Author's response to reviews

Title: Conceptual models for Mental Distress among HIV infected and uninfected: A contribution to clinical practice and research in primary-health-care centers in Zambia

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Author's response to reviews: see over
To the Editor,
BMC Health Services Research,

Re: Responses and revisions to reviewer’s comments

Kindly find below our responses to the reviewers. We have attended to most of their concerns. However there are a few that we do not agree with and so we have not revised them. We have however explained why we do not agree. Specific examples are:

REVIEWER 1 REPORT - Katja Rudell

1. Review the content of the article and the resulting abstract
Currently the two parts do not entirely match and it is almost as if they were written by two separate authors.
The abstract produces for example numbers on 40% of the HP reporting mental distress to be HIV dependent but there is no elaboration on this in the text. The final conclusions about that treatment decisions are based on EMs are also not substantiated by the data presented as there is no longitudinal data to back up such claims. This is the main problem with the submission.

We do not agree with this reviewer on this point as we feel the abstract is adequate and is a correct representation of the main issues discussed in the manuscript.

Reviewer’s comment
On the less important side I found the taxonomy confusing based on the text quotations that were provided. The authors grouped the EMs according to social, biological, psychosocial and situational in content but then quote in the psychosocial section an EM that refers to a patient being not able to have children and to have polio as a child - which I would have classed as biological.

Also I cannot foresee that situational aspects are not psychosocial in origin and where is the difference between social and psychosocial?

We feel that the reviewer may not have looked at these taxonomic classifications in the context within which they have been presented. Taxonomic models take on different nomenclature and we are not the first to have made taxonomic models tailored to our environments. We should also be quick to say that despite the differences in classification by culture, the guiding principles are the same. If read within their context, the classification holds.

REVIEWER 2 REPORT - E C Ward

Major Compulsory Revisions:
1) In the background section it would be helpful to provide more information about health perceptions in Zambia to give more context for the present study.

We feel this reviewer was very helpful and his comments are very constructive. The suggestion above is very important and interesting, however we feel it is too general to be included in within the context of this manuscript.

Sincerely,
Peter Jay Chipimo BSC HB, MBChB, M.Phil
Responses and revisions to reviewer’s comments

REVIEWER 1 REPORT - Katja Rudell

Reviewer's report

Major compulsory revisions

Review the content of the article and the resulting abstract
Currently the two parts do not entirely match and it is almost as if they were written by two separate authors.
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Response

Thank you very much for your having taken the time to look through our work. We value your comments.

Firstly we do not agree that there are disparities between the abstract and the main text. Further the content of the abstract was as a result of consensus among the authors.

The contentious statement over the reported 40% of institutionalized mentally distressed patients being due to HIV, emanates as response to a question posed to the HP as to what, in their opinion, based on observations and records, is the proportion of mental distress attributable to HIV+ status. These HP had served in the mental health institution between 11-22 years and their reports were based on available documentation (page 13, heading: Health professionals and healer perspective, paragraph 1). We have as such included a statement to clarify this, added statement marked in red font.

We agree that the final treatment decisions are based on EM. This was part of the aim of the study. To show that treatment preferences tend to be based on how the patient perceives their illness (explanatory models). This is by no means the first study that has shown these findings and we have cited, Aidoo& Hapman 2001 as one such example. This is to say that it is important for the clinician to be alert to these explanatory models so as to tailor treatment accordingly. There is obviously need for more research into the area and we allude to this in the abstract and we have now stated this now under limitations of the study. However based solely on this study our conclusion is warranted.
**Reviewer’s comment**

On the less important side I found the taxonomy confusing based on the text quotations that were provided. The authors grouped the EMs according to social, biological, psychosocial and situational in content but then quote in the psychosocial section an EM that refers to a patient being not able to have children and to have polio as a child - which I would have classed as biological.

Also I cannot foresee that situational aspects are not psychosocial in origin and where is the difference between social and psychosocial?

**Response**

Explanatory models in general have to be taken into context and we admit that these can be confusing at times. A lot of literature exists with many varying ways and methods of classification (Aidoo & Hapman 2001, Karaz et al 2003). Some authors will have one broad category which they call psychosocial, the other being Biological, while others will have one they would call Biosocial and leaving the other at merely psychological. Often these models are interrelated. However the guiding principles for the models are the same and lay in the context of the narratives. Explanatory models used in one area are not transferable to another, hence the importance of the explanatory models being culture specific.

In the quotations here referred to on page 12, the 34 years old woman has polio as being the physical illness, however you will see in the narrative that the polio does not take centre stage, but instead it’s the psychological element of not having children and not being married that is the source of the distress. This tallies very well with the cultural predisposition in Zambia where an unmarried woman or worse still a woman with no children is often looked down upon. The shame of not being married or not having children far outweighs any physical debilitation that could have lead to it. This is what we bring out in this narrative.

This view towards childless and/or unmarried women is not unique to Zambia. In 1970 in Swaziland, a book was written and a play made concerning experiences of a childless woman. The humiliation, shame, accusations etc suffered by such a woman were portrayed. Society positions a childless woman in a valueless and worthless space.


A woman who is unable to bear children suffers severe social alienation, name calling, accusations or classification. Any misfortune that may happen to a pregnant woman in the neighborhood (death with pregnancy, still birth cases), the childless woman is always the cause, when there is death among the under five children, the childless woman is the one to blame. What is depicted in this book is common in most African communities, although in countries such as Zambia, verbal ill-treatment to such a woman is what dominates. Perpetual exposure to these eventually has a bearing on the mental status of an individual. A witch in my heart film and book depicted this clearly
Minor essential revisions

Introduction first paragraph
Correctly reference Kleinman as the person who coined the term EM in the introduction in 1980
Refer to assessment of EMs as possible via other methods bar interviews

Response

Author Kleinmann has been acknowledged for coining the EM on page 6 paragraph 3 line number 3, as well as on table 2 on page 30

Reviewer’s comments

Results
Health seeking and coping section
The data presented here is only cross-sectional - patients often try to explain their behaviour or were they ended up in order to make sense of their lives - it is a human trademark. I think we cannot rule out that attributes of the patients EMs have contributed to the treatment response etc but at the same time we do not know how much of this is attributable to it. To believe that all or a large proportion of it are directly associated seems not grounded based on quantitative findings of the literature to me.

Response

We agree with the reviewer that the extent to which EM actually have an effect on treatment choices is difficult to judge. We certainly do not claim that in our paper. We merely highlight that the importance of EMs and what effect they have on shaping treatment and that they should be borne in mind by all clinicians
Reviewer's report I commend the authors for doing this research as it is very timely and certainly makes a contribution to improving health care provided to a vulnerable population (patients who are HIV+ comorbid with mental illnesses and other chronic physical illnesses).

Major Compulsory Revisions:
1) In the background section it would be helpful to provide more information about health perceptions in Zambia to give more context for the present study.

Response

The reviewer’s comment is dully noted. We find this suggestion to be very interesting and important, but a bit too general to respond to and include within the framework of this paper.

2) In the section on Explanatory Models, Mental Distress and HIV Infection, the authors mention “only one study was found that investigated explanatory models for mental health” (Chipimo & Fylkesnes, 2010). However, no details are provided about the Chipimo & Fylkesnes, 2010 study. It would be helpful to provide more detail about the study, which would strengthen the rational/need for the present study. Also, it would be helpful to know the results of that study, in particular, how it informed the present study and how the results of the present study are similar or different from the Chipimo & Fylkesnes 2010 study.

Response

The reviewer’s comments have been noted and we have made revision on page 4, text is in red. However we wish to say that the one study we found was ref 10: Aidoo & Hapman 2001 and not Chipimo & Fylkesnes 2010.

3) In the data collection section no information is provided as to the SRQ-10 cut off score indicating distress or poor mental health (“case”).

Response

The reviewer’s comments have been noted and we have made revision on page 7, paragraph 1 text is in red.
4) In the data collection section there is brief mention that a "pilot study was conducted to
determine the validity of the interview schedule prior to data collection. Results are are
provided elsewhere." It would be helpful to provide a brief overview of the results of the pilot
in the present manuscript as directing the reader to another article is rather burdensome.

Response

The reviewer’s comments have been noted and we have decided to delete the sentence
pertaining to the pilot study. The results of the pilot did not exactly produce results that are
directly relevant to this study, but instead informed the study Chipimo & Fylkesnes, 2010

5) In the data analysis section there are no citations to support the rigor of the data analysis
in the present study. Appropriate citations to support this method of analysis will help
reviewers and readers determine the rigor of the analysis and the credibility of the study
results.

Response

This method of analysis has been employed in so many of this kind of qualitative research.
One such reference is; Moser, C.A., & Kalton, G. (1997). Survey methods in social
investigation. (2nd ed.). London: Heinemann Educational Books Ltd.
We have added this reference to the section on data analysis.

The process of the analysis is as follows:

Initial analyses were manually done using the code sheet, which is an interpretative approach
(Moser and Kalton 1971). A sheet containing all phrases representative of the five models was
created. Names of models were used as codes. These standardized codes were then assigned
to same or similar phrases. Phrases in this case refer to responses given according to the
question posed. All common phrases were grouped together and placed under the same or
similar sub-theme. Themes in this case were describing the codes, and the codes were
representative of names of models. These themes which were grouped together were able to
provide unique and contrasting features of the narration of the symptoms. In order to check
for consensus relating to codes assigned to phrases, authors 1 and 2 independently produced
two separate code sheets, but with identical standard codes, then swapped. This was done to
identify agreements and disagreements of standard codes assigned to phrases. Where there
were disagreements, a re-coding of the phrase was done. This method thus selectively
discarded untypical data and focused more on the most common answers. To ensure validity
of responses, transcripts were read and re-read. The frequency and occurrence of common
phrases was then noted. To check for reliability of phrases, occurrences and frequencies of
common phrases within single IDIs and across IDIs was compiled and noted.

Further in order to aid efficient linkages of common phrases, the data was entered in SPSS so
as to enable electronic analysis of basic statistics such as frequencies and cross tabulations. A
theoretical taxonomic model was then developed to aid in classifying the contrasting
symptom narrations. The narratives were grouped into representational categories which
 mirrored the contrasting models between the role of social circumstances, worries and the emotional experience.

6) In the results section there are two "health-seeking and coping strategies" section, but one section indicates among HIV positive individuals. So is the other section specific to HIV negative individuals? appropriate headings would be helpful.

Response

The reviewer’s comments have been noted and we have added a new subheading on page 17, text in red.

7) There is no limitations section in this manuscript and it is certainly needed.

Response

We agree with the reviewer that we overlooked the section on limitations. However in our revised version we have included a paragraph on limitations on page 25 paragraph 1, text is in red