Reviewer's report

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

Version: 1 Date: 14 July 2007

Reviewer: Scott Patten

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This is a mixed methods, but largely qualitative, study describing perceptions of depression and anxiety disorder recognition, diagnosis, and management among FPs in the Netherlands. The main justification for the study is that the existing literature has not taken the experiences of FPs adequately into account. Only a few such studies appear to have been conducted.

I am not sufficiently familiar with this literature to confirm that all relevant prior investigations have been identified by the author, but it is certainly true that the literature about depression and anxiety management in primary care has tended to emphasize other factors than the views of FPs and has usually used other approaches (e.g. estimating recognition rates, the impact of screening measures, looking at guideline compliance etc.).

The authors acknowledge the main limitation of the study, which is that it is based on a very small number of participants.

Discretionary Revisions

I don’t think the case is strongly made that efforts to improve the quality of depression care in primary care have been disappointing, as stated by the authors without citation of supporting data. There is a great deal of enthusiasm in the psychiatric literature about disease management strategies in primary care, shared care and other collaborative care models. There have been several recent reviews of these topics, e.g. see Bland et al. May 26th Supplement of the Canadian Journal of Psychiatry, and reviews Wayne Katon (see citation, below) and [1, 2]. Of course, this does not negate the importance of FPs opinions, but it creates a need to justify that efforts to improve management in primary care have been a failure.

There are concerns expressed about the DSM-IV diagnostic criteria. These were developed by the American Psychiatric Association. Unexpectedly, there is no mention of the ICD-10 criteria in this paper.

Some of the results require additional discussion and justification. For example, some of the barriers that the FPs perceive in their patients against acceptance of the diagnosis are actually symptoms of depression: negative thoughts, feelings of guilt, anhedony. How are do these come to be considered barriers?
The issue of deciding when psychiatric symptoms justify a diagnosis has been addressed in a series of papers by Jerome Wakefield and the perceptions of the FPs are consistent with some of his ideas (the model is called “harmful dysfunction”) – as this is the dominant alternative to the empirical symptom threshold approach taken in DSM-IV it would be advantageous at least to mention this model [3].

The introductory chapter in DSM-IV is very clear in saying that diagnostic criteria should not be used to supplant clinical judgment. As such, the attack on the idea that diagnosis should automatically determine intervention is more an assault on the misuse of DSM than on the manual itself. This should probably be clarified.

In the presentation of results, there seems to be an intermixing of reported perceptions, interpretive judgments and conclusions. E.g. “more attention should be paid to non-verbal signs, particularly when observed over a long period of time (pp12)” – is this is a perception drawn out as a theme in the qualitative analysis or is it a conclusion drawn from the data? If it is the latter, it should be moved out of the results section.

Minor Essential Revisions

It appears that there were three focus group meetings, held sequentially (until saturation) with three different groups of FPs, the final one being a random sample (albeit with a response rate <10%) of FPs, but the sampling frame from which the random sample was drawn is not identified. I appreciate that purposive approaches were used, but there should nevertheless be greater clarity in describing how the sample was selected.

The situation in primary care in different countries differs, particularly in the UK and the US. The latter has some unique features, such as HMOs – from which a lot of relevant literature derives (e.g. see [4] for a somewhat dated review). Additional description of the Netherlands context would assist readers in determining the extent to which the results may generalize to their own countries. This is particularly relevant since many of the study’s conclusions pertain to health system factors such as payment mechanisms and time pressures. For example, the literature about “disease management” strategies for depression care is explicitly about changing “structural” factors.

Major Compulsory Revisions

Although this is primarily a qualitative study, there are some elements of a survey (random sampling of some subjects, use of a questionnaire) included in the study design. The manuscript does not do a good job of integrating the qualitative and quantitative results. Table 1 is difficult to interpret in the absence of any reference to other data. The means and ranges presented are not very meaningful in the way that they are presented. It would be helpful to know how these ratings compare to those that have been reported by other professional groups, or whether there is any relationship between FP demographic characteristics and the attitudes measured by the DAQ.
My sense is that there needs to be additional context provided for some of the results. The idea (pp. 9) that two weeks is insufficient to justify a diagnosis has also been put forward as a conclusion of a previous study conducted by myself (http://www.cpementalhealth.com/content/2/1/13) – so the perception of the FPs is consistent with epidemiological data. The criticism of DSM is of course not new – nor unique to FPs. See, for example, Mechanics critique of the idea that criteria fulfillment is an indicator of treatment need [5]. When the FPs are advocating “watchful waiting” they are probably making reference to the UK NICE criteria [6]. Taken together, my main critique of the paper is that the perceptions of the FPs are treated as if they are challenging a false doctrine, which to some extent they are (many authors in the psychiatric literature do tend to interpret the diagnosis of major depression as a proxy for treatment need, leading to never ending claims of vast under treatment), but a lot of what they are saying is consistent with a current evolution in thinking and consistent with other data sources and clinical recommendations – something that is really not acknowledged very well in the manuscript.


What next?: Unable to decide on acceptance or rejection until the authors have responded to the major compulsory revisions

Level of interest: An article whose findings are important to those with closely related research interests

Quality of written English: Needs some language corrections before being
published

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests