The development of distance education for general practitioners on common mental disorders through participatory action research.

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Results

The results of action research have both 'action' and 'theoretical' findings. The action findings resulted in a distance education programme that implemented the research findings and which can be visited at http://learn.sun.ac.za using the guest login 'bobguest'. The research findings recommended specific changes to both the original printed material and the web-based course as well as describing a model that can be used to understand the process of recognition and management by GPs. This model can also be used to guide the design of educational programs that seek to change the behaviour of GPs. The model describes a process of testing a single hypothesis 'mental problem', assessing the patient in the 'lobby' of general practice, considering specific diagnoses and managing the patient. This process has 6 governing variables described as the 6 C's: cues, communication skills, continuity of care, confidence, course tools and community resources / referral.

Conclusions

This study employed innovative participatory action research methodology to bridge the gap between theory and practice. In particular it adapted the co-operative inquiry group to the development of educational materials. This programme is the first formal introduction of the WHO materials into Africa and the first time, internationally, that the programme has been adapted for web-based distance education. This study provides a new model of the consultation for mental disorders that is practically useful for general practitioners. This study also shows how specific educational tools and strategies can be created to support each part of this consultative process. The action research findings will be reported back to the WHO and incorporated into the design of the next edition of their program 'Mental Disorders in Primary Care'. The action research findings with this course on mental disorders are now being used to develop a Masters Degree in Family Medicine by web-based distance education at Stellenbosch University.

2. Instruksionele ontwerp van 'n 16-week lange internet gebaseerde afstandsonderrig (AO) program wat die bevindinge van die koöperatiewe navorsingsgroep omvat het.
3. 'n Aksie ondersoek met die 21 praktisyns wat ingeskryf het vir die AO program.

RESULTATE

Die resultate van aksie navorsing het beide "aksie" en "teoretiese" bevindinge. Die aksie bevindinge het uitgeloop in 'n AO program wat die bevindinge van die navorsing implementeer. Dit kan besoek word by http://learn.sun.ac.za deur gebruik te maak van die wagwoord "bobguest".

Die bevindinge van die navorsing het spesifieke veranderinge aan beide die oorspronklike gedrukte materiaal, sowel as die internet gebaseerde AO program aanbeveel. Dit het ook uitgeloop op 'n unieke model wat praktisyns kan help om geestesiekte makliker uit te ken en te hanteer. Hierdie model kan ook behulpsaam wees met die ontwerp van onderrig programme wat daarop ingestel is om algemene praktisyns se professionele gedrag te verander. Die model beskryf die toetsing van 'n enkele hipotese "geestesiekte probleem", deur die pasiënt in die "wagkamer" van die algemene praktyk te evalueer, terwyl meer spesifieke diagnoses oorweeg word. Hierdie proses het 6 geldende veranderlikes, wat beskryf word as die 6 C's (in Engels): "cues, communication skills, continuity of care, confidence, course tools and community resources / referral"

GEVOLGTREKKINGS

Hierdie studie het vernuwende deelnemende aksie-navorsing metodes gebruik om die gaping tussen die teorie en die praktyk te oorbrug. Meer spesifiek het dit die koöperatiewe navorsingsgroep metode aangepas om opvoedkundige

materiaal te ontwikkel. Hierdie program is die eerste formele aanwending van die WGO onderrig materiaal in Afrika, en die eerste keer internasionaal dat die program aangepas is vir internet gebaseerde AO. Hierdie studie stel 'n nuwe model voor vir die konsultasie in geestesiekte wat baie prakties en bruikbaar vir algemene praktisyns is. Die studie toon ook aan hoe spesifieke opvoedkundige gereedskap en strategieë ontwikkel kan word om beide dele van hierdie konsultasie proses te ondersteun. Die resultate van die aksie navorsing sal deurgegee word na die WGO vir insluiting in die volgende weergawe van hul program 'Mental Disorders in Primary Care'. Die studie resultate word ook tans gebruik in die ontwikkeling van 'n nuwe internet gebaseerde AO Meestersgraad program in die Huisartskunde aan die Universiteit van Stellenbosch.

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CHAPTER ONE - AIMS AND BACKGROUND TO THE STUDY

BACKGROUND TO THE STUDY

In March 1995 the World Health Organisation's (WHO) Division of Mental Health published the results of its *Collaborative Study on Psychological Problems in General Health Care* (Ustun and Sartorius, 1995). This landmark study interviewed 25,000 people in 14 countries and examined the type, frequency and management of psychological disorders in the community. This study demonstrated that as many as one in four people who attend primary care facilities worldwide are suffering from mental disorders such as depression or anxiety. It also found that less than half of these patients are recognised by primary care providers and in those who are recognised treatment is often inadequate. It was concluded that although mental disorders are frequent, disabling and long-lasting with a number of effective treatments they are not adequately recognised or treated in primary care (Ustun, 1998). As a result of this study the WHO launched an international educational programme designed to improve the performance of primary care providers.

The original WHO educational materials consisted of the *"International Classification for Diseases (Version 10) (ICD-10): Diagnostic and Management Guidelines for Mental Disorders in Primary Care"* (WHO, 1996) and an educational package *'Mental Disorders in Primary Care'* (WHO, 1998). The ICD-10 book provided concise guidelines for both the diagnosis and management of 26 mental disorders (Table 1.1) and the educational package focused on the six most common conditions: depression, anxiety disorders, alcohol use disorders, sleep problems, chronic tiredness and unexplained somatic complaints. This package included checklists and flowcharts, for each condition, that were intended to help with their diagnosis. Information handycards were provided that could be used interactively with patients to explain the conditions and show the various management options. Patient leaflets were given to educate the patient about each condition and provide

tools for self-help and assessment. Finally diagnostic questionnaires based on the ICD-10 were provided for each condition. The contents of the package are illustrated in Appendix A.

The philosophy of the WHO in developing this educational initiative was outlined by Prof. Bedirhan Üstün (1998) at the London Meeting of the WHO Educational Programme. The WHO hoped to disseminate the educational materials to all regions and countries through a process of training of trainers using established WHO networks. The emphasis was on including and integrating mental health into primary care and it was noted that mental health was not included in the primary health care model as originally outlined at Alma Ata. Primary care providers were seen as key because not only are they the first point of contact for patients with a high frequency of mental health problems, but they also have less stigma and the potential for a more comprehensive and sustained approach. In addition they are relatively inexpensive and can act as gatekeepers and co-ordinators of more specialised care. The educational package was seen as having a dual function for both training and use in daily practice. The need for the generic package to be adapted in each country to local language, culture and conditions was also recognised. The intention was to develop regional training programmes worldwide which would use primary care providers as trainers supported by psychiatrists. Ten to fifteen primary care providers would be trained in group sessions at a time. The programme would therefore require collaboration between primary care and mental health services. The need for evaluation and ongoing research into the effectiveness of this programme was also emphasised.

Prof. Pierre de Villiers, Head of the Department of Family Medicine and Primary Care at the University of Stellenbosch was invited to the London meeting of the 'WHO Mental Disorders in Primary Care Educational Programme' in February 1998. At this meeting the WHO programme was presented to an international audience together with selected examples of how the programme would be used in Turkey, India, and the Eastern Mediterranean Region (Murthy and Mohit, 1998; Ogel, 1998). In Turkey a total

Table 1.1. Categories of mental and behavioural disorders in the ICD-10 Primary Care Version

Code	Disorder
F00	Dementia
F05	Delirium
F10	Alcohol use disorders
F11	Drug use disorders
F17.1	Tobacco use disorders
F20	Chronic psychotic disorders
F23	Acute psychotic disorders
F31	Bipolar disorders
F32	Depression
F40	Phobic disorders
F41.0	Panic disorder
F41.1	Generalised anxiety
F41.2	Mixed anxiety and depression
F43.2	Adjustment disorder
F44	Dissociative (conversion) disorder
F45	Unexplained somatic complaints
F48.0	Neurasthenia
F50	Eating disorders
F51	Sleep problems
F52	Sexual disorders
F70	Mental retardation
F90	Hyperkinetic (attention deficit) disorder
F91	Conduct disorder
F98.0	Enuresis
Z63	Bereavement disorders
F99	Mental disorder, Not Otherwise Specified

of 40 general practitioners (GPs) were trained by psychiatrists to offer further training on a regional basis to other GPs through a series of one day courses. Chronic tiredness was omitted from the six conditions in the package. In India

a similar process of training of trainers was planned with 1-3 day training programmes offered to GPs. Chronic tiredness and unexplained somatic complaints were excluded and the need for material on psychoses was highlighted. In the Eastern Mediterranean Region of the WHO similar strategies were also planned, although it was noted that the programme assumes that GPs will be the primary care providers and that in many countries they are more situated at the secondary level of care. It was also noted that in some countries it may be necessary to add categories such as psychosis or epilepsy. Despite Medline searching and personal approaches to role players within the WHO and various regions no formal evaluation of these planned educational initiatives has yet been published.

Later that same year Prof. Bedirhan Üstün from the WHO Division of Mental Health visited South Africa (SA) and made a presentation to the Department of Family Medicine and Primary Care at the University of Stellenbosch. He challenged the Department to adapt the WHO educational programme for the local context and to launch the programme in SA. Sanofi-Synthélabo, who sponsored the programme internationally, were willing to fund a research fellowship in the Department of Family Medicine and Primary Care with the aim of meeting this challenge.

I was appointed to this research fellowship in May 1999. I am a family physician working in Khayelitsha, a large township on the edge of Cape Town. The majority of my patients are poor and speak Xhosa as a first language. My experience of working as a GP in this context for 10 years and my joint-appointment with the Provincial Administration of the Western Cape and Department of Family Medicine and Primary Care at the University of Stellenbosch provided a suitable background for the research fellowship.

During initial networking and discussion with key role players in the South African mental health field it became clear that a large number of training packages and initiatives already existed for the primary care nurse and that attempts were being made to co-ordinate and standardize these packages. There was no support for yet another initiative aimed at nurses. However little

attention had been given to the education of doctors and therefore it was decided to focus on the general practitioner (GP) as the target group for the educational programme.

DEFINITIONS AND TERMS

General practitioners

In this study the term general practitioner (GP) will refer to a generalist doctor working in either the public or private sector. He or she may work in primary care or at the secondary level of care in a district or rural hospital.

Family physician

A family physician is a general practitioner, who has completed formal post-graduate studies and registered as a family physician with the Health Professions Council of South Africa.

PURPOSE OF THIS RESEARCH

The purpose of this action research is to adapt the WHO's Educational Programme "Mental Disorders in Primary Care" for GPs in the South African context and for distance education based on established educational theory and principles. This study will explore the relationship between the GPs and the original WHO Educational Package as well as the distance education programme. New insights and learning that are generated from the experience of GPs within these educational encounters will be used to further adapt and modify the programme.

Although this educational programme is intended to improve the recognition and management of mental disorders by GPs, the primary purpose of this study is not to measure changes in these outcomes, but to understand how GPs interact with the educational materials and process, and to create a more practical and effective educational experience. The rationale for this research methodology is further discussed at the beginning of Chapter 3.

In this manuscript the study is considered in three phases:

1. To assess how useful the WHO educational package is reported to be by GPs in their clinical practice and to understand what should be changed, omitted or added to the educational package to make it more practically useful for GPs in SA
2. To design and develop a distance education programme based on the WHO materials
3. To assess how the GPs engaged with the distance education programme and how it could be adapted or modified as a more effective learning experience.

The chapters that relate to these three phases and the structure of this manuscript are shown diagrammatically in Fig 1.1:

PUBLICATIONS AND PRESENTATIONS

A number of the chapters in this thesis have been published in peer reviewed journals or presented at conferences as shown below. In the South African context a recent review of local research (1967-1999) found that out of 542 titles, none were written by primary care providers (Thom, 2000). In the South African context therefore these publications will hopefully encourage other primary care practitioners to research and address issues of mental health.

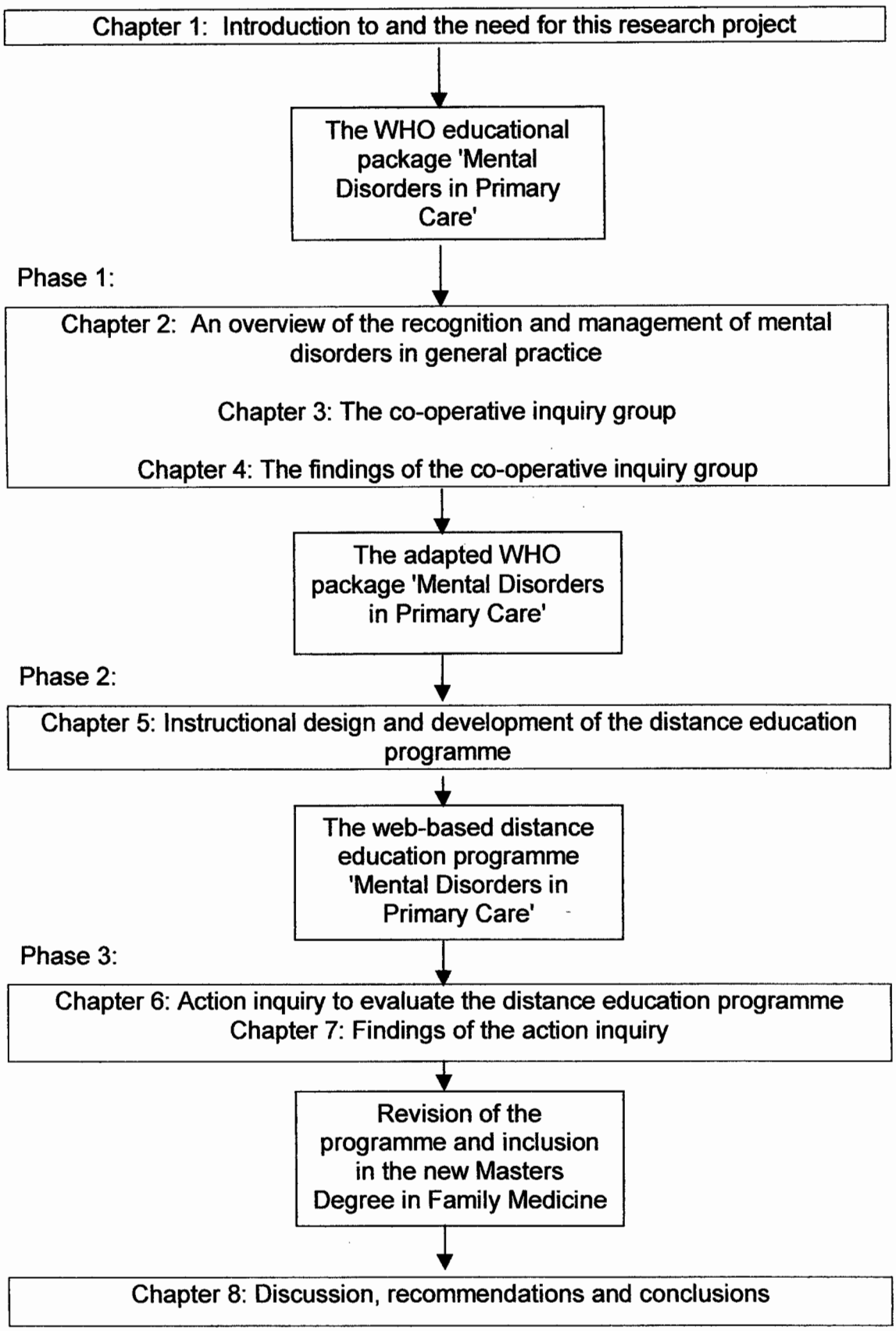
Chapter 2:

