

https://dspace.org/

Exploring general practitioners' management of patients with depression within the private health care sector in Johannesburg, South Africa.

Repensek, Milica

2013-04-03
http://hdl.handle.net/10539/12617

Downloaded from a DSpace repository. https://dspace.org/

Surname: Repensek
First Name/s: Milica
Student Number: 573212
Supervisor: Sumaya Laher
Title: Exploring general practitioners' management of patients with depression within the private health care sector in Johannesburg, South Africa.

Declaration:

I, **Milica Repensek**, know and accept that plagiarism (i.e., to use another's work and to pretend that it is one's own) is wrong. Consequently, I declare that:

- The research report is my own work.
- I have correctly acknowledged all direct quotations **and** paraphrased ideas/content. **In addition** I have provided a complete, alphabetized reference list, as required by the APA method of referencing.
- I have not allowed, and will not allow, anyone to copy my work with the intention of passing it off as his or her own work.
- I understand that the University of the Witwatersrand may take disciplinary action against me if there is a belief that this is not my own unaided work, or that I failed to acknowledge the sources of the ideas or words in my writing.
- The word count (excluding the Reference List, etc.) given above is correct.

Signed: _____

Date: _____

EXPLORING GENERAL PRACTITIONERS' MANAGEMENT OF PATIENTS WITH DEPRESSION WITHIN THE PRIVATE HEALTH CARE SECTOR IN JOHANNESBURG, SOUTH AFRICA.

By

Milica Repensek

A Dissertation

Submitted to the Faculty of Humanities, in Partial Fulfilment of the

Requirements for the

Degree of Masters of Arts (Community-Based Counselling Psychology)

The School of Human and Community Development

at the University of Witwatersrand, Johannesburg

November 2011

Supervised by Dr. Sumaya Laher

Abstract:

The majority of persons within South Africa (of whom 16% have claimed to have suffered from common mental disorders such as depression) that use medical treatment do so through primary care (Patel et al., 2007; Williams et al., 2007). However, studies have shown that general practitioners (GPs) often overlook, ignore, misdiagnose and even offer inappropriate treatment for mental illness (c.f. Lotrakul & Saipanish, 2009; Qwabe, 2009). Since South Africa is comprised of a multitude of diverse peoples from varying culture backgrounds, cultural diversity needs to be considered within every interaction, especially when GPs consult with individuals with depression. This study, thus, aims to explore GPs' management of depression by investigating diagnosis or detection, treatment and referral patterns of GPs where their considerations of patient's cultural worldviews are also investigated. This study utilised a semi-structured interview schedule on a convenient sample of six GP's. Thematic content analysis was used to analyse salient themes from the data. Eight themes were found, namely: diagnosing, treating and referring patients with depression, cultural implications in general practice, training of GPs, the evolution of the medical field and its practices, disadvantaged communities and access to health care resources as well as the ethics of practice. These results are discussed in relation to local and international literature in the field.

Declaration:

I declare that this dissertation is my own unaided work. It is submitted in partial fulfilment of the requirements for the Degree of Masters of Arts (Community-Based Counselling Psychology) in the department of psychology, University of Witwatersrand, Johannesburg. It has not been submitted before for any other degree or examination at any other university or institution.

Milica Repensek

29 November 2011

Acknowledgements:

I extend my sincerest gratitude to the following persons:

- My supervisor, Sumaya Laher, for all of your insightful thoughts, opinions and guidance throughout this entire process. You have always been available, dependable and dedicated, which has put me at ease on many occasions. For this, I thank you.
- My Kannon, Matt McKay, you were always there, providing me with the support and encouragement that I needed. Thank you for your dedication, patience and strength. I could not have done this without you.
- My parents, for always being so understanding and loving. Those many lost hours of quality time will be caught up on soon, I promise.
- My friends, Andy, Lisa, Matt, Riaan and Tarry, you guys were all so supportive and patient! Thank you all for your words of encouragement in the darkest of times. You are all truly special and I look forward to bonding with you again.
- The rest of my family, Jasmina, Ferna, Dale as well as the rest of the McKays, Underwoods, Repenseks and Ramosajs I love you all and thank you for being part of my life.
- Seth, Rogan, Jedi and Mate, thank you guys for those many hours of laughter and for always providing me with unconditional love. You're all truly special.

Table of contents:

Plagiarism declaration 1
Title cover page 2
Abstract 3
Declaration 4
Acknowledgements 5
Table of contents 6
Chapter 1: Literature review 9
1.1. Introduction 10
1.2. Diagnosing depression 10
1.2.1. The diagnosis of depression by GPs 12
1.2.2. The importance of a multicultural perspective in the diagnosis of depression by GPs 14
1.3. Treating depression 15
1.4. Referral patterns and liaison with other mental health professionals 19
1.5. Cultural considerations in diagnosing, treating and referring patients with depression 20
1.6. Conclusion 24
Chapter 2: Methods 25
2.1. Aims 26
2.2. Rationale 26
2.3. Research questions 27
2.4. Participants 28
2.5. Instruments 28
2.6. Research design 29
2.7. Procedure 29
2.8. Ethics 30
2.9. Data analysis 31
2.10. Self-reflexivity 32
Chapter 3: Results 33
3.1. Introduction 34
3.2. Diagnosing or detecting depression 34

3.2.1. *GPs' overall attitudes on the diagnosis or detection of depression* *34*
3.2.2. GPs' problems with differential diagnosis and classification of depression *37*
3.2.3. Diagnostic criteria *39*
3.2.4. Extraindividual factors that impede detection or diagnosis *42*
3.3. Treating depression *43*
3.3.1. GP's opinion of their efficacy with regards to treatment of depression *45*
3.3.2. Problems incurred within the process of treating *46*
3.3.3. Follow-up of patients diagnosed with depression *46*
3.4. Referral liaison between GP and secondary mental health professionals 47
3.4.1. Problems incurred within the process of referral 50
3.5. The influences of culture in general practice 51
3.5.1. The importance of culture in general practice *51*
3.5.2. The stigma that resides in cultural worldviews *53*
3.5.3. Denial as a hindrance to diagnosis, treatment and referral *54*
3.6. The training of general practitioners 54
3.7. The evolution of the medical field and its practices 55
3.8. Disadvantaged communities and access to health care resources 56
3.9. The ethics of practice 57
3.10. Conclusion 58
Chapter 4: Discussion 59
4.1. Introduction 60
4.2. Diagnosing or detecting depression 60
4.3. Treating depression 67
4.4. Referral liaison between GP and secondary mental health professionals 71
4.5. The influences of culture in general practice 74
4.6. The training of general practitioners 76

4.7. The evolution of the medical field and its practices 77
4.8. Disadvantaged communities and access to health care resources 78
4.9. The ethics of practice 79
4.10. Self-reflexivity findings 81
4.11. Conclusion 83
Chapter 5: Limitations and Recommendations 84
5.1. Introduction 85
5.2. Limitations of the study 85
5.2.1. Conceptual limitations *85*
5.2.2. Methodological limitations *86*
5.3. Recommendations for future research and practice 90
5.4. Conclusion 91
Reference List 92
Appendices 102
Appendix A: Subject Information Sheet 103
Appendix B: Consent Form (Interview) 104
Appendix C: Consent Form (Recording) 105
Appendix D: Interview Schedule 106
Appendix E: Ethical Clearance Notification 109
Appendix F: Feedback Summary Sheet 111

Chapter 1: Literature Review

1.1. Introduction

Depression is often considered as one of the most prevalent mental health concerns among South Africans (Williams et al., 2007), where treatment is most often sought from primary health care settings (Patel et al., 2007). A recent study conducted within South Africa indicated that major depression was prevalent at 9.7% throughout one's lifetime and 4.9% within a 12 month period (Tomlinson, Grimsrud, Stein, Williams & Myer, 2009). Since it is the responsibility of a primary health care professional (such as a GP) to offer an appropriate diagnosis and treatment of depression, it is imperative that such medical care be provided in a manner that is most beneficial for the particular patient. If the GP is unable to offer a suitable diagnosis or treatment then referral should ensue. Throughout this entire process it is highly important that cultural sensitivity toward the patient is exercised.

In the literature review that follows I will first outline the diagnostic criteria of major depression. Following this, I will discuss the manner in which GPs diagnose depression. Treatment of depression will also be discussed with a particular focus on the medical profession. The referral liaison patterns between GPs and mental health professionals will consequently be explored. The literature review will conclude with a discussion of cultural diversity in South Africa and the importance of its accommodation within a doctor-patient consultation.

1.2. Diagnosing depression

Depression is often classified as the most prevalent life disturbance that affects individuals from all walks of life (Lotrakul & Saipanish, 2009). Lay understandings of depression include a depressed mood, anhedonia (loss of interest or pleasure in activities that would usually excite the individual at hand), feelings of low self worth or shame, disturbances in sleep or eating habits, lethargy and concentration impairments (WHO, 2010). Sadock and Sadock (2007, p. 543) elaborate that "[a] depressed mood and a loss of interest or pleasure are the key symptoms of depression". Those suffering

from depression often describe their mood as agonising, almost as if they are in a state of emotional turmoil and pain (Sadock & Sadock, 2007). What is more, some reveal their inability to express their emotions or even cry; however, this improves with adequate treatment (Sadock & Sadock, 2007). Generally, diagnosis of depression by professionals involves rigorous identification of symptoms alongside a set of criteria. The set of criteria most often used in detecting depression form part of either the Diagnostic and Statistical Manual for Mental Disorders (DSM) or the International Classification of Diseases and Related Health Problems (ICD).

Major depression is categorised as a mood or affective disorder by both the International Classification of Diseases and Related Health Problems – version 10 (ICD-10) (WHO, 1992) as well as the Diagnostic and Statistical Manual for Mental Disorders – Text Revision of Version Four (DSM-IV-TR) (APA, 2000). Apart from major depressive episodes, mood disorders also consist of bipolar disorders. The two are distinguished by the presence or history of manic, mixed or hypomanic episode in bipolar depression. To be sure, major depression is characterised as unipolar as it is devoid of any such manic episodes. Throughout the literature henceforth, when depression is discussed, it will be with reference to major depression.

According to the DSM-IV-TR (APA, 2000), a major depressive episode may be diagnosed in the presence of five or more of the following symptoms that need to be present nearly or mostly everyday for at least a two week period: depressed mood, noticeably diminished interest or pleasure in all or most activities, significant weight loss (whilst not dieting) or decreased appetite, weight gain or increased appetite, insomnia or hypersomnia, psychomotor disturbances, fatigue or loss of energy, feelings of worthlessness or inappropriate guilt, reduced ability to think or concentrate and/or recurrent thoughts of death or the desire for death. Furthermore, according to the DSM-IV-TR, depression is diagnosed when it results in significant distress or impairment in important areas of functioning (such as with social or occupational activities).

Similarly, the diagnostic criteria for depression according to ICD-10 include the presence of one of three key symptoms that need to be present for at least two weeks: enduring sadness or low mood, loss of interest or pleasure, fatigue or low energy levels (WHO, 1992). Other common symptoms include: reduced concentration and attention, diminished self-esteem and confidence, feelings of guilt and worthlessness, negative perceptions of the future, ideas or acts of self-harm or suicide, disturbed sleep and/or diminished appetite (WHO, 1992). What is more, the ICD-10 classifies the depressive disorder in three categories, i.e. mild (two to three of the above mentioned symptoms), moderate (at least two or three of the key symptoms as well as a minimum of three to four of the other common symptoms mentioned above) and severe (where several of the above listed symptoms are markedly distressing).

1.2.1. The diagnosis of depression by GPs

According to a study conducted by Krupinski and Tiller (2001) in Australia, over half of the GPs participating in the study listed either sleep disturbances, loss of appetite (or weight changes) or depressed mood in their diagnosis of depression with their patients. In this respect, the participants were generally accurate in detecting the main symptoms of depression but fell short in listing at least five DSM-IV (APA, 2000) diagnostic criteria.

In another study by Dickmann, Dickmann and Broocks (2008) in Germany, 182 GPs volunteered to give a diagnosis based on a case study presented to them. Participants were asked to select the most probable diagnosis from a list of possible diagnoses (such as personality disorder, unspecified; depressive episode, unspecified; mixed anxiety and depressive disorder and somatoform disorder). The most accurate diagnosis for this particular case study was rather specific: recurrent depressive disorder, current episode severe without psychotic symptoms. This diagnosis would require a more thorough and detailed understanding of the classification criteria for depression as opposed to simply differentiating between more global classifications, such as with personality, anxiety and somatoform disorders. Results indicate that only 24% of the participating GPs were able to give an

accurate diagnosis according to the ICD-10 criteria. A further 57% were able to detect the probability of depression as opposed to personality or somatoform disorder.

It is evident, within these two studies, that GPs have a relatively broad understanding of depression. Symptoms were generally perceived in terms of more concrete symptoms that were somewhat factual and observable (such as symptoms pertaining to eating habits, sleeping disturbances and depressed mood). Whereas lack of enjoyment or pleasure or changes in thought patterns was least often listed and would require further exploration from the GP, where answers from the patient would most likely yield a more subjective disclosure of personal experience.

Sadock and Sadock (2007) state that individuals who are suffering from depression often do not recognise it and may not complain about their depressed mood. Instead, they may quietly withdraw from social situations and activities they enjoyed and rather complain about their sleeping patterns, impaired difficulty conducting day-to-day endeavours, weight problems, lethargy and lack of sex drive (Sadock & Sadock, 2007). Thus, one may observe that individuals suffering from depression might become preoccupied with manifest symptoms of their depressed mood, but may not necessarily have the required insight. This may become a problem for GPs in their diagnosis of depression as the symptoms may be treated as a problem in itself, not as a representation of an even greater issue.

Furthermore, the study conducted by Dickmann, Dickmann and Broocks (2008) illustrates that GPs often either misdiagnose or under-diagnose depression by mistaking it with similar psychiatric disorders (such as anxiety for instance). This proves to be a common problem in general practice and is outlined in many empirical studies to date (cf. Ashworth, Godfrey, Harvey & Darbishire, 2003; Cape, 1999; Lotrakul & Saipanish, 2009; Younes et al., 2005). This is not to say that GPs do not necessarily have the skills required to diagnose depression effectively, but there may be other external factors influencing its detection.

A potential variable affecting accurate diagnosis may include duration of consultation, which ranges between 10 to 20 minutes (Dickmann, Dickmann & Broocks, 2008). In a similar vein, the symptoms presented by the patient – which are often medically related -- may also influence the diagnostic process (Lotrakul & Saipanish, 2009).

1.2.2. The importance of a multicultural perspective in the diagnosis of depression by GPs

A study conducted by Lehti (2009) in Sweden illustrated how depression was both expressed by patients and understood by GPs differently across various cultural contexts and social backgrounds. She found that individuals from different socio-cultural backgrounds tended to focus on different bodily areas in describing depressive symptoms where certain cultural beliefs may ignore the prevalence of depression altogether and thus blaming it on something external to them. For example, one culture defined sadness and depression as normal where men were reluctant to seek help and tended to abuse alcohol instead (thus externalising the problem). In another example, other cultural groups in the study did not have a word to express depression and for them, it did not exist. Herein, it is important to be able to recognise manifest bodily experiences as a sign of depression and not as a problem in itself.

Lastly, in the same study, the GPs who worked with migrants tended to either under-recognise or over-estimate depressive symptoms. There tended to be a tension between the two different cultures in that communication was difficult. In this regard, GPs tended to understand and conceptualise patients (who were foreign to his or her socio-cultural background) within their own frame of reference. This resulted in a blurry interaction and consequently resulted in confusion where clear conceptualisation was rarely obtained.

Within the South African context we are faced with a similar dilemma. There seems to be a tension between conceptualising depression through the Western, biomedical lens and the scope of the collectivist culture (as will be

further discussed later). Briefly, as seen in the study above, non-Western cultures differ to Westernised cultures in that they understand depression differently, express symptoms in a variant manner and may even dismiss the notion of depression as a whole. What is more, when working with members of a non-Western community, doctors who are trained within the biomedical (Westernised) approach tend to understand their patients through their own world-view and thus fail to conceptualise their patients' symptoms through their understanding. As mentioned in Lehti's study (2009), this may either lead to an under-recognition or over-estimation of depressive symptoms which may lead to an array of other problems if not dealt with in an adequate manner.

1.3. Treating depression

Once a reliable diagnosis of depression has been made by a trained professional, the next line of protocol would be to offer the patient a course of treatment in an attempt to alleviate its effects. The treatment of depression is not as straightforward as one would expect. There is an array of different treatments available, ranging from conventional or common treatments to unconventional or traditional healing. Generally, though, the most favourable outcome is gained when medication and psychotherapy are combined to suit the patient at hand (Sutherland, Sutherland & Hoehns, 2003).

Pharmacotherapy is a form of treatment for depression and involves the prescription of medication. Anti-depressants are usually prescribed and fall under three main categories: monoamine oxidase inhibitors (MAOIs), tricyclic anti-depressants (TCAs) and selective serotonin reuptake inhibitors (SSRIs) (Sutherland et al., 2003). Although different anti-depressants work in different ways, they generally prove to elevate mood by increasing the levels of three monoamine neurotransmitters: norepinephrine, serotonin and dopamine (Sutherland et al., 2003). However, SSRIs are newer and, as a result, tend to be safer and have fewer side-effects and are therefore the treatment of choice in pharmacotherapy (Sadock & Sadock, 2007).

Reactions to medications do differ from person to person; therefore, it is imperative that the patient and doctor consult frequently to monitor progress (Apfel, 2003). There should be an emphasis on collaboration and observation here; the doctor must work together with the patient (through frequent communication and feedback) to ensure the best possible treatment for the patient – devoid of any complications or difficulties (Lyons & Chamberlain, 2006).

Even though medications are effective when taken alone, they work most efficiently to alleviate depression when taken alongside psychotherapy, or other non-pharmacological therapies (Apfel, 2003). Although there are a wide range of psychotherapies available to treat depression, the most commonly utilised is cognitive behavioural therapy (CBT) (Baas et al., 2010). Briefly, CBT encompasses a group of treatment practices that are directed towards identifying and changing faulty thought processes, attitudes, attributions as well as problematic behaviours (Barlow & Durand, 2009). Other frequently used interventions include supportive counselling, family or marital counselling, therapy aimed to target alcohol problems and problem-solving therapy (McGarry, Hegarty, Johnson, Gunn & Blashki, 2009).

