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**Managing the Challenge:
Conflict and Resolution in the Diagnosis of Depression**

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Abstract

This paper reports some findings from a broadly ethnomethodological study of the diagnosis of Major Depression Syndromes (MDS) in primary care, in which a majority of the diagnosed patients were found to offer some form of direct 'resistance' to the diagnosis itself *in situ* - questioning, challenging or even visibly rejecting it. Typically, within contemporary medical and policy-related literature, any resistance to such a diagnosis is generally accounted for through the explanatory frameworks of 'patient ignorance' or 'stigma'. This reflects a widespread, foundational assumption that reluctance to accept a diagnosis of *any* mental illness is inevitably the direct result of: (a) a lack of information on the part of the patient, or (b) a distorted view of the condition effected by social stigma or troublesome cultural/religious norms. Consequently, it is usually argued that 'educating the patient' in the true nature of their condition is the only realistic solution to the problem. This approach, rooted in a social cognition model of human interaction, proposes a relatively 'static' patient whose 'misguided' beliefs relating to their condition, although problematic, are 'modifiable' by a medical professional. Once in possession of the correct knowledges relating to the real character of any pertinent mental illness, the patient will generally acquiesce and the diagnosis will be accepted (with 'obvious' benefits for their rehabilitation).

It is interesting that, in such research, patients' knowledge of any matter is nearly always measured abstractly (i.e. through 'attitude-based' survey research, not in the concrete contexts in which such knowledges are practically mobilised) and against the 'correctness' of the medical understanding of the phenomenon in question - what Brian Wynne terms a 'Deficit Model'. In these terms, the possible types of findings and recommendations *of* that research are already set in stone before the research is even conducted; the patient is taken to be a 'judgmental dope', 'attitudes' and 'stigmas' are instead treated as the real active agents. Moreover, it also reduces

General Practitioners (GPs) to a neutral ‘holders of correct knowledge’, rather than highlighting their practical skills in actually managing and resolving (or not) difficult diagnostic moments in-context.

Drawing, particularly, on Harvey Sacks’ work on categories and ‘everydayness’, the analysis presented here explores in detail a ‘troublesome’ diagnostic phase in one particularly telling primary care consultation. It foregrounds, initially, how resistance-to-diagnosis itself is demonstrably accountable to local, practical concerns relating to speaker credibility, rather than to imperfect or biased knowledges of MDS, through an exploration of the ways in which the patient actively mobilises a particular version of depression *to* contest the diagnosis. This, in turn, facilitates a description of the skilled methods through which the GPs ‘manages the challenge’ in ways sensitive to its contextual production, and the impacts of particular courses of action for the trajectory of the consultation. It is, thus, contended that an exploration of these ‘awkward’ diagnostic events as sites of social action, rather than as conglomerations of cognitive and structural influences, leads us to a fuller understanding of practical, engaged-in-context matters relating to ‘public understanding’ of MDS, and their relationship with the everyday work of a GP.