Mash, RJ. Are you thinking too much? Recognition of mental disorders in South African general practice. *South African Family Practice Journal* 2000;22(2):22-27

Chapter 3:

'Mash, B. Meulenberg-Buskens, I. Holding it lightly': The co-operative inquiry group: a method for developing educational materials. *Medical Education* 2001;35: 1108-1114

Fig 1.1: Overview of the thesis



The co-operative inquiry group: Changing practice through participatory action research. Workshop given on 15th May 2001 at the 16th International WONCA 2001 Congress

Chapter 5:

Mash, B. Development of the programme 'Mental Disorders in Primary Care' as Internet based distance education in South Africa. *Medical Education* 2001;35:996-999.

Development of the programme 'Mental Disorders in Primary Care' as Internet based distance education in South Africa. IT presentation given on Monday 14th May 2001 at the 16th International WONCA 2001 Congress.

Chapter 6 and 7:

Mental Disorders in Primary Care: The development and evaluation of a web-based programme for general practitioners using participatory action research. Paper presented at the 3rd Annual Conference on World-Wide Web Applications, Rand Afrikaans University, 5-7 September 2001.

Chapter 8:

Adapting the WHO's educational programme 'Mental Disorders in Primary Care' for South African general practice. Presentation given on 14th May 2001 at the 16th International WONCA 2001 Congress.

Mash,B. How to design education on mental disorders for general practitioners in South Africa. Forthcoming in *South African Family Practice Journal.*

PHASE ONE: CHAPTER TWO - AN OVERVIEW: RECOGNITION AND MANAGEMENT OF MENTAL DISORDERS IN GENERAL PRACTICE

INTRODUCTION

The literature reviewed in this chapter focuses on what factors are already known that influence the recognition and management of mental disorders by GPs. This literature is also helpful in considering to what extent the WHO educational programme incorporated this knowledge into the design of its materials and how these factors can be explored further in the action research process. Much of the evidence comes from studies performed in developed countries within a very different context. Nevertheless I have attempted to summarize the evidence and to discuss its relevance to South Africa.

WHAT ARE THE COMMON CONDITIONS

Mental disorders are a major public health problem causing 10% of the global burden of disease in both developing and developed countries. Depression alone is the fourth leading cause of the global disease burden (Brundtland, 1998).

It is now well established that the majority of mental disorders are managed in primary care and not in specialist psychiatric services (Ustun and Sartorius, 1995). Primary care providers therefore should be highly skilled in recognizing and managing these disorders. Internationally 24% of patients attending primary care facilities were found to have an identifiable disorder using the *International Classification of Diseases -Version 10 (ICD-10)* (Ustun and Sartorius, 1995). In South Africa a study in Soweto found a prevalence of mental disorders of 14.4% among adults at a primary care facility (Thom et al. 1993) and a study of children and adolescents in Khayelitsha found a prevalence of 18.8% (Ensink et al. 1995). These studies suggest that in a morning surgery of 24 people between 3 and 6 people on average could be suffering from a diagnosable mental disorder.

Among these patients with mental disorders the commonest conditions are depression and anxiety. Community studies in South Africa have found a high prevalence of depression and anxiety disorders with values ranging between 16.6% for depression and panic disorder in Lesotho (Hollifield et al., 1990), 24% for generalised anxiety, major depression and dysthmia in KwaZuluNatal (Petersen et al. 1996) and 44% for depressed elderly women in Khayelitsha (Gillis et al. 1991). These findings are consistent with the international literature which describes 12-month prevalence rates for mental disorders in the range 15-25% (Kessler, 2000). A large international study by the WHO identified the six most common conditions at primary care facilities as depression, anxiety disorders, alcohol use disorders, sleep disorders, chronic tiredness and unexplained somatic complaints (Ustun and Sartorius, 1995). A study in Kwa-Zulu Natal found a prevalence of 7.8% (Petersen et al. 1996) for alcohol abuse and in Fraserburg, North West Province a very high rate of 56% for alcohol dependence (Claassen, 1999). Violence in South Africa is an important determinate of mental illness. A national survey in general practice found that 21.5% of women in general practices had a history of domestic violence (Marais et al. 1999). Amongst these women 35% were suffering from post-traumatic stress disorder and 48% from depression. Another study of Xhosa children in Khayelitsha found that 95% had witnessed violence and 56% had experienced violence themselves (Ensink et al. 1997). Amongst these children 40% were suffering from mental disorders, especially post-traumatic stress disorder. The HIV/AIDS epidemic is likely to have a major impact on the mental health of both sufferers and their families (Foster et al. 1997).

HOW WELL DO GENERAL PRACTITIONERS RECOGNISE THESE CONDITIONS

The overwhelming message from international studies is that primary care providers detect approximately half of all patients with mental disorders (Higgins, 1994; Ustun and Sartorius, 1995);. All of these studies detected

"cases" by the use of standardized tools and questionnaires based on international classifications of disease such as the ICD-10 and compared these "cases" with the diagnosis given by the primary care provider.

An important debate in the South African context is how useful are these standardized categories for defining mental disorders in our communities? The WHO has conducted extensive international research that shows the presence of these categories in all communities studied in both developing and developed countries (Sartorius et al. 1995). However within this system of classification some of the most common problems in primary care such as acute anxiety and somatisation are represented by non-categories such as "anxiety not otherwise specified" (Goldberg et al. 1992; Rickels and Schweizer, 1997). The WHO approach has also been criticized "as you will only find what you look for" and may miss or ignore expressions of mental illness that are not included in the definitions, but are relatively common in local communities or cultures (Kleinman, 1977). This dilemma has been labeled as the "universalistic approach" versus the "relativist" approach (Swartz, 1998). It is a familiar story in family medicine where the need to explore both the "disease" and the "illness" can be seen as a parallel argument. On the one hand the doctor's training in explanatory models of disease attempts to fit patient's symptoms with internalized diagnostic categories but on the other hand only 50% of patients in primary care can be allocated within these categories. In order to manage all patients a broader definition of illness using a "systems" model and not a "disease" model is more practically useful and an approach which elicits and accepts the patient's own explanatory model (Silverman et al. 1998). In the field of mental health for example there may be a need to recognize and explore local expressions of emotional distress such as "Thinking too much", "I felt like throwing down the spears" or "I feel things crawling through the body" (Abas and Broadhead, 1997). In addition it may be necessary to elicit explanatory models given by traditional healers such as "amafufunyana" (Robertson and Kottler, 1993). "Amafufunyana" may present as an emotional disturbance with agitation, weeping, aggression or delirium. It is believed to be caused by sorcery resulting in spirit possession (Ellis, 1999).

In summary family medicine operates in a relativist worldview where exploration of the patient's unique explanatory model is important to build understanding and enhance accurate diagnosis, patient satisfaction, compliance, outcome and recall of information (Silverman et al. 1998). This is in tandem with the use of the doctor's explanatory model to recognize and treat diseases. The doctor's explanatory model is based to some extent on universally accepted diagnostic categories.

DOES NON-RECOGNITION MATTER?

Having outlined the evidence that shows GPs do not recognize cases of mental disorder identified by standardized screening tools; we should now consider what factors are important in understanding this phenomenon.

The implied criticism of GPs should be balanced by the comments of Simon and VonKorff (1995) who note that mental disorders may be recognized and treated, but not recorded in the medical record and therefore not counted. In addition, studies that only use self-reported questionnaire tools to detect disorders, may over-estimate their prevalence. Studies also varied in the way recognition was determined and defined (Higgins, 1994). Furthermore GPs may be aware of mental disorders but resist diagnosing them due to likely spontaneous improvement, lack of effective treatment or unwillingness of the patient to accept this diagnostic label (Higgins, 1994). One study demonstrated that a psychiatrist who became a general practitioner failed to detect one third of patients with mental disorder (Goldberg and Blackwell, 1970). This may point towards the difficulties inherent in general practice of sifting through undifferentiated and multiple symptoms within a brief consultation.

It is also noted that the more severe mental disorders are more likely to be recognized and so, if the less severe are overlooked, does this matter? Evidence is conflicting on this issue (King, 1998). One naturalistic study

concluded that recognition was positively associated with a better course and outcome of psychological problems in primary care (Ormel et al. 1990). In addition recognition was associated independently from treatment with a better outcome and it was postulated that re-framing of the illness by the patient may allow them to pursue more effective solutions within their own support network. Other naturalistic studies have argued that non-recognition of depression does not adversely affect outcome compared with recognised cases, because unrecognised patients have less severe, fewer and more recent symptoms, but this may also be because recognition is not associated with effective treatment (Goldberg et al. 1998). Obviously maximum benefit from recognition will be obtained when an effective treatment strategy exists and is used. It has also been noted that non-recognition is linked to prolonged disability for the patient, an increased consultation rate, unnecessary investigations and a waste of resources (Prestridge and Lake, 1987). Greenberg et al. (1999) estimate that the annual cost of anxiety disorders in the United States was approximately $42.3 billion in 1990. Direct non-psychiatric medical treatment accounted for 54% of these costs and represented a considerable economic burden from inefficient treatment of undiagnosed or misdiagnosed anxiety disorders. In studies looking at the natural history of mental disorders, physical illness, social adversity, poor housing and poverty, which are all common problems in South Africa, have been linked to poor outcomes (King, 1998).

What level of performance is reasonable to expect from general practitioners? Bowman (1995) summarises the findings of Simon and VonKorff's study (1995) as the "rule of two thirds". This study performed in an established health system and with well trained family physicians found that two thirds of patients with major depression were recognized, two thirds of these were treated and two thirds of these were treated adequately. Two thirds of all patients, whether recognized or unrecognized were well 1 year later. The recognized cases however were more symptomatic and not the same as the unrecognized. In the best of circumstances only one third of recognized patients with depression took adequate doses of antidepressants and achieved significant improvement (Bowman, 1995). In South Africa one could

anticipate that with no systematic vocational training in general practice, barriers of language and culture, and many limitations in the health system our less than ideal situation would lead to a lower performance and patients with even severe disorders could go unrecognized.

Therefore despite some evidence in more developed settings, that unrecognized cases may do as well as recognized, these studies may not be generalisable to the South African context. I would argue that in South Africa our present ability to recognize and treat mental disorders in the primary care system might be so poor that the benefits of treatment are denied a substantial proportion of eligible patients. In the Soweto study 93% of patients with mental disorders were unrecognized and in Petrusburg 76% of patients with depression, (Strauss et al. 1995; Thom et al. 1993).

WHAT FACTORS INFLUENCE THE DOCTOR'S ABILITY TO RECOGNISE MENTAL DISORDERS?

It seems therefore that non-recognition is a real issue and can lead to adverse outcomes for both the patient, GP and health system. If we accept this then we must consider what factors influence this problem and what can be done to improve the situation. In order to answer this question I will consider the factors relating to the doctor, the patient and the health system separately.

1) Factors relating to the doctor.

- Decision making in general practice often involves hypothesis generation and testing (Like and Reeb, 1984). From the moment the patient walks in the room the doctor's internal dialogue is generating and testing hypotheses. Hypotheses may be considered and discarded as the patient tells their story or as a result of inquiry by the doctor. A doctor who fails to generate and test psychological hypotheses alongside physical ones will of course fail to recognize mental disorders. Psychological problems in primary care frequently present with somatic complaints such as

headaches, musculoskeletal pain, palpitations and chest pain (Prestidge and Lake, 1987). An emphasis therefore on always exploring physical hypotheses first will systematically prevent the recognition of mental disorders. An approach of if "there is nothing wrong" it must be "in the head" will be a frustrating one for both patient and doctor. Recognition should be followed by the ability to decide on severity and formulate a specific diagnosis according to accepted criteria.

- Communication and consultation skills in general practice have also been clearly linked to effective recognition and management of mental disorders (Bowman et al. 1992; Craig and Boardman, 1997; Docherty, 1997; Goldberg and Gater, 1996; Millar and Goldberg, 1991). For example skills in attentive listening such as not interrupting the patient's narrative, use of facilitative silence and responding to what the patient has said rather than asking questions from theory have been linked to better recognition. The ability to ask questions with a psychological and social content has also been identified as important (Paykel and Priest, 1992). In short, effective communication skills within a patient-centered clinical method are essential. Skills in working with an interpreter, learning the language of your patients as well as local customs and expressions of illness may be needed (Ellis, 1999). In addition to this a more holistic approach that inquires about the person, their family and context is more likely to elicit mental problems. Continuity of care with the same doctor and repeated consultations favor recognition. Whilst longer consultations favor recognition the use of a patient-centered approach does not necessarily mean longer consultations (Silverman et al. 1998).

