrialized societies is structured by a hegemonic form of masculinity (Bengs, Johansson, Danielsson, Lehti, & Hammarstrom, 2008; Hammarstrom et al., 2014; Ussher, 2010). This implies that the dominant notions of masculinity and men's subjectivity are constituted by ideals about strength, independence, potency, rationality, success, lust and desire as well as effectiveness, stoicism, autonomy, and emotional control. Taken together, all of these ideals also frame the position(s) of feminized subjects, because they characterize the subject of the woman as the exact opposite: weak, impotent, empathic, lacking autonomy and self-reliance, the absence of rationality, effectiveness, lust, desire, and personal success (Connell & Messerschmidt, 2005; Emslie, Ridge, Ziebland, & Hunt, 2006; Emslie, Ridge, Ziebland, & Hunt, 2007; Fullagar, 2009; Fullagar & O'Brien, 2013; Fullagar & O'Brien, 2014; Ridge, Emslie, & White, 2011). Drawing on this understanding of hegemonic masculinity and emphasized femininity, international studies have demonstrated that depression can be seen as a feminized condition distinguished by the absence of ideals of masculinity (Connell & Messerschmidt, 2005; Ussher, 2010). Taken together, the studies' findings bear a resemblance to Jack and Ali's (Jack & Ali, 2010) "silencing the self" theory, which offers a suggestion as to why women develop signs of depression and lose their self-esteem. This implies that women connect to other people in ways characterized by self-sacrifice, compulsive caretaking, pleasing the other, and inhibition of self-expression, if, that is, women conform to the societal norm of playing a feminized role in interpersonal relationships. All of these studies also highlight why depression and masculinity are considered to be incommensurable social phenomena. As such, the dominant discourse of masculinity structures subordinate and marginalized forms of masculinities, i.e. men diagnosed with depression are associated with signs of weakness, incapability and lack of authority and potency (Bottorff, Oliffe, Kelly, Johnson, & Carey, 2014; Connell, 2012; O'Brien, Hunt, & Hart, 2005; Oliffe, Galdas, Han, & Kelly, 2013; Oliffe, Kelly, Bottorff, Johnson, & Wong, 2011; Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012).

Methods and data

This gendered analysis of involvement and depression is part of a larger field study. The goal of the overall project was to make clear the constitutive social conditions for, and consequences of, the involvement of relatives in treatment and rehabilitation in Danish psychiatry. By means of multisited ethnography, the first author (Oute) investigated the social transformation of notions of involvement across a family site, a clinical site and a

political site (Oute et al., 2016). The studies from the political and clinical sites elucidated how relatives were articulated as semi-professionals who were expected to identify themselves as those who ought to take on the responsibility for the diagnosed person's compliance with medical treatment (Oute et al., 2016; Oute et al., 2015). Building on empirical materials from the field work in the family site, this article contests the dominant discourses about involvement that were identified in and around the political and clinical sites.

The field work in the family site took its point of departure in the everyday life of seven, purposefully selected, heterosexual couples, in which an adult person (18+) was suffering from moderate or severe unipolar depression, according to ICD-10 criteria (F32 and F33). The formal selection criteria were drawn from the studies critiqued in a qualitative meta-synthesis (Hansen et al., 2011) and were applied purposefully to select informants who could yield in-depth insight into the overall research issue. Informants suffering from problems of severe mental illness, such as psychosis, alcohol and substance abuse and acute risk of suicide were excluded.

Moreover, the couples were recruited in collaboration with the medical and nursing professionals at two out-patient units at which individuals suffering from affective disorders in the Region of Southern Denmark were treated. The clinics were located at two regional psychiatric hospitals on the outskirts of medium-sized towns. Besides the formal selection criteria, the final selection of diagnosed people and their relatives was framed by the professionals' gendered discourse(s) about involvement, because they held very protective and somewhat dominant attitudes towards the possible informants who were often described as weak, vulnerable or chaotic (Oute et al., 2016). The field work at the clinical site showed that the professionals' efforts to safeguard their patients from the researcher meant that the researcher was only permitted to invite the diagnosed people and their relatives to participate if the professionals saw them as well suited, strong, responsible, ready, "good enough" or appropriate (Hansen, 2016). This common outlook, that was identified among the white, middle-class professionals, was not only based on their patients' conditions, but was also framed by an overriding view of a suitable way of being involved with illness management as a patient and as a relative. This meant that female patients and relatives, as opposed to male patients and relatives, were repeatedly portrayed as being primarily responsible for caregiving (Hansen, 2016; Oute, 2016). All included informants were of Danish ethnic origin. The ages of the 14 informants ranged from 25 to 60, with an average age of 44. Out of the seven recruited couples, two were husband-depressed couples (27%). The occupational composition of the sample, outlined in Table 1, showed a spread from CEO to public employee to unemployed:

