Author's response to reviews

Title: Barriers in recognising, diagnosing and managing depressive and anxiety disorders as experienced by Family Physicians; a focus group study.

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Author's response to reviews: see over
Dear Miss Phillips,

Please find enclosed the revision of our article Barriers in recognising, diagnosing and managing depressive and anxiety disorders as experienced by Family Physicians; a focus group study.

We would like to thank the three reviewers for their valuable comments on our manuscript and their suggestions to improve the quality of it. We used most of their remarks in this revised manuscript. In this letter we would like to respond to their concerns.

Reviewer Peter Bower:
The use of a qualitative method to study the barriers in diagnosing and treating depression and anxiety disorders is welcomed by him. He asked to draw out the implications of the results of our study. In the discussion section we added specific suggestions i.e. concerning the use of psychometric instruments to monitor the severity of the disorders and the use of self-management programs. Also other possibilities were mentioned, most of them are evidence based, although the levels of evidence can differ. To limit the number of references we have decided not to refer to studies or guidelines. When necessary we will provide these references.

The general themes were discussed in the three different groups with differences at the detailed level. All groups consisted of FPs who all were working in clinical practice and only one of the groups were FP trainers as well.

We clarified the sentences that were unclear indeed. We summarized the result of previous qualitative studies shortly in the introduction. In the discussion we compared those results with our results. We also compared the Depression Attitude Questionnaire scores on the different subscales with the results of the discussions, especially on management of depression.

We like to thank dr. Bower for his valuable comments and suggestions. We hope and think that we have addressed them properly.
Reviewer Scott Patten

This reviewer states that our emphasis on the views and experiences of FPs can add to the body of knowledge on (improving) care for patients with a depressive of anxiety disorder. The aim of qualitative studies is to generate hypothesis and provide more insight in experiences of FPs in clinical practice. Generalizing the results to all FPs is not an aim in studies using a qualitative design. The number of participants is guided by reaching 'saturation'; no new themes or insights emerged in the discussions.

This reviewer asks us to relate the scores on the (subscales of) the Depression Attitude Questionnaire. In the discussion section of the manuscript we used this valuable suggestion to point at the differences regarding the management of depressive disorders. Unfortunately it was only possible to compare the results of our FP sample with international data. National data were not available. Although it would be interesting but the FP sample was too small to analyse relationship between FP demographic characteristics and the FP attitudes.

This reviewer refers to the current evolution in thinking about both disorders and the consistency of the results of our study with other data sources. Nowadays, but certainly in the period when we performed the study the Dutch guidelines recommended active treatment i.e. with antidepressant drugs. Discussions about under-recognition and under-treatment were vivid at that moment. It is encouraging that the experience of physicians in clinical practice and the results of both epidemiological, theoretical and health services research are quite consistent. In the actual discussion section we also refer to the other data sources.

We only used the DSM IV criteria while these are used in the Dutch guidelines on depressive and anxiety disorders. FPs are, in general, not familiar with the ICD 10 criteria. The reviewer is right when he refers to the probable misuse of the DSM IV in both diagnosing and treating the disorders, but that is the way FPs experienced it. Discussions in medical journals, guidelines and marketing strategies of the pharmaceutical companies were called upon as source for this feeling by FPs.

All sentences in the result section are reported perceptions of the participating FPs. We added some information about our health care systems which is to a certain extent comparable to other European and Northern American systems. Beneath that we rephrased the sentence about the effectives of the efforts to improve the quality of care. It was formulated too strongly although there is still much room for improvement.

We also like to thank dr. Patten for his remarks and valuable suggestions. We hope and think that we have addressed them properly.

Reviewer Peter Verhaak
This reviewer considers research on the opinions and views of FPs regarding the recognition and management of common mental disorders a very relevant. He has concerns about how to
value the results and how to generalize the results of our study. Most of the statements presented in the result section had the support of a substantial number of the participants, mostly a majority of the participants. In the text of result section we provided information about the proportion of participants when indicated. The citations presented in the boxes are to support and illustrate the data in the result section. I can not be said that none of the participants had more positive opinions about the etiology.

The aim of qualitative studies is to generate hypothesis and provide more insight in experiences of FPs in clinical practice. Generalizing the results to all FPs is not an aim in studies using a qualitative design. The number of participants is guided by reaching ‘saturation’; no new themes or insights emerged in the discussion.

In the discussion the participants were challenged to discuss the evidence presented in the Dutch guidelines and its recommendations. The aim of the focus group study was not to test the validity of the FPs arguments but to get more insight in their opinions.

The reviewer gives some examples where he has concerns.
- ‘Specific diagnosis had few consequence for treatment…’ while … substantial differences in severity or burden between patients with the same diagnosis are seen by FPs.
- the reviewer is right that ‘difficulties in accepting the diagnosis…’ can not be a barrier for the diagnosis but as a barrier for treatment. We reviewed the original transcripts and have to admit a mistake. All other quotes were reviewed but no other mistakes were found.
- recognising a deficiency in their own knowledge of specific anxiety disorders can not be considered as a expression of dislike of psychiatric nomenclature.

We corrected the sentence about the ‘lack of evidence’ according to the reviewers suggestion. We also made a correction about the year of the guideline. We refer to the guideline of the year 2000 while the 2003 guideline was not available when the discussions took place.

We added the suggestion that mental health nurses could provide patient education when FPs do not have enough time to provide this.

The focusgroups did not provide an alternative for the medical paradigm. The question is or FPs in clinical practice are able to provide a new paradigm. FPs provided valuable suggestion and solutions as presented in under ‘needs and solutions’ paragraph in the result section.

This reviewer also asks us to relate the scores on the (subscales of) the Depression Attitude Questionnaire. In the discussion section of the manuscript we used this valuable suggestion to point at the differences regarding the management of depressive disorders. Unfortunately it was only possible to compare the results of our FP sample with international data. National data were not available.

We like to thank dr Verhaak for his comments and valuable suggestions. We hope and think that we have addressed them properly.
We hope that the revised version of our manuscript will be accepted for publication in your journal.

With regards,

Eric van Rijswijk, MD, PhD.