- Another important factor is the beliefs and attitudes of the GP. GPs who do not see managing mental illness as part of their role, who blame the patient in some way for their illness or who can see "a good reason" (such as a concomitant medical illness or a serious problem in the patient's life) for the patient's illness will struggle to recognize mental disorders (Docherty, 1997). Conversely GPs who believe that effective treatment

exists, that they have the ability to treat mental illness, that there is enough time to deal with psychological issues and that psychological factors are important in both physical and mental problems are more likely to recognize mental disorders (Craig and Boardman, 1997; Docherty, 1997).

- Finally there may be a lack of knowledge about common mental disorders due to a historical emphasis on the more severe and unusual disorders during undergraduate training and a lack of effective and relevant postgraduate vocational training and continuing professional development for general practice.

2) Factors relating to the patient.

- Patient's help-seeking behavior is important. Not all patients with mental disorders seek help and not all who do seek help look to the primary care services. A large number of people will deal with their illness themselves within their own social network or "popular" health sector (Kleinman, 1978). The opinions and attitudes of key family members towards consultation and treatment will be important. Others will consult within the "folk" sector and attend traditional healers or alternative practitioners. Kessler (2000) notes that in Canada the perceptions that treatment was ineffective and the problem self-limiting influenced help-seeking behaviour, there was also a desire to deal with the problem oneself, without outside help. This last factor may point to the stigma that is frequently associated with being diagnosed with a mental disorder. In the WHO study only 50% of people with a mental disorder consulted a primary care provider (Ustun and Sartorius, 1995). In a Zimbabwean study only 29% of depressed women consulted in the "professional" sector (Abas and Broadhead, 1997); 82% of them were treated with paracetamol and none with anti-depressants. In addition patients may not share the same concepts as doctors and for example have no word for "depression" (Gillis et al. 1982). The mental illness itself may cause symptoms that inhibit help-seeking behavior. For

example in depression you may not feel worthy of help, you may not believe that any help is possible or be too lethargic to seek help (Docherty, 1997). It has also been shown that it often takes many years before people suffering from mental disorders present to a health professional for the first time (Kessler, 2000).

- The presentation of the problem is also important. Mental disorders present frequently with physical symptoms and as outlined above this makes the differentiation of mental disorders a huge challenge in general practice (Weich et al. 1995; Kleinman, 1977). However in the Zimbabwe study although 60% of terms used to describe emotional distress were physical; the 40% of psychological and behavioral terms were used more frequently (Abas and Broadhead, 1997). In addition some expressions that were translated as physical symptoms were in reality metaphors for emotional distress. Skills in language or interpretation may be a particularly relevant issue in South Africa (Ellis, 1999). In addition although patients present physical symptoms to the primary care provider their own explanation of the problem is often psychosocial. In Kwa-Zulu Natal Petersen reported that body aches and pains was the main reason for encounter, 56% had the problem for one or more years and 62% saw their problem as psychosocial (Petersen et al. 1996). This again demonstrates that a question such as "What do you think is the problem?" may be an efficient short cut to the real issues.

- Co-morbidity with serious physical illness in women reduces the chance of recognition by a factor of five (Tylee et al. 1993) whereas co-morbidity with other mental disorders increases the chance (Craig and Boardman, 1997). Co-morbidity of untreated mental disorders with physical disorders has also been shown to impact negatively on the outcome of the physical disorder (Kessler, 2000). More severe disorders are, not surprisingly, more likely to be recognized whereas depression that is not of recent onset, has less overt or less typical symptoms is less likely to be recognized (Paykel

and Priest, 1992). A past history of mental illness will also increase the chances of recognition.

3) Factors related to the health system.

- One of the most important issues is the availability and accessibility of primary health services (Goldberg and Huxley, 1992). In many parts of South Africa access is still limited by geographical distance in rural areas or by sheer numbers of patients in peri-urban areas. Specialist mental health workers such as psychiatrists are also few and poorly distributed throughout the country (Lee and Zwi, 1997).

- The perception of psychiatry as being a separate vertical program from primary care with its own psychiatrists, psychologists and psychiatric sisters may support the notion that mental health is not part of the GP's role. Indeed staff, at the district level, have felt that this additional role in mental health was being foisted upon them with little attention to their concerns regarding workload and training (Lee and Zwi, 1997).

- In the public sector the lack of a range of effective drugs with a low side effect profile may be important, as GPs will not recognize what they feel unable to adequately treat. In the private sector the cost of treatment may also be a limiting factor, especially for "cash" patients who must pay directly for medications or where the cost of medications is included in the consultation fee. Financial barriers are an important factor in limiting access to treatment (Kessler, 2000). In private practice the unwillingness of medical aid organizations to pay GPs for psychological therapies may also be important.

- The secondary and tertiary level support for the primary care provider is also a factor. Doctors with readily available mental health services have a much higher referral rate than those without this support (Goldberg and Huxley, 1992). If the general practitioner feels unsupported and without

access to specialist advice and support she may resist diagnosing disorders which might require referral and for which she feels "out of her depth."

HOW CAN RECOGNITION OF MENTAL DISORDERS BE IMPROVED?

The previous discussion, of factors related to the GP's ability to recognize mental disorders, naturally leads on to a consideration of what can be done to improve recognition and what evidence exists for facilitating effective change.

Traditional "Continuing Professional Development", for example talks and lectures, are the least effective methods (Cantillon and Jones, 1999) for changing professional practice. However In a recent review of Continuing Professional Development it was concluded that there are no particular teaching or learning methods that are 'more effective' per se, rather that effectiveness in a function of the process with attention to needs assessment, appropriate selection of methods and reasonable evaluation of outcomes (Grant and Stanton, 1999). There is a strong body of evidence that interview skills training using experiential learning techniques, in particular video feedback, can improve not only detection of psychological problems, but also their management (Novack et al. 1989). The use of screening tools and questionnaires in general practice has been recommended by several studies (Broadhead et al. 1995; Goldberg and Blackwell, 1970) although I think there may be an underlying assumption that tools developed as research instruments will be practically useful in every day practice. The use of self-rating scales outside of the consultation time may be limited in South Africa by barriers of language and literacy. Widespread screening of patients without improving the interviewing skills of the general practitioner is also unlikely to be helpful (Paykel and Priest, 1992) . A number of clinical guidelines and algorithms have been produced and may be useful (Abas et al. 1994; Rix et al. 1999;), although research indicates that producing and disseminating a guideline does not in itself lead to effective change. The ICD-10 PHC mental

health guidelines were assessed with GPs in the UK and found to have no impact overall on the detection of mental disorders, the accuracy of diagnosis or the prescription of antidepressants. There was a significant increase in the number of patients diagnosed with depression or unexplained somatic complaints and an increased use of psychological interventions (Upton et al. 1999). Katon (1996) comments that programs that have been successful in improving patient outcomes have targeted multiple levels including patient, physician and the process of care. In terms of curricular content the following areas have been highlighted; patient-centered interviewing and treatment, the therapeutic effect of the doctor-patient relationship, a biopsychosocial approach to clinical reasoning and care, synergistic attitudes and values, and the ability to diagnose and manage common mental disorders (Novack et al. 1989; Paykel and Priest, 1992).

MANAGEMENT OF MENTAL DISORDERS BY GENERAL PRACTITIONERS

Recognition of course is only the beginning of management and not an end in itself. This chapter does not attempt to do justice to the management of mental disorders, but I will offer a brief overview of the possible options for the GP.

In South Africa GPs work at both the primary and secondary levels of care and attention must be given to the knowledge and skills required by both. Whilst the above discussion relates to the primary care level the needs of rural generalists must be considered; for example the in-patient management of drug or alcohol withdrawal, the management of the acutely disturbed or aggressive patient and the assessment of suicidal patients. In many rural areas the follow up of patients with severe psychiatric disorders such as schizophrenia also falls to the GP.

At the primary level the therapeutic effect of the doctor-patient relationship and effective interview skills should not be overlooked (Silverman et al.

1998). GPs should be capable of assessing and managing psychosocial problems and have conscious strategies of how to do this, such as the MAPP (Tannenbaum and McGillivray, 1996). Problem-solving therapy in general practice can also be effective (Mynors-Wallis et al. 1995, Moore, 1997). Cognitive-behavioral therapy has been shown effective in depression, anxiety and stress related disorders but also requires considerable training and time and is not a practical solution for most GPs (Craig and Boardman, 1997; Moore, 1997). Non-directive counselling while commonly advocated in general practice does not have proven efficacy (Churchill et al. 1999; Craig and Broadman, 1997). Inter-personal therapy may be as effective as antidepressant treatment for mild to moderate depression (Churchill et al., 1999), but similarly requires additional training and extended consultation time. Brief cognitive behavioural techniques are frequently used by GPs within primary care consultations. Robinson et al. (1995) found that 61% of depressed patients reported advice from their GP on identifying activities that helped them feel better and between 22-44% of patients reported recommendations regarding planning pleasurable activities, problem solving, dealing with negative thoughts and enhancing confidence. The study found that these suggestions by GPs were associated with the use of these strategies in the months following the visit as well as better adherence to treatment. The study however did not examine in detail the efficacy of these interventions. A recent randomised controlled trial that compared non-directive counselling, cognitive-behaviour therapy and usual GP care for patients with depression found that both psychotherapeutic interventions were more effective than usual care in the short term, but at one year there was no difference in outcomes (Ward et al. 2000). One systematic review found that the evidence generally supported the efficacy of psychosocial treatments in primary care, although there were some methodological concerns with the 18 included studies that limited their generalisability (Brown, 1995). The results of further, more recent, systematic reviews within the Cochrane Library are awaited. In patients with alcohol dependence the use of the "stages of change" model as a conceptual framework and motivational interviewing as a management strategy is currently highlighted (Butler, 1996; Austoker, 1994). There has been local success with NETWORK therapy as described by

Galanter (1993) for alcohol use disorders (personal communication Prof. Willie Pienaar, Stikland Hospital Alcohol Rehabilitation Unit), but no formal assessment of its use by GPs.

Even if GPs are not able to deliver specialised therapies themselves they have access to other health professionals at the primary care level or by referral. Social work interventions may help in depression (Churchill et al. 1999) and more time consuming psychological therapies may be available from psychiatric nurses, psychologists and psychiatrists in some areas. A large number of non-governmental and community-based organizations have mental health issues as part of their focus and may be a useful resource (Foster et al. 1997). GPs should make themselves aware of the community resources in their area.

Having said this, the reality for most South African patients is that these sophisticated therapies are not available, mainly due to a lack of trained therapists in the public sector. For example in the Khayelitsha district, psychological therapies are most likely to be offered by lay counsellors, social workers or psychiatric nurses. The last patient I referred to the psychiatric nurse for counseling with a major depression came back with the notes "encouraged not to be lazy" written in the medical record. In addition to the issue of accessibility is the issue of relevance or acceptability to the patients. There is little research in African communities, like Khayelitsha, to know if therapies developed in a different culture will be accepted and effective here. For example a leaflet on relaxation therapy that advises the person to lie on the floor in a quiet room and listen to music may just seem nonsensical to a woman who shares a shack with 8 other people and has no electricity or collection of soothing music! There is a need to develop simple, brief and culturally appropriate therapies for our communities that can be delivered by primary care providers with minimal training (Inaugural address Prof. Leslie Swartz, Stellenbosch University, May 2nd 2001)

It is self-evident that GPs must be informed about effective drug therapy, be aware of indications for treatment, be able to make an informed choice of

drug, prescribe the drug in therapeutic doses and educate the patient about the use and possible side-effects (Stein et al. 1999). In some areas of the country it may still be necessary to simply have access to effective drugs within the Essential Drug List (Mokhobo, 1998). However even in relatively ideal conditions only 33% of patients complete 6 months of antidepressant therapy in a general practice context (Schulberg et al. 1995).

SUMMARY

In South Africa the majority of patients with mental disorders go unrecognized in general practice. This problem may be addressed by educational initiatives that target effective patient-centered interviewing skills, knowledge of diagnostic categories and therapeutic options and create awareness of beliefs and attitudes towards mental disorders within both the GP and the patient. There is a need to make effective and acceptable pharmacological therapies available to all communities and to develop simple culturally appropriate psychological therapies that can be offered at the primary care level.

PHASE ONE: CHAPTER THREE - RESEARCH METHODOLOGY: THE CO-OPERATIVE INQUIRY GROUP

Who was that research
I saw you with last night?
That was no research,
That was my life!
(Reason, 1988)

INTRODUCTION

This chapter describes the action research methodology for the first phase of the study, which aims to adapt the original WHO educational package for South African GPs. This chapter discusses why action research was chosen as a methodology and gives an overview of this type of research. This is followed by a more detailed description of the co-operative inquiry group (CIG) and how it was used in this study. The concepts used to judge the quality of co-operative inquiry are described and the strengths and weaknesses of our inquiry are discussed in the light of these concepts. Finally specific techniques used in the inquiry process are briefly outlined.

CHOOSING A RESEARCH METHODOLOGY

In comparing various research approaches with each other the following three broad paradigms are generally accepted: the empirical-analytical, the interpretative-hermeneutic and the emancipatory-critical (Habermas, 1972; Smaling, 1992). A paradigm may be defined as the thoughts, perceptions and values that form a particular vision of reality. Key attributes of these paradigms are compared in Table 3.1. The co-operative inquiry group fits within the emancipatory-critical paradigm, but before discussing this paradigm and co-operative inquiry in more detail, I would briefly like to compare this approach with

Table 3.1: Key attributes of the research paradigms. Source: Meulenberg-Buskens, adapted from (Smaling, 1992).