Peter/ Charlotte	John/ Betsy	Jasper/ Linda	Sarah/ George	Harry/ Mary	Liz/ Robert	Charles/ Sophia
Married, 34 years together	Not married, 3 years together	Married, 22 years together	Married, 36 years together	Married, 13 years together	Married, 41 years together	Married, 12 years together
Age: 52/51	Age: 25/27	Age: 42/42	Age: 53/52	Age: 37/37	Age: 59/60	Age: 41/33

CEO/ unemploy ed health prof.	Farmer/ unemploy ed health prof.	Blue- collar worker/ unemploy ed worker	Public sector/ unemploy ed worker	Public employee/ masters student	Unemploy e/ public employee	Incapacity benefit/ unskilled worker
2 adult children	1 baby	2 teenagers	2 adult children	2 toddlers	0 children	2 toddlers
First episode in 2008	First episode in 2012	First episode in 2009	First episode in 2003	First episode in 2011	First episode in 2012	First episode in 2003
2 episodes	1 episode	4 episodes	2 episodes	1 episode	2 episodes	1 episode

Table 1. Sociodemographic and illness characteristics of the recruited couples

The regional Research Ethics Committee in the Region of Southern Denmark was informed about the study and consented to the conduct of the field work. In accordance with the Act of Processing Personal Data, the Danish Data Protection Agency was notified about the study. All ethical requirements concerning informed written consent, confidentiality and utilization of data were met. Before obtaining the written consent of the research participants, Oute did make it clear that he was willing to breach confidentiality if a diagnosed participant was to express acute suicidal ideation or other potentially lethal, self-inflicted behaviour without wanting to seek professional help. All informants consented to this.

Due to the circumstance that most couples expressed that they were often exhausted by their situation, this part of the study was conducted as an “arranged ethnography”, relying on frequent visits and appointments with the couples. Frequent follow-ups about informants’ wellbeing and ability to participate were therefore conducted over the telephone, just ahead of the home visits. Taken together, the data consists of formal interview data and field notes from informal talks and interaction between the couples, their children and others (e.g., family members or professionals) during the visits and conversations. In total, 21 formal interviews were conducted; a joint interview with the couple and a separate interview with the diagnosed person and the cohabitant relative with each of the couples. The joint interview was conducted in order give the diagnosed person and the relative the same information about the study, to give them the opportunity to withdraw their initial verbal consent, or to get their written consent and sociodemographic data. Moreover, the joint interviews were also conducted in order to facilitate the couples in constructing a baseline narrative that could be nuanced in the subsequent individual interviews. The formal interviews ranged from 47 to 112 minutes and lasted, on average, 78 minutes. All interviews were initiated by an open-ended, narrative-invoking question “When did it all begin?” in order to generate rich descriptions of the interviewees’ understandings of their family situation and how they were articulated (Hansen et al., 2011; Karp, 1994; Kvale & Brinkmann, 2009). The individual interviews did not differ significantly from the joint ones with regard to the structure of the narrative. Given that the interviewer possibly represented a somewhat neutral outsider for the couples, several informants went into more detail about sensitive topics such as frustration, shame and anger during the individual interviews than during the joint conversations. The interviews were conducted in the informants’ private homes or in the researcher’s office – at the request of one informant. During and immediately after each visit or interview, extensive

field notes were produced in order to describe the atmosphere, actions and conversations before, during and after the interviews. Informal conversations lasted from 15 minutes and up to more than three hours. The field notes ranged from two to 15 pages. The field notes were produced by writing up thorough descriptions of conversations and interactions with the family members; preferably on the spot (Hammersley & Atkinson, 2007). This way of triangulating these methods of inquiry worked particularly well to generate rich descriptions of the couples' practices and articulations of their interactions with each other (Hammersley & Atkinson, 2007). The frequent contact with the couples and the fact that the interviews took place at the primary setting of their everyday life made it possible for the interviewer to build up a trusting relationship and to ask for detailed depictions of their concrete routine interactions in their home. Interviews were audio-recorded and transcribed verbatim. In total, the empirical material for the article consisted of 991 pages of interview transcripts and field notes. The field notes and transcripts were first coded inductively between visits to the families' homes. Assisted by NVivo 9.0 software, the initial coding guided the themes that could be elaborated during the following visit at the family's home. This way of working up analytical categories as an inherent part of the research process meant that unexplored themes could be elaborated during the individual interviews, whereas the coding process became increasingly focused on the couples' understanding of "gender characteristics" and their "ways of organizing involvement" in the problems associated with the illness. Taken together, the triangulation of methods and the process of coding not only enabled the researcher to produce a rich and nuanced understanding of daily family life with depression, but also made it possible to confirm or nuance different aspects of involvement and management of problems with the informants.

Who gets involved with what?

The categories reflected two different constitutive aspects of a uniform discourse about gender and caregiving labour across all of the seven families. The coherence of these aspects formed a discourse that framed how relatives were involved with the organization of practicalities and care in everyday family life with depression. However, because the present analysis displays a common and shared discourse among the seven families, the analysis might not necessarily reflect all family members' individual concerns, personal motivations or explanations about their involvement in issues surrounding the illness. As such, the analysis elucidates how the couples' extra-individual understanding of gender ordered their positions in their relationship, and how it framed two different ways of dividing caregiving labour among them in their everyday life.

Gender positions in the families

The couples articulated the generalized understanding that women and men occupy binary subject positions. In comparison to the abovementioned hegemonic notions of masculinity and femininity (Emslie et al., 2007; Fullagar, 2009; Fullagar & O'Brien, 2013; Fullagar & O'Brien, 2014; Johansson, Bengs, Danielsson, Lehti, & Hammarstrom, 2009; Lehti, Johansson, Bengs, Danielsson, & Hammarstrom, 2010; Ridge et al., 2011; Ussher, 2010), the couples' articulation of gender signified two identities that were characterized as each other's counterparts. For example, one woman explains how the characteristics of women differ from those of men:

We are just a man and a woman behaving badly. Well, if the both of us are in the living room, and Harry is fiddling with electronics, such as his phone, his iPad or something else, he is absolutely shut off. And the children address me because I am the one hearing everything. Well, I am always busy, whereas Harry is better at shutting down, shutting out everything around him. That way, I am just becoming more and more absorbed in the role of being a parent than Harry is. (Individual interview, Mary, diagnosed woman, 37 years of age)

By saying that “we are just a man and a woman”, she articulates a naturalized or taken-for-granted understanding of the difference between men and women and the ideals regarding their positions in the family. The understanding reflects the notion that men can be expected to be “absolutely shut off” and that they “shut out everything around” them; i.e. they exert their independence and orientation towards their own desires. Conversely, women are characterized by an expectation of being “busy” and “hearing everything”; being empathetic as well as socially and emotionally orientated towards others; i.e. their children in this case. This categorical separation of the gender positions signifies the woman as a subject that is, primarily, involved with emotional labour in the family. The quotation highlights how the informant conceives the category of the woman, and how it frames her “absorption”, alertness and sense of obligation, because she is “hearing everything”. Thus, a woman’s way of being empathetic and constantly vigilant towards the children established that she identified with and was characterized by the primary obligation to partake in the families’ emotional problems, social suffering and wellbeing. Within this hegemonic understanding of gender, the woman is then characterized by sensitivity towards the needs and suffering of her partner and other family members, rather than being occupied with her own sovereignty, needs, pleasure and desires. By contrast, the man was articulated as a more autonomous and self-indulgent person with a clearer sense of boundaries of obligation towards the members of the family and his ill partner. This understanding emerged during the first interview with Linda and Jasper, a diagnosed woman and her husband in their forties:

Jasper: But there is something about taking on others’ problems that one, well ... I might be a little better at thinking that it is not my problem.

Linda: [making a joke about it] I already asked [him] if I could borrow some of that [capability].

Jasper: ha ha....yes...

The quotation also signaled the couples’ articulation of gender because their notion of the difference between masculinity and femininity was explicated. Whereas the husband was conceived as someone who did not “*take on others’ problems*” and thought “*that it is not my problem*”, the wife was signified by her deficiencies to do exactly that because she was a woman and/or depressed. The separation of their genders was confirmed by the wife’s joke or request to “*borrow some of that*”. The articulation reflects the fact that she is characterized by a lack of ability to distance herself from the problems of others; i.e. the ideal for femininity, such as empathy. Whereas the joke can be said to presuppose that her husband is characterized by an emotional distance to others and autonomy because he is a man, the articulation suggests that she has become depressed because she lacks “*some of that*”; i.e. her husband’s characteristics. As this understanding of gender was apparent in all of the included families, their articulations of depression suggest that the condition was

implicitly conceived as a lack of a masculinized capability to distance oneself from others. Thus, depression is not only represented as a gendered deficit consisting of a shortage of masculinity or excessive femininity, but the articulation of gender characteristics also contextualizes the division of practical labour and emotional care within the families.

Gendered division of practical and emotional caregiving labour

Data from the point of entry into all of the couples' lives – and particularly from conversations about the couples' consent to participate – proved to be significant, because the issue of getting access exemplified the discourse around gender and the division of practical labour and caregiving. The following excerpt stems from the first appointment with one of the seven couples:

At 7 p.m., I turned up at their address. At first, I saw a man in his fifties standing in the driveway. As I parked my car, he watched me with a confused look on his face. I waved at him as I got out of the car and then presented myself. I stated that 'we have not met before, but I have made an appointment with Charlotte because I am doing a study on family life with depression'. As it turned out, Charlotte had forgotten our appointment and had not involved Peter in it. (Charlotte and Peter, first visit, June 2012)

The excerpt highlights the taken-for-granted understanding that Charlotte, who had been diagnosed with depression, managed their appointments with others regarding depression and emotional problems in the family and that, if she forgot about it, none of the other cohabitant family members would know or remember. Without exception, the interviews and field notes showed that it was the women in all of the seven couples who conducted the emotional "weather forecasts" and managed appointments, because they were in charge of the family's social activities and schedules with regard to caregiving and the management of the family's emotional wellbeing. Linda's and Jasper's case was particularly exemplary of this rationale.