Linden, Christof and Rentzsch (2008) state that counselling should form a natural part of a GP's consultation with their patients and should start with building a good therapeutic alliance. This partnership develops through the communication shared with the patient – from exploration of personal experiences and histories to identifying, explaining and monitoring course of treatment. This therapeutic alliance serves to influence treatment in a positive direction by increasing co-operation, compliance and efficacy of medications as well as decreasing the rate of undesirable effects. This patient-centred approach is largely favoured by patients when compared to the doctor-centred approach (Linden et al., 2008). However, Lyons and Chamberlain (2006) suggest that patient-centred health care is not always provided by all GPs.

Since we live in a society that is dominated by Western ideals, the health care system is primarily based on the biomedical model – which tends to reduce

personal experiences of illness to signs and symptoms (Lyons & Chamberlain, 2006). In doing so, the patient is objectified and studied as an organic machine, rather than a subjective and experiencing being within a system of interlinking worlds. This may be problematic when dealing with patients with depression as treatment should go beyond symptom management (such as controlling changes in eating and sleeping patterns).

To provide the best possible care for any patient, treatment should move beyond the focus of overtly observable signs and symptoms and enter into the subjective, idiosyncratic world of the experiencing individual. McGarry et al. (2009) state that more than half (80%) of the GPs that participated in their study prescribed medication even after receiving short CBT training. This further illustrates the focus on biological intervention for medical imbalances, where, even when these particular GPs have the opportunity to offer short-term CBT, they made preferences to prescribe medication.

In another study, Krupinski and Tiller (2001) found that over a third of the GPs that participated in their study relied on medication alone for treating depression (where TCAs were the drug most often prescribed). The remaining GPs used mostly a combination of pharmacological and non-pharmacological therapies in their treatment. According to Krupinski and Tiller (2001) the non-pharmacological therapies were not specified and were questionable on the grounds of GP training and experience. In the same study, almost two thirds of the GPs that participated stated that they would refer less than one in five of their depressed patients to psychiatrists. From this study, it is evident that GPs generally do treat depression themselves by prescribing medication alongside other forms of treatment.

Also worth noting is the preference to refer patients to psychiatrists as opposed to psychologists or counsellors. This is important to investigate within this study as it is unclear what knowledge and perceptions GPs may have about psychologists and what they do. It may be that doctors operate in accordance with the biomedical model and may, hereby, prefer to liaise with professionals who work within a similar paradigm. However, as mentioned

earlier, depression may be conceptualised and treated on multiple levels. An individual is not simply a biological being, but also a thinking and sociable person situated within a particular context. It is upon these multiple levels that a life disturbance (such as depression) may be treated. Indeed, biological interventions prove to be highly successful for many individuals; but one must not forget the importance of other or alternative interventions offered by psychologists and other such persons.

Even though traditional teachings of medicine have been largely Westernised and biologically inclined, Larivaara, Kiuttu and Taanila (2001) state that post-modernist perspectives have shifted GP training by bringing patient-centeredness to the fore. In this manner, patients have a better appreciation of how and what they are feeling and are better able to liaise with their doctor and agree to treatment; in essence, patients are able to gain a sense of control and understanding of their own bodies (Michie, Miles & Weinman, 2003).

Although there have been many initiatives geared towards providing better quality health care within South Africa, results of such actual practices have been varied (Econex, 2010). Some areas within South Africa may have an extreme poverty of GPs, where the ratio of doctor to patient is very low. In such circumstances, optimal standards of health care per individual may be marginalised in favour of treating the greater local population. What is more, in more urbanised areas, although GPs' services are more widely available, private health care is costly and may hereby exclude a large portion of the population from making use of the services. This may, in turn, negatively impact those persons who cannot afford to visit private practitioners and who are consequently obligated to visit public health sectors for treatment. Although this point is beyond the scope of the presented study, one may note how a lack of financial resources may inhibit one's opportunity to receive private primary health care.

Thus far, this review has explored issues surrounding diagnosis and treatment of depression with GPs in the health care system. The following sections will

discuss patterns of referral liaison within primary care settings as well as the issues of cultural complexity and sensitivity within general practice.

1.4. Referral patterns and liaison with other mental health professionals

Even though there is a global trend towards more humanistic patient care within the medical system, it is evident by the research discussed that this is merely the start of the trend. There are recent studies that illustrate that diagnosis and treatment of depression within primary care settings is not as favourable as it could be. According to the South African mental health policy (Lund et al., 2008), GPs should be screening and assessing mental health problems and treating only minor psychiatric problems. However, if a patient presents more serious problems or is in need of counselling, the GP should refer the patient to a more specialised mental health professional – in order to strengthen referral liaison between primary health care systems and specialised mental health care systems as well as to provide more specific and focused care for the individual patient (Younes et al., 2005).

One may question the conditions under which such a referral is made, as there are no criteria that specify when a problem is severe enough to refer (Lund et al., 2008). Further, the quality of health care provided to patients with mild problems may also be questioned in some cases on the basis of misdiagnosis (where treatment is incongruent with diagnosis) (e.g. Younes et al., 2005) or when treatment is inappropriate for the specific patient at hand (e.g. Krupinski & Tiller, 2001). Although GPs generally do have adequate skills to diagnose and treat depression, this is not always the case (Mash, 2002). In the case of the latter, referral is warranted and often required; however, whether or not this is adhered to is debatable. If referral protocol is not followed when required, then reasons for this are in need of exploring.

One of the most prominent reasons why GPs may opt not to refer their patients to specialised mental health professionals within South Africa is due to the overwhelming amount of patients who live in poverty and are unable to afford secondary care (Lund et al., 2008). Such patients often cannot afford

medical aid (as already discussed) and are forced to pay cash for consultations. GPs may sometimes lower their rates to accommodate such persons, whereas this is often not guaranteed in secondary treatment. In these cases, GPs are forced to treat patients themselves, using medication alone as there is often lack of time and monetary resources to provide additional care.

Other reasons GPs provide for not referring patients include lack of secondary mental health resources (where waiting lists are often encountered), deficiency of a working collaborative relationship with mental health professionals (where trust in the abilities of the second party is amiss) as well as the perceived benefit (or lack thereof) that referring will offer (Stavrou, Cape & Barker, 2009).

Herein, it is evident that the referral process is a complicated and convoluted one that depends on an array of variables. Providing adequate health care for individuals with depression goes beyond the skills of the GP and enters into a sphere that encompasses broader issues within the South African context. It is only when these larger issues are confronted that we can start insisting on better referral liaison between primary and secondary health care systems.

The topics discussed in the sections above are somewhat delicate and may be further complicated by issues of culture. The following section will investigate the importance of careful cultural considerations in general practice and the implications thereof within a South African context.

1.5. Cultural considerations in diagnosing, treating and referring patients with depression

The nation of South Africa is a particularly diverse one, comprising of a vast selection of cultures, traditions and ways of life. Every culture understands a human being and his or her world in a different manner. Defining culture is an exceptionally complicated task as its meaning is multifaceted and complex. In the 1950s culture was abundantly characterised by many theorists. There

were so many descriptions that Kroeber and Kluckhohn (1952) decided to categorise them into six major divisions, which were either: descriptive, historical, normative, psychological, structural or genetic. Kroeber and Kluckhohn (1952) suggested that “culture consists of patterns, explicit and implicit, of and for behaviour acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiments in artifacts” (p. 357).

Tylor (1964) understands culture as a “complex whole which includes morals, laws, customs, and any other capabilities and habits acquired by man as a member of society” (p. 1). Herskovitz (1948) offered a more concise description by stating that “culture is the man-made part of the environment” (p. 17).

Meyers (2008) defines culture as “enduring behaviours, ideas, attitudes, and traditions shared by a large group of people and transmitted form one generation to the next” (p. 11).

More recently, however, culture has been defined as

> a unique meaning and information system, shared by a group and transmitted across generations, that allows the group to meet basic needs of survival, coordinate socially to achieve a viable existence, transmit social behaviour, pursue happiness and well-being, and derive meaning from life (Matsumoto, 2007, p. 1293).

Thus, understandings of culture are multifaceted, but fundamentally situated within a social backdrop where persons sharing the same culture also share a frame of reference, world-view as well as a system of values and beliefs.

In South African Black communities, for instance, an *Ubuntu* (collectivist) understanding of themselves within the world is adopted (Louw, 2002). Persons who subscribe to these notions believe that one exists through others, as an inseparable community held together by unity. Individualism is

often unwarranted where togetherness is most favoured. In South African culture, the term *Ubuntu* has a deeply spiritual connotation, where the focus of togetherness is not only with the living community, but also with the ancestry who have passed (Louw, 2002). In this instance alone, one may observe how different these understandings of human nature are compared to traditional Western perspectives.

Literature pertaining to depression in a collectivistic, *Ubuntu,* culture is significantly limited. It may be hypothesised that depression, from this cultural viewpoint, is somewhat of an anomaly. It may also be argued that depression is a predominantly a Westernised phenomenon, with Westernised origins, where the understanding thereof in a collectivistic, *Ubuntu*, culture may appear rather foreign, arbitrary and unfamiliar. Broodryk (2006, p. 20) illustrates how the manifestations of stress (such as that of depression and even suicide) are completely contrary to the beliefs espoused by the *Ubuntu* culture:

> The tendency of a child committing suicide for not passing school subjects, is unheard of in African society. If a child fails a year at school, he/she merely returns back to school the next year to repeat the course without any feelings of inferiority or shame.

Furthermore, such a collectivistic culture acknowledges that sorrow can be experienced by an individual (as a result of sickness or death of a loved one or other painful events) but this sorrow is always shared with a friend, family member or fellow neighbour (Broodryk, 2006). Depression, on the other hand, differs from sorrow in that it manifests with a multitude of clinical signs and symptoms that are predominantly experienced by one individual alone – unlike in the *Ubuntu* culture, where such suffering is shared amongst a collective.

Tsai and Chentsova-Dutton (2002) argue that Westernised cultures differ from other cultures in three ways. Firstly, in Western cultures, it is generally accepted and normal to have positive emotions and feel “good”. In such

cultures, feeling “bad” or “down” would be seen as maladaptive or symptomatic. Other cultures, on the other hand, have a greater tolerance for short-lived negative emotions and are more accepting of them. Secondly, Western views have advanced their studies in neurobiological underpinnings of depression, whereas other cultures would not sever the mind from the body by ascribing depression to a chemical imbalance within the brain. Lastly, Western ideals are deeply individualistic and autonomous, where a person is fundamentally governed by the self and is accountable for his / her depressive disturbances. On the other hand, many non-Western cultures (as mentioned above) understand persons as connected to others and recognise that emotional problems are situated within an interpersonal and social context (Meyers, 2008).

In Zulu culture, depression is understood in a complex manner, symbolically, through story telling and metaphors, with an emphasis on spirituality – where the body, mind and soul are united as one (Ellis, 2003). Diagnosing depression from a Westernised, biomedical perspective, according to a set of criteria, seems to be troublesome when one is faced with an individual who does not share knowledge of such a paradigm. In this respect, one may encounter difficulties in diagnosis and treatment if not accounted for appropriately. GPs need to accommodate for cultural diversity within practice in order to maximise potential for the best possible treatment. When necessary, GPs need to meet their patients’ cultural needs and avoid attempting to enforce their own beliefs of illness onto their patient. To be sure, the GP should not try force the patient into a box that they do not naturally fit in.

Accommodating for cultural differences should go beyond diagnosis and treatment, GPs should also consider cultural diversity when referring patients. Most often, Black members of the community would seek help from a traditional or faith healer before consulting with a medical professional, but this is not always the case (Lund et al., 2008). Prescribing to the referral patterns already discussed – GPs should also be able to liaise with traditional

or faith healers in order to provide the best possible care for that particular individual (Lund et al., 2008).

In fact, the South African mental health policy encourages the collaboration between traditional healers and GPs; however, interviews with traditional healers illustrate that this is often a one-way relationship (Lund et al., 2008). To elaborate, traditional healers would frequently refer individuals with whom they consult to medical doctors, but the traditional healers are often treated with disrespect and receive no feedback about the progress of the patient who was referred (Lund et al., 2008). Within this study alone, it is apparent that GPs should take greater care in accommodating cultural diversity when referring patients. This accommodation needs to extend beyond liaising, to be present at every moment in consultation with every individual patient in order to ensure the best possible care for all.

1.6. Conclusion

In order to provide adequate health care for individuals with depression, it is necessary for primary health care professionals to have suitable knowledge of how to diagnose as well as treat such a life disturbance. However, if the manner in which GPs understand and manage individuals with depression is less than favourable, then the GP at hand may be required to follow relevant patterns of referral and refer the patient to an appropriate mental health practitioner. Furthermore, because South Africa is a land of diverse cultures, it is imperative that each cultural heritage be acknowledged and honoured along this entire process. It is essential that all these points be present when dealing with every patient in order to maximise efficiency, quality and compassion. If, however, these standards are not met in any circumstance, it would be valuable to explore such avenues and rectify any problems in an attempt to restore (or create) better health care for every patient. Thus, this study aims to investigate all of these points surrounding the health care of depression, namely: diagnosis or detection, treatment, referral and the overarching influence of culture, with the goal of better health care for all.

Chapter 2: Methods

2.1. Aims

This study aims to investigate the manner in which general practitioners in a private health care setting in South Africa manage patients with depression. GPs' conceptual knowledge of diagnosing and treating depression will be explored. Furthermore, patterns of liaison and referral to other mental health professionals will be considered. Since South Africa is a nation of diverse cultures it is imperative that cultural differences are accommodated for. Thus, this study will also investigate if and to what extent GPs consider these cultural differences when diagnosing, treating and/or referring patients with depression.

2.2. Rationale

The majority of persons who use medical treatment for their illness do so through the primary health care sector, i.e. GPs (Dixon, Roberts, Lawrie, Jones & Humphreys, 2008). South Africans may (and most often do) seek effective medical attention from trained primary health care professionals (such as GPs as well as nurses) situated within the private health care sector (Patel et al., 2007). Approximately 16.5% of the South African population claim to have suffered from common mental disorders such as depression, anxiety or substance abuse in 2007 (Williams et al., 2007). Thus, considering that the majority of the population both within South Africa as well as abroad seek health care primarily from GPs, it is of high importance to investigate the quality of health care provided, particularly among patients with depression.

Horton-Hausknecht (2005) argues that GPs do not have a clear and comprehensive knowledge of mental illness and the practices of psychology. Herein, they often overlook, ignore, misdiagnose and even offer inappropriate treatment for mental illness. Both Qwabe (2009) as well as Lotrakul and Saipanish (2009) state that depression, in particular, is often misdiagnosed or under-recognised within primary care as the focus is predominantly placed on biological causes of discomfort (such as physical symptoms as opposed to psychological problems). Such physical symptoms may include headaches (or

other bodily aches), insomnia, weight loss or gain and so forth. In this respect, such presenting problems may be viewed as signs of a biological concern, rather than of a psychological one. For instance, an individual suffering from chronic headaches or even insomnia may be referred to a neurologist for brain scans in an attempt to discover a neurobiological cause for the presenting problem. Since it is possible, and often recommended, for a GP to refer patients to a more suitable specialist, it is necessary to investigate under which conditions this referral is suggested as a secondary health service by the GP (Lotrakul & Saipanish, 2009) as well as to whom this referral is made.

South Africa is comprised of a multitude of diverse peoples with a wide variety of histories, traditions, ethnic backgrounds and cultures. In this respect, each person differs through their patterns of language, thought, understanding and experiences of the world. This cultural diversity needs to become part and parcel of every interaction, and is especially important when consulting with individuals with depression in general practice. GPs need to be able to meet their patients' cultural needs at every point of interaction in order to ensure that the patient is conceptualised and understood within their specific context, thus aiding in maximising a comprehensive and holistic understanding of every individual (Duncan, Bowman, Naidoo, Pillay & Roos, 2007). This study will investigate if and the extent to which cultural diversity is taken into account within the doctor-patient consultation. In doing so, this study aims to contribute to cultural awareness within this context.

2.3. Research questions

- How do GPs understand and diagnose depression?
- How do GPs treat depression?
- Under which conditions do GPs decide to refer their patients to mental health professionals?

- To what extent do GPs consider their patients' cultural background when diagnosing, treating and/or referring patients?

2.4. Participants

A non-probability convenience sampling technique has been used in this study. A sample of six GPs within the private health care setting were selected within the Johannesburg area. GPs were selected primarily for convenience from four private clinics in the vicinity of the University of the Witwatersrand. Phone calls were made to these clinics where names and contact details of GPs practicing within each clinic were acquired. These GPs had then been contacted individually and invited to participate in the study.

During the time of the interviews, all six GPs were practitioners at a private practice within a clinic. Five participants were male and one was female. All participants stated that they consult with patients with various problems and who have differing demographic backgrounds. The number of years spent in general practice varied from approximately two to 48 years. All GPs had undergone further training post-graduation which included locums, hospitals and casualty sessions. Three of the six participants also extend their services beyond their personal practice, whereby they also engage in locums, theatre assistance, hospital assistance (non-specified) as well as mentoring and training of senior medical students.

2.5. Instruments

Interviews were conducted using a semi-structured interview schedule. Interviews lasted approximately 45 minutes to an hour. The questions in the schedule may be located in Appendix D. The questions in the schedule were based on general practitioner's understandings of depression with particular reference to diagnosis, treatment and referral within the South African Context. The questions were developed by reviewing literature in this area as well as consulting with my supervisor. There are 22 questions in the interview schedule that are divided into five sections which deal with the GPs' working

context, detecting or diagnosing depression, treatment of depression, referral patterns as well as questions surrounding culture. The initial interview schedule was piloted on two GPs and was also read by two lecturers at Wits. The pilot required that the GPs and lecturers carefully read the questionnaires and comment on the appropriateness of the questions. Following this, a final interview schedule was compiled whereby the questions were modified and improved as per the suggestions made by the pilot participants.

2.6. Research design

This study utilised a qualitative research design which aimed to accomplish an in-depth and rich understanding of the participants. The interview schedules attempted to capture the essence (or core components) within the communication. Sofaer (2002) states that qualitative research methods are generally favoured in studies within the medical field since interviews may be used as a tool to evaluate knowledge and attitudes in health care. In a similar vein, this study conducted face-to-face semi-structure interviews with all the GPs in an attempt to rigorously understand and conceptualise the manner in which the participants manage patients with depression.

2.7. Procedure

After ethical clearance had been received from the Human Research Ethics Committee of the University of Witwatersrand[1] [2], each clinic within the vicinity of the Witwatersrand University was contacted telephonically so as to obtain the names and the contact details of the general practitioners practicing within each clinic. Potential participants were contacted telephonically and invited to participate in the study. When potential participants required further information on the study, they were provided with a one-page information

[1] For further information pertaining to ethical approval see Appendix E.

[2] Ethics protocol number: MACC/11/006 IH

sheet (cover letter) offering information of the general nature and content of the study.