Key attributes	Research Paradigms		
	Empirical – Analytical	**Interpretative-Hermeneutic**	**Emancipatory- Critical**
Relationship with research 'reality'	Testing Measuring	Exploring Interpreting Constructing	Changing Creating Transforming
View of researched person	Object to be studied and measured	Subject to be understood and interpreted by researcher	Participants in the research
View of truth	Correspondence to facts	Coherence with in the data	Consensus of each persons learning
Research Process	Predominantly quantitative measurements	Predominantly qualitative interpretations	Participatory using both qualitative and quantitative techniques
Research question	Fixed hypothesis. Set by researcher.	Open-ended hypothesis. Set by researcher.	Part of the research process. Negotiated in dialogue between participants.
Implementation of results	Recommendations made for action by people other than the researchers	Insights offered for use by other people	Findings implemented as part of the research process and the implementation studied
Concept of methodological objectivity	Generalisability	Transferability	Transferability
Concepts of reliability and validity	Standardisation and control of bias, chance and confounding factors. Statistical analysis	Triangulation Respondent validation Thick description Reflectivity Deviant case analysis Fair dealing	Practical application Alignment with purpose Ownership Group process Documentation Reflectivity Knowledge construction

the way in which my research would, in all probability, be addressed in other paradigms.

Empirical-analytical paradigm

The empirical-analytical approach to adapting the package would be to gather together a team of mental health specialists, academic experts and general practitioner representatives who would deliberate on what changes to make and then test the adapted intervention with GPs in a controlled trial. This approach however can fall into the theory-practice gap whereby training material that is developed from a theoretical perspective fails to be useful when implemented in practice and due to the rigid research design cannot then be modified (Hart and Bond, 1995; Brookfield, 1986).

For example, a recent study of the use of ICD-10 Guidelines with GPs in the UK concluded that they had no impact on the overall detection of mental disorders, the accuracy of diagnosis or the prescription of antidepressants (Upton et al. 1999). The study however was unable to explore how the guidelines were actually used or how the educational programme could have been changed to make it more useful or practical for the GPs. In this empirical-analytical approach the educational intervention is seen in much the same terms as giving a drug to a patient (Smith, 2000). Measurements of the 'drug' or intervention are made using pre-determined outcomes and generalisable conclusions drawn as to its effectiveness. The social interactions however between GPs and their educational experience is highly complex and cannot be reduced to simple predictable, linear causes and effects. Factors such as prior training, the type of health system, the political environment, the educational principles used, the mode of delivery, the length of the course and so on all influence the impact of the intervention. Indeed one of the problems that systematic reviewers face with the plethora of current empirical-analytical educational studies is that "differences

in these specifics make it difficult to compare studies using a single intervention class" (Smith, 2000).

Torbert (1981) has also noticed how orthodox educational research frequently leads to negative findings. These controlled trials often tell us what an educational program does *not* do, as in the example above, but has difficulty describing what the program did do, what it ought to do, and how it could be modified to educate more successfully. He argues that as this type of knowledge cannot "help acting systems learn how to act better next time" a different model of research is required, and not just more rigorous controlled trials (Torbert, 1981).

This research therefore focuses not on the measurement of pre-determined outcomes that are designed to measure changes in recognition and management, but starts by exploring in detail the nature of the relationship between the GPs and the educational process. It seeks to understand what happens within the educational encounter before measuring whether the intervention has made a significant change in empirical outcomes.

Interpretive-hermeneutical paradigm

Another approach to adapting the package would be to explore the perceptions of GPs regarding their educational needs and the WHO educational program. This could be done in the form of a questionnaire or by using qualitative interview techniques. While this approach would be closer to the realities of the target audience the theoretical concerns and perceptions of GPs may differ significantly from their experience of *actually using* the materials. These approaches are useful for exploring perceived needs, possible areas of resistance, opinions, values and beliefs. These perceptions however may change through the experience of actually using the package and what was believed to be unhelpful

may turn out to work quite well. I was more interested in what will actually work in practice.

Emancipatory-critical paradigm

To avoid this theory versus practice dilemma and to allow more flexible development of the educational programme it was decided that GPs should adapt the programme using an approach within the emancipatory- critical paradigm. This approach is particularly useful where there is a need to develop potential solutions to identified problems in clinical practice(Meyer, 2000).

The value of this approach was also confirmed in the United Kingdom where action research was adopted as a way to develop and research a national mental health training programme for general practice after the programme failed to develop effective training initiatives using more traditional approaches (Singleton and Tylee, 1996). In this project the educational program was initially seen as "pedagogy in andragogic clothing"[1] whereby tutors were expected to apply a centrally designed course and tailor it to local needs. This met with great resistance from the local tutors and GPs. The second stage was seen as "andragogy in pedagogic clothing" whereby tutors were asked to assist with developing local interventions. Tutors still perceived the program as "top-down" and resisted involvement. Lastly an action research approach was adopted. The regional fellows responsible for the program focused more on how to make the program practical and formed their own co-operative inquiry group that allowed action and reflection on the developing programs (personal communication Prof Andre Tylee). As a result of this research methodology 11 different but successful educational programs were developed.

[1] Pedagogy is teacher-based didactic education traditionally aimed at children and andragogy learner-centred participatory education based on adult-education principles.

THE EMANCIPATORY-CRITICAL PARADIGM: ACTION RESEARCH

What is action research?

Action research does not refer to a specific technique, but to a particular philosophy and approach to research that within itself has several different traditions. This philosophy and approach has also been referred to as the emancipatory-critical paradigm (Table 3.1). This approach to research is characterized by a commitment to doing research *with* people rather than *on* people. Instead of measuring or interpreting the focus of the research, action research changes, creates and transforms this focus into something new, as a part of the research process. Action and change are integral to the research process. People involved in the research are not seen as objects to be studied or interpreted from outside, but as co-researchers who reflect on their experience and at the same time are co-subjects who are engaged in their own experience. The research findings therefore are implemented in the process of the research. New knowledge is constructed from this experience and is a consensus of the learning of each person involved in the research process. The research questions are not imposed by an outside researcher, but are negotiated by the group and can even change during the research process. In summary action research has three important elements (Meyer, 2000):

- A simultaneous contribution to new learning about and change within the particular focus of the research. This is a dialectical relationship where action and research, theory and practice are seen as 'two sides of the same coin' (Rowan, 1981). It has also been referred to as 'grounded theory' where the theory is developed from the actual experience or practice and not theoretical ideas (Green, 1998). This research approach closes the 'theory-practice' gap and requires the implementation of research findings as part of the research.

- A participatory character that involves people, in designing the research questions, in action and reflection, in a learning community and dialogue with each other, in reaching consensus and disseminating their findings. People are not alienated from each other or from the research itself.

- A democratic character that strives for ownership of the process by all participants and equal opportunities for all to contribute.

One underlying assumption is that people can learn and create knowledge (Zuber-Skerritt, 1992),

- on the basis of their concrete experience;
- through observing and reflecting on that experience;
- by forming abstract concepts and generalisations; and
- by testing the implications of these concepts in new situations

The knowledge created therefore is both propositional, practical and experiential (Zuber-Skerritt, 1997). Propositional knowledge (knowing), of a conceptual or theoretical nature, is created through the process of reflection. Practical knowledge (doing) is created through the action-phase and development of new skills. Experiential knowledge (being), in terms of self-awareness and personal change, is an inevitable part of the reflective stance and process of change.

Almost all models of action research are perceived of as cyclical and continuous (Zuber-Skerritt, 1997).

Different types of action research

Kurt Lewin, a social psychologist, is often seen as the founder of action research through his pioneering work with intergroup relations and minority problems in the United States during the 1940s (Lewin, 1946).

Although there is no universal agreement on the definitions and classification of action research, a useful typology has been suggested by Hart and Bond (Hart and Bond, 1995). This typology identifies 3 types of action research: organisational, empowering and professional. I will briefly outline each of these.

Organisational

In the field of business and industry, action research has been used as a method for developing new solutions to organisational problems, overcoming resistance to change and restructuring the balance of power between managers and workers. One pioneering example of this was the use of participatory action research to change the organisation of the merchant shipping fleet in Norway (Whyte, 1991). Action research cycles have also been seen as a means of developing quality assurance in both industry and the health sector (Fisher and Torbert, 1995) (Meyer, 2000).

Empowering

Participatory action research (PAR) has been widely used in developing countries where adult education is combined with investigation of and change in the socio-political situation. PAR has harnessed people's capacity to think and work together for a better and more equitable life through personal and social transformation (Smith et al. 1993). This type of action research has been committed to consciousness raising and the empowering of oppressed groups. This tradition is strongly linked to the work of Paulo Freire and adult education theory that honours people's ability to reflect on their own situation and develop ways of transforming it (Hope, 1984). This tradition of empowering action research has been emphasised by the North American Primary Care Research Group (Macaulay et al. 1999).

Professional

Action research has also been used to help professionals reflect on and change their practice. There has been a strong tradition of action research in the field of education (Zuber-Skerritt, 1992 ; Kemmis, 1988) and to a much lesser extent within professions allied to medicine. For example action research has been used by health visitors (Traylen, 1994), primary care nurses (Webb and Pontin, 1997) and nurse educators (Davis, 1991). In the medical field, doctors have seen it as a means of evaluating medical interventions (Malterud, 1995) and more recently family medicine has embraced it as a means of developing GP research networks (de Villiers, 1999) and developing useful educational programs (Singleton and Tylee, 1996).

This study falls within the professional type of action research, where GPs develop and evaluate an educational program designed to change their practice in the area of mental health. Zuber-Skerritt has defined the characteristics of this type of professional action research in the CRASP model (Zuber-Skerritt, 1992):

Critical collaborative inquiry by
Reflective practitioners being
Accountable and making the results of their inquiry public,
Self-evaluating their practice and engaged in
Participative problem-solving and continuing professional development.

PERSONAL MODEL OF ACTION RESEARCH

Zuber-Skerritt has suggested that each researcher should identify the way they have constructed their own model of action research from the different traditions and schools of thought, by considering the following 3 areas (Zuber-Skerritt, 1997):

- The researcher's philosophical background
- The researcher's methodology
- The techniques used within this methodology

Meulenberg Buskens has also emphasised the importance of clearly thinking of the research project at three levels: the research paradigm or philosophy of science, the research methodology and specific techniques (Workshop in facilitation and leadership in participatory research, 2-3 August 1999). This approach moves away from the classification of research as either quantitative or qualitative and allows both qualitative and quantitative techniques to be used within the action research methodology. I will describe my own study and model of action research by using these 3 levels.

Philosophical background

My philosophical background to action research has been strongly influenced by Peter Reason et al and his approach to what he calls "new paradigm research" (Rowan, 1981; Reason, 1988, 2001; Rowan and Reason, 1981, Reason and Torbert 2001). Looking back I can see that I was ripe for this "new paradigm research" and was able to embrace it due to a variety of changes in my own life. I believe that it would be difficult, if not impossible, to engage successfully with participatory action research unless one's own values, beliefs and perspectives could resonate with those of the research paradigm. Another reason for outlining my own values, beliefs and perspectives is to clarify any preconceptions or prestudy beliefs and to be transparent about how these may influence my effects as a researcher. This is what Malterud (2001) refers to as the "researcher's backpack". I will explore my philosophical background and researcher's backpack in three areas below relating to my ways of thinking, levels of awareness and commitment to participatory and democratic processes.

Ways of thinking

Firstly, I have moved in my way of thinking from linear cause-effects models to more system-based and dialectical models. The linear model assumes that no proposition can be both true and false at the same time and that it can only be true or false. Dialectical thinking can accept apparent contradictions as potentially being part of the same phenomenon, without the need to exclude one or the other. The relationship between them may not yet be fully realised or understood (Rowan, 1981).

The very term action research embraces this dialectical thinking in putting together two previously contradictory concepts. The nature of consensus building in participatory action research can illustrate this point. The consensus of the group does not consist of the points on which everyone can agree (and excludes the other points), but is a way of incorporating all viewpoints, even when apparently contradictory. For example in the consensus of the co-operative inquiry group, regarding the WHO educational package, the GPs found that the package helped them to make a specific diagnosis of a mental disorder and at the same time brought an awareness that a specific diagnosis is not always possible or desirable.

This way of thinking is also modeled by the discipline of family medicine. This discipline has moved away from simple pathological explanations of disease where doctors attempt to find the cause of illness in simple cause-effect relationships. The discipline has adopted a model based on systems-theory, which assesses illness in a bio-psycho-social framework and that recognises the multiple factors within a hierarchy of systems that can contribute towards illness in a person (de Villiers, 2000). For example the three-stage assessment attempts to assess the illness at the clinical (biological), individual (personal) and contextual (family, work, community) levels. In addition the clinical skills of the GP, in handling large amounts of undifferentiated information and tolerating

uncertainty, also contribute towards the skills necessary to cope with the building of consensus. This more holistic approach to understanding phenomena helped me to embrace the dialectical thinking necessary for action research.

The discipline of family medicine also emphasises the need to be patient-centred and to understand the perspective of the person towards their illness (McWhinney, 1997). It is a process of discovering the meaning attached to the illness experience and can be compared to the interpretative and hermeneutical process that is often a key feature of action research techniques (Rowan and Reason, 1981). In family medicine qualitative research techniques have been seen as a 'marriage made in heaven' because the interpretative research process is a parallel to the consultative process (Murphy and Mattson, 1992). The patient-centred clinical method (Levenstein et al. 1986) can be a good preparation for the action researcher not only in its exploration of the meaning of events, but also in its acceptance of viewpoints that are different from one's own.

The style of thinking involved in action research is closely linked to ideas on adult education and learning. Both emphasise a constructionist approach: new knowledge is constructed by the researcher or learner from reflection on their action or experience (Fosnot, 1996). In my involvement with family medicine as a tutor and 'lecturer' I had explored current ideas in adult education and found these to be coherent not only with the principles of family medicine, but also with the approach to learning within action research (Mash and de Villiers, 1999). These educational principles and theories are further elaborated in Chapter 5.

Levels of awareness

The ability to construct new knowledge from one's own experience within a research project requires the conscious development of reflectivity and self-awareness. You are both the subject and object of the research and the

'research instrument' itself. In order to keep this instrument clean and reliable a high degree of self-awareness and reflectivity is required (Heron, 1985; Heron, 1988).