JO: Do you use the calendar too, Jasper?

Jasper: Oh, no. That is hers.

Linda: Yes it is. For instance, what are we doing this Saturday?

Jasper: Yes, to me, it is more like 'do we have plans and when are we doing this and that'? [Directed towards Linda:] You always kept track of our appointments.

Linda: [loving tone] Well, yes, then it won't have to fill up space inside your head. (First visit, March 2012, Jasper and Linda)

Their case also reflects a general pattern about what was at stake for all of the couples: a division of practical and emotional caregiving labour. This division of different areas of obligation emerged as an important premise for the ways of accessing the families' everyday lives as a field worker. The discourse implies that husbands and other male relatives of women diagnosed with depression were not significantly involved with the emotional care and psychiatric treatment and care regarding their partners' illness. This was brought about, at least partially, by the fact that the diagnosed women chose other women to be involved with, and responsible for, managing those types of obligations when they could not manage themselves. The couples articulated that it was adult women (daughters, sisters, mothers, sisters-in-law), both within and outside of the core family

unit, who were responsible to a greater or lesser extent for managing the emotional care work in the families when the diagnosed wives could not. Equally, the family members' articulation also relied on a dominant understanding of masculinity, which subsequently constituted the ways in which men were, at least primarily, obliged to get involved with the management of practical work linked to the illness and family life.

Managing practical labour

The couples' shared understanding of the gendered position of the man framed the ways male, cohabitant relatives engaged in different types of labour in everyday life. In the following excerpt, from a couple in their late twenties, the husband of a woman diagnosed with depression articulates how his subject position is symbolized by practical rather than by emotional labour:

I feel bad if I do not get to work [his job]. That is also why I do not come and attend that [outpatient clinic]. Well, the first time [she was admitted], it was bad back then. And then one must take time off. But I think it is hard to [take time off]. Especially, when the situation is as it is right now. [Making an example] Do you want to be on sick leave for a long long time or then all of a sudden you do not have a job anymore and you want to have another baby and then. Well, in my head. I always plan much further ahead than what a lot of others do. It is the same thing with our finances. That is something that we have always discussed a lot because I am always ... We may have money in our account now, but if I can see that something is coming up in a month or three, we cannot afford [to spend it] right now. (John, relative, 25 years of age)

As he explicated his constant efforts to plan and think ahead about his work and the couple's financial situation, he articulated that he was concerned with bearing responsibility for the practical labour in their family. When he referred to his ill partner's wish to be on a long sick leave, he underscored how his subject position and obligation to provide is contrasted by his partner's lack of practical responsibility for their finances. In contrast to the woman, the man was perceived as the primary individual concerned with the structural or objective practical tasks involved in the family's everyday life, such as earning money for the household, paying the mortgage, or securing the structural needs of the family. Within the home, the man was primarily obliged to initiate sexual activity and, at times, take care of practical household chores, such as making dinner or vacuum cleaning. In several interviews, the man was explicated as a "*provider*" (Peter, cohabitant relative, 52 years of age), a position that was also presented in contrast to the woman's:

I had a lot to do at work, so we made the arrangement that she had a part-time job and took care of the factory at home (Peter, cohabitant relative, 52 years of age)

As an effect of this discursive understanding, it is considered legitimate that the husbands spend much of their time at work in order to ensure financial security for the household, while the woman is obliged to stay at home and run things in the family. The articulation of the man as a provider then brought into effect the view that the women are the primary managers of the emotional labour in the "*factory at home*".

Managing emotional labour

The idea that the women are the primary managers of emotional caregiving labour is articulated in terms of the woman's ability to relate to and sense the emotions, needs and desires of others and care for the social milieu in the family. Below, a diagnosed man articulates how this works:

George: Sarah is good at observing how I feel.

JO: Yes.

George: And she conforms to it. Well, not that she pays special regard to it, but she knows that she cannot expect too much of me if she can see that I am tired.

JO: What do you mean by conforming to it?

George: Well, yes. She silently accepts that I am not at my peak.

JO: Could you give an example of what you are thinking about?

George: As you may have noticed, not much has happened here since you started coming here [in their home]. The living room floor still needs to be fixed and things need to be put up on the walls and the furniture is placed temporarily. And, well, it has to wait until I am ready. And yes, she accepts this. (George, diagnosed man, 52)

The quotation shows that the wife of a diagnosed man notices, accepts and conforms to the emotional problems of her husband. This suggests that the wife's subject position is constituted by emotional labour, encompassing recognition of and response to her diagnosed husband's (as well as her children's) emotional needs. Her sensitivity towards others, her recognition and emotional support signify her subject position. This is underscored by the fact that, by contrast, the diagnosed man is expected to put the couple's furniture in place and fix the couple's living room floor and walls. Taken together, the couples' coherent articulations of gender and division of labour constituted a discourse framing an institutionalized pattern of interactions among all the members of the families.

Disrupted family institutions

The gendered family institution of the seven couples was, however, disturbed after the onset of depression, and this posed a range of new considerations for everyone. The institutionalized, everyday life practices of both the man and the woman were partially changed by the obligation to care or by the debilitating forces of the depression. The illness thus signaled the onset of a transformation of the gendered relationship between the diagnosed person and their partner. The transformation involved a disruption of their previous, normal rationale about what it means to have the role of a man or a woman. Consequently, the disruption challenged the taken-for-granted social order within the couples' institutionalized relationship. The disturbance led to a range of considerations, depending on the sex of the diagnosed person and the relative; i.e. couples with a diagnosed woman and a male relative or vice versa.

Diagnosed women with male partners

The following quotation from a conversation with a male relative showcases how the subject position of a male partner was challenged on his recognition that his wife had been diagnosed with depression:

JO: What happened in there [in the emergency room (ER)] that evening? Was she admitted or what happened?

Jasper: No, but she.. [long pause]

JO: So, you drove there, picked her up and then went back home?

Jasper: Yes.

JO: How did that go for you?

Jasper: [Long pause] Uh, well. I don't think that I did more than that. The next morning ... I suppose I got out of bed and ... I didn't really do much else than what I normally do. (Jasper, Male relative, 42)

In couples with male partners to diagnosed women, the man was constituted by emotional control and a limited sense of moral obligation to be involved in the illness and emotional wellbeing of his partner. Jasper was, however, obliged to take care of the practicalities of the household. In this sense, he was not considered as overly responsible for involving himself in the emotional labour. But, given that his wife had been diagnosed in the ER due to her illness, the seriousness of the situation morally obliged Jasper to bear some responsibility for the emotional care of Linda, because he was faced with her emotional problems when he picked her up at the hospital. Because this kind of task had primarily been carried out by other female family members, it transpired that his usual obligation to deal with the practicalities was combined with an obligation to care for her emotional wellbeing. As he came to reflect upon his obligations to be involved in the management of his wife's illness, his long pauses, his suppositions and unfinished sentences could indicate that he was faced with new and challenging considerations. The considerations could be either that his temporary emotional labour might have disrupted his understanding of his masculinity or that he realized that his masculinity situated him in an inadequate position to care emotionally for his wife. During conversations with the male partners in the other participating families, they articulated that they were faced with similar considerations: their position became ambiguous when they had to engage in an emotional-practical grey area, concerning, e.g., the management of their wives' sick leave, hospital admission, rights, or when arranging a family holiday. However, as the above quotation indicates, the disruption was time-limited, due to the fact that, in this case, Jasper had been only partially involved with the emotional caregiving labour, because Linda *"had brought her mother and sister along to the first psychiatric sessions"*.

Given that mothers, sisters, sisters-in-law or grown-up daughters were available to take upon themselves the emotional care and wellbeing of the ill person, partner or children, the threat of a disrupted social order in these families was therefore diminished in the couples selected for the study. This reduction of the threat entailed a redistribution of the emotional labour among the other women in the family. This meant that, in Linda's case, she retained her position as a manager of the emotional wellbeing of her children and relatives, because she continued to make arrangements regarding which of the other women in the family were to be involved. Conversely, Jasper remained the person primarily responsible for the practical labour. During acute periods of illness, the practical labour entailed non time-intensive tasks, such as bringing clothes and making sure that Linda came home safely or, as was the case in other families, he was obliged to be concerned with the safety of the ill partner in cases of suicidal ideation. The redistribution of emotional labour then made it possible to retain the gendered constitution within the

family, because the division of practical or emotional labour, respectively characterizing the man and the diagnosed woman, was only disturbed for a short time, if at all. In those instances, the reciprocity of positions in the family did not suffer a breakdown.

Diagnosed men with female partners

In the two couples with female relatives to diagnosed men, the reciprocal positioning of the man and the woman was disrupted after the onset of depression. The disruption entailed the couples trading places, in terms of the idealized masculine and feminine gender positions. At first, these couples tried to return to their previous, normal positions. In spite of ongoing struggles with depression in both couples, the couples tried to sustain the norm that the men maintained their careers and masculinized obligations within and around the family. This is indicated below:

Well, and the activities we normally had, they were important, so we still keep up with them. That is because that they are a part of our life. That we are not just here within these four walls, right. So, we have to find the balance in managing everything. Then Brett can go to work again, and he can begin to work more [repairing things in the house] too again, right? (Liz, relative, 59)

Here, the wife of one of the depressed men in his sixties, who has a career as a public sector employee in a typically masculine line of work, articulates an idealized heterosexual gender relation by striving to maintain his position as an autonomous family provider, while she stays at home. As this proved difficult to uphold over time when the depression returned, the disruption was neither socially or emotionally unproblematic for the couples. Whereas the abovementioned potential disruption could lead to shame or confusion, the disruption in these male diagnosed couples, to a great extent, led to frustration and anger. In the quotation below, during a visit to their home, the female relative, Sarah, articulates her frustration with her husband's lack of progress and ability to take on his practical obligations:

JO: Do you see any progress in him [her ill husband]?

Sarah: Well, yes.

JO: Like what?

Sarah: Well, on his own he is starting to get things sorted. At home.

JO: The lawn and?

Sarah: Well, yes the lawn and ... and he rides his bike and all that, that he ... The exercise and those things. But he still has not made an effort to ask the bricklayer from the other side of the road about those tiles.

JO: What tiles?

Sarah: For the kitchen. Above the sink. (Sarah, cohabitant relative, 53)

Sarah's frustrated articulations can be seen as a sign of her struggle to uphold the characterization of her husband's masculinity; hence making it difficult for her to sustain her sense of femininity. As she articulates that her husband is "*starting to get things sorted. At home*", she suggests that it is difficult for her to retain a coherent conception of her husband as a man, because her husband is only partially characterized by conducting practical labour due to the debilitating forces of the depression. Her addition of "*at home*"

underscores her difficulty and subsequent frustration, due to the fact that her husband is unemployed, and thus is neither performing responsibly nor in accordance with dominant ideals for his gender, because he is not earning money for the household. However, she affirms that *“he rides his bike and all that”*. In doing so, she affirms that her husband is partially occupied with his own wishes and desires to ride a bicycle, which then is articulated as a symbol of self-indulgence or hedonism; i.e. activities considered congruent with masculine ideals as well as effectual ways of countering the illness. But, despite this, she reinforces her frustration by stating that *“Well, yes the lawn and. [...] But he still has not made an effort to ask the bricklayer from the other side of the road about those tiles”*. This suggests that, at least partially, she sees her husband as characterized by a form of femininity in spite of his biological sex. His femininity, or at least subordinated masculinity, is established by his slow emotional progress, lack of potency and the fact that he had not got around to sorting things out; all of which are negative or opposing characteristics of masculinity, thus constituting his femininity. Her articulation elucidates that the way of understanding the diagnosed man is framed by his loss of hedonism, constant vigilance towards and occupation with his wellbeing, thoughts and feelings. This incoherence between the expectations towards the biological sex of the man and his way of “acting like a woman” disrupts the gendered order between the couples and then required alternative gender positions and relations. The incoherence was brought into effect by the fact that the man only bore partial responsibility for practical labour in and outside their home due to his diminished capacity to work or provide for the household. Symbolically, this positioned him as a disturbed man with a diminished masculinity which, at least for a while, obliged his female partner to take on a proximate masculine position. Then, the transformation of the diagnosed man symbolically excluded him from being considered capable of bearing responsibility for either the emotional or the practical labour in the family during the time of the illness. Similarly, frustration, or perhaps even a sense of degradation, was evident during the visits at the homes of the diagnosed men and their relatives, as well as in interviews with the diagnosed men. This was indicated in the aforementioned quotation:

Sarah is good at observing how I feel [...] And she conforms to it. [...]. Well, yes. She silently accepts that I am not at my peak. (George, diagnosed man, 52)

Here, the diagnosed man articulates that his wife has to “accept” or “conform” to his feelings or the fact that he is not at his peak. By using words that reflect an obligation or claim, his articulation suggests that he is critiquing and problematizing himself or his condition with regard to how it burdens his wife. This indicates that he feels frustrated and shameful, due to the fact that his wife has to conform to his current shortcomings and incapacity to manage his practical chores at home. As such, he implicitly refers to the aforementioned conception that depression could be seen as a deficit of a range of presupposed masculine capabilities, traits and behaviours. Time and again, the frustration and shame articulated by the two diagnosed men was brought about by their loss of hegemonic masculinity. On several occasions, the spouses as well as other close relatives of the diagnosed men articulated the diagnosed man’s loss of masculinity, for instance by stating that he *“is more fond of talking than women are”* or *“when he is not around, we laugh at him, and call him a wimp”* (field note, Ingrid, sister-in-law of diagnosed man).

As a consequence, the diagnosed men were concerned with restoring their sense of masculinity:

During the visit, George kept telling me that he is really not impotent, but that his current sexual inadequacies are a side effect of the antidepressants. He told me that this was much worse than the depression itself. (Field note, George, 52)

Due to the medically inflicted sexual inadequacies and the signs of loss of masculinity (e.g., inability to work or earn money), George's position as a man is disrupted. The disruption, then, places him as a failed or subordinated male. He explicates that he experiences this positioning as "*much worse than the depression itself*", which may add to the burden of being ill and be a hindrance to his social recovery, because he articulates his marginalized position as discrediting and ridiculing.