Once they had agreed to participate in the study, a time and place for the interview had been decided upon together with the participant. At the start of the interview meeting, the participant was asked to give both verbal and written consent[3] for the interview as well as grant permission for the interview to be recorded and used verbatim within the research paper. All interview material was then transcribed and the transcriptions analysed. Should the participants wish to know about the results or the outcome of the study, they will be provided with a one-page summary of the contents discussed in the study, after its completion, upon request[4].

2.8. Ethics

Before the interview commenced, the participants were asked to give both verbal as well as written consent of their participation. They also formally agreed for the recorded material within the interview to be used in this particular research study. The participants had been informed both verbally and via the informed consent form that their participation in the study is voluntary and that they could choose not to answer any questions if they are not comfortable with them. They were also able to withdraw from the study at any point without consequence if they wished to do so. They were also able to withdraw their responses from the study at any time. There are no benefits or risks associated with the study.

Furthermore, participants were assured of confidentiality - only myself and my supervisor will have access to the tapes and transcripts. The tapes and transcripts will be kept in a locked cupboard at the university for a period of three years, thereafter they will be destroyed. Even though anonymity is not possible, participants' identities are protected in that no identifying information

[3] See Appendix B for an example of this consent form.

[4] A feedback summary of this study is available in Appendix F.

is used in the research report and participants have been referred to by a pseudonym (e.g. Participant A). To ensure transparency and openness, participants will be informed about the nature and the results of the study after the report has been written and will take form of a one-page summary sheet which will be available on request. This request may be made directly to the researcher, where the contact details were provided on the cover letter that accompanies their invitation to participate within the study and which they were requested to keep.

2.9. Data analysis

Thematic content analysis was used within this study. This approach of analysis aimed to extract themed meanings from language within data, in this case – the interviews, in order to locate patterns that are relevant for the particular research at hand (Braun & Clarke, 2006). This analysis involved an active involvement on behalf of the researcher – recognising and highlighting certain themes in communicative language, where they were previously less observable. Braun and Clarke (2006) provide a step-by-step guide on how to analyse data and these steps were adhered to within this study.

Step one involved making oneself familiar with the data (transcribing data, reading data repeatedly and taking note of initial ideas). Step two involved generating codes for interesting features of the data, methodically, across the entire span of the data. Step three comprised of searching for themes (gathering codes into possible themes as well as collecting all data pertinent for each theme). Step four included the reviewing of themes (ensuring that codes worked successfully across the entire data set as well as within the specific coded extracts). Step five involved describing and giving name to each theme. Lastly, step six entailed generating the final, scholarly report of the analysis where each theme was discussed with examples or extracts and then related back to the literature and research questions that were central to the study at hand (Braun & Clarke, 2006). Thus, this study followed all six steps in the same manner as discussed above in order to thematically analyse the data gained in the interviews.

2.10. Self-reflexivity

As a researcher within the field of psychology, I acknowledge that I have my own perceptions, opinions and attitudes about this world and reality that we live in. I understand that I have biases that favour psychologists in the treatment of depression. Furthermore, I recognise that I have prejudices concerning the medical field, where my perceptions of the profession are at times unfavourable. Throughout the entire research process, I have aimed to, as far as possible, manage my own biases so that they did not impede or hamper any aspect of this process. In order to aid this process, I kept a journal of my daily activities and experiences before, during and after the interviews where I disclosed and endeavoured to deal with feelings and thoughts that were hereby relevant. In this manner, I explored these thoughts and feelings so as to discover what influences they had both within the interviews as well as in the research report itself. If they had any potential for influencing this research process in a negative manner, I sought to manage them directly and effectively.

Chapter 3: Results

3.1. Introduction

Following the gathering and transcription of data, an analysis was conducted on the transcribed material. According to Braun and Clarke (2006), the transcribed analysis process involves becoming familiar with the transcriptions, taking note of broad ideas within the text and finally drawing on more nuanced themes and subthemes that emerged from within the data. This section aims to report on the findings from the data analysis. The four themes (that were congruent with the research questions) will be presented first. Briefly, these themes include: Diagnosing or detecting depression, treating or managing depression, referral and culture. Following these four themes are a further four themes that also emerged from the interviews (which include: the training of general practitioners, the evolution of the medical field and its practices, disadvantaged communities and access to health care resources as well as the ethics of practice).

3.2. Diagnosing or detecting depression

The first theme that will be reported upon is the diagnosis of depression in general practice. Four subthemes were found during data analysis and these include: GP's overall attitudes on the diagnosis or detection of depression, GPs' problems with differential diagnosis and classification of depression, diagnostic criteria and extraindividual factors that impede detection. These subthemes will henceforth be discussed.

3.2.1. GPs' overall attitudes on the diagnosis or detection of depression

GPs' general opinions about diagnosis and detection were rather varied but the general consensus between those who had an outlook on this was that it was complex and difficult to detect. Both Participants 1 and 5 agreed that depression is usually masked in general practice and that it is the responsibility of the GP to be sensitive to this phenomenon and unmask it so that it can be confronted and treated. However, the detection (or "unmasking")

of depression appears to be rather complicated. As Participant 3 explained, it is often an “educated guess” on the GP’s behalf. Participant 1 further added that it is frequently a “trial-and-error” process where medication is prescribed (even over-prescribed) alongside every minor symptom of depression. Therefore, Participant 1 was of the opinion that depression is over-diagnosed and hence over-treated since medicine (at affordable rates) is readily available in today’s society and that it is often an “easy way out” for many GPs:

> Participant 1: “...But I think it’s over-diagnosed – I really do, hm. I think we use, cos we’ve got anti-depressants now since the Prozac generation, that, uh, should the woman doctor prescribes anti-depressants, hm. And, eh, again, I’m wondering how many are really depressants. And whether the medicine’s gonna work.”
>
> Researcher: “Why do you say it is over-diagnosed?”
>
> Participant 1: “Because there are so many people that I see that I don’t think are depressed, that are smiling and happy and living well and we’ve put on anti-depressants. And they don’t fit my criteria. I think it’s an easy way out cos doctors don’t spend time with the patients. Even psychiatrists, that’s the easy way out is just to prescribe, eh, anti-depressants and see how it is that they feel and ask them to feel better. It’s more about trial and error than actually making a proper diagnosis”

Participant 2 agrees that depression is difficult to detect in general practice and Participant 3 states that it may even take two or three consultations to make an initial diagnosis:

> Participant 3: “...Investigations don’t show anything. Repeated blood tests, x-rays, brain MRIs – all normal. Eventually, it’s obvious the patient’s depressed – there’s no obvious physical cause for the symptoms. So it’s often just a question of time. And may not be present in the first, second or third sometimes. Also, they might just tell you about family or stressors going on in their lives, bereavement – it might be easier to diagnose then. Or chronic fatigue – so the presentation also. Also very widespread – not a very straightforward presentation of depression.”

Participants 2 and 3 both stated that they are frequently confronted with patients who present with aches and pains and that it is the GP's responsibility to seek the root cause of this problem. All 6 of the participants assent to the fact that they almost always seek a medical or physiological explanation for the patient's presentation before looking to an alternative account. Participant 5 explains that is a GP's responsibility to screen patients medically first and only once these objective tests come back negative should the GP consider depression: "let's do this blood test because we can be scientific, but if it comes back negative, you know, what do you think about the idea of depression?" Thus, the consensus amongst GPs was that medical screening needs to precede a psychological diagnosis, where (as Participant 1 highlights) phenomena such as imbalanced hormones (like hyper or hypothyroidism) need to first be eliminated. Relative to the abovementioned reportings, two participants agreed that it is considerably more difficult to make a psychological diagnosis than a physiological one as psychological issues are more abstract than concrete, observable, tangible and objective manifestations of disease.

It should also be noted that even though most participants were of the opinion that diagnosing depression was complicated and convoluted, Participant 5 stated that depression was easily diagnosable once scientific measures have ruled out the possibility of a medical condition.

Participants considered a few factors that may hinder or impede the process of detection which will hence be reported upon. Participants 1 and 4 noted that the doctor's qualifications and knowledge of criteria of depression influenced the diagnosis thereof. Furthermore, the nature of the GP's upbringing and the influence of his or her current living environment (mentioned by Participants 4 and 6), doctor's sensitivity of the patient's affective state (stated by Participant 5) as well as his or her own emotional state and level of empathy (which Participant 1 made reference to) may all also have an impact on the detection of depression.

Participants 1 and 2 state that the lack of patience (on the GP's behalf) may also act as an impeding factor in the detection of depression, in addition to the doctor's personality type and the effects it may have on the patient's disclosure (as mentioned by Participant 4). As stated by Participant 5, if patients do not perceive doctors as understanding and approachable this may lead to a diminished disclosure and confidence in the doctor where depression may go even further unrecognised. Lastly, both Participant 3 and 4 highlight the importance for the doctor to possess courage and confidence when diagnosing. Participant 3 illustrates this very point in the following extract:

> Participant 3: "Someone's got to have the courage to tell them they're depressed - 'this is not a medical problem per se, this is depression and there is treatment for it'. So I think it often takes, I wouldn't say courage, it takes a bit of a leap to actually say that that this is the problem...You have to actually be willing to do that and risk chasing the patient away, which often happens and 'I'll find somebody else."

Both Participants 3 and 4 elaborate that it is often easier not to make a diagnosis at all. Participant 6 takes this statement further by elaborating on the reason why a diagnosis of depression may be avoided. He states that the GP may fear chasing the patient away by diagnosing depression and that it is often preferred that the patient gain the doctor's trust first before any diagnosis can be made. Participant 5 states that she would rather try and find a more familiar cause to a problem (i.e. one that is medically explained) rather than delving into psychological explanations.

3.2.2. GPs' problems with differential diagnosis and classification of depression

Participants 1, 4 and 5 explained their difficulties with differentiating anxiety and depression as well as somatoform and depression. With regards to anxiety and depression Participant 1 explains "there's a very thin line between depression and anxiety, hm. Ahh, I don't think most doctors really understand the difference, and they usually give medication which covers both, just in

case, ey." An attempt at differentiating depression from anxiety is exemplified by Participant 1 in the following instance:

> Participant 1: "...try and differentiate between depression and anxiety and often the two are associated. But, my idea of depression, I use certain criteria guidelines. For example, if a person, goes, falls asleep, uhhh, and then wakes up and can't fall asleep again, I use that as a guideline for depression, as opposed to the person who can't fall asleep at all, then I say that's more likely to be anxiety".

Thus, there appears to be some confusion around the differences between anxiety and depression.

With regards to somatisation and depression, Participant 2 states that:

> Participant 2: "depression is not something that is easy to pick up because, you know I can tell you, a patient will sometimes somatise problems and then they come to you complaining about the problem that will be organic that you'll think is the typical problem. That is a physical problem. But when you speak with the patient you realize, here we are talking about something else because this man didn't came to see me because he has flu, or this man didn't come to see me because he has a sore ankle or a sore whatever. So you start to, you know, gravitate from what you thought was a physical medical problem, to something that you can see, no this is a psychological one."

As noted by Participants 3 and 5, differentiating between depression and a true medical condition also needs to be taken note of where the presence of chronic illness or disease (such as AIDS or cancer) may also impede detection where the symptoms of the medical illness may overlap with the symptoms of depression. The differentiation between depression, somatisation and a medical problem appears rather complicated here where a thorough investigation of the patient is often required.

The diagnosis of depression may be even further complicated by the side-effects of a patient's medication. As Participant 3 states, the depressed mood may be attributed to the side-effects of the medication rather than a possible underlying depression. Thus, when diagnosing, this is yet another factor that

needs to be accounted for so that a valid diagnosis of depression can be made.

The presence of depression with some patients was also classified as a personality disorder. Participant 1 explained that patients who relapse from treatment or who suffer chronic depression appear to be suffering from a depressive personality disorder: “even those that get better, they often, after a period of time, relapse again. So it seems to be a personality disorder as well, hm.”

Participants 1, 5 and 6 highlighted the importance of classifying depression into two different types, namely: endogenous and reactive depression. They explain that endogenous depression is as a result of chemical imbalances in the brain that are not triggered by external social or contextual circumstances, whereas reactive depression follows from a specific or several series of life events that impact negatively on the individual and thus causing depressive symptoms. Participant 6 suggests that collateral information from the social environment is also valuable as it assists the GP in understanding the nature of the depression and plan the way forward.

Participant 1 noted that depression is an idiosyncratic occurrence where the manifestation thereof differs from patient to patient. According to Participant 1, the presence and presentation of depression depends on one’s age, lifestyle, environment, relationships and finances. Thus, in line with the comments made above regarding reactive depression, it may also be noted here that one’s circumstances and context appear to be taken into account where each individual exhibits depression in a unique manner.

3.2.3. Diagnostic criteria

With regards to the diagnosis and detection of depression, participants were asked to name the criteria they used to diagnose depression as a clinical disorder. Some participants admitted that their knowledge of diagnostic criteria was insufficient where Participant 1 stated that psychiatry was not his

strong point and that he did not understand what was meant be “criteria” per se; Participant 2 mentioned that he could not remember the criteria; and Participant 6 expressed that he was out of touch with the DSM. In diagnosing depression, Participant 3 stated that he generally uses an objective scoring system (Hamilton Rating Scale of Depression) which also assists him in conveying the diagnosis of depression where the patient is more likely to be accepting. The same participant also stated that he values history-taking over a medical examination as it yields more relevant information that is used to aid in diagnosis. The manners in which the participants understood depression and its criteria are summarised in Table 1 below.

Most frequently stated criteria of depression were changes in sleeping and eating patterns (as mentioned by Participants 1, 3, 4, 5 and 6). With regards to sleeping patterns, most participants mentioned hyposomnia (or the inability to sleep or stay asleep) more frequently than hypersomnia. Change of eating habits also included responses of over-eating, under-eating, gaining weight and losing weight. Participants 2, 3 and 6 mentioned loss of interest as another criterion that constitutes towards the detection and diagnosis of depression. Similar to loss of interest were two further criteria: loss of drive and lust for life (as stated by Participants 2 and 4) and loss of desire and motivation (noted by Participant 1). Other criteria that participants identified include: low mood (Participants 4 and 5), suicidal tendencies (both ideations and attempts – as mentioned by Participants 1 and 3), fatigue (chronic and otherwise – as noted by Participants 3 and 5) and low or loss of libido (Participants 4 and 6).

The remainder of the criteria were mentioned only once across participants: feelings of worthlessness (Participant 1), feelings of hopelessness (Participant 3), lack of energy (Participant 5), having an altered state of mind (Participant 4), having a deep disturbance (Participant 4), crying (Participant 3), having negative thoughts (Participant 3), having the inability to be happy (Participant 4), poor concentration (Participant 4), change in lifestyle (Participant 1), inability to cope (Participant 1), feeling down, gloom and dark (Participant 4), going down a slippery slope (Participant 4), lack of insight in dealing with

Criteria or description of depression	Participant/s	Frequency mentioned
Insomnia (hypo and hyper)	1, 3, 4, 5, 6	5
Change in eating habits	1, 3, 4, 5, 6	5
Loss of interest in daily functioning	2, 3, 6	3
Loss of drive or lust for life	2, 4	2
Low mood	4, 5	2
Suicidal tendencies	1, 3	2
Fatigue (chronic and otherwise)	3, 5	2
Low or loss of libido	4, 6	2
Lack of desire or motivation	1	1
Feelings of worthlessness	1	1
Feelings of hopelessness	3	1
Lack of energy	5	1
Altered state of mind	4	1
Deep disturbance	5	1
Crying	3	1
Negative thoughts	3	1
Lack of ability to be happy	4	1
Poor concentration	4	1
Change in lifestyle	1	1
Inability to cope	1	1
Feeling down, gloom and dark	4	1
A slippery slope to slide down on	4	1
Lack of insight into dealing with things	4	1
GPs' countertransference experience	3	1

Table 3.1: Summary of participants' understanding of depression and its criteria

things (Participant 4) and the GP's countertransference experience (where Participant 3 feels sad or depressed when the patient leaves consultation). What is more, Participant 1 added that "everybody gets depressed sometimes" into his clinical understanding of depression.

3.2.4. Extraindividual factors that impede detection or diagnosis

It is worth mentioning a few extraindividual factors. These factors are as a result of situational, contextual, circumstantial or environmental forces that impact on the relational pattern and communication between patient and doctor.

The first instance is that of a language barrier where there is a loss in essential communication between doctor and patient - as noted by Participants 1 and 3 - where patients, for instance, may not understand or have an equivalent word for "sadness" in their own language. Participant 5, however, believes that she is able to negotiate past the language barrier by finding a common way of communicating with the patients that she consults with.

Participant 3 mentions how some patients may move from doctor to doctor, searching for help from a variety of sources and may "fall through the cracks of the system" so to speak. A diagnosis of depression in this case would be amiss if any one doctor does not make a detection. Participant 3 elaborates:

> Participant 3: "...they're demanding medicine for something a, non-organic problem, and they often go from doctor to doctor, shopping around until someone will actually tell them 'you're depressed' and this is the issue. But it may not be the first doctor or the second or the third even."

Lastly, time constraints were cited by most of the participants (in one form or another) as an impeding factor. Participants 2, 3 and 6 mentioned that in general practice there is frequently too little time to do a thorough investigation of the patient's qualms where there is often pressure from the

external world (in the form of a queue of patients for instance) to be swift in consultation. Participants 3 and 4 stated that 20 minutes is not enough time to do a comprehensive assessment where Participant 6 elaborates that the period of time allocated per consultation does not allow for the whole problem to be addressed – only a few key problem areas. What is more, during the interview process five interviews were hurried and met with interruptions.

Participant 1, however, appears to feel less pressured under time and argues that time is malleable and that should the consultation time be up, he would reschedule another consultation time with the patient. Participants 4 and 5 attest to having no problems with time constraints whatsoever and Participant 5 further states that 15 - 20 minutes is enough time for an investigation into the patient's qualms.

3.3. Treating depression

Overall, the five participants reported that they prescribe medication once they have diagnosed depression with a patient where, as Participant 5 explains, prescribing medication after the first consultation may even occur. Participant 2 stated that he often prescribes anti-depressants, hypnotics and sleeping pills once *mild* depression has been detected. Participant 5 also suggests that combining anti-depressants with tranquilisers is sometimes necessary: "I'll combine it with a tranquiliser just for ten days so that, you know, they don't get into that panic spin". Participants 1, 3 and 5 explained that they would take some time to explain how the medication worked (e.g. the length of time medication needs to be taken in order for positive effects to emerge) to put patients at ease.

Participants 1 and 6 stated that they preferred to prescribe medication alongside psychological care if it was available. Participant 1 illustrates this point in the following extract:

> Participant 1: "...get them to understand their condition and then try and treat it psychologically and then also try and give them an anti-depressant and explain

> how it works and how long it takes to work and what they must expect, and see if it works. But often I don't want to bear the, if I pick up that it's depression, I don't think I want to bear the responsibility myself – I'd like to share it with, eh, a professional."

Participants 3 and 6 reported that they often explain to their patients that taking medication will help them cope better but they will not resolve their problems. Herein, Participants 1, 3, 4 and 6 mentioned that they take into account the patient's contextual circumstances where biopsychosocial causes of depression (Participant 6) and duration of symptoms (Participant 4) are considered. What is more, Participant 6 often attempts to involve family members of the patient so that social support is strengthened. As mentioned by Participant 1, should time be available, he would take the time to teach his patients coping mechanisms to deal with the depression more effectively.

Participants predominantly varied in their responses to the way in which they approach treatment once depression has been detected or diagnosed. Participants 1 and 3 stated that once depression was detected they tell their patients, explain that it is not their fault and foster an understanding of their condition. Participant 3 explains this point further:

> Participant 3: "It can be normal to feel sad or unhappy – depending on circumstances. I often let them come back again to discuss it, think about it, maybe give them some information to read (which I'll show you later) to explain that it can be normal – doesn't mean that there's something wrong with them specifically, they're not a psychiatric patient."

As may be noted in the above extract, Participant 3 makes an attempt to normalise the patient's condition by taking into account external circumstances. After diagnosis, Participants 3 and 5 often explain the benefits of receiving treatment.

Participant 4 reports that he approaches the patient about the diagnosis, asks them how they are currently managing with the depression and if they would require additional assistance:

> Participant 4: “Ok, so if I say to them that I feel that there’s a depression, generally I would suggest that, you know, if it’s possible for them, ask them in terms of how they’re dealing with it...how they managing with it. Um, do they feel they need extra support in terms of psychological help, in terms of being with a psychologist?”

On the other hand, Participant 5 states that once depression is detected she discusses it with the patient and conducts scientific, objective tests to rule out other conditions. Should these results come back negative, the possibility of depression is addressed where the introduction of treatment (in the form of medication or counselling) is made.

Participant 4 believes that depression is not adequately addressed and suggests that more training be available to GPs on the treatment of depression. Participant 6 further recommends that nurses in community clinics should undergo similar training where they can learn to diagnose and treat depression at the grassroots level.

3.3.1. GP’s opinion of their efficacy with regards to treatment of depression

Once again, participants’ opinions varied in their responses, but the general consensus was that their treatments were not optimally successful. Participants 1 and 6 both agreed that they effectively treated 30 – 40% of their patients. Participant 3 reported that his treatment was 50 – 70% effective and Participants 4 and 5 mentioned that their efficacy was fair to good. Participants 1 and 2 stated that it was difficult to measure their efficacy as they frequently lose track of their patients. Participant 1 believes that he is able to effectively treat depression on a short-term basis but that on a long-term basis he states that patients relapse. To add, Participant 2 feels that he is not offering the right kind of treatment.

3.3.2. Problems incurred within the process of treating

Participants 3 and 5 stated that fear of addiction to the medication prescribed by GPs is a barrier to treatment and Participant 5 expands on this by stating that it is the GP's responsibility to debunk any myths or stereotypes about the consumption of medication.

Financial constraints (as mentioned by Participants 1 and 3) also impede the process of treating. Participant 2, however, does not agree with this statement as his secretary screens all patients to ensure they are able to afford consultations. Participant 2 illustrates his comment in the following quote:

> Researcher: (interrupting) "I was just wondering about people who can't, who don't have medical aid at all who find it difficult to afford?"
>
> Participant 2: "Oh yes, that's uh, that's another challenge. But usually that would be dealt with by administration, you know, the reception. They sort out those kind of problems before the patient can be able to come to me. If you happen to find that, that would be very very rare because they screen them, they phone medical aid and confirm, you know, medical aids, you know. Validity and medical aid fund and those things will be sorted out before the patient come here and then those who have to pay cash they pay that side before they come in and then I see the patient and, you know, I hope it's settled."

Other hindrances to treatment include: time constraints on behalf of the patient (e.g. taking time off work – Participant 3), transport problems (Participant 3), undesired side-effects from medication (Participant 6), termination of medication made by the patient (Participant 2) as well as migration of patients (where the GP looses contact with the patient – Participant 6).

3.3.3. Follow-up of patients diagnosed with depression

Participants 1, 4, 5 and 6 stated that they definitely follow-up with the patients whom they diagnosed with depression where Participant 5 stated that she

insists on follow-up sessions to ensure that the medication prescribed is working effectively:

> Participant 5: “Um, if I prescribe medication in the first consultation, I insist that they’ve got to give me feedback if anything is not to their liking or if, you know, if anything’s bothering them but definitely a routine bit of feedback after two weeks, one to two weeks to ask how they’re going”.

Participant 2 stated that he will welcome his patient’s return if they have any problems and if or when they return he often refers to secondary mental health professionals. Participant 3, on the other hand, states that he does not follow-up with his patients (due to time constraints) but emphasises its importance:

> Researcher: “Ok. In your previous experience, would you typically follow up with your depressed patients? Please discuss.”
>
> Participant 2: “You know what, that should be done, but it doesn’t happen as often as it should be done. That I’ll make a note to phone them but the time factor’s pressure may not get done. But ideally it should be done, doesn’t happen often though.”

3.4. Referral liaison between GP and secondary mental health professionals

All of the GPs commended that they look to the severity of the depression when deciding to refer patients to secondary mental health professionals. Participant 1 refers patients who have undergone a change in lifestyle, are struggling to cope, are suicidal and are suffering from severe depression that is impacting on their health, life and relationships. The other five participants specified their referral patterns based on the degrees of severity. For mild symptoms where the person has a stable lifestyle and good support structures (Participants 2 and 4) the GPs tend to treat the depression themselves. For moderate symptoms such as everyday problems (Participant 4) the GPs usually refer to a psychologist. For severe depressive symptoms such as with the co-occurrence of a personality disorder, bipolar or a crisis (Participant 4)

and suicidal ideation or attempts (Participants 1, 3 and 4) the patient is referred to a psychiatrist. For instance, Participant 3 makes the following point:

> Researcher: “And when do you refer to a psychiatrist?”
>
> Participant 3: “If a patient is really, not just pure depression, but suicidal, maybe other symptoms – psychotic – really not able to deal with the therapist alone or myself alone.”

Participant 1 also mentions that referral depends on the patient’s demographics (such as if the patient is a child versus an adult).

Despite agreeing to having a criteria for patterns of referral (as outlined above) some participants illustrated preferences of referral. Participants 1 and 5 stated that they predominantly liaised with psychiatrists. Whereas Participant 6 prefers to refer to psychologists as there is often a stigma or negative perception attached to psychiatrists. Participant 5 prefers rather to “recommend” than to “refer” and also states that she liaises with psychiatrists when “fine-tuning” of medication is required. As a disclaimer Participant 4 recommended that there should be a better referral of depressed patients to secondary mental health professionals.

With regards to liaising with traditional or faith healers, the participant’s opinions were generally negative where referral to such sources was predominantly dismissed. Participants 2, 3, 5 and 6 stated that they would not refer depressed patients to such parties as they were not a trustworthy source or sufficiently scientific. This point is illuminated by Participant 2 who argues the following:

> Researcher: “And, how do you feel about other non-medical forms of treatment for depression, such as with traditional or faith healers? Would you refer someone who seeks your help to one of these professionals?”

> Participant 2: “Um, not myself, believe me, I’m just for scientific or, you know, well researched, you know, modes of treatment and then the traditional and the homeopathic and all those other medication, uh I mean modes of treatment are not scientific based. I’m actually weary because, I mean, there’s no track record or mode of reference of what they are doing. Is it effective? ... I’m interested in trying to see if those kind of unresearched, you know, mode of treatments, are they effective, are they doing what they should be doing? You know. I don’t know about that one. No. I wouldn’t recommend it to anybody. I wouldn’t encourage anybody to go there or to take that route”.

On the other hand, Participants 3, 5 and 6 reported that they accept and encourage the wide-ranging use of traditional and faith healers throughout the population but that treatment of depression needs to be delivered in accordance with Western medicine too. In agreement with the above statement, Participant 6 states: “as far as traditional healers go or spiritual healers go, I encourage it…provided they don’t give up their pharmaco therapy. Ok. So we do both of them side-by-side”. Participants 1 and 5 acknowledge that traditional and faith healers have a role to play in the treatment of depression but specify that such parties need to know their limits.

Other participants remarked that such parties financially exploited their customers (Participant 5), offer unorthodox treatment (Participant 5), provide “unsafe” and “murky” treatment (Participants 5 and 6), are irresponsible (Participants 5 and 6), are unethical (Participant 5), offer effective treatment on a short-term, not long-term basis (Participant 6), have been compared to criminals (Participant 2) and were viewed as ineffective overall (Participant 2). The following quote made by Participant 5 further illustrates some of the abovementioned attitudes and opinions:

> Researcher: “Ok, how do you feel about other non-medical forms of treatment for depression, such as with traditional or faith healers? Would you refer someone who seeks your help to one of these professionals?”

> Participant 5: “I would say, um, I’m not uncomfortable with it. I always quote a version of the Hippocratic Oath - do no harm, either to the patient physically or to the patient’s bank balance. So I think the alternative medical practitioners, um, you can be in a very murky area of exploitation there, um, and irresponsible practice.

> However, I say to the patient “if you feel comfortable there, then I support you.” But I do ask the leading questions, you know: “are you being charged a fortune is it unorthodox treatment?”, “is it reasonable treatment?” I just don’t know of many alternative practitioners who I feel that, you know, that I can comfortably and responsibly refer people to. But I think if it works along side, and I’m also quick to point out that if we are going the route of, say, a pharmaceutical intervention, then understand the pharmaceutical and the chemical process here and then don’t go off your medication just because a faith healer tells you to”.

Participant 4 stated that although he has no qualms about and is open to non-medical forms of treatment, he would not refer the patient himself. Participant 1, on the other hand, has made attempts to liaise with such parties in the past but has had little satisfaction with the results.

3.4.1. Problems incurred within the process of referral

The most frequently mentioned hindrance to referral (as noted by Participants 2, 3, 4, 5 and 6) was the patient’s financial constraints where Participant 2 had to refer the depressed patient that he was treating to a less expensive source that was significantly further in distance.

Waiting lists (especially in the public sector) are also of concern for Participants 1 and 6 where, it is the opinion of Participant 6 that, there is an overload in patient influx within the public health care system that leads to long waiting lists. Participants 1 and 5, however, argue that they are able to bypass waiting lists in the case of urgency or severity (such as with suicidal patients).

Participant 3 states that he often refers patients whom he diagnoses with depression but that they resist going and would prefer to see a secondary mental health professional when they are desperate. In this case, this resistance is based upon the patient’s perceptions of a psychologist. This point is evident in the following abstract:

> Researcher: “Alright. In your previous experience, have you ever referred your depressed clients to a mental health care professional?”
>
> Participant 3: “Often to psychologists. Often. They don’t always go. And they often phone me back when they’re desperate and I say ‘I definitely suggest you go, here’s the number again’. And often then they do go – but only when they’re desperate, when they’ve reached a point where nothing else is working – they’re often resistant to going.”
>
> Researcher: “Why do you think they resist?”
>
> Participant 3: “Ag, they don’t believe psychology can help them, how can talking help them? It won’t make them richer, it won’t make them win the lottery, it won’t take their stressors away and often they have a distorted perception of what a therapist can actually do for them. And they often think ‘how can talking help?’ and when they do go, they’re often very grateful saying ‘thank you’ for sending them. I think a very good therapist will make a very big impression on them and help them.”

Not only do the perceptions of psychologists create resistances to referral, but also the perceptions of psychiatrists. As Participant 4 highlights, patients may have beliefs about psychiatrists over-prescribing medication and may thus resist a forward referral. As mentioned by Participant 1, referral may further be complicated by the ethical demand of confidentiality.

3.5. The influences of culture in general practice

3.5.1. The importance of culture in general practice

Participants 1, 3, 4 and 6 stated that they believe that culture is an influencing factor in general practice where it impacts and may hamper the process of diagnosis, treatment as well as referral. With regards to the above statement, Participant 3 explains that: “you’ve got to take the patient’s belief system into account as well”. The patient’s cultural beliefs may also make treatment difficult as they may perceive Western medicine to have little value for them. Participant 3 explains this in the following extract:

> Researcher: “So you’re saying that people normally come *from* traditional healers...”
>
> Participant 3: (interrupts) “Often, yes when that hasn’t worked often they do that. They’ve tried everything – traditional healer, over the counter medicines, they’ve vouched for their friends, maybe alcohol, and as a last resort, and as a last resort they come and see a Western doctor – certainly not the first stop.”

Participants 5 and 6 highlight how the GP needs to be sensitive to a person’s culture, to be perceptive of the patient’s mood and condition and be able to communicate through a common language. However, this may be a difficult task, as noted by Participant 1, who declared that he sometimes feels that there is a cultural gap between himself and the patient: “And I, uh, have difficulty there, cos, I have, uh, what’s the word?, I suppose, cultural gap between myself mind’s way of thinking and those patients”. Similarly, Participant 4 states that he does not have adequate knowledge and understanding of other cultures where there may be possible culture bias with regards to this.

The doctor’s own culture may further impede the detection of depression where (as Participant 2 highlights) the GP may show bias to their own cultural view and hence assume the same world-view for their patient (rather than considering the patient’s perspective). The following interview segment illustrates this exact notion:

> Researcher: “So there is a stigma attached to depression in different cultures?”
>
> Participant 6: “Yes, absolutely. Ok. And obviously umm…the doctors perception umm…within society, of depression. Umm…I think it plays an important role. So if I am living in a society where depression is accepted and uhh…you know, freely talked about, it’s a little easier to convince your patient and yourself that, ok, this is depression and it needs to be treated and followed up… umm…then if you… there is a stigma associated to it, you know…you often less likely to make the diagnosis.”

Even though there appears to be the threat of the GP's own cultural views and affiliations, Participants 5 and 6 stated that they often use the patient's cultural world-view and understanding of depression whilst at the same time acknowledging and treating depression from a Westernised perspective.

3.5.2. The stigma that resides in cultural worldviews

Cultural or religious understandings of depression as well as the stigma related to this may also dictate the acceptability of diagnosis and the length of time the symptoms take to emerge. As Participant 4 illustrates:

> Participant 4: "To detecting, to support as well, and culture would probably also influence the time, perhaps, of the presentation of the depression as well. People may feel that, um, you know, that , um, I can give, like, a known issue in terms of that, for example, um, abuse or depression in the Jewish religion would be, um, would come out, maybe, five to six years later than it would in some other religion because, you know, people would say, it can't be this guy, it can't be my son, he's too good of a guy to be abusive, so maybe from a whole perspective in regard to that, and it's not culturally ok to do that, or it's not culturally ok to be abusive towards one's wife, but no this happens in every culture and, you know cultural influence will influence how long it will take someone to reach that break point or the point of presentation of their symptoms though."

Stigma of mental illness as well as fear of society's perception of the patient is factor that obstructs treatment – as agreed upon by five participants. This is evident in a point made by Participant 3, who states: "Uh, often there is a stigma – people don't want to be told they're depressed and that they have a psychiatric problem. And often it's not socially acceptable to be told they depressed or go onto anti-depressants".

The stigma attached to being referred to, predominantly, psychiatrists also impedes the referral process as many patients (as cited in the interviews – Participants 1, 3, 4 and 6) proclaim that they are "not mad". Participant 3 elaborates on this point by stating that patients would rather be diagnosed with a medical or physiological condition than a psychiatric one such as depression.

3.5.3. Denial as a hindrance to diagnosis, treatment and referral

Participants 1, 2, 3, 4 and 6 stated that a hindrance to treatment is often the patient's inability to recognise and accept the challenges they are faced with or that they need help and often refute the doctor's diagnosis. In line with this, Participant 2 states: "From the patients side they, you know, they will always think that, you know what, they are fine." Participant 3 elaborated that some patients may even stop seeing the GP once they make a diagnosis because they are unable to accept the diagnosis.

3.6. The training of general practitioners

Almost all of the participants (except for Participant 5) felt that their university training was insufficient in the becoming a general practitioner. Participant 5 explains:

> Participant 5: "I think, no, um, the university training definitely I don't think is, um, trains you to, you know, just walk out the doors and be a GP, I think, um, technically you, um, it is a very good training and it was at a time when, I feel that, you know, I could trust the training and feel that I'm a safe pair of hands on the block, um GP work does require, um, far more though, than that what you have as a graduate."

In this regard, Participants 2 and 4 explain that they had to gain further training as a GP in hospitals and locums so that they could gain confidence in fulfilling their roles as a general practitioner. Participants 1 and 6 agreed that the quality of training has waned over the years and (as Participant 1 notes) training in the 1950s was superior in nature to the schooling currently being offered. When asked to specifically describe what was amiss in their training they responded as follows. Participants 2 and 4 stated that they were inadequately prepared for the financial management of a practice. Participants 4 and 6 agreed that there was insufficient training on ear-nose-and-throat management, anxiety, depression and face-to-face interactions. Participant 6 stated that there was a lack of training in the area of dermatology. Participant 4 explained how there was a tension between theory

and practice. Participant 5 noted that there was a deficit in the education of portraying empathy, having the ability to manage patients across situations and to target the actual root of a specific problem. Participant 5 further explains that university training instead teaches students how to be safe practitioners who need to know the limits to their knowledge.

3.7. The evolution of the medical field and its practices

Participant 1 noted how medical practice has changed over the years. He stated that recently, there has been a shift in focus where economic earnings have taken preference over providing quality health care. He argues that practices have become less patient-centred and Participant 4 adds to this point by sharing his own experiences during training:

> Participant 4: “Yeah, one thing that stood out for me is, um, what I found very difficult is um, to grasp was the fact that, um, working in the hospitals, was uh, mothers with chronic sick kids, in terms of, you know, chronic sores, like cerebral palsy, brain injury, strokes in the paediatric wards was really a difficult thing to comprehend, in terms of having to see the mothers on a daily basis...And um, I just found it difficult, that I used to just drop off the round to have a quick chat to the mom, to see how she was doing, you know, because everyone just sort of walked off and ignored them...Um, that was more what stood out, in terms of, I did lots of other issues, in terms of that, but that was the main one that really was bothersome to me, the lack of attention that was given to these people, just at a personal level, never mind, you know, helping the sick children just that no one engaged in how they felt or how to deal with it though.”
>
> Researcher: “So you feel that maybe, the humanity or the humaneness in the practice…”
>
> Participant 4: “Is becoming a forgotten thing, though...people, ya, just the simple thing of asking people how they’re doing, you know, instead of looking at it as a whole academic medical case, you know, you’ve got to drop down and see what people are feeling and try to just lend a hand as well, um with them too. I think it helps in the whole healing process you know, just to address people as people.”
>
> Researcher: “Do you think it’s becoming worse as it progresses?”

> Participant 4: “I think it is, you know, I think with the time, and I’m sure I’m at fault as well with many of my patients that I don’t spend enough time asking, and there’s no doubt about it, but it definitely is, I mean, time constraints are worse, life’s pressured, the pace has increased dramatically, you know, sort of, as you say, people are becoming numbed to them...”

Participant 4 highlights how modernisation comes with a fast-paced lifestyle where people feel pressured for time. Both Participants 1 and 6 pointed out how medical practice has become more difficult with the limitations made by institutions such as medical aids that have many regulations and legalities that need to be upheld. What is more, Participant 1 states that the gap between physicians and specialists is growing further apart and that GPs are no longer allowed to do house-calls.

3.8. Disadvantaged communities and access to health care resources

Some of the participants also commented on the financial constraints faced by individuals within disadvantaged communities. This can also include the refugee population (as Participant 3 points out) where many cannot afford medical aid and seek pharmaceutical treatment instead of having to pay for a consultation in general practice. This is a problem for Participant 3 as it is only once a condition is severe that such individuals seek a GP’s help. Participant 1 reports that he often helps one of his colleagues in a cash practice which predominantly caters for disadvantaged populations where approximately 40 or 50 patients are seen on a daily basis. Participants 1 and 6 argue that those without medical aid have to pay cash for consultations which is also limiting in terms of what assessments can and cannot be done:

> Participant 6: “...obviously the problems uncounted with the private patients is the limitation on investigations that you can do because on price constraints...with your private patients there’s a little bit more leverage, you can do what you know should be done um except there the limitation is uhhh monetary.”

Herein, Participant 6 notes how the quality of health care depends and is often limited by the amount of money a person has at their disposal. On the other hand, two participants mention that with the availability of generic medication – pharmacological treatment is more affordable.

3.9. The ethics of practice

One of the most notable ethical concerns that emerged throughout the interviews was GPs management of suicidal patients. Participants 1, 3 and 4 stated that if their patients were suicidal they would immediately refer them to a psychiatrist. The other three participants, Participants 2, 5 and 6, stated that they would first hospitalise such persons and only after psychological stability was gained would they refer these patients to a psychiatrist. Participant 1 highlighted how treating a patient who is deeply depressed may in fact be dangerous as anti-depressants may provide the patient with the energy required to commit suicide: “by treating the depression, when they getting better, they can then attempt suicide which they may not do when they’re deeply depressed”. The same participant explained how some patients are happy to be depressed: “Some of them are just happy being that way, do you wanna change them?”

The second most noteworthy ethical concern is that of confidentiality. When the same practitioner is treating more than one patient from the same family, it often becomes difficult to maintain confidentiality. This may be observed in the following excerpt with Participant 2: “Um, you know someone comes and you say ‘Mrs. so and so your husband was here, how is he now?’” Similarly, Participant 6 believes in a more holistic treatment with his patients where he attempts to involve the family (such as with cases of substance abuse):

> Participant 6: “... So the important part of it sometimes we call in the spouses, or family members that may be responsible for triggering this off. Umm…unfortunately we have a huge drug problem in this community so we often tend to get parents, even the drug user himself, a lot of the drugs they do abuse

> tend to cause depression so, you know, the idea is sometimes we have to deal with it in a holistic fashion and get the whole family involved ..."

Participant 6 seems to be deceitful in his treatment as it will increase compliance to medication-taking:

> Researcher: "So they would manifest in, like, muscle pains?"
>
> Participant 6: "Muscles pains and you know, *phone rings* they often think of depression as rheumatism because that's what their practitioners used to call it. So, the idea is, you tell him, this is part of your rheumatism…here's the medication for it. Unfortunately you gotta disguise it a little..."

3.10. Conclusion

This chapter has highlighted the most prominent themes that emerged from the data analysis. The following chapter will facilitate a discussion based on the above notions that will be aligned with relevant literature.

Chapter 4: Discussion

4.1. Introduction

The following chapter will elaborate on and discuss the themes that were reported in the previous chapter. The findings of this research paper will be compared and contrasted to local and international literature available on each topic. The discussion section will mirror the sequential order of the results section.

4.2. Diagnosing or detecting depression

Overall, general practitioners agreed that the detection and diagnosis of depression was difficult and complicated and was compared to a “trial-and-error” process as well as an “educated guess” on the GP’s behalf. In accordance with research conducted by Barley, Murray, Walters and Tylee (2011) it may be noted how the detection of depression is a complicated task in general practice which is further convoluted by the possible co-morbidity of other medical conditions. In their paper on depression and physical illness, Barley and colleagues (2011) as well as MacHale (2002) argue how a diagnosis of depression is complicated in populations with medical conditions. Some of the physical symptoms pertaining to the illness (such as weight loss, changes in sleeping patterns, lethargy and psychomotor retardation) often overlap with depressive symptoms – making a diagnosis difficult. MacHale (2002) hereby emphasises the importance of psychological symptoms when making a reliable diagnosis.

On a similar note, many participants stated they had difficulty differentiating between depression and anxiety as well as somatisation. Löwe, Spitzer, Williams, Mussel, Schellberg and Kroenke (2008) explain that general practitioners’ difficulties with differentiating between depression, anxiety and somatisation are predictable and normal. They provide three explanations for this: (1) all three have similar diagnostic criteria and presentation, (2) the presence of one of the conditions may act as a risk factor for the development of one of the other disorders and (3) all three may share the same biological or psychosocial predisposing factors. However, Löwe and colleagues (2008)

state that although there are significant overlaps in the presentation of all three, they are unique and differentiable disorders that require close and careful attention by the medical practitioner.

One participant stated that depression could also manifest as a personality disorder as evident by many patients' relapse after the treatment has been initiated. Depressive Personality Disorder was removed from the DSM-III as further research is required on the disorder (APA, 2000). However, the criterion of "relapsing during treatment" is not accounted for by Depressive Personality Disorder and may possibly be better explained by Dysthymic Disorder. Nonetheless, it appears as if there is some confusion regarding the manifestation of depression with some participants. This apparent confusion may be explained by participants' exposure to ongoing adequate and more current training for the management of depression. It is hereby suggested that continuous training for depression be negotiated where CPD points can be earned.

Classification of depression into various categories also seems to be essential for some participants. Such categories include differentiating between reactive and endogenous as well as reversible and irreversible depression. According to Gill (2007) endogenous and reactive classifications of depression are legitimate but are, however, outdated. Although outdated, this distinction highlights the extent to which these participants consider contextual, circumstantial and situational predisposing factors when diagnosing depression which is favoured when managing depression in a holistic manner (Lehti, Hammarström & Mattsson, 2009).

The participants of this study stated that it is their responsibility to screen patients for medical conditions first as well as eliminate the possibility of physical problems before seeking other explanations for the patient's presentation. As participants in Backenstrass, Joest, Rosemann and Szecsenyi's study in Germany (2007, p. 193) point out: "one reason for a detailed somatic diagnostic examination is to let the patient feel they are being taken seriously". Thus, medical screening was generally favoured amongst

participants where the identification of depression was viewed as complex and challenging (especially when compared to the identification of medical conditions – as noted earlier).

Some participants in this study also noted that side-effects of medications should also be eliminated as a possible cause to a depressed state of mind. The Citizens Commission on Human Rights International (2009) had released a report to inform fellow citizens of the uses and abuses of psychiatric medications as well as their side-effects. This report mentioned several psychiatric medications that may produce depressive side-effects, which include: psycho-stimulants, anti-psychotics, anti-anxiety medication and surprisingly older depression medication (such as Tricyclics, Tetracyclics and Monoamine Oxidase Inhibitors) as well as newer depression medication (such as Selective Serotonin Reuptake Inhibitors or Selective Norepinephrine Reuptake Inhibitors) where withdrawal from medication can induce an even deeper depression (Citizens Commission on Human Rights International, 2009). It is uncertain whether the participants of this study are aware of the side-effects of certain medications; however, it is an important avenue to explore. Exposure to current literature of this nature is essential and can aid in the prevention against misdiagnosis.

Qwabe (2009) and Lotrakul and Saipanish (2009) highlight how general practitioners tend to favour the biomedical model whereby the focus of diagnosis is primarily made through an emphasis on one's medical complaints rather than psychological difficulties. Some participants took this point further by arguing that depression is often masked by the patient's physiological presentation and that it is the responsibility of the GP to "uncover" or "get to the root of" the problem by doing objective tests that eliminate other medical conditions. As noted in this study, the fact that general practitioners perceive medical conditions to be more observable and concrete may explain why GPs tend to emphasise physiological explanations over psychological ones as mental health is predominantly understood as abstract in nature. Herein, it can be hypothesised that perhaps GPs tend to focus more on medical

explanations as they are more familiar within their field of practice than psychological perspectives on problems.

Several factors that impede the process of detection and diagnosis have been noted by the participants and will henceforth be discussed. Some participants stated that the doctor's knowledge and understanding of diagnostic criteria of depression have played a factor in the detection of depression. This is further validated by Sigel and Leiper's study (2004, p. 280) where they argue that "GPs with greater academic ability have been shown to use their knowledge of psychiatric illness more appropriately than other GPs in clinical practice".

The doctor's sensitivity to the patient's affective state, as confirmed in Sigel and Leiper's study (2004) that was conducted in the United Kingdom, is another factor worthy of considering when diagnosing, since patients may often only disclose medical qualms alone, thereby neglecting other troubles they are facing. As Louch (2009, p. 43) points out – one of the obstructions to diagnosing depression include the patient's non-disclosure of emotional issues: "80% of patients with depression present with non-specific physical symptoms and avoid mentioning any emotional or psychological symptoms". Thus, this study recommends that GPs be attune to every patient's emotional presentation so as not to under-recognise the possibility of depression. To facilitate this, training regarding signs and symptoms can commence whereby GPs can be informed of the varying manifestations of depression.

The GP's own emotional state and level of empathy have been noted by the participants as important when diagnosing. As elaborated on by the participants of this study, the practitioner may not detect a depressive state with a patient if they are overly concerned with their own state of mind. Herein, if they are engrossed within their own happiness or content, it may be difficult to understand or empathise with another person's sorrow or sadness. This notion is in line with Ellen, Norman and Burrows' study in Australia (1997) who state that the doctor's empathic style has a significant influence on the detection of depression.

Other features that may impede a diagnosis of depression also include the GP's employment of patience as well as the personality type of the doctor. The personality of the doctor may have an effect on the disclosure of the patient, especially if the patient does not view the doctor as approachable. In such a case, the patient's innermost concerns may be left undisclosed due to their lack of self-assurance with the doctor. This aforementioned feature was also noted by Tylee and Walters (2005) who illustrate that doctors who have a keen interest in their patient's social life (and the problems therein) are more likely to be successful in their detection of depression than doctors who shy away from this.

GP's courage and personal confidence in disclosing the diagnosis are further features that are of significance when diagnosing depression. In this regard, and in accordance with the research conducted by Mitchell, Vaze and Rao (2009), GPs may decide not to diagnose the patient with depression (even if suspected) for fear of disrespecting the patient and consequently losing the patient and their trust. This leads to a further favouring of medical diagnosis which is better accepted amongst the patient population.

Participants were required to provide specific diagnostic criteria that define depression. Most often cited were insomnia (hyper and hypo) and changes in eating habits. Other criteria, and the frequency with which they were mentioned, are noted in Table 1 in the results section above. Upon examining all participants' responses, it may be noted that almost all criteria for Major Depressive Disorder were collectively accounted for. Missed by all participants, however, was the criterion pertaining to psychomotor agitation. What is more, none of the participants mentioned the number of criteria required to make a valid diagnosis of depression. Some participants described depression in a unique manner where criteria were not clinically or diagnostically appropriate. Such responses include: altered state of mind, lack of ability to be happy, a slippery slope to slide down on, lack of insight into dealing with things and the GPs' countertransference experience. One participant stated that "everybody gets depressed sometimes" where the use

of the term “depression” seems to have colloquial relevance rather than a solid clinical foundation.

In a study conducted by Krupinski and Tiller (2001), it can be noted that two of the most frequently mentioned diagnostic criteria were also sleep disturbances and changes in eating habits. The respondents in their study mentioned additional criteria that were broader than the formally recognised understandings of depression that include: behavioural problems (such as aggression), pessimism, headaches or dizziness, appearance, heavy use of substances, delusions or hallucinations, reaction to probable cause of events, family or past history of depression, obsessive ideations, lack of insight and period of life (such as menopause). A depressive rating scale was also used by 5 out of 3289 respondents, which reflects the results of this study whereby one participant used the Hamilton Rating Scale of Depression to aid in his diagnosis.

The respondents in their study, however, deviated from the diagnosis of depression quite considerably when compared to the participants of this study (who did not deviate as widely). One notable difference between this study and Krupinski and Tiller’s study (2001) is the number of respondents (3289) in their study compared to the number of participants (six) in this study. With a larger sample, there is a greater possibility that errors can be encountered. What is more, the methods used to obtain data also differed where their study used a questionnaire and this study utilised a semi-structured interview schedule. It is hypothesised that those who partook in the interview were more invested in the process of answering questions than those who answered questionnaires (where responses may not have been granted adequate attention, time and thought).

Factors that may influence the detection or diagnosis of depression, but cannot be accounted for by either doctors or patients, will now be discussed. A participant in this study noted that individuals who seek refuge in South Africa tend to “fall through the cracks of the medical system” since they travel from one doctor to another through the process of migration. What is more, as

mentioned earlier, the diagnosis of depression in general practice is often a complex process where a formal diagnosis may not be obtained following the first or second consultation. To this end, it may be hypothesised that a great proportion of South Africa's refugee population that is suffering from depression is under-recognised and under-diagnosed. This area is in need of further research as literature on this topic is significantly scarce. There is a strong rationale for literature on this topic to be cultivated, especially since refugees and migrants alike are considerably more susceptible to being affected by mental health problems (such as depression) than other South Africans, particularly if they have suffered from trauma or discrimination (Matzopoulos, Corrigall & Bowman, 2009).

The language differences between patient and doctor may act as a barrier to diagnosis of depression and is further recognised by authors Lehti, Hammarström and Mattsson (2009) who emphasise that problems with communication can further complicate the detection of mental illness. They state that immigrants, in particular, are vulnerable to misdiagnosis as they are frequently misunderstood where their symptomatology is under-appreciated.

Even though many authors (e.g. Peveler & Kendrick, 2001) acknowledge that time pressures play a role in the under-diagnosis of depression, participants that were involved within Pollock and Grime's study in the United Kingdom (2003) found that they were able to navigate within the allotted time with ease and flexibility. Such participants also viewed depression as easily identifiable where treatment was straightforward. A possible reason for deviation of this latter study to this study may be the GPs' perceptions of the ease with which depression can be identified. The participants in this study may require more time to assess and investigate the presence of depression and thus feel more pressured for time as opposed to the participants in Pollock and Grime's study (2003) where depression was viewed as uncomplicated.

4.3. Treating depression

Most of the participants prescribe medication as a form of treatment, even after the first consultation. This is in agreement with Louch (2009) who states that patients in primary care who are diagnosed with depression are usually treated with anti-depressants. The majority of GPs stated that they prescribe anti-depressants (for mild depression in some cases) where other medications also included hypnotics, sleeping pills and tranquilizers. The use of hypnotics and tranquilizers as a form of treatment for depression is noteworthy as they are considered anxiolytic drugs that are predominantly used in the treatment of anxiety disorders. Going back to a former discussion on differential diagnosis, the reader may be reminded that some of the participants of this study had trouble differentiating a diagnosis of depression from anxiety. It is thus hypothesised that, as a way of overcoming this problem, GPs may be prescribing both depression and anti-anxiety medication *together* to combat *both* disorders. This very point was noted by one of the participants in this study who stated that, because of the confusion that many GPs face regarding anxiety and depression, they often prescribe medications that cover both.

The National Institute for Health and Clinical Excellence (NICE, 2009) provide guidelines for the diagnosis and treatment of depression which stipulate that, in the case of mild depression, medication should only be prescribed once other avenues of treatment have been sought. In opposition to these aforementioned guidelines, some participants in this study frequently prescribed medication (for both anxiety and depression) in the treatment of mild depression, without seeking other avenues of treatment first. These guidelines also stipulate that practitioners should take time to discuss the treatment plan and the effects and side-effects of the medication being prescribed (NICE, 2009). To this end, many of the participants in this study negotiated the effects of the anti-depressants and the period of time the medication takes to show adequate results with their patients.

The NICE guidelines (NICE, 2009) recommend that moderate to severe depression be treated through a combination of drug and psychological or psychosocial intervention to ensure optimum results. Many of the participants in this study stated that they preferred to administer medication in conjunction with psychological treatment where the involvements of social support structures are often required. They did not, however, stipulate when this combined treatment should be implemented (i.e. when depression is declared mild, moderate or severe). It should also be noted that some participants took some time to normalise the presence of depression and offer information about the condition where myths and stigmas attached to the diagnosis can be debunked. Other participants asked their patients how they were currently managing their contextual circumstances and extended additional help if they patients required it.

A participant was of the opinion that, despite the efforts made in general practice, depression is still inadequately managed. This is in congruence with Peveler and Kendrick's (2001) paper which illustrates how treatment of depression in primary care is in need of improvement. They argue that medication is often the first-line intervention where the use of non-medical forms of treatment is frequently under-emphasised. What is more, the administration of medication is "often given in doses below those shown to be effective, and for periods shorter than those which have been shown to be necessary to prevent relapse and recurrence" (Peveler & Kendrick, 2001, p. 195). Some participants of this study, hereby, suggested that further training be implemented for GPs as well as practitioners at the grassroots levels.

Participants' opinions concerning the efficacy of their treatment abilities varied overall but were predominantly pessimistic. Herein, the participants were generally less confident in their treatment regime where there was often a concern with regards to relapse. This point relates to the abovementioned argument regarding GPs' steadfastness to treatment guidelines. There is a possibility that institutions that offer medical graduate training do not offer sufficiently detailed guidelines to the treatment of depression, where adherence to this in general practice may be under-emphasised. Some

participants graduated as far as 48 years ago where the understandings of psychiatric disorders have changed since the release of the second DSM (which was published 43 years ago). It is essential that practitioners undergo continuous training so that current understandings of depression are adhered to and used in the process of offering treatment for the patient.

Barley, Murray, Walters and Tylee's (2011) study in the United Kingdom yielded similar results to this study where GPs' attitudes on their management of depression differed. In Barley et al.'s study (2011), participants reported three varying results: pessimism regarding treatment outcomes, positivity in the effects of treatment as well as optimistic attitudes which were accompanied by ambivalence.

Some problems, however, may be incurred during the treatment process and will henceforth be discussed. Some participants noted that patients frequently portray a fear of addiction to the medications prescribed by the GP and may thus be reluctant to engage in pharmacotherapy. Similar findings were yielded in studies conducted by Louch (2009) and Peveler and Kendrick (2001).

The participants of this study also noted that financial constraints may also hinder adequate treatment of depression with some patients as they are unable to afford the treatment prescribed. As will be discussed in the section to follow, one participant refrained from referring patients diagnosed with depression to traditional or faith healers as they were perceived as economically exploitative. However, general practitioners too play a part in economically exploiting patients who seek their services. The directors from Surgicom (2010) conducted a revision of the tariff structures of general practitioners in private practice where the average cost per consultation was R26.52 per minute. Herein, for a 20 minute consultation, patients are paying approximately R530 per visit.

As already mentioned, the time limitations on the GP's behalf have been widely reported across literature (Backenstrass, Joest, Rosemann & Szecsenyi, 2007; Mitchell, Vaze & Rao, 2009; Peveler & Kendrick, 2001;

Pollock & Grime, 2003; Smith, Walker & Gilhooly, 2004; Telford, Hutchinson, Jones, Rix & Howe, 2002). However, there appears to be a gap in research with regards to time limitations from the patient's perspective. Perhaps a reason why this area is under-explored is because of the pressures exerted upon general practitioners' service delivery to a wide range of the population. However, if one would apply a more critical lens, it may be hypothesised that the doctor's time is perceived as more precious and valuable (and as noted above – time equals money - a lot of it) where the possible time taken off work to see the doctor is of less importance.

Negative side-effects from the medication (as agreed upon by Louch, 2009) and the patient's non-compliance to treatment (also stated in Backenstrass, Joest, Rosemann and Szecsenyi's research, 2007) may also impede the treatment process of depression whereby patients may resist constant use of medication.

Lastly, during migration many GPs lose contact with their patients and hence are unable to continue treatment, unless in the case where a schedule has been repeated by the doctor. This can be an exceptionally frustrating experience especially if significant progress has been made. Literature in this area is particularly sparse, where more research on this topic is in need of more exploration. Should such a situation arise within private practice, it is recommended that the practitioner be aware of the patient's future migration activities, whereby a referral to a practitioner in the patient's impending vicinity may be made. In this regard, there can be a more steady continuation of treatment where the patient need not be overly concerned with starting afresh with a new GP.

Overall, participants varied in their follow-up patterns with patients but most declared that they do follow up. Those who did not follow-up with patients did not do so because of time constraints but acknowledged that it was necessary. In Pollock and Grime's study (2002), GPs frequently attempt to make a follow-up consultation to review the effects of treatment, however, the majority of patients did not return following the first consultation. Regrettably,

the participants of this study reported neither absenteeism nor attendance when following-up.

4.4. Referral liaison between GP and secondary mental health professionals

When referring to secondary mental health professionals, participants agree that considering the severity of the depression is crucial. Mild symptoms (where good support structures and a stable lifestyle are present) may be treated by the GP him/herself either by prescribing medication, offering advice or coping strategies, or a combination of the two. Patients with moderate symptoms (such as everyday problems) are referred to a psychologist and the presence of severe symptoms (such as suicidal ideation) is indicative of a referral to a psychiatrist. A study conducted by Sigel and Leiper (2004, p. 281) also found that GP's referral patterns are premised upon the acuteness of the diagnosis: "GPs make differential decisions between psychology and psychiatry referrals on the basis of such risk, referring more acute problems to psychiatry and less severe problems to psychology". The same study emphasized how referral usually took place once the "GP felt he or she had reached the limit of his or her capabilities for addressing a problem" (Sigel & Leiper, 2004, p. 287).

The participants of this study did seem to take preference for some referrals over others. Some participants favoured referring to psychiatrists (for "fine-tuning of medication" for instance) whereas others stated that psychologists were a preference as there was less stigma attached. Those who favoured referral to psychiatrists may be demonstrating their loyalty to the medical profession and preferences for the understandings espoused by the biomedical model. In a study that examined primary health care clinicians' referral patterns, it was noted that 52.5% of participants were highly likely to refer their depressed patients to a psychologist and another 35% referred to a psychiatrist (Anthony, Baik, Bowers, Tidjani, Jacobson & Susman, 2010).

The referral of depressed patients to traditional or faith healers were generally dismissed by most participants. Many of the participants in this study believed that such parties were untrustworthy, unscientific, economically exploitative of their clientele, offer unorthodox treatment, practice irresponsibly, were compared to criminals, viewed as providing ineffective treatment on a long-term basis and were seen as supplying their clients with “unsafe” and “murky” treatment. All of the participants stated that they would not explicitly refer their depressed patients to one of these practitioners; however some did state that they were open to their patients use of these alternative services (as long as they did not discontinue their pharmacotherapy).

A study conducted in South Africa by Nxumalo, Alaba, Harris, Chersich and Goudge (2011) illustrates the economic expenditure of individuals who seek services from traditional or faith healers. They reported that “[t]wo-thirds of all households (64 per cent) and approximately 72 per cent of households in the poorest quintile spent more than 10 per cent of their monthly expenditure on traditional healer services” (Nxumalo et al., 2011, p. 131). This economic spending may further deepen the impoverished conditions experienced by many individuals who live in disadvantaged communities. Nxumalo et al.’s study (2011) does not validate the point mentioned above regarding economic exploitation but does, however, provide a context for individuals’ spending on such services.

The negative views of traditional and faith healers within South Africa appear to be rather widespread (Meissner, 2009). As Meissner (2009) points out, such practitioners are unregulated by the South African medical sector, are under-protected by the South African law and are not financially supported by the government. However, some efforts have been made in the legitimisation of such services, where (for example) 2001’s National Health Bill encourages cooperation between general practitioners (and other such health care providers) and traditional healers (Meissner, 2009). This cooperation between such parties is not evident within this study as most participants viewed such practitioners in a negative manner where liaison between parties was predominantly rejected.

Participants also stated a few factors that may influence of impede the process of referral, which will be briefly examined. Stated most frequently were patients' financial constraints to the impediment of referral. Depending on the referral party, prices and frequency of consultation vary. However, in private practice, tariffs for consultations are generally within the range of several hundred Rand, where psychological treatment is most often a once-a-week endeavour. Herein, referral to a secondary mental health professional is indubitably a financial investment on the patient's behalf where it is often less costly to disregard the referral or seek other forms of treatment.

The stigma of being referred to secondary mental health professionals (especially psychiatrists) was also a concern for patients – as highlighted by the participants. This is supported by research conducted by Smith, Walker and Gilhooly (2004) who noted the same concern regarding referral.

Participants also noted that waiting lists (especially in the public sector) were also a problem. A study conducted in the United States of America by Hartley, Korsen, Bird and Agger (1998) agrees on this very point whereby waiting lists are perceived as a hindrance within the process of referral. In this study, however, when participants were confronted with a patient who required an urgent referral, waiting lists were able to be bypassed by most participants so that a quicker referral and treatment could be ensured.

Lastly, the perceived threat to confidentiality was also an impeding factor in the process of referral. Herein, patients who were concerned about the transference of personal information from the GP to the secondary mental health practitioner were more reluctant to welcome a referral than patients who were not as concerned about confidentiality. This very point is also evident in Smith, Walker and Gilhooly's study in the United Kingdom (2004) where patients' concerns for privacy were of importance when referring.

4.5. The influences of culture in general practice

Almost all participants acknowledged the role that culture plays when diagnosing, treating and referring depressed patients and that the GP needs to be sensitive to every patient's world-view and unique symptom presentation. Consideration of the patient's culture was also essential as many are sceptical of modern, Westernised medicine. Herein, some participants stated that they frequently adopted the patient's cultural world-view when diagnosing but generally treated depression from a Westernised medical perspective. Falicov (2003) and Pritzker (2007) point out that cultural ontologies are highly complex and multifold where symbols, metaphors and meaning-making evident in each complicate the recognition of depression on the GP's behalf. What is more, participants stated that the process of detection is further convoluted by refugees and migrants. Falicov (2003) agrees with the participants of this study and adds that the detection of depression is difficult as migrants usually undergo a cultural transition and change. He elaborates that the translation of Westernised manifestations of depression with more culturally diverse populations is complicated and that the root of depression is often founded upon "sociopolitical discourses and power differentials regarding gender, class and race" (Falicov, 2003, p. 371).

It is considered essential for GPs to acknowledge their patient's cultural understandings of depression (rather than their own) and hence maximise its consistent and reliable diagnosis (WONCA, 2004). Herein, the extent to which this diagnosis is welcomed in the GP's culture impacts on the disclosure of the diagnosis to the patient. Despite participants' efforts with regards to applying cultural relativity, some participants highlighted the cultural gap that often presents in consultation, where a cultural bias towards the practitioner's world-view is sometimes evident. Lehti (2009) illustrated this very point in her study whereby practitioners tended to apply their own understandings of depression (within their own cultural world-view) without considering the patient's process of meaning-making. Ellis' study (2003, p. 342) adds to this

point by illustrating another way in which a cultural gap may be manifest. He explains that:

> The patient works within the experience of his or her social and cultural life whereas the doctor works within the criteria laid down by the Diagnostic and Statistical Manual-IV (DSM-IV) and has a list of symptoms that have to be fulfilled before the diagnosis can be made. These symptoms and references are derived from both a biomedical perspective and the doctor's own experience of living in the Western world…When we encounter a traditional African culture that is not informed in this way and that experiences illness differently, we are often at a loss as how to assess, diagnose and treat such patients.

Thus, the participants in this study acknowledged that taking the patient's cultural viewpoint into account is beneficial, but some of them struggled to do so, which, according to WONCA (2004), may lead to an inconsistent and unreliable diagnosis.

In agreement with Backenstrass, Joest, Rosemann and Szecsenyi's (2007) study, participants stated that a possible impediment to the process of treatment is the patient's ability to accept the diagnosis made by the practitioner. The stigma attached to the diagnosis of depression was also of concern with regards to treatment and was in correspondence to other studies on the topic (cf. Barley, Murray, Walters & Tylee's, 2011; Louch, 2009; Smith, Walkers & Gilhooly, 2004). What is more, participants of this study noted how patients preferred a referral to a psychologist, rather than a psychiatrist. Once again, the impact of stigma may be highlighted where there resides a fear of being labelled "mad", "insane" or "crazy" if others within the community were to learn that they were referred to a psychiatrist. This statement is akin to Anthony, Baik, Bowers, Tidjani, Jacobson and Susman's study (2010) in the United States of America which reported that patients were more willing to accept a referral to social worker or a psychologist than one to a psychiatrist,

since the term “psychiatrist” is loaded with such powerful connotations and implications of severe mental handicap.

4.6. The training of general practitioners

The majority of participants felt that their graduate training was insufficient and that further training was required through practice in locums and hospitals. Other participants stated that the quality of education in the medical field has waned over the years, especially when compared to the training that was available in the 1950s. When participants were asked to identify the areas that required further training, they noted several areas that require further attention. In agreement with Visser’s South African study (2009), some participants mentioned that the financial management of a general practice was difficult and that training of this nature was usually given by a colleague who has already established their own practice. Regarding medical conditions, participants felt that their dermatology and ear-nose-and-throat treatment was inadequate, and was agreed upon in research conducted by Clamp, Gunasekaran, Pothier and Saunders (2007).

In relation to psychological problems in general practice, some participants expressed their uncertainties concerning the management of anxiety and depression and felt that their graduate training was not adequate in addressing these problems. It appears as if these concerns are not unique to the practitioners of this study within South Africa. Similar findings were mentioned in a study conducted in Ireland where training for the management of psychiatric disorders (such as depression or anxiety) was significantly lacking and considered inadequate (Copty & Whitford, 2005). Other studies that were conducted in Punjab, India, yielded similar results (Chaudhary & Mishra, 2009).

With regards to social encounters in general practice, Mercer and Reynolds (2002, p. 11) argue that empathy is a necessary component to health care but that it is “under-valued and under-taught”. They suggest that empathy can be enhanced in the primary health care sector by teaching medical students

about empathy and its importance. The participants in this study had stated that this was something amiss in their training where the focus on face-to-face etiquette and social interaction was lacking.

It was further noted that medical training helps practitioners be safe where the limits to their knowledge are recognised. This last point is a noteworthy one as it assumes that most practitioners practice safely and acknowledge the limitations in their training. However, if training is widely recognised as insufficient (as described by participants of this study), is it universally guaranteed that all practitioners know their limits and refer when required? This point is debateable, however, there is limited research in this area to adequately accept or refute this statement.

4.7. The evolution of the medical field and its practices

The rise in global modernisation has affected a wide range of disciplines – of which one is the medical field. Some participants in this study noted a few changes that have taken place over the past few decades that have come with the increase of globalisation and modernity. They stated that more recently, doctors have been more financially driven than altruistic and that monetary reward takes preference over patient care (for instance, house-calls are no longer standard practice).

Others stated that practitioners often neglect the importance of social and interpersonal interactions with their patients where treatment was predominantly geared towards resolving the necessary medical queries alone. It was stated that the predominant reason for this is the fast-paced lifestyle that many practitioners are faced with since time is a scarce and limited resource. Medical aid limitations were also stated by some participants where distinctions between what assessments and treatments can and cannot be done are seen as significantly debilitating for practitioners. This topic is widely under-researched within the field of psychology. Further studies of this nature would be helpful and are in need of development.

4.8. Disadvantaged communities and access to health care resources

Three participants took into consideration individuals who lived under impoverished conditions. It was stated that refugees, for instance, often cannot afford health care services offered by GPs and frequently seek help from pharmacists instead – only consulting with a GP once their condition becomes markedly severe. It was also mentioned that GP practices that cater for individuals in disadvantaged communities sometimes offer services to 40 or 50 persons daily. Under such pressurised working conditions, one may question the quality of health care extended to such individuals. A participant highlighted how economic status dictates the quality of health care offered to people where the higher the monetary expenditure, the better the quality of health care. This point is mirrored by research conducted by the European Commission (2008) who note a very clear link between health and income inequality and also note that barriers to health exist but that they are considerably complex.

The South African Department of Health released The Charter of the Public and Private Health Sectors of The Republic of South Africa in 2005 that focused on the following key areas: access to health services, equity in health services, quality of health services and black economic empowerment. The Charter (South African Department of Health, 2005) acknowledges that access to health care is a complex issue that is influenced by many factors including the patient's financial status. Other notable factors include, but are not limited to, geographical, physical, communication and sociological (such as discrimination and stigmatization) factors. The Charter (South African Department of Health, 2005) adds that a large number of factors that constitute as barriers to health care emerge from and have been founded upon South Africa's history of prejudice, discrimination, inequality, exploitation and suffering. The Charter (South African Department of Health, 2005) highlights that one of the challenges that South Africa is facing is equality of health care. As stipulated in The Charter (South African Department of Health, 2005, p. 17), there are "[d]iscrepancies in the quality of health services across different groupings within the socio-economic spectrum". Thus, The

Charter (South African Department of Health, 2005) is stressing a salient problem within the South African context which was also noted by the participants in this study.

Even though economic spending determines health care received, some participants noted the relatively affordable prices of generic medication for the treatment of depression which proves to be beneficial for those living in poverty.

4.9. The ethics of practice

Most striking about participants' responses was the management of suicidal patients. Many participants stated that following the detection of a suicidal patient, they would immediately refer them to a psychiatrist. However, participants did not specify the severity or seriousness of suicidal patients or whether patients were presenting with ideations, had a plan or have made attempts in the past. Furthermore, there was no mention of ensuring patients' safety by follow-up or otherwise. Bryan and Rudd (2011) recommend that once the possibility of suicide is identified with a patient, the practitioner needs to conduct a comprehensive assessment to determine the potential risk and management plan. They also provide specific guidelines (that are rather detailed) to the management of depression based on the severity of suicide risk. This protocol was not described by the participants of this study. Other participants, however, did consider hospitalisation as an option to ensuring patients' safety where a referral to a psychiatrist was still made, but only after stability was gained.

Interestingly, it was the opinion of a participant that treatment of depression should sometimes be avoided as it may be dangerous for patients with severe and debilitating depression. It was argued that treatment of depression may provide the patient with the energy required to commit suicide which would otherwise be impossible since the patient may have been significantly hampered. This poses an ethical dilemma where the ethical principle – "do no harm" is brought to the fore. Is it ethical for medical practitioner to refuse a

patient treatment based on the premise that more harm can be done if treatment commences? What if such treatment proves to be beneficial to the patient where a significance improvement in one's quality of life is obtained? Hence, the ultimate question becomes: is the practitioner doing more harm by administering treatment (and running the risk of a suicide attempt) or denying the patient treatment (wherein lies the possibility for improvement).

Confidentiality was another ethical concern that emerged within the interviews. Some participants shared that they sometimes discussed the contents of their consultation with relatives of the patient. Herein, some participants followed-up with their patients by enquiring about their wellbeing through persons related to the patient. Maintaining doctor-patient confidentiality and privacy are one of the most fundamental and basic principals within health care (Gold, 2009) where the violation thereof discounts one's personal rights. However, in a collectivist community, upholding these ethical values may not be as important since emphasis is placed on sharing rather than withholding (Broodryk, 2006).

In such communities, sharing takes place within every aspect of life, including: the company of others, thoughts, commodities, experiences, emotions, wages, poverty and even personal items (such as toothbrushes) (Broodryk, 2006). Herein, in a community where personal boundaries are deemphasised, ethical principles such as confidentiality may not be as highly regarded as it would be in Westernised, individualistic, communities for instance. What could complicate matters is when there is a discrepancy between the practitioner and patient with regards to cultural affiliation and opinions on confidentiality. One such example is if the doctor was from a collectivist community (where confidentiality and privacy may not be highly valued) and the patient from an individualistic community (where such ethical values and principles are held in high esteem). Thus, there needs to be an agreement of ethical values and principles between the doctor and the patient where both parties are satisfied and content.

The final ethical query made in the interview process was that of truth-telling and open disclosure of diagnosis and treatment on the participant's behalf. A participant in this study cloaked a diagnosis of depression with another medical condition to ensure compliance of medication. Such an incidence may be viewed as deceitful as the patient has the right to know their true diagnosis and be able to consent to the use of a particular kind of medication that the doctor prescribes. Most of the literature available on truth-telling and diagnosis focuses on terminal medical conditions (such as cancer or AIDS).

Buken (2003) argues that when a doctor withholds a diagnosis of cancer, for instance, the dynamics of the relationship become more physician-centred rather than patient-centred. A physician-centred doctor-patient relationship is one where the doctor is in control of the process of diagnosis and its disclosure to the patient and the patient's family (Buken, 2003). It may be argued that the withholding of a diagnosis of depression may create an unfavourable doctor-patient dynamic (Linden, Christof & Rentzsch, 2008) where the doctor leads the process rather than working collaboratively with the patient towards a mutually agreed-upon and desired outcome.

Sokol (2006), on the other hand, discusses instances where it is actually more morally fair to withhold information from a patient which involves balancing core ethical values where the practitioner needs to consider whether it is more harmful to the patient to disclose or to refrain from disclosing. In this instance, the patient may be benefiting from the anti-depressant medication where further psychological harm may have been avoided.

4.10. Self-reflexivity findings

Throughout the entire research process I have reflected on and managed my own thoughts, opinions and attitudes so that my personal prejudices and biases did not hamper this process. I have done this by keeping a daily journal where I reflected on my experiences before, during and after interviews. Through the exploration of my experiences, I investigated the emotions and thoughts attached to certain events and have attempted to

make certain that my subjective meaning-making did not impede the interviews, analysis of data or the write-up of the findings. During the process of self-reflexivity, several significant notions emerged and will be henceforth discussed.

One of the most provocative experiences was the consistent interruptions during interviews. Almost all interviews were met with disturbances from either a secretary or telephone, whereupon some participants proceeded to answer their phones during the interview. These interruptions made the interview feel sidelined and it appeared as if other matters were of higher importance. I then began to wonder if a similar scenario unfolded within doctor-patient consultations, where patients may too feel secondary to the process. I did, however, acknowledge that the doctor's time is a valuable commodity and I appreciate the time they have taken to participate in this research.

One participant arrived half an hour late to the scheduled interview and consequentially proceeded to postpone the interview for another time. This experience was rather disappointing and frustrating as I had expected the participant to arrive at the negotiated time or contact me to reschedule should the arrangements not be suitable. I do understand that arriving timeously is a principle that I personally adhere to and is not a universal law that all individuals have to abide by. Herein, I recognised that I show preferences towards my own personal values and principles but I have tried my utmost to disallow them from impacting negatively on the research process.

During the interview, another participant continuously used medical language, of which I was unfamiliar. The tension and distance between the field of medicine and psychology appeared evident. When medical terminologies were utilised, as a researcher, I felt intimidated and belittled where these words appeared to be used as a tool to establish a power hierarchy and that the participant, as a medical professional, was on a superior plateau when compared to a psychology student. I know that this meaning-making process is subjective and personal and I did not permit my reflections to impact on the interview or data interpretations.

Lastly, the discourses utilised by the participants regarding patients diagnosed with depression as well as psychologists and traditional healers were rather fascinating. It was evident that the participants of this study had certain underlying opinions and attitudes that were not openly discussed. I acknowledge that every person has the right to their own opinion and I feel that I was able to navigate through the interview, data analysis and write-up without allowing their discourses to impact on the study in any way. I do, however, note that a discourse analysis would be a favoured alternative to thematic content analysis for future research.

4.11. Conclusion

This chapter has focussed on discussion all the various themes and subthemes that have been outlined in the results section above. The four main themes that are in line with the research questions were discussed first and broadly include: diagnosing and detecting depression, treating depression, referral patterns in the management of depression as well as the relevance of culture when diagnosing, treating and referring in general practice. Other themes that were detected in the process of data analysis also include: the training of general practitioners, the evolution of the medical field and its practices, disadvantages communities and their access to health care and the ethics of practice. Lastly, this chapter also discussed several salient issues that arose during the self-reflexivity process. The concluding chapter to follow will highlight some limitations that were identified within this study as well as a few recommendations for future research and practice.

Chapter 5: Limitations and Recommendations

5.1. Introduction

Thus far, this study has provided a backdrop to the management of depression in the literature review, where a particular focus was placed on its management in general practice. Following this was an outline of the methods employed in this study. The results chapter then reported on the significant themes and subthemes that emerged from the data analysis process. The discussion chapter that consequently ensued then discussed these relevant themes and subthemes by relating this study's findings to relevant research and literature on the topic. This chapter concludes this study where the conceptual and methodological limitations will be explored. What is more, this chapter will also provide recommendations for future research and practices.

5.2. Limitations of the study

5.2.1. Conceptual limitations

Conceptual limitations of this study may include anything from gaps in literature to problems with theoretical constructs of phenomena. More specifically, it was evident that culture was a difficult construct to define and that this study investigated culture from a rather broad perspective where a more unambiguous viewpoint could have perhaps yielded results that were more detailed and nuanced. However, since culture was investigated more broadly, the participants were able to project their own meanings of this notion which allowed for more liberal and free understandings to be gathered that were uninhibited by structure.

This research paper was not particularly grounded within a theoretical framework (such as with a mental health perspective or a critical perspective). In this regard, the arguments that were formulated were not lead by a specific viewpoint or theoretical structure. This allowed me to review, report and discuss my findings in an unregimented manner where the bounds of one particular perspective were not restricting whatsoever. However, this study could have benefitted from a certain perspective in that it would have added

richness to the report where more detailed explanations in one specific area could have been fostered.

This study focused predominantly on the management of depression by GPs in private practice. The fields of enquiry are rather specified in that the investigations of other mental health disorders were limited. What is more, this study only explored management trends with general practitioners alone where other practitioners in health care were left unexplored. It may have been valuable to expand the study to encompass a broader exploration of mental illness within the medical field at large; however, this would have taken away from the specificity that this study brings.

I also encountered some gaps in research regarding the destructive developments in the modernisation of medicine with regards to depression as well as the problems encountered by general practitioners and migrants and refugees. Findings on such phenomena would have been useful in the write-up of this research study in that it would have added depth to the discussions thereof.

5.2.2. Methodological limitations

Before the interviews were conducted, the participants were contacted and informed about the nature of the study. Since participants were aware that the interviews were concerning GPs' management of depression, they may have prepared for the interview by studying or revising criteria for depression, treatment guidelines and other management strategies.

This study relied solely on participant's opinions on the management of depression, where actual practices were not investigated. Herein, participants' accounts may not have been wholly honest where a rough estimation may have been obtained instead. To add, this study focused on GP's management on depression which limited the findings of their practices. To obtain more holistic management it may have been beneficial to also explore attitudes and

opinions of other parties involved in the management process (such as patients, nurses, administrative staff or referral persons).

The sample in this study was limited to only six participants within the Johannesburg area. A wider sample from wide-ranging locations (rather than one area alone) would have yielded more breadth and may have been more favourable. However, the richness of the results would have compromised somewhat for a larger range.

This study utilised thematic content analysis as the method of data analysis. Upon reviewing the findings and the language used by participants, it would have been interesting to conduct a discourse analysis alongside a backdrop of critical theory.

The use of a qualitative semi-structured interview was time-consuming for the participants, where interviews were frequently hurried and met with interruptions. All of the participants did not wish to complete the interview after working hours. Taking this into consideration, perhaps a questionnaire could have been an alternative. However, such a method is risky as many participants may not complete the questionnaires, thereby disrupting the availability of these results.

The questions posed to the participants relied on their memories regarding each particular phenomenon. Participants had to thus call into question their memory capacity with regards to their management of depression, which may not be as accurate as the true accounts of experiences.

Although I have aimed to account for and manage my own biases and prejudices that have emerged during the interviews by keeping a daily journal, there is a possibility that some subjective material may have impacted on the study without my knowing of it. Thus, it is possible that personal matters have not been accounted for and may have influenced the research process.

Qualitative analysis is frequently questioned by positivists - who tend to favour quantitative methods because they believe that quantitative studies yield more reliable and valid results. (Shenton, 2004). However, one may argue that positivists and realists are somewhat flawed in their beliefs. They claim to obtain information and data from the external world in an objective fashion where the interpretation and meaning-making thereof is completely sterilised from their unique experiences of reality (Trochim, 2006). This study assumes that an objective and sanitised interpretation of raw data from the external reality is unfeasible. Instead, it is believed that the researcher's inner reality does, to some extent, impact one's interpretations of the external world and thus qualitative methods were favoured here. As this study espouses that it is unrealistic to objectively explore the world, notions such as validity and reliability appear arbitrary since they ensure that the findings of the research consistently mirror external reality.

Since researchers are so integrally involved with the analysis of information, other methods of ensuring the soundness of data interpretations have been established (Trochim, 2006). Herein, validity, reliability and objectivity are considered in qualitative research, but are done so through a different lens. Credibility is equivalent to internal validity, where (in qualitative research) this would involve ensuring that the participant's opinions match the results of the interpretations (Trochim, 2006). This study cannot certify credibility since this would involve obtaining comments from the participants regarding the accuracy of their comments (which was not done).

Transferability accounts for the external validity or generalisability of quantitative research where the findings may be transferred to other situations, contexts or circumstances (Trochim, 2006). As noted earlier, individuals (both researchers and participants alike) are unique and experiencing beings who interpret the external reality in a subjective manner. Even though others who are immersed within a different context may share similar views and opinions on certain phenomena, one's most fundamental and core belief systems remain true for each individual alone. Herein, other persons may share similar viewpoints on the points discussed in this study

(where transferability would be made certain of), but this may not be the case for other persons whose opinions differ. It may be assumed that persons in contexts most similar that of the participant will agree more with the findings of this study (ensuring transferability) than individuals situated within a completely different contextual backdrop.

Dependability is akin to reliability within the realm of quantitative research methods (Shenton, 2004). According to Trochim (2006), dependability measures the extent to which findings stay consistent when the study is replicated. However, since every moment throughout the research process is completely unique, reliability can never truly be achieved. There are a multitude of extraneous variables that may impact on the results, which cannot be fully and consistently accounted for. A qualitative researcher can ensure dependability by acknowledging that the research context is ever-changing and dynamic (Trochim, 2006). This study has, as far as possible, accounted for the possible elements that may have impacted on the results of the research so as to ensure that dependability was achieved.

Confirmability may be understood in relation to objectivity (Shenton, 2004). Even though objectivity is perceived to be unfeasible within this study, confirmability was attempted where I revised the raw data to ensure that the interpretations were not tainted by my personal biases and prejudices. Furthermore, I kept a journal of my experiences which acted as an outlet for possible emotions and thoughts that may have hampered the research process. Despite these efforts, complete confirmability cannot be promised as reflections on some personal material (that could have impacted on this study) may have been missed without my knowledge.

This study favoured only one method of analysing data. The findings were, thus, limited by thematic content analysis which yielded information from one particular angle alone. A mixed method may have been an alternative to a purist method, which could have produced results that were more varied and had stronger reliability. For instance, such a mixed method could involve a combination of both group forum and individual interviews or an

amalgamation of open-ended qualitative questions within a closed, Likert-type, questionnaire.

5.3. Recommendations for future research and practice

I recommend that research of the nature explored within this study continue where benign areas, that were amiss in this study, are further explored. Herein, future research could investigate: the management of depression: within the public health care sector; with specific cultural groups; as well as with the refugee or immigrant population. It is also proposed that more care is taken in investigating participant demographics (such as age and years of experience within the medical field) as this could also be an avenue of exploration when comparing management patterns.

With regards to future practices, it is recommended that workshops be held for the management of depression and suicide where CPD points could be earned. This would improve the management of depression in general practice where better health services would be available to all patients.

To increase practitioners' knowledge and understandings of various cultural groups, it is recommended that GPs set aside extra time with each patient to explore their personal worldviews and perspectives. This will improve with the under-diagnosis and over-diagnosis of depression nationally and globally, where depression is reliably diagnosed and detected when required.

In order to prevent future researchers from allowing their own personal material from influencing the study and its findings, I recommend that a private journal be kept where all experiences and their impacts can be reflected upon. As was done in this study, it is recommended that this journal be utilised so as to avoid a possible negative impact on the study.

5.4. Conclusion

This chapter thus concludes this thesis on GPs' management of depression within the private health care sector within Johannesburg, South Africa. This chapter has explored the conceptual and methodological limitations of this study as well as the recommendations for further research and practice. Overall, the study has examined the management of depression in general practice by looking at diagnosis or detection, treatment and referral of persons with depression. What is more, the implications of culture (regarding diagnosis, treatment and referral) were looked into within the context of South Africa. It is evident from the findings of this study that further training is required for general practitioners in the management of depression. This training can address specific guidelines pertaining to the diagnosis, treatment, referral and cultural implications of depression with the aim of offering high quality mental health care for all within South Africa.

Reference list

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Anthony, J. S., Baik, S. Y., Bowers, B. J., Tidjani, B., Jacobson, C. J., & Susman, J. (2010). Conditions that influence a primary care clinician's decisions to refer patients for depression care. *Rehabilitation Nursing, 35 (3),* 113 – 122.

Apfel, J. L. (2003). Depression and its treatments: A college sample. *Journal of College Student Psychotherapy, 2,* 67 – 81.

Ashworth, M., Godfrey, E., Harvey, K., & Darbishire, L. (2003). Perceptions of psychological content in the GP consultation - the role of practice, personal and prescribing attributes. *The Journal of Family Practice, 4,* 373 – 375.

Baas, K. D., Koeter, M. W. J., van Weert, H. C., Lucassen, P., Bockting, C. L. H., Wittkampf, K. A., et al. (2010). Brief cognitive behavioral therapy compared to general practitioners care for depression in primary care: A randomized trial. *Trials Journal, 11,* 1 – 6.

Backenstrass, M., Joest, K., Rosemann, T., & Szecsenyi, J. (2007). The care of patients with subthreshold depression in primary care: Is it all that bad? A qualitative study on the views of general practitioners and patients. *BioMed Central Health Services Research, 7 (190),* 1 – 11.

Barley, E. A., Murray, J., Walters, P., & Tylee, A. (2011). Managing depression in primary care: A meta-synthesis of qualitative and quantitative research from the UK to identify barriers and facilitators. *BioMed Central Family Practice, 12 (47),* 1 – 10.

Barlow, D. H. & Durand, V. M. (2009). *Abnormal psychology: An integrative approach* (5th ed.). Belmont, CA: Wadsworth, Cengage Learning.

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3,* 77 – 101.

Broodryk, J. (2006, October). *Ubuntu. African life coping skills: Theory and practice.* Paper presented at the CCEAM Conference of Philosophy, Cyprus, Lefkosia.

Bryan, C. J. & Rudd, M. D. (2011). *Managing suicide risk in primary care*. New York, NY: Springer Publishing Company.

Buken, N. O. (2003). Truth-telling information and communication with cancer patients in Turkey. *Journal of the International Society for the History of Islamic Medicine, 2,* 31 – 36.

Cape, J. & McCulloch, Y. (1999). Patients' reasons for not presenting emotional problems in general practice consultations. *British Journal of General Practice, 49,* 875 – 879.

Chaundhary, R. K. & Mishra, B. P. (2009). Knowledge and practices of general practitioners regarding psychiatric problems. *Industrial Psychiatry Journal, 18 (1),* 22 – 26.

Citizens Commission on Human Rights International. (2009). *The side effects of common psychiatric drugs*. Retrieved November 18, 2011, from http://www.cchrint.org/pdfs/The_Side_Effects_of_Common_Psychiatric_Drugs.pdf

Clamp, P. J., Gunasekaran, S., Pothier, D. D., & Saunders, M. W. (2007). ENT in general practice: training, experience and referral rates. *The Journal of Laryngology and Otology, 121 (6),* 580 – 583.

Copty, M. & Whitford, D. L. (2005). Mental health in general practice: Assessment of current state and future needs. *Irish Journal of Psychological Medicine, 22 (3),* 83 – 86.

Dickmann, C. E. B., Dickmann, J. R. M., & Broocks, A. (2008). How reliably can general practitioners diagnose depression using ICD-10 criteria? *German Journal of Psychiatry, 11,* 146 – 148.

Dixon, R. P., Roberts, L. M., Lawrie, S., Jones, L. A., & Humphreys, M. S. (2008). Attitudes of medical students: Medical students' attitudes to psychiatric illness in primary care. *Medical Education, 42,* 1080 – 1087.

Duncan, N., Bowman, B., Naidoo, A., Pillay, J., & Roos, V. (2007). *Community psychology: Analysis, context and action.* Cape Town, CT: UCT Press.

Econex. (2010). Patient choice and referral. *Health Reform Note 5.* Retrieved January 10, 2011 from http://www.mediclinic.co.za/about/Documents/EXONEX_Health%20reform%20note_5.pdf

Ellen, S. R., Norman, T. R., & Burrows, G. D. (1997). Assessing anxiety and depression in primary care. *Medical Journal of Australia Practice Essentials, 3,* 14 – 19.

Ellis, C. G. (2003). Cross-cultural aspects of depression in general practice. *South African Medical Journal, 5,* 342 – 345.

European Commission. (2008). *Quality in and equality of access to healthcare services.* Retrieved November 12, 2011, from http://www.euro.centre.org/data/1237457784_41597.pdf

Falicov, C. J. (2003). Culture, society and gender in depression. *Journal of Family Therapy, 25,* 371 – 387.

Gill, H. (2007). *Hughes' outline of modern psychiatry* (5th ed.).Chichester, UK: Wiley & Sons.

Gold, R. B. (2009). Unintended consequences: How insurance processes inadvertently abrogate patient confidentiality. *Guttmacher Policy Review, 12 (4),* 12 – 16.

Hartley, D., Korsen, N., Bird, D., & Agger, M. (1998). Management of patients with depression by rural primary care practitioners. *Archives of Family Medicine,* 7, 139 – 145.

Herskovitz, M. J. (1948). *Man and his works: The science of cultural anthropology.* New York: Knopf.

Horton-Hausknecht, J. (2005). *Perceptions of psychology through the eyes of Government Mental Health policies*. Paper presented at the Brisbane Conference, Brisbane, Australia.

Kroeber, A. L. & Kluckhohn, C. (1952). *Culture: A Critical Review of Concepts and Definitions*. New York: Vintage Books.

Krupinski, J. & Tiller, J. W. G. (2001). The identification and treatment of depression by general practitioners. *Australian and New Zealand Journal of Psychiatry, 35,* 827 – 832.

Larivaara, P., Kiuttu., J., & Taanila, A. (2001). The patient-centred interview: The key to biopsychosocial diagnosis and treatment. *Scandinavian Journal of Primary Health Care, 19,* 8 – 13.

Lehti, A. (2009). *Struggling for clarity – cultural context, gender and a concept of depression in general practice*. Unpublished doctoral dissertation, Umeå University, Sweden.

Lehti, A., Hammarström, A., & Mattsson, B. (2009). Recognition of depression in people of different cultures: A qualitative study. *BioMed Central Family Practice, 10 (53),* 1 – 9.

Linden, M., Christof, T., & Rentzsch, C. (2008). Contents of general practitioner-patient consultations in the treatment of depression. *Journal of General Internal Medicine, 23,* 1567 – 1570.

Lotrakul, M. & Saipanish, R. (2009). How do general practitioners in Thailand diagnose and treat patients presenting with anxiety and depression? *Psychiatry and Clinical Neurosciences, 63,* 37 – 42.

Louch, P. (2009). Depression in primary care: Diagnosing and treating depression. *Practice Nurse, 37 (10),* 42 – 48.

Louw, D. J. (2002). Ubuntu and the challenges of multiculturalism in post-apartheid South Africa. *Ubuntu: African reciprocacy in a multicultural context.* Retrieved December 14, 2010 from http://www.phys.uu.nl/~unitwin/ubuntu.html

Löwe, B., Spitzer, R. L., Williams, J. B. W., Mussel, M., Schellberg, D., & Kroenke, K. (2008). Depression, anxiety and somatization in primary care: Syndrome overlap and functional impairment. *General Hospital Psychiatry, 30,* 191 – 199.

Lund, C., Kleintjies, S., Campbell-Hall, V., Mjadu, S., Petersen, I., Bhana., A., et al. (2008). Mental health policy development and implementation in South Africa: A situation analysis. *Mental Health & Poverty Project: Phase 1. Country Report.* Retrieved November 30, 2010 from http://www.who.int/mental_health/policy/development/SA%20Country%20Report%20-%20Final%20Draft%20Jan%202008.pdf

Lyons, A. C. & Chamberlain, K. (2006). *Health psychology: A critical introduction*. Cambridge: Cambridge University Press.

MacHale, S. (2002). Managing depression in physical illness. *Advances in Psychiatric Treatment, 8,* 297 – 306.

Mash, B. (2002). How to design education on mental disorders for general practitioners in South Africa. *South African Family Practice, 5,* 4 - 10.

Matsumoto, D. (2007). Culture, context, and behaviour. *Journal of Personality, 75,* 1285 – 1319.

Matzopoulos, R., Corrigall, J., & Bowman, B. (2009). A health impact assessment of international migrants following xenophobic attacks in Gauteng and Cape Town. *Forced Migration Studies Programme*. Retrieved on July 18th, 2011, from http://programs.ifpri.org/renewal/pdf/JohannesburgHealthImpact.pdf

McGarry, H., Hegarty, K., Johnson, C., Gunn, J., & Blashki, G. (2009). Managing depression in a changing primary mental healthcare system: Comparison of two snapshots of Australian GPs' treatment and referral patterns. *Mental Health in Family Medicine, 6,* 75 – 83.

Meissner, O. (2009). *Traditional medicine and its accommodation in the South African national health care system with special attention to possible statutory regulation*. Unpublished doctoral dissertation, University of South Africa, Johannesburg.

Mercer, S. W. & Reynolds, W. J. (2002). Empathy and quality of care. *British Journal of General Practice, 52,* 9 – 12.

Meyers, D. G. (2008). *Social psychology* (9th ed.). New York, NY: McGraw-Hill.

Michie, S., Miles, J., & Weinman, J. (2003). Patient-centeredness in chronic illness: What is it and does it matter? *Patient Education and Counseling, 51,* 197 – 206.

Mitchell, A. J., Vaze, A., & Rao, S. (2009). Clinical diagnosis of depression in primary care: a meta-analysis. *The Lancet, 374,* 609 – 619.

National Institute for Health and Clinical Excellence. (2009). Depression: The treatment and management of depression in adults. *NICE clinical guideline 90.* Retrieved November 13, 2011, from http://www.nice.org.uk/nicemedia/pdf/CG90NICEguideline.pdf

Nxumalo, N., Alaba, O., Harris, B., Chersich, M., & Goudge, J. (2011). Utilization of traditional healers in South Africa and costs to patients: Findings from a national household survey. *Journal of Public Health Policy, 32,* 124 – 136.

Patel, V., Araya, R., Chatterjee, S., Chisholm, D., Cohen, A., De Silva, M., et al. (2007). Treatment and prevention of mental disorders in low-income and middle-income countries. *The Lancet, 370,* 991 - 1005.

Peveler, R. & Kendrick, T. (2001). Treatment delivery and guidelines in primary care. *British Medical Bulletin, 57,* 193 – 206.

Pollock, K. & Grime, J. (2003). GPs' perspectives on managing time in consultations with patients suffering from depression: a qualitative study. *Family Practice, 20 (3),* 262 – 269.

Pritzker, S. (2007). Thinking hearts, feeling brains: Metaphor, Culture, and the self in Chinese Narratives of depression. *Metaphor and Symbol, 22 (3),* 251 – 274.

Qwabe, B. R. (2009). *Medical doctors' perceptions of psychologists as health professional partners in the Pietermaritzburg region*. Unpublished master's thesis, University of KwaZulu-Natal, Pietermaritzburg.

Sadock, B. J. & Sadock, V. A. (2007). *Kaplan and Sadock's synopsis of psychiatry: Behavioral sciences/clinical psychiatry* (10th ed.). Philadelphia, PA: Lippincott Williams & Wilkins.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22,* 63 – 75.

Sigel, P. & Leiper, R. (2004). GP views of management and referral of psychological problems: A qualitative study. *Psychology and Psychotherapy: Theory, Research and Practice, 77 (3),* 279 – 295.

Smith, L., Walker, A., & Gilhooly, K. (2004). Clinical guidelines on depression: A qualitative study of GPs' views. *The Journal of Family Practice, 53 (7),* 556 – 561.

Sofaer, S. (2002). Qualitative research methods. *International Journal for Quality in Health Care, 4,* 329 – 336.

Sokol, D. K. (2006). Truth-telling in the doctor-patient relationship: A case analysis. *Clinical Ethics, 1 (3),* 1 – 5.

South African Department of Health. (2005). The Charter of the public and private health sectors of The Republic of South Africa. 1 – 33.

Stavrou, S., Cape, J., & Barker, C. (2009). Decisions about referrals for psychological therapies: A matched-patient qualitative study. *British Journal of General Practice, September,* 289 – 298.

Surgicom. (2010). Newsletter 2010 January. *Tariffs, coding and practice cost studies in the doldrums*. Retrieved November 18, 2011, from http://www.surgicom.co.za/images/Surgicom_tariff_2010_advisory.pdf

Sutherland, J. E., Sutherland, S, J., & Hoehns, J. D. (2003). Achieving the best outcome in treatment of depression. *The Journal of Family Practice, 3,* 201 – 209.

Telford, R., Hutchinson, A., Jones, R., Rix, S., & Howe, A. (2002). Obstacles to effective treatment of depression: a general practice perspective. *Family Practice, 19 (1),* 45 – 52.

Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African Stress and Health study. *South African Medical Journal, 99 (5),* 368 – 373.

Trochim, W. M. K. (2006). Qualitative validity. *Research methods knowledge base.* Retrieved on November 29, 2011, from http://www.socialresearchmethods.net/kb/qualval.php

Tsai, J. L. & Chentsova-Dutton, Y. (2002). Understanding depression across cultures. In I. H. Gottlieb and C. L. Hammen (Ed.), *Handbook of Depression*. New York, NY: Guilford Press.

Tylee, A. & Walters, P. (2005). Early recognition and management of depression in primary care. In M. Maj, J. J. López-Ibor, N. Sartorius, M. Sato, & A. Okasha (Eds.), *Early detection and management of mental disorders* (pp. 249 – 277). Chichester, UK: Wiley & Sons.

Tylor, E. B. (1964). *Researches into the early history of mankind and the development of civilization.* Paul Bohannan (Ed.). Chicago: University of Chicago Press.

Visser, H. (2009). *An exploration of the nature of a private general medical practice as a social system: A case study*. Unpublished master's thesis, Nelson Mandela Metropolitan University, KwaZulu-Natal.

Williams, D. R., Herman, A., Stein, D. J., Heeringa, S. G., Jackson, P. B., Moomal, H., et al. (2007). Prevalence, service use and demographic correlates of 12-month psychiatric disorders in South Africa: The South African stress and health study. *Psychological Medicine, 2,* 211 – 220.

WONCA. (2004). Culturally sensitive depression guideline. *Adults with depressive disorder in primary care.* Retrieved November 11, 2011, from http://www.globalfamilydoctor.com/aboutWonca/sig/FinalguidelinedepressionSIG_Version1.0.pdf

World Health Organization (WHO). (1992). The ICD-10 classification of mental and behavioral disorders: Clinical descriptions and diagnostic guidelines. Retrieved December 1, 2010, from http://www.who.int/classifications/icd/en/bluebook.pdf

World Health Organization (WHO). (2010). Depression: What is depression? *Mental Health.* Retrieved December 1, 2010, from http://www.who.int/mental_health/management/depression/definition/en

Younes, N., Gasquet, I., Gaudebout, P., Chaillet, M., Kovess, V., Falissard, B., et al. (2005). General practitioners' opinions on their practice in mental health and their collaboration with mental health professionals. *The Journal of Family Practice, 6,* 1- 7.

Appendices

Appendix A: Subject Information Sheet



School of Human and
Community Development
Private Bag 3, Wits 2050, Johannesburg, South Africa
Tel: (011) 717-4500 Fax: (011) 717-4559

Dear Sir/ Madam

Hello. My name is Milica Repensek and I am a Master's student at the University of Witwatersrand. As part of my course I have to complete a research project. My research focuses on exploring general practitioners' management of patients with depression within the private health care sector in a South African context. I would like to invite you to participate in this study.

Participation is completely voluntary and you may withdraw at any time and there will be no negative consequences. You may also withdraw your responses at any time. Your participation would consist of a one-on-one interview with me where you will be asked a range of questions dealing with the above-mentioned issues. Although it would be appreciated if you could answer all of the questions, you are free to omit questions if you wish. I assure you that all information gathered will be dealt with in a confidential manner. No information that will allow you to be identified will be included in the research report. You will be referred to by a pseudonym (Respondent X, Respondent Y etc.) throughout the research. The interview materials (tapes and transcripts) will not be seen by anyone other than my supervisor and me. The tapes and transcripts will be kept in a locked cupboard at the university for three years and then destroyed.

If required, feedback will be available approximately 6 months after the interview. Feedback will be in the form of a one-page summary of the study and its results. If you require any further information or feedback, please feel free to contact me. My details appear in signature below. You may also contact my supervisor, Sumaya Laher.

Your participation in this study will be greatly appreciated.

Milica Repensek
082 740 1754
milica.repensek@gmail.com

Sumaya Laher
(011) 717 4532
sumaya.laher@wits.ac.za

Appendix B: Consent Form (Interview)

I, _____ consent to being interviewed by Milica Repensek, for her study exploring general practitioners' management of patients with depression within the private health care sector in a South African context. I understand that:

- Participation in this study is voluntary.
- I may refrain from answering any questions.
- I may withdraw my participation and/or my responses from the study at any time.
- There are no risks or benefits associated with this study.
- All information provided will remain confidential, although I may be quoted in the research report.
- If I am quoted, a pseudonym (Respondent X, Respondent Y etc.) will be used.
- None of my identifiable information, or that of my clients, will be included in the research report.
- I am aware that the results of the study will be reported in the form of a research report for the partial completion of the degree, Master of Arts in Psychology (Research).
- The research may also be presented at a local/international conference and published in a journal and/or book chapter.

Signed:_____

Date: _____

Appendix C: Consent Form (Recording)

I, _____ give my consent for my interview with Milica Repensek to be audio recorded for her study exploring general practitioners' management of patients with depression within the private health care sector in a South African context. I understand that:

- The tapes and transcripts will not be seen or heard by anyone other than the researcher and her supervisor.
- The tapes and transcripts will be kept in a safe place for three years and will be destroyed thereafter.
- No identifying information will be used in the transcripts or the research report.
- Although direct quotes from my interview may be used in the research report, I will be referred to by a pseudonym (Respondent X, Respondent Y etc.)

Signed: _____

Date: _____

Appendix D: Interview Schedule

Introduction

Hello,

I'm Milica. We spoke on the phone. I would like to thank you for agreeing to participate in my study. Before beginning with the interview, I would like to assure you that everything you say during this interview will be kept confidential, and only I and my supervisor will have access to the tapes. The tapes and transcripts will be kept at the university in a locked cupboard for three years. This is primarily because we will probably publish the findings of the study. After three years they will be destroyed. Although I know who you are, confidentiality will be maintained by not disclosing any information that is of a personal nature in the report. I will assign a pseudonym to your information in the report, for example, Participant A or Respondent B.

I would like to remind you that you have the right to withdraw from the study at any time. You also have the right to refrain from answering any question should you wish to do so. A feedback sheet in the form of a one to two-page summary of the study and its findings will be provided to you upon request. You may e-mail or phone me if you would like to receive this. The feedback will be available approximately 6 months after the collection of the data.

Before beginning the interview I will need you to read through and sign these two consent forms (See Appendix B & C). These forms just confirm that you are aware of everything that we have discussed concerning confidentiality, feedback and privacy.

Thank you. If you are ready we can begin the interview.

Questions:

Section 1: Work context

1) Tell me a bit about your work here in the clinic.
2) What kinds of clients do you consult with? Not only their problems/pathologies but also their demographic characteristics especially population group, gender, cultural affiliation? (Remind practitioner that they should not compromise their clients' confidentiality).
3) What are the more general/practical problems you encounter with these clients/with assisting these clients?

4) Before working here, where else did you consult (ever since internship)?
5) Is there anything that stood out with the patients you saw at all the other places?
6) Besides the clinic, do you currently practice elsewhere (if yes, where? What work do you do? With what clients?)
7) Do you feel that your university training adequately prepared you for this or are there additional aspects that, in retrospect, you feel could have been added? Please elaborate.

Section 2: Detecting and diagnosing depression

8) In your opinion, how does depression differ from everyday problems?
9) Given both your training and practical experience, how would you define depression? (Please discuss all symptoms and/or diagnostic criteria).
10) If possible, could you think of any variables that may influence or even impede detection of depression with your clients?

Section 3: Treatment of depression

11) Once you have detected or diagnosed depression with a client, how would you go about communicating this with them?
12) What steps would you follow in offering treatment for the client? Please elaborate.
13) In your previous experience, would you typically follow up with your depressed patients? Please discuss.
14) If possible, could you think of any variables that may influence or even impede treatment of depression with your clients?
15) Taking into account your previous experience, how would you rate your efficiency in managing depression?

Section 4: Referral patterns

16) How do you feel about other non-medical forms of treatment for depression, such as with traditional or faith healers? Would you refer someone who seeks your help to one of these professionals?
17) In your previous experience, have you referred your depressed clients to a mental health care professional?
18) If so, who would you predominantly liaise with? (E.g. psychiatrists, psychologists, social workers, counsellors etc?) Please elaborate on choice or preference.

19) In your previous experience, at what point would you typically decide to refer a depressed patient to a mental health care professional? Please elaborate on line of protocol followed.
20) If possible, could you think of any variables that may influence or even impede referral liaison with secondary health care professionals?

Section 5: Culture

21) Do you believe that one's culture is a key factor when detecting or diagnosing depression? Please elaborate.
22) Do you believe that one's culture is a key factor when treating depression? Please elaborate.
23) Do you have any further comments, or would you like to add any other information that you feel we have not discussed?

Thank you for your time and co-operation.

Appendix E: Ethical Clearance Notification

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

HUMAN RESEARCH ETHICS COMMITTEE (SCHOOL OF HUMAN & COMMUNITY DEVELOPMENT

CLEARANCE CERTIFICATE ***PROTOCOL NUMBER:***
MACC/11/006 IH

PROJECT TITLE:	Exploring general practitioner's management of patients with depression within the private health sector in Johannesburg, South Africa.
INVESTIGATORS	Milica Repensek
DEPARTMENT	Psychology
DATE CONSIDERED	23/03/11
DECISION OF COMMITTEE*	Approved

This ethical clearance is valid for 2 years and may be renewed upon application

DATE: 19 May 2011 **CHAIRPERSON**

_____

(Professor M. Lucas)

cc Supervisor: Dr Sumaya Laher

Psychology

DECLARATION OF INVESTIGATOR (S)

To be completed in duplicate and **one copy** returned to the Secretary, Room 100015, 10th floor, Senate House, University.

I/we fully understand the conditions under which I am/we are authorized to carry out the abovementioned research and I/we guarantee to ensure compliance with these conditions. Should any departure be contemplated from the research procedure, as approved, I/we undertake to submit a revised protocol to the Committee.

This ethical clearance will expire on 31 December 2013

PLEASE QUOTE THE PROTOCOL NUMBER IN ALL ENQUIRIES

Appendix F: Feedback Summary Sheet

The understandings and manifestations of depression is not a universal phenomenon and differences may be noted across different cultural backdrops. Because of this, as well as the influence of other factors, depression is not always accurately detected in general practice. What is more, some factors may even impede the treatment and referral process and lead to a poor management of depression. Hence it is essential that such factors be accounted for so that depression can be addressed in the best possible manner in general practice.

Thus, this research investigated general practitioners' (GPs') management of depression within the private sector in a sample of six GPs that practice in the area surrounding the University of Witwatersrand. Semi-structured interviews were conducted to determine the process of diagnosis, treatment and referral where the impact of culture was also explored.

Based on the information obtained from the interview material, four broad themes or categories emerged, namely: diagnosing, treating and referring patients diagnosed with depression as well as the impact of culture. The process resulted in a number of subthemes in each category. The first category is divided into four subthemes, namely: GP's overall attitudes on the diagnosis or detection of depression, GP's problems with differential diagnosis and classification of depression, diagnostic criteria and extraindividual factors that impede diagnosis. The second category consisted of three further subthemes: GP's opinion of their efficacy with regards to treatment of depression, problems incurred within the process of treating and follow-up of patients diagnosed with depression. The third category also reported on the problems incurred within the process of referral. Lastly, the fourth category was divided into three subthemes which include: the importance of culture in general practice, the stigma that resides in cultural views and denial as a hindrance to diagnosis, treatment and referral. Four further themes were identified within this study which also includes: training of GPs, the evolution of the medical field and its practices, disadvantaged communities and access to health care resources as well as the ethics of practice.

The findings of this study suggest that depression is adequately managed once several factors are taken into account when diagnosing, treating and referring patients with depression. Such factors include: the culture of the patient (as well as the imbedded shame, stigma and denial), the patient's contextual and circumstantial background, limitations of time, financial limitations, the doctor's characteristics, the patient's characteristics and extraindividual factors.