This self-awareness must therefore embrace the 'subjective' as part of the research experience, rather than alienating and banishing it as in more orthodox research (Heshusius, 1994). Indeed in qualitative research subjectivity may be seen as a problem when it is ignored and not made explicit or accounted for (Malterud, 2001). Awareness of one's thoughts, feelings, judgements, reactions and beliefs is an important aspect of reflecting on one's experience. The rehabilitation of the 'subjective' in the consultation has been an important aspect of family medicine, where the doctor's feelings and intuitions are seen, not as something to be ignored, but as providing important information about the doctor-patient relationship and even clues as to the diagnosis (McWhinney, 1997). This acceptance of the subjective in my own discipline again prepared me to accept this as part of action research.

The development of self-awareness, creativity and spirituality are closely linked (Cameron, 1995). It is no surprise therefore that some of the research techniques described below, which are designed to enhance self-awareness and reflectivity, come from the work of artists and writers who seek to develop both creativity and spirituality in their students. The development of myself as an artist and the development of my spirituality, have both contributed to and been enriched by this research process. This research process has indeed been a part of 'my life' as a whole.

Commitment to participatory and democratic processes

As already discussed the action research process is characterised by both participatory and democratic modes of co-operation and group work. My involvement in the National Progressive Primary Health Care Network (NPPHCN) prior to the 'new South Africa' in 1994 and involvement with community-based

non government organisations led me, often screaming and kicking, into an appreciation of the need to strive for participation, inclusion and democratic decision making. This was often in groups of people widely separated by educational levels, professionalisation, language and culture. Looking back I can see that this was also a kind of apprenticeship for participatory action research.

The methodology: co-operative inquiry group (CIG)

The CIG has been described and defined by Reason (1988) as a way of working with professionals who would like to reflect on and change their practice. It was decided to modify this approach to the task of adapting the WHO educational package with the aim of making it practically useful to GP practice.

The members of a co-operative inquiry group are all committed to action and reflection in a particular field of inquiry. The group follows a cyclical pathway and it is necessary to go through the cycle several times before arriving at any conclusions. This continuous cyclical process may be conceptualised as an 'action research spiral' (Kemmis, 1988). The underlying foundation of the co-operative inquiry is a continual cycling between the research ideas and reflections on the one hand and the action and experience on the other. This sets up a process of constant feedback that clarifies, diversifies and deepens both the ideas and the actions. A typical cycle consists of 5 steps:

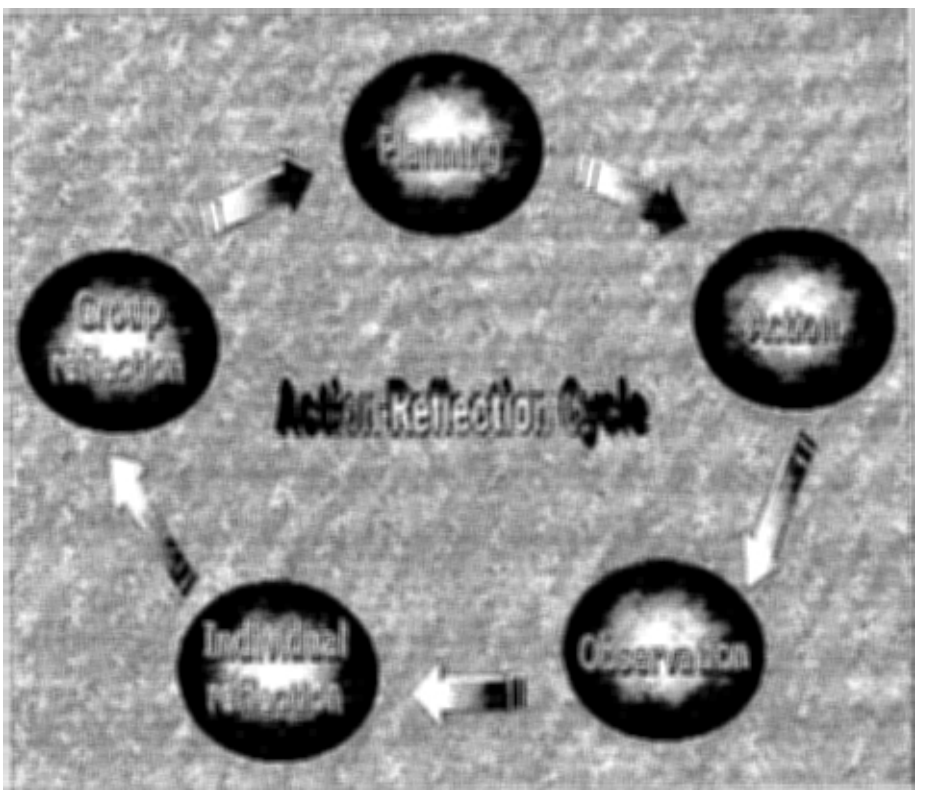
1. Planning: The group agrees together on the focus of inquiry, develops questions that must be explored, agrees on action needed to explore these questions and agrees on how they will observe and record their experience.

2. Action: The group members engage in the agreed action.

3. Observing: The individuals observe and record their experiences.

4. Individual reflection: The individual reflects on his or her observations.

5. Group reflection: The group reflects on its collective observations and develops new insights, understanding and ways of seeing the problem. The group considers its original propositions and questions and re-frames them for the start of a new cycle.



With completion of each new cycle the depth of knowledge increases as ideas move from the commonplace to more formed and challenging concepts.

What did we do?

The CIG was advertised through the South African Academy of Family Practice / Primary Care and GPs with a known interest were also invited. After an initial introductory meeting ten GPs from the Western Cape committed themselves to the CIG. Although they shared a common interest in the topic these GPs came from a variety of practices, including private practices in suburban and inner city areas as well as public practices in community health centres on the Cape Flats

Table 3.2. Profile of members of the co-operative inquiry group.

Name	Description of the practice profile.
Dr BM	An academic family physician working in a large public sector, community health centre, in the peri-urban community of Khayelitsha. This community is mostly poor and Xhosa speaking.
Dr SG	A general practitioner working in both the public and private sector. In the public sector he works in the same context as BM and privately in an urban medical-aid practice.
Dr SM	A private general practitioner who works in an urban setting with a wide mix of patients from students at the University of Cape Town to workers catching transport home from the nearby stations and taxi ranks.
Dr NM	A private general practitioner in Khayelitsha, a Xhosa speaking peri-urban informal settlement.
Dr RM	A private general practitioner in an urban medical-aid practice.
Dr AM	A semi-retired general practitioner working in a middle class urban setting and the Cape Town Drug and Rehabilitation Project.
Dr SN	A medical officer in the public sector working at a large Community Health Centre on the Cape Flats with a mixture of Afrikaans and Xhosa speaking patients from mostly low socio-economic communities.
Dr FC	A medical officer in the public sector working at a large Community Health Centre on the Cape Flats with a mixture of Afrikaans and Xhosa speaking patients from mostly low socio-economic communities.
Dr BS	An academic family physician who sees patients at a large Community Health Centre on the Cape Flats with a mixture of Afrikaans and Xhosa speaking patients from mostly low socio-economic communities.
Dr SL	A private general practitioner with patients from relatively high income suburban communities.

and surrounding townships (Table 3.2). First languages, used by patients and doctors, included English, Afrikaans and Xhosa.

The venue for the meetings of the CIG was chosen to be a quiet reflective space and the GPs were provided with refreshments and a small honorarium for the professional time spent. The CIG went through 4 cycles of action-reflection each lasting from 4-6 weeks as shown in Table 3.3.

Table 3.3. Summary of workshops and meetings for the co-operative inquiry and facilitators

Date	Type of meeting	Description
2-3/8/99	Facilitation and leadership in participatory research and action: Ineke Meulenberg Buskens	Training workshop for myself as facilitator of the co-operative inquiry group
19/8/99	Introductory meeting : Bob Mash and Pierre de Villiers	Presentation of the research project to interested GPs and commitment to the CIG
25/8/99	Qualitative data analysis workshop: Ineke Meulenberg-Buskens	Training workshop for myself as facilitator of the co-operative inquiry group
4/9/99	Co-operative inquiry group training workshop	Training workshop for the co-opertive inquiry group in research methodology
18/9/99	Co-operative inquiry group planning meeting	Planning of questions and actions for the first AR cycle
16/10/99	Co-operative inquiry group meeting	Reflection on action in the first AR cycle
23/10/99	Co-operative inquiry group meeting	Planning of questions and actions for second AR cycle

28/11/99	Co-operative inquiry group meeting	Reflection on action in second AR cycle and planning of questions and actions for third AR cycle
11-12/12/99	Co-operative inquiry group writing workshop: Dorian Haarhof & Ineke Meulenberg Buskens	Training workshop on writing and reflection in co-operative inquiry
22/1/00	Co-operative inquiry group meeting	Reflection on action in third AR cycle and planning of questions and actions for fourth AR cycle. Planning of individual writing to describe the process and content of each person's inquiry.
11/3/00	Co-operative inquiry group meeting	Reaching a consensus on the findings of the co-operative inquiry group

All group meetings were audiotaped on a conference recorder, which recorded the process of planning, group reflection and knowledge construction. Key group discussions were also recorded on newsprint and each facilitator kept detailed personal notes of both process and content contributions within the group. Important discussions and decisions were subsequently documented in a written summary of each meeting that was distributed to each member. A summary of a planning meeting is shown in Appendix B and a reflection meeting in Appendix C.

Individual members kept observation notes and narrative accounts of what happened in their practices. In between group meetings people communicated their writing electronically using a group list-server that maintained an electronic archive. I had negotiated with the group for a 6-month commitment. At the end of this period each person wrote a document describing his or her own personal inquiry over the 6 months (An example is shown in Appendix D). These documents were shared on the list server and the principal researcher then drew up a tentative 'reflective summary'. The final meeting of the CIG was devoted to debating and refining the 'reflective summary' and coming to a consensus.

Quality and co-operative inquiry

Table 3.4 outlines the concepts of quality that were used in the CIG and which were developed by Meulenberg-Buskens (MB) in her teaching of participatory research methodology (Meulenberg-Buskens, 1994). How these were applied to our CIG will be discussed below:

Alignment with purpose

Three key steps were used for this: assessing oneself, assessing the purpose of the research and choosing your most effective position with regard to both. The purpose of the research was clearly outlined in the introductory meeting and research proposal. This purpose was re-iterated at each group meeting and constantly revisited by the facilitators during group discussion and feedback. The members were assisted to reflect on their own intentions and process of change by use of a visual 'egg' model developed by MB (see page 53).

Ownership of the inquiry process

Transfer of ownership of the inquiry from the initiating researcher to the group members was a gradual process that began with a commitment to the research purpose, understanding of the research methodology and ended with the maturing of each person's individual inquiry and documentation of their inquiry findings. The training of the members in the research methodology was crucial to this process. In addition the openness of the facilitators to embrace each person's inquiry was also essential.

Table3.4. Quality criteria in co-operative inquiry

Quality criteria	Definition
Alignment with purpose	Alignment of the group members with the purpose of the research both drives the process and acts as the contract between the members. Aligning oneself with a particular outcome or personal intention, rather than the purpose of the research, may lead to a lack of openness in the inquiry.
Ownership of the inquiry process	Ownership of the research by members of the group is crucial to the quality of the inquiry. The initiating researcher will need to transfer power, knowledge of the research methodology, ownership of the research questions and process so that after the group is established he or she does not dominate the inquiry.
Development of reflectivity	As the members of the group are both the researchers and the researched, the quality of the inquiry will depend on their ability to become a 'research instrument'. This requires a reflective stance that is characterised by heightened awareness, open-mindedness, critical questioning and commitment to dialogue (Smaling, 1995; Meulenberg-Buskens, 1994).
Democratic and collaborative group dynamics and facilitation	The facilitator must strive for a genuine collaborative and democratic group process. The level of trust will be related to telling the truth without judgement and staying within the common purpose. Breaking this contract with each other leads to a loss of trust and commitment and the facilitator must guard against this.
Commitment to practical action and experience	The group must be committed to a balance of both action and reflection. Some groups may find it easy to take action, but difficult to pause for adequate documentation and reflection. Others may be good at planning and reflecting, but short on actually engaging with the practical action.
Documentation of the process	The following 3 aspects must be documented: The individual experience and action. The group process and dynamics. The developing reflections, research statements and conclusions. The quality of the research process is made publicly accountable through documentation as emphasised in the CRASP model of action research (Zuber-Skerritt and Perry, 1992).
Transferability	Transferability is another aspect of quality whereby the groups findings should be sufficiently clearly described to enable readers to understand what aspects of the inquiry can be appropriated to their own context (Heron, 1988). The reporting of this research therefore should be in its "rich contextual detail" (BMJ).
Construction of practical knowledge	The purpose of co-operative inquiry is to construct practical knowledge through cycles of action and reflection. Therefore one way of judging the quality of the research is in the practical usefulness of this new knowledge (Heron, 1988). The way in which this consensus was constructed will also reflect on the quality of the inquiry.

Development of reflectivity

The development of a reflective stance was a key part of the training offered by MB and involved the use a number of techniques such as the diary keeping, morning pages, blind writing, drawing, free attitude interviews and the reflectivity-5-steps (see pages 50 to 60). The development of reflectivity was also an ongoing process that deepened as the inquiry progressed.

Democratic and collaborative group dynamics and facilitation

MB, an expert in participatory action research, co-facilitated the CIG with BM, the principal researcher. MB focused on the research process and developing the necessary capacity in the participants while BM focused on the content and progress of the group. Before the start of the inquiry BM attended a training workshop on group facilitation skills and during the inquiry de-briefed with MB after each group meeting on the facilitation and group dynamics.

Commitment to practical action and experience

A balance between time spent in practical action and observation between the meetings and time spent in planning and reflection during the group meetings was carefully maintained. The facilitators paid attention to whether people were engaging with the agreed actions and whether their reflections were based on practical experience or theoretical opinion.

Documentation of the process

The group attended a training workshop on writing and participatory research that enabled them to record their experiences in brief narrative form, use writing as a means of exploring their experience and develop their own documents that

described their personal inquiries. Each aspect of the inquiry process was documented as described above.

Transferability of the findings

The findings of the CIG should be reported in sufficient depth to enable readers to apply the findings, where relevant, to their own situations.

Construction of practical knowledge

The practical usefulness of the knowledge created by the CIG was further tested when GPs used the adapted educational package in the web-based program. This is reported on in Chapter 7.

What happened and what did we learn?

Throughout this process we underestimated the extent to which our medical training has conditioned us to think according to the empirical-analytical paradigm. It was a constant battle to think clearly about new methodology in this emancipatory-critical paradigm and to not misappropriate norms and values from a different paradigm. We had to be willing to examine our assumptions about research and quality criteria all the time. For example one member of the group commented:

"Not having heard the term Participatory Action Research, I found the first cycle meeting and all the articles on PAR, Free Attitude Interviews and for example the 'Egg Theory', very philosophical and 'much ado about nothing'. I felt I was being used for some psychological research project, the meaning of which was purposefully being withheld from the group and that the others were unable to recognise it."

Initially most people aligned themselves, almost exclusively, with their own personal needs and intentions, rather than the actual purpose of the research. Although they were doing justice to their own personal inquiry, they were not aligned with the purpose of the research. For example one GP who struggled with a fear of over-involvement and emotional enmeshment with her patients set as her initial question:

"Will it [the package] help me not to be in the shoes of my patients."

Another GP commented:

"I knew that I had not started the action I had proposed. 'Today I must start doing something with this package. I am resisting because it's a hassle, I find the demands of patients enough without adding more. It feels like an intruder.' I decided instead to discover how I did treat patients with mental illness. I videotaped my consultations for two days and noted down what I observed."

It became clear that two inquiry processes were taking place for each participant. On the one hand people engaged with their own personal inquiries and journeys. These journeys started with people reflecting on their own learning needs, asking their own questions and planning their own actions as illustrated by the quotes above. On the other hand people were also required to engage with the purpose of the research which was to adapt the WHO educational package. This required people to use the package in their practices and to reflect on what happened. During the group time both these journeys were addressed and the facilitators held them in a creative tension. Ultimately both the personal inquiries and the individual research inquiries spoke to and enriched each other. The participants in the CIG found an effective position, which honoured both themselves and the research.

One useful picture of reflectivity was imagining an inner researcher who sits on your shoulder and without judgement says *"this is interesting, I am feeling this,*

thinking this, reacting like this." It was necessary to balance passionate involvement in the research process with an ability to *"hold it lightly"*. On the one hand to be immersed in and committed to the action, but at the same time detached enough to reflect on the experience. The reflective ability took time to master and matured during the research process. Once mastered *"reflection doesn't take time, only guts."*

At the beginning as we tried to develop this reflectivity a number of people queried *"Is this psychotherapy or research?"* We discovered that we had to be prepared to open ourselves up and to be honest about what we saw. At times increased self-awareness uncovered hidden memories and led to painful insights. For example one member of the group uncovered the pain of being separated from her child and another uncovered a long-standing "inferiority complex" and tendency to judge. The development of self-awareness and reflectivity as part of the inquiry process inevitably led to personal change. It was important to be aware of emotional distress in order to prevent this from interfering with the group process.

In this CIG we had to guard against the tendency of busy and often skeptical GPs to not actually use the materials in their consultations. Initial resistance to practical action had to be overcome. One GP after using the WHO materials, commented:

"I have also learnt that you cannot judge the package by reading or studying it – that is how people came to the conclusion that there was nothing new in the package about diagnosis and management of mental disorders that they did not know before. The only way to discover its strengths or weaknesses is by using it in practice – in our individual practices."

This initial judgement of and resistance to using the package may have stemmed from the way that the CIG started with a pre-conceived action that had not been

developed by the group itself. In the CIG process, as described by Reason et al (Reason, 1988), the group would not start with any pre-conceived actions. The action strategy would be developed from a consideration of the topic or theme of the inquiry. In our CIG the group started with an action, to use the WHO educational package in their practice. In effect the WHO had completed the initial steps of reflecting on the problem of poor recognition and management of mental disorders in primary care and had developed the educational package as an action. As the CIG is a cyclical process it is possible to start at any place within the cycle. However the decision to start our inquiry at the step of 'action' rather than 'planning' may have had important implications in terms of the GPs commitment to practical action. For example the initial resistance to using the package may reflect a lack of ownership of this as an appropriate action strategy and a desire by the GPs to pursue their own independent actions. Even though the use of the package was clearly negotiated as a basis for participation in the CIG the members naturally wanted to pursue their own actions that related to the topic. The decision to start the inquiry cycle in this way seemed to enhance the tension between the personal and research inquiries.
During the CIG process the group members gradually engaged with the package and found that their theoretical judgements were not necessarily confirmed in practice. This affirmed the use of the CIG as a methodology for adapting the package from practical experience and not theoretical discussion.

"However, despite the negativity and repressed anger at attempting something against my nature I exposed a patient to the charts and the patient leaflet. Within one consultation my attitude was converted from rejection and questioning to one of amazed acceptance of a program that is practical, that I grew more and more to accept as a relevant accessible and practical tool in my patients and setting."

As BM was writing a thesis based on the inquiry and people initially thought *"we are doing this for him"* this created a tension with people owning the inquiry for themselves. It was important to be open about this tension and to negotiate

acknowledgement of or participation of the group members in any formal reporting.

It was important to individually document what we did and what happened as close to the experience as possible. One problem was that we were used to asserting our conclusions in the group without showing how we arrived at them. Group members had to learn to document what happened in a brief narrative form so that they could show how they arrived at their personal reflections and learning. We developed the concept of a personal portfolio of stories rather like a collection of paintings. After this, the process of reflection on the portfolio could also be recorded and any new concepts or theories summarised. The act of writing was found to be not just a way of recording our thoughts, but in itself a way of thinking and reflecting. Often the very act of writing unblocked the mind and enabled new insights to be developed. The guiding light in this writing was the need to *"show and not tell, establish and not assert".*

One challenge for the facilitators was to avoid funneling each person's contribution too soon. There was a tendency in BM to use the group time to try and establish common ground prematurely, rather than using it to help people go deeper in their own perspective. There may have been a need to see results too quickly. The task was not to find ways of forcing consensus, but of preventing this happening prematurely before people had gone to sufficient depth themselves and developed their ideas. At the beginning resistance to using the educational package drove people into their own personal inquiries, but at the end the need to form recommendations on how to adapt the package was pivotal in enabling people to reach a consensus.

Research techniques

During the inquiry process different techniques were used to help people understand the research methodology, develop their questions, plan their actions, document their experience and reflect both as individuals and as a group. A distinction should be drawn between these techniques and the methodology described above. While the methodology describes the formal research process that we followed and the quality criteria used which could in principle be applied to any co-operative inquiry group, the techniques described here are more informal and personal to this particular research. These techniques were used to enable the participants to fulfill the methodological requirements outlined above. Many of them were developed through the practical experience of my research consultant Meulenberg-Buskens. In my reading of the literature on action research, while I found a wealth of information on the philosophy and methodological issues discussed above, there was very little information on how people actually conducted their inquiries at the level of techniques. It is partly for this reason that I have decided to include a description of some of the key techniques here.

Free attitude interview (FAI)

During the co-operative inquiry group meetings, participants interviewed each other in pairs using the FAI technique. This was designed to help people make sense of their experiences in the previous cycle and plan their actions for the next cycle. The facilitators also attempted to model the principles of the FAI in their facilitation of the group discussions.

The FAI has the following characteristics (Adapted from an unpublished manual by Meulenberg Buskens for the Free Attitude Interview Technique, January 1996, "Research For Intervention in Action Research" Summer School, Cape Town)

- It is *non-directive* in that it gives the respondent complete freedom to explore his or her own ideas and opinions. After the initial opening question the interviewer does not direct the interview with further questions, but uses communication skills to structure and facilitate the response. The opening question should be an open-ended question that invites the respondent to elaborate on the topic. After this the interviewer should not introduce his or her own ideas, concerns or opinions.

- It is a *controlled* interview in that the interviewer sets the framework or focus for the interview in the opening question and the pre-interview information.

- The *attitude of the interviewer* should communicate interest, respect and 'unconditional positive regard' for the respondent. Non-verbal cues are particularly important, such as eye-contact, nodding, open body posture, attentive listening and use of silence.

- *Facilitative responses* such as encouragement ("go on", "uh-huh"), repetition or echoing, and paraphrasing may be used.

- The interviewer should use skills in *clarification* to fully understand the concepts and ideas being expressed, but should be wary of using clarification to interrupt the flow of the respondents narrative.

  "Could you explain what you mean by.....?"

The interviewer should make use of *reflective summaries* to provide structure for the interview, make his or her understanding explicit and allow the respondent to correct or add to this understanding. The reflective summary thus also acts as a facilitative response for the respondent and a way of making sense of the information for the interviewer. The reflective summary is offered tentatively so that it invites a response and should capture not only the content of what has

been said but the feelings behind it. The reflective summary would take the form of:

"If I understand you well, you are saying....?"

- The interviewer *ends the FAI* by making a final reflective summary of the entire interview and hopefully eliciting the response:

"Yes, that is exactly how I feel / think."

The principles of the FAI are very similar to the principles of gathering information in a patient-centred consultation as outlined in the Calgary-Cambridge Observation Guide (Silverman et al. 1998). The FAI technique therefore should be familiar territory for trained family physicians.

The reflectivity 5-step

A process of qualitative data analysis (QDA), developed by Meulenberg-Buskens, was adapted by the principal researcher to guide members of the co-operative inquiry group in reflecting on their experiences. In the initial training workshop participants were trained in this process by using a story that they had written regarding a patient with a mental health problem. During the inquiry process people used the reflectivity 5-steps to reflect on their own written observations and experiences.

Traditional approaches to QDA honour the text more than the researcher in the interpretative process. Traditional QDA would develop themes by systematically coding and classifying the text (Mason, 1996). In the reflectivity 5-step the researcher is honoured equally with the text in the interpretative process. The 5-steps are outlined below:

1. Read and re-read the text and observe and watch your reactions, thoughts and emotions, while doing justice to the text. Write them down, one by one.

2. What main issue jumps out for you? In the process, watch your reactions, thoughts and emotions, while doing justice to the text. Write them down, one by one.

3. Formulate a theme from / on the basis of the issue. Observe and watch your reactions, thoughts and emotions, while doing justice to the text. Write them down, one by one.

4. Scrutinise your relationship with the theme. Observe and watch your reactions, thoughts and emotions, while doing justice to the text. Write them down, one by one. Look at whether this theme occurs often in your life, your work? Is it part of your pet theory? Write about it, this will not only benefit your understanding of this text, but of other texts to come. You may want to re-formulate your theme here.

5. Select a theoretical concept (or lens) to give new meaning and understanding to the theme. Observe and watch your reactions, thoughts and emotions, while doing justice to the text. Write them down, one by one.

6. Continue this process until the text is exhausted.

A model of personal change - "the egg".

Action research through its commitment to change and its building of self-awareness inevitably leads to personal change and growth as part of the research process. This change and growth is not always experienced as positive and may at times be quite painful or lead to tension and anxiety. It is important

therefore to anticipate the issues that may arise in individuals and the group as a consequence of this process. To help the group in this regard Meulenberg-Buskens introduced the "egg" model that we could use to understand the process of change and our intentions in this process. The model is illustrated in Fig 3.1 and the components described below:

Inside the "egg" is our current self with our daily thoughts, emotions and reactions. This experience can be likened to that of watching a tumble-drier where our thoughts, emotions and ideas continually cycle and flash past us. With self-awareness we may begin to recognise the same thoughts, ideas or emotions passing through our minds in much the same way as the same shirt continually appears in the window of the tumble-drier. We spend most of our time in this messy re-cycling of our most current and superficial thoughts, emotions and ideas.

This self is contained by an *iron ring* that defines who we are and gives us a sense of safety and security. This will define our current norms, values and rules about ourselves. For example "As a Christian I believe..." or "As a doctor I am ...". This ring may prevent us from reaching our dream and at the same time erosion of the ring may feel like losing our identity.

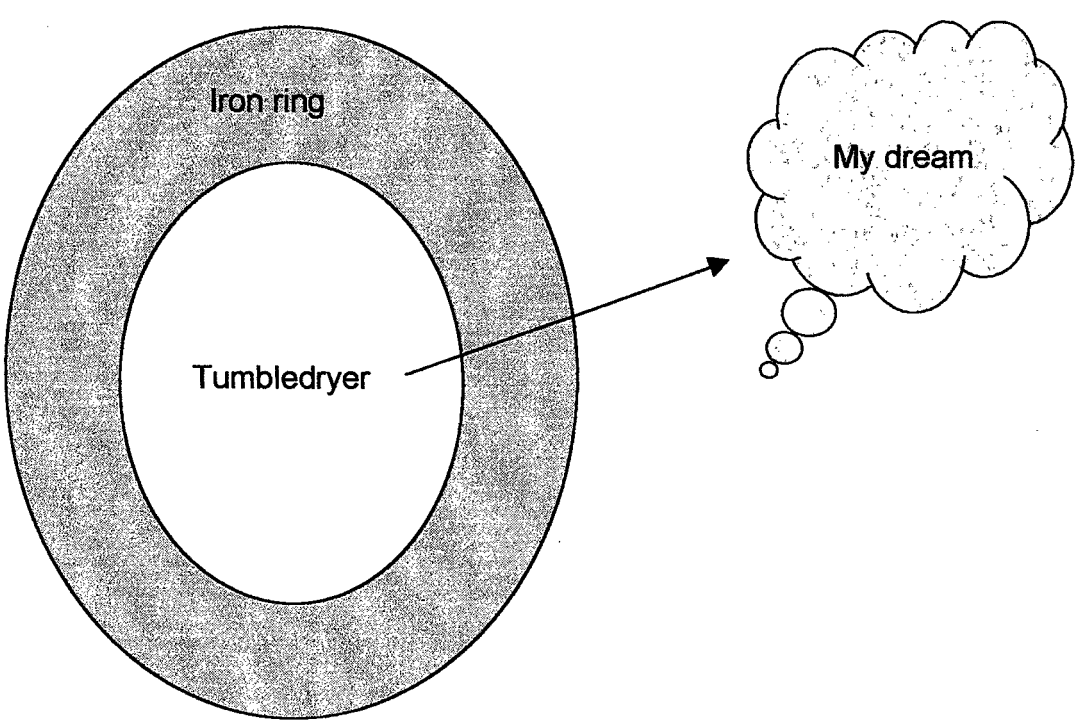
Outside this ring is the world of dreams and intentions. This is where we can place our vision and goals for ourselves, who we would like to become. This deeper and outer space is also inhabited by our less conscious fears, anxieties and deeper memories.

In the process of change we must move from the "tumbledryer" inside the ring and break through the ring to reach the dreams and intentions we have for ourselves. There are a variety of tools that can be used to facilitate this journey, but the breaking of the ring involves a loss of safety and security. This breaking down of our current norms and values may be experienced as threatening,

frightening and lead to heightened tension or anxiety. As we re-formulate ourselves into a more expanded version, a new expanded ring will emerge which will accommodate the dream as a part of the (new) tumble-dryer reality. The tension around identity will subside until we again make a substantive change. As the ring expands towards our dreams and intentions we may also encounter deeper fears and anxieties which emerge from where they have been buried, and these too must be dealt with in the process of change.

The egg model was used by the participants to become aware of their own personal intentions, issues with change and alignment with the purpose of the research.

Fig 3.1. The 'egg' model



Writing and reflection

A number of techniques were introduced in the group to facilitate the keeping of observation notes, personal journals or diaries and the use of writing as an aid to reflection.

Blind writing

Blind writing was used to facilitate individual brainstorming of ideas and to unblock people when they felt that they had nothing to say. The technique attempts to silence the inner critic that often stifles our creativity and construction of new knowledge. The technique involves (Haarhoff, 1998):

Place a sheet of carbon paper between two sheets of lined A4 paper. Use a kebab or other stick to write with by pressing on the top sheet and letting the carbon paper transmit the writing to the sheet underneath, where it is hidden from the writer.

Once you have started writing you should keep going without censoring or critiquing what you have said. Let the ideas flow onto the page without lifting up the stick.

Once you have finished you can then read your writing on the second page.

The morning pages

Participants were introduced to the keeping of 'morning pages' as a way of releasing their creative energy and becoming more aware of the content of their mind. New ideas, associations and emotional awareness sometimes emerged in the process. The emptying of the mind's clutter each morning was primarily a

way of 'cleaning the instrument of research' and a means of 'creative recovery'. This technique involves (Cameron, 1995):

Take 30 minutes soon after you have woken up to write your morning pages.

Write three pages of longhand writing in a strictly stream of consciousness approach.

There is no wrong way to do morning pages. Nothing is too petty, too silly, too stupid, or too weird to be included.

Once you have started writing you must continue uninterrupted until you have filled three pages.

You do not need to read or reflect on their contents.

Personal journal

Each member was encouraged to keep a personal journal to record their experiences with patients in a narrative format and their own personal thoughts, reactions and emotions (Walker, 1985). Story telling and the narrative were emphasised as a way of recording experience and providing a text from which further reflection was possible. These stories both acted as the starting point for the reflective process and the means of showing where the group's reflections had come from. In addition the process of writing is not just a means of documenting what has happened and what you know, but the motion of writing is itself a form of thinking and reflection. The personal journal was used by each person to document their own unique journey with the research. One technique used to develop this style of writing was developed by Meulenberg-Buskens:

1. Find a place of your own, pen and paper

2. Write a story about something which concerns you in your life or work, something you have a strong emotion about. It may have happened a while ago, that is fine, provided you can still connect with a strong emotion about it.

3. Find a partner: read her/him your story and ask for answers on the following questions in writing: "What did you feel when I read my story?" and "What have you come to understand through listening to my story?"

4. Receive each others feedback and check whether the effect of your story has the desired effect? Have you been able to bring across what you felt?

5. Everybody has received their partner's feedback on their story and now writes on: what other feedback do I need to enhance my writing?

All participants attended a 'Co-operative inquiry group writing workshop' facilitated by Dorian Haarhof author of the book *The Writer's Voice: A workbook for writers in Africa* (1998).

Drawing

During the group meetings analog drawings and other visual techniques were used to help participants express their learning and discover new connections by drawing on the visual and spatial abilities of the 'right brain' (Edwards, 1986).

For example the analog drawing was used in the training workshop:

1. Become aware of your feelings and reactions to the research project

2. Do not analyse the words that come to mind or try to make sense of them

3. Draw your feelings and reactions. You do not need to know what the drawing will look like before you start. The purpose is to express them intuitively and in a way that may shed new light on them. Draw a boundary line for your picture and then let the drawing emerge on paper. Do not censor what you draw. Do not draw any objects, recognizable symbols, letters, or words. Nothing but marks and lines on the paper. If you want you can erase parts of the drawing or do more than one.

4. You have now stated your feelings and reactions in a visual parallel language.

For example the 'research garden ' was used in the writing workshop to help people conceptualise their relationship to and ownership of the research process (Haarhoff, 1998):

1. Collect three stones from the garden outside. One stone represents the research, one yourself as a researcher and one represents the others involved in the inquiry group.

2. Draw the relationship between these three elements in the research process and place the stones in your picture.

3. Share your picture and your understanding with another person in the group.

SUMMARY

This chapter has discussed in some detail the rationale for choosing this type of research methodology, an overview of action research and a description of the

model of action research used in this study at three different levels. These three levels can be summarised as the paradigmatic / philosophical, the methodological and the technical. The paradigmatic level describes the thoughts, perceptions and values of the researcher. The methodological level describes the process and quality of the co-operative inquiry group and the third or technical level gives practical examples of the specific techniques used in our inquiry. In the next chapter the findings of the co-operative inquiry are presented.

PHASE ONE: CHAPTER FOUR - THE FINDINGS OF THE CO-OPERATIVE INQUIRY GROUP

INTRODUCTION

In this chapter the findings of the co-operative inquiry group, as to how the WHO materials should be adapted, are presented as themes that emerged from the group consensus. The themes are illustrated by quotes from the individual group members. These themes are not intended to be read as empirical facts, but as a consensus of the group's learning from their experience of using the WHO package in their clinical practices.

Testing one hypothesis

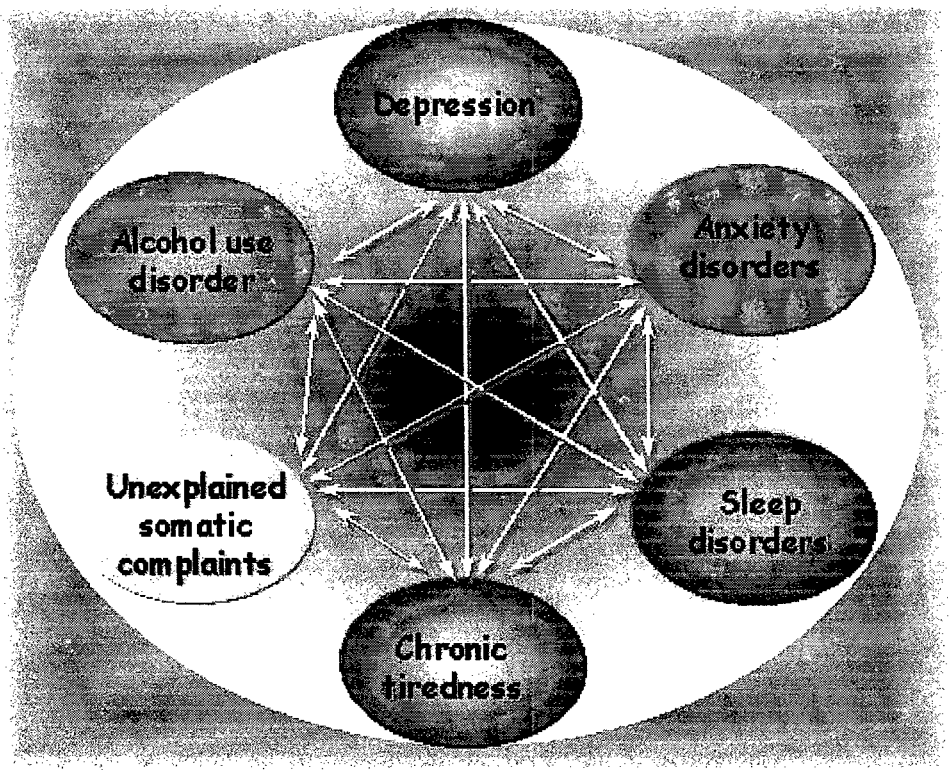
The group reported that, on the basis of their clinical experience, the 6 most common mental disorders, as defined by the WHO, were inter-related to such an extent that it did not make sense to consider them separately (Fig 4.1). For example the GPs observed:

> *"Patients did not fit into neat packages and many of the categories overlapped. General practice is not as compartmentalized as the package." FC*

> *"I felt that the disorders themselves were very interlinked and it would be useful to just use the word "emotional distress"." BS.*

Sleep disturbance may be a feature of depression, alcohol or anxiety disorders. Depression or anxiety may accompany alcohol disorders and depression and anxiety frequently co-exist. It made more sense to test one hypothesis of 'mental problem' that covered all these possibilities and then pursue in more diagnostic detail the avenue that seemed most relevant. Thus two steps were described 'testing the hypothesis of mental problem' and then 'making a specific diagnosis'. Similarly GPs did not screen every patient for mental disorder as in a research project, but responded to cues from the patients and the emergence of their own inner hypotheses. The group reported that the package did not increase their

awareness of the type of cues that should prompt the hypothesis of a mental Fig 4.1. Considering the 6 conditions as one hypothesis 'mental disorder' due to their interconnectedness.



disorder. Increasing this awareness was seen as important in helping GPs to decide when to use the package. Testing one hypothesis of 'mental problem' alongside other more physical hypotheses reportedly helped to make the consultation clearer and more time-efficient. For example one GP used the concept to exclude a mental disorder:

> *"A 52 year old patient came in complaining of tiredness, headaches, body pains and swollen legs. Ah-ah I thought a mental health problem. I asked the screening questions. They were negative. Not thinking too much, not worrying too much, not feeling sad. I then looked more closely for a physical cause. She had peripheral edema and a chest X-Ray that showed cardiomegaly and pulmonary congestion. She was in heart failure. The screening questions were useful to briefly explore the hypothesis of mental disorder and were also helpful in pointing away from a mental disorder to a more physical problem." BM*

The questions developed to test this hypothesis of 'mental problem' in Khayelitsha are shown as an example in Table 4.1.

It should be noted that the GPs were not rejecting the existence of the separate diagnostic categories per se, but felt they had found a more practical way of utilising them in the primary care consultation.

Somatic complaints were the most frequent presentation and making the link between somatic problems and the concepts of 'stress', 'nerves' or 'psycho-social issues' was seen as useful. The original section on 'unexplained somatic complaints' while intended to refer to the specific ICD-10 category of 'somatisation disorder' was actually used to help patients attribute their somatic symptoms to their mental or psycho-social problems:

> *"My biggest problem lies with these diagnostic labels- there is so much overlap of symptoms between depression, anxiety, sleep disorders, fatigue, somatic symptoms and, yes, STRESS to make it difficult at the beginning to decide which of those sections to use. That probably explains why I have tended to use the somatic complaints section more, as it allows me to address patients offers before defining them into disease entities." SM*

The 'lobby' of general practice

The picture of a large 'lobby' or 'messy entrance hall' with many side rooms was used to conceptualize the process of assessment, diagnosis and management of patients with mental problems in primary care (Fig 4.2).

"In the package, the most relevant section dealing with these somatic complaints was the "Unexplained Somatic Complaints" and I found this section very useful in explaining my patients somatic "offers". It occurred to me, however, that these were not strictly speaking, "unexplained" yet and so this was not the right section to use in these patients…

Table 4.1. Mental Disorders Checklist as developed for Khayelitsha.

These questions can be used to test the hypothesis of "mental problems?" The questions were developed in the context of Khayelitsha a Xhosa speaking township.

1. Are you thinking too much ? ..... ❑
2. How are you sleeping at the moment? ..... ❑
3. Do you feel exhausted or tired even when you are not working hard? ..... ❑
4. Do you feel sad or like crying for no reason ? ..... ❑
5. As a person there are things that you enjoy doing – do you find that you no longer enjoy these things? i.e. listening to music or going out with friends. ..... ❑
6. Do you sometimes have the feeling as though you are going to hear bad news? ..... ❑
7. a) Have you ever felt you should cut down on your drinking? ..... ❑
   b) Have people annoyed you by criticising your drinking? ..... ❑
   c) Have you ever felt bad or guilty about your drinking? ..... ❑
   d) Have you ever had an eye-opener first thing in the morning to steady your nerves or to get rid of a hangover? ..... ❑
8. Have you experienced traumatic events that made you feel extremely threatened or endangered? Or witnessed someone else in this situation? ..... ❑

If positive to **any one** further assessment may be required – see Mental Problems Flowchart.