This gendered understanding also frames the position and burden for the female relative: The woman becomes constituted by ideals of masculinity and femininity, given that, like most Danish women, she earns money for the household while, simultaneously, bearing responsibility for doing repairs in the house and for caring emotionally for all of the family members. The abovementioned frustrations felt by the wife could then indicate that she feels that she is bearing responsibility for more than her fair share; i.e. what has been described by psychologists Fadden, Bebbington and Kuipers (Fadden, Bebbington, & Kuipers, 1987b; Fadden, Bebbington, & Kuipers, 1987a) as a breakdown of reciprocal arrangements, which often leads to a combination of objective burden (changes in household routines, relations, work and leisure and health) and subjective burden (subjective distress among family members) (Kumar & Gupta, 2014). However, as depression often stretches over a considerable time span and often returns with renewed intensity, the masculine signification of the wife becomes more permanent. Over time, the illness and symbolization of the position of the female relative frame an overall obligation to take over responsibility for all aspects of family life, including the practical and emotional labour (Hansen et al., 2011). Then, she becomes absorbed by her involvement in what one male relative described as a "*provider*" (Peter, cohabitant relative, 52 years of age) and protector, thus, at the same time, reinforcing and sustaining the positioning of her subordinate man into a marginalized or minor position. In line with a previous Danish study on involvement and depression, this indicates that her absorption and the couples' disrupted, heterosexual marital institution either force the female relative to separate from the ill person or to recover by balancing the extent of her vigilance and obligation to care (Hansen & Buus, 2013).

Discussion

Our analysis displays seven heterosexual couples' binary rationale concerning the difference between men and women and their practice of involvement in the context of depression. The analysis points out that their idealized heterosexual gender positions, their understandings of caregiving labour and their subsequent burdens are constituted by the disruption of their subject positions.

Caregiver burden in family life with depression

Studying the rationale(s) that inform couples' reciprocal ways of organizing caregiving labour in their everyday lives can expose how relatives, and especially female relatives, could be both objectively and subjectively burdened (Kumar & Gupta, 2014) by taking over "more than their fair share". From this perspective, the present analysis of the ordering gender rationales and burden elucidate the link between how couples divide labour in everyday life after the onset of illness (objective burden), and how that could contextualize hostility, disappointment and socially repugnant ways of interacting if the social routines of the families' everyday life have stagnated (subjective burden). As such, our findings suggest that caregiving labour (involvement) and burden is highly dependent on the gendered context of depression; a link that psychologists have investigated numerous times in people diagnosed with depression and their partners. The studies of burden by Fadden, Bebbington and Kuipers demonstrated that relatives experience subjective burdens that match our findings: Social and leisure activities are impacted and marital relations are strained while facing problems with understanding, partly, due to lack of professional support and information about the illness (Fadden et al., 1987a; Fadden et al., 1987b). This indicates that depression could be maintained and reinforced in the interaction between depressed people and relatives. As such, the present article also sheds light on qualitative aspects of the findings from the survey of relatives of depressed individuals carried out by psychologists Coyne and Benazon (Benazon, 2000; Benazon & Coyne, 2000; Coyne et al., 1987) and an early review (Teichman & Teichman, 1990), in which it was concluded that "*depression is reinforced by the reciprocity of cognitions, emotions, and behaviors on the intra- and interpersonal levels*" (p. 349). Taken together, this supports the notion that the subjective burden of relatives could have serious health implications for both the diagnosed person and the relative, depending on the gendered context of depression and the families' division of labour.

The gendered context of depression, recovery and involvement

The importance of considering the gendered context of depression, recovery and involvement is emphasized by the fact that several studies have also identified differences in the relationship between partner hostility and depression in both husband-depressed and wife-depressed couples. Especially, wives and female partners in husband-depressed couples have been known to exhibit significant levels of burden and depressive symptoms (Kumar & Gupta, 2014; Rehman, Gollan, & Mortimer, 2008; Teichman, Bar-El, Shor, & Elizur, 2003). However, despite the fact that intersecting variables, such as education, social class, geographic position, occupation or age are given some consideration, individualistic orientation in much psychological and medical research often downplays the understanding of gender dynamics (Connell, 2012; Ussher, 2010). Following this line of inquiry, multiple qualitative studies have also elucidated the gendered context of depression in both women and men.

For example, critical scholars have argued that the cultural construction of women's subjectivity promotes responses that are constructed as symptomatic of depression. Compared to this article, similar analysis of gender and depression suggest that depression is discursively articulated as a social effect of what can be seen as too much femininity or deficient masculinity (Crowe, 2002; Fullagar & O'Brien, 2012). Bearing resemblance to a dominant discourse about caregiving, parenting and housework that has been identified in heterosexual families all across Scandinavia (Magnusson, 2008; Stefansen et al., 2016),

the couples from our study articulated strong alignments to idealized heterosexual gender relations: The couples' orientation towards such white, middleclass ideals of masculinity is connected with emphasized femininity, which could be seen as their efforts to return to "business as usual" (OliFFE et al., 2011). In spite of ongoing struggles with depression, their efforts to "return to normal" implied that the diagnosed men and male relatives tried to maintain their careers and domestic obligations in typically masculine arenas, while the diagnosed women and female relatives sustained their association in equivalent feminized positions. However, the diagnosed men's unemployment and signs of resisting medical treatment (due to sexual side effects) constituted a combination of what has been called "protest masculinity" and women's "ambivalent-protest femininity"; categories that resemble the abovementioned proximate positions of the female relative to the diagnosed man (OliFFE et al., 2011). This framed mismatching of gender expectations, which resulted in tenuous relationships that often fostered resentment and unresolved conflict among diagnosed men and female relatives. This mismatch could not only function as a hindrance to the diagnosed person's recovery but also as a barrier to the involvement of relatives. Following this line of thought, Fullagar and O'Brien (Fullagar & O'Brien, 2013; Fullagar & O'Brien, 2014) showed that women could be seen as subjects in recovery when they resisted the constraining forces of their families' and professionals' categorizations of their deficiencies and treatment needs by articulating themselves in new ways, rather than identifying with the category. This study showed that diagnosed women either strove towards normalization of their self by way of dutifully treating their deficient self or they redefined their notion of recovery and depression by identifying with the practice of caring for oneself and relating to others in different ways. In this study, the participating women were largely preoccupied with managing their process of normalization, because they continuously reflected upon their understanding of their deficient self and subsequent treatment needs, which to a large extent sustained the internal order and coherence of the family institution. Moreover, Bottorff, OliFFE, Kelly, Johnson and Carey (Bottorff et al., 2014) suggest that idealized femininity positions women as endlessly caring and patient. The female relatives also felt the strain of living with their depressed male partner, because they were hesitant to take over the position as constant emotional caregiver while, at the same time, having a job and bearing the burden of the family's practical, day-to-day responsibilities. By comparison, our findings also indicate how men's depression could lead to a disruption of heterosexual family institutions. The disruption was not only brought about by the fact that female relatives of diagnosed men are objectively strained by the multiplicity of emotional and practical tasks. They were also subjectively burdened by a prospect of a requirement to identify with masculinized ideals permanently while living with a man who was characterized by femininity.

New questions and further research

First, the heteronormative rationale discussed in this article questions the sustainability of the coherence of family life if or when the diagnosed women from our sample wished to recover from depression by identifying more with personal hobbies or engaging with others in different ways. As such, the gendered, organizing discourse could, in fact, work as a hindrance to diagnosed women's recovery, if male relatives continue to abide by a heteronormative family ideal in which diagnosed women are obliged to take on emotional and social functions in the family. As such, it puts into perspective what might happen to the structure of the heterosexual families with diagnosed women if no sisters, mothers or grown-up daughters, etc. were available to assist the psychological milieu in families.

Moreover, this analysis of the gendered context of involvement also calls for further qualitative studies that, to a larger extent, would clarify how the gender dynamics play out over time: To what extent do the partners' age, the length of their relationship, the number of children and the number of times they have experienced a depressive episode together matter (Hansen et al., 2011)? And how do diagnosed men over time recover from their symbolic positioning as failed or subordinated males? Do they develop strategies for restoring their masculinity by signaling hedonism, such as using alcohol or other substances or engaging in sexual activity or expressing vitality (e.g., aggression) in relation to others – an issue that has previously been discussed (Brownhill, 2005; Neitzke, 2015; Rochlen et al., 2010; Wilhelm, 2009).

Second, this gendered discourse equally shapes how male relatives are not expected to involve themselves in emotional caregiving labour. This insight might clarify why relatively few male relatives attend psycho-educational sessions for relatives in Denmark (Hybholt, 2014). Then, these insights contribute to the broad range of health and political studies that question the evidence, efficiency and productivity of political and clinical involvement efforts that tend to institutionalize relatives' responsibilities for emotional labour, given that female relatives are likely to take on such tasks (Hansen & Buus, 2013; Oute et al., 2015; Oute et al., 2016; Sulik, 2007; Umberson & Montez, 2010).

Third, the study questions the benefits of involvement of relatives in similarly positioned couples with a diagnosed man. Given that couples continue to abide by white, middle class, heterosexual ideals, feminized relatives could be burdened severely while the diagnosed men seem to be marginalized and stigmatized. Hence, the long-term effects of clinical efforts to involve relatives in Danish psychiatry by holding them responsible for care and treatment (Oute et al., 2016; Oute et al., 2015) could exacerbate the disruption of family life, and possibly inflict divorce. However, it still remains largely unexplored how gender, sexuality, education, class and the length and type of relationship (e.g., spouse or parent) could be constitutive of involvement processes in everyday life. As previously pointed out in a Scandinavian qualitative metasynthesis (Hansen et al., 2011), there is also a need for further research on how the various problems and burdens among diagnosed people and their relatives might be associated with the psychosocial trajectories linked to depression.

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