*If positive to **2, 3, 4, 5** then consider **depression**.*

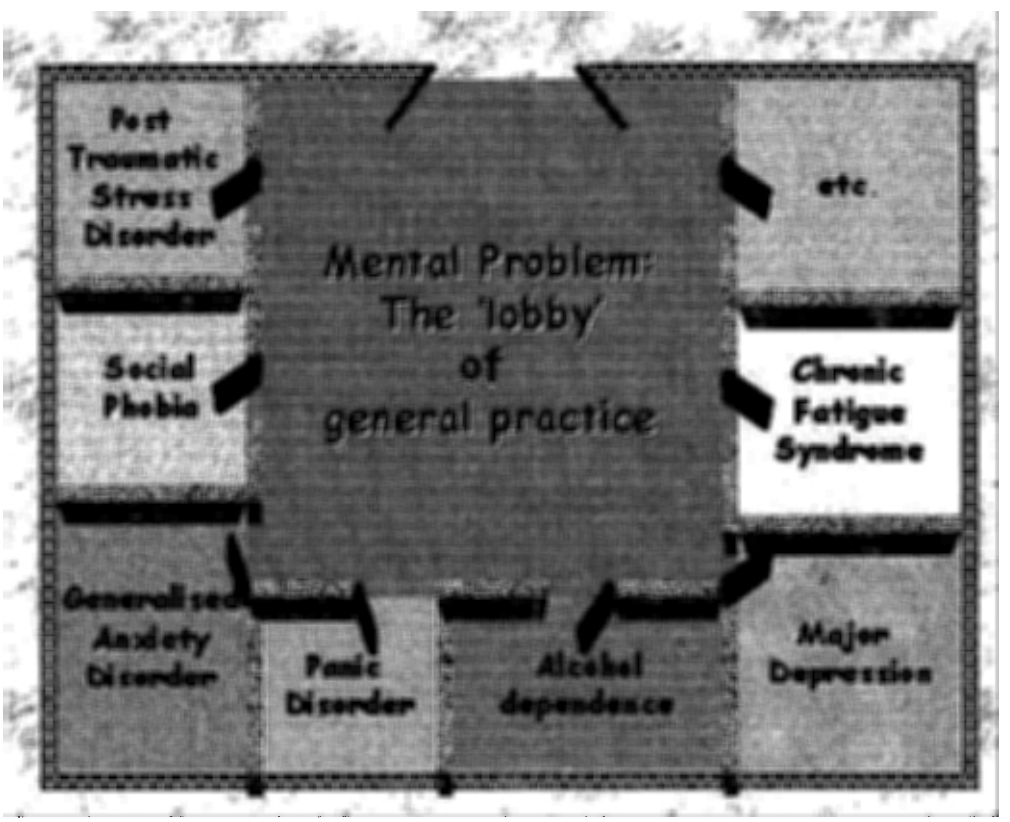
*If positive to **1, 2, 6** consider **anxiety disorders**.*

*If positive to **7** consider **alcohol use disorders**.*

*If positive to **8** consider **post traumatic stress disorder**.*

We therefore needed to consider a first diagnostic category in the package that would deal with undifferentiated symptoms and somatic complaints. Something like a "lobby" in a house of mental disorder management where patients would be managed before moving them to specific rooms if diagnostic criteria satisfied their allocation into one of the six rooms (depression, anxiety, sleep disorders etc)" SM

Fig 4.2. The lobby of general practice.



Patients entered the lobby by answering positively to the hypothesis 'mental problem'. A large number of patients in the lobby could be assessed and managed without making a specific ICD-10 diagnosis. These patients were often referred to as having 'stress' or 'nerves' or 'problems of living'. This idea was expressed by one GP:

"Are we medicalising emotional distress? Is it more important to make a diagnosis or to "make sense" of distress"? Sometimes it may be better to look at skills for improving mental health rather than making a diagnosis.

> *What are the boundaries between pathological mental illness and distress? The ICD-10 makes the division a clear one, but in fact it may be blurred. Sub-threshold patients may be defined as adjustment disorder, but does this help? I need an approach to assessing patients holistically (that includes sub-threshold conditions, psycho-social problems, problems of living)." BS / BM*

Reportedly, both doctor and patient more readily understood these concepts than diagnostic labels such as 'adjustment disorder', 'sleep disorder' or 'neurasthenia'. One GP explained this:

> *"The first thing that came to mind the minute she left was my realization for the first time that "stress syndrome" is not an ICD10 diagnosis! Yet this is a very common diagnosis in general practice so much so that patients know about this more than the other diagnostic labels apart from depression! Should we discard "stress" as a diagnosis?" SM*

The GPs thought that the original package did not reflect the importance of an open management system such as the 'lobby' in general practice.

> *"Not all mental problems fit into neat ICD categories. This was a good example of a "lifecycle issue". A problem of living – would ICD call it an "adjustment disorder"? At the end of the day the label was not as important as the understanding of the problem and making a plan." BM*

In the lobby these patients were assessed in a holistic way that heard the patient's story and explored the psychosocial and family context. From this holistic assessment the doctor together with the patient could determine what contributions she or he could make to this patient's mental health. At the same time the doctor could explore the possibility of entering a 'side-room' for a more specific diagnosis and treatment strategy.

Three of the conditions, chronic tiredness, sleep disorder and unexplained somatic complaints, were incorporated into the lobby. These labels were not reported to be useful as specific diagnoses and did not lead to a separate

treatment strategy. On the one hand they could be the presenting complaint of a 'problem of living' or could be a feature of a specific mental disorder such as depression. Under each label there was also the possibility of more uncommon specific diagnoses such as 'narcolepsy' and negative categories such as 'chronic fatigue syndrome.' Negative in the sense that this is a diagnosis of exclusion and does not lead to a well-defined treatment plan. Doctors should feel free to move back to the lobby when a specific diagnosis is not substantiated or becomes unhelpful.

Making a specific diagnosis

The package was reportedly useful in helping the doctor to construct an approach that felt comfortable where none previously existed. It helped to reduce uncertainty and fears associated with entering unfamiliar territory. For example:

> *"The screening questions of the mental disorder checklist enabled me to recognize depression earlier and thus start therapy earlier. I was always trained to exclude organic causes for diseases before considering psychological etiology. Using these screening questions as part of one's general history taking, empowers one to confidently make a diagnosis of a mental disorder without suffering the nagging doubt that one may still be missing a physical illness. " RM*

The GPs reported that the package helped them move from vague diagnoses like 'stress' to more refined diagnoses such as 'major depression'.

> *"One thing this package is doing for me is to force me to think beyond a diagnosis of 'stress' which is a nice cozy label in primary care, I think." SM*

The group felt that there was a need to include post traumatic stress disorder as one of the anxiety disorders in the SA context.

Universalistic versus relativist approaches

Most elements within the package related to the exploration of the disease (checklists, flowcharts, and questionnaires) and to the need to place the patient within a diagnostic category.

> *" I did not develop or use the screening questionnaire. I resisted the idea when it came to doing it. I resisted the rigid approach of questionnaires and lists of questions. I find the process of the consultation, the relationship, and the communication most important. The package honors the doctor's agenda of reaching a diagnosis, but does not honor the patient's agenda or the interaction between the doctor and patient." BS.*

These diagnostic categories were seen as 'universal' and described in the ICD-10 classification. The group reported that the package did not address the exploration of the patient's own more 'relative' perspective (beliefs, concerns, expectations, feelings) or context (family, work or community environment). The process of understanding the patient's narrative and context was reported to be as useful as the diagnostic categorization.

> *"I was initially ambivalent about using the package. I had a suspicion that it would be difficult to engage her in a meaningful way, but was interested to see how the interaction would proceed. Her initial enthusiasm appeared to be diminshed as I tried to get her to answer the questions on the assessment sheet. She seemed to be more interested in telling her story. It was actually by allowing her to tell her story that the diagnosis of true depression was excluded." SG*

> *" It was only 2 days later that we sat down and I said what is it that's getting to you? Put the manual aside. What is going on in your life? Then it came out. My grandfather passed away recently. She had this big discussion with my mother about her mother's childhood and about the issues there and about the fact that my Mum phones her whenever there*

is a problem in the family. There's issues in her life that are troubling her and me labeling them as panic disorder and putting it into a nice category didn't really look at the issue. Do we categorize these issues into these artificial DSM4 categories or do we look at them as real issues that patients experience. I found it difficult to categorize." SG

"RBM had an unshakeable belief in traditional healers as the cause of his symptoms. Is he psychotic or is this culturally acceptable? The cross-cultural loading of this case highlighted my need for heightened awareness of the co-existence of traditional African beliefs as well as Western beliefs in educated Africans." SM

In particular the use of a genogram was reported to be helpful.

"Some of the other patients that I saw had a mixture of depression, insomnia, anxiety, unexplained somatic complaints and/or alcohol dependence. There were also various ways where the mental illnesses were expressed e.g. low self esteem, obesity, poor appetite, etc. etc. in all cases I found the Genograms useful. Most households were shown to be dysfunctional. " SN

GPs felt that in the WHO package the communication skills necessary to elicit the disease and illness, to explain the problems and to negotiate a mutually acceptable plan were not adequately addressed. The CIG found these skills to be essential to the process of recognition and management.

In addition the experience in primary care is that patients often have multiple problems with both physical and mental elements:

" I felt that the package had no depth, was not natural. I felt like an automaton. I felt that the package did not have the sense of primary care. Psychiatrists often see the patient for a single diagnosis. In primary care the patient presents with depression as just one of their problems. Depression and piles occur in the same consultation." BS

Allowing for diversity

Experience with the package differed considerably between patient populations with different levels of literacy, different languages and cultures.

> *"With limited language skills it is hard to have a conversation that flows intuitively and picks up subtle cues. Non-verbal is still there of course. In this type of consultation with an interpreter the list of more specific and directive questions is maybe more efficient. How do you treat something that is not recognized by the patients as an "illness"? There is no concept of depression. The patient leaflet may help here in getting the patient to identify with the diagnosis and understand what is being said. This can be done outside of the consultation time. Best to have a leaflet in Xhosa that explains the concept and helps people to identify their symptoms / problems within this. Many do have people at home who can speak English." BM*

For example in literate English speaking patients the handycards were reportedly useful in giving information, establishing mutual understanding and negotiating a management plan. In illiterate Xhosa speaking patients they were of little use.

> *"The use of the file and reading it through together has reduced barriers between myself and the patient; as we are reading from a common script the barriers of from where we each come from are minimized...here both the patient and the doctor share the sheet of information with few hidden aspects. This lifting of the patient onto a higher plane and sharing of information has also reduced barriers to treatment. It has facilitated the use of antidepressant or tranquilizer medications, as appropriate, each time the subject has been raised, without the common side issues of "why must I take an antidepressant' and 'why for so long'; conversations that previously were the bane of my life in managing psychological disturbances and trauma. The handycard and the questionnaire each*

have their own innate benefits in the working through with the patient of the problems at hand." SL

"I have not really used the handycard in my consultations and this begs the question why? The main reasons seem to be: Patients will not read the English well without interpretation. Too go through the card line by line with an interpreter and discuss it will take too long. Patients are not used to interaction around a card like this and seem to wonder what it is all about.
The information on prescribing and therapeutic options is not useful in this format. The instructions needed are better internalized and given by me with the help of the interpreter. I have used the first section briefly with a number of patients. Going through the symptom list and identifying the diagnosis of depression. I did not get the impression this was helpful to the patients. They had something of a blank expression while staring at this strange card." BM

The use of self-reporting questionnaires also relied on literacy and familiarity with this type of task. The questions and even the concepts had to be translated into the local language and idioms. For example the calculation of the number of standard drinks in a township setting where people shared alcohol in groups out of a common jug and drank homemade alcohol became irrelevant. In Khayelitsha the concept of 'anxiety' could not be directly translated and had to be expressed as 'the feeling you get when you hear bad news'. No single set of materials was relevant to all GPs. The adapted program should incorporate the need to develop diversity as part of the learning experience. Materials can be adapted, modified and translated for each context as part of the program.

Journey with the package.

All the GPs who took part in the CIG were initially quite skeptical and critical of the package. There was both resistance to using the materials in their practices and to exploring mental health problems in greater depth in the consultations. The experience of actually using the materials however was more positive than their initial theoretical judgements.

"During this time my thoughts were very negative towards the package. A lot had to be changed in it…I still prefer using my own way of handling the conditions referred to in the package. Communication skills are very important when talking to such a patient." AM

"I have also learnt that you cannot judge the package by reading or studying it – that is how people came to the conclusion that there was nothing new in the package about diagnosis and management of mental disorders that they did not know before. The only way to discover its strengths or weaknesses is by using it in practice – in our individual practices." SM

"I found that the style of layout and format of the interview and consultation with the patient was not the way I had worked for 30 years in practice and I doubted that the format suggested had relevance to my practice in an upper middle class setting. However, despite the negativity and repressed anger at attempting something against my nature I exposed a patient to the charts and data and the patient leaflet. Within one consultation my attitude was converted from rejection and questioning to one of amazed acceptance of a program that is practical that I grew more and more to accept as a relevant accessible and practical tool in my patients and setting." SL

The reflective process enabled self-awareness of attitudes, feelings and values held by the doctor. This was important in becoming aware of the ways in which we resist, judge and blame patients with mental disorders. For example:

- Fears of being manipulated or fooled by patients when there are no clear physical signs and queries as to whether mental disorders are real.

"Being fooled" by patients - mistrust of psych patients - Continually asking myself "am I being lead on? Am I being manipulated?" Package could look at power issues in the consultation with patients with mental illness. Could address suspiciousness we have for problems which have no visible

lesion and dealing with patients whom we believe are faking or exaggerating symptoms for self gain." BS

- Feeling overwhelmed by the co-morbidity of physical, mental and social problems and not having enough time to hear, process and understand all of this. Struggling with where to set the boundaries in a consultation on what is realistic to achieve and what you should engage with as a doctor. The need for doctors to be nurtured and supported and to have coping mechanisms to deal with stress.

"Another issue is the sense of being overwhelmed by patients and not feeling able to take on more. Patients tend to have so many problems that need attention at any one consultation. A patient will come for medicines for hypertension and diabetes and also want a form filled in for new glasses and then one might detect a breast lump. At the same time her sugar is poorly controlled and one needs to adjust her diet. To then add depression or alcohol abuse to that just seems too much to handle." BS

- Finding mentally ill patients to be "difficult" patients in terms of their stories, expectations and demands.

"Discovering that the patient has a psychological problem, makes my heart sink (voel moedeloos) at the thought that this is going to be a long consultation, made even longer by working through the package with the patient." AM

- Feeling that it is part of your role to hear psychological problems.

" I need a will to change. A form is not enough. One needs an attitude that is receptive to psychological problems, but also time to deal with them. Time and patience and inclination." BS

- Feeling pressurised by the extra time that psychological problems are assumed to require

"I also felt pressed for time and this definitely added to the discomfort…There was as always the important factor of time, and I wondered whether the time was being wasted on a patient who had not really exhibited any real readiness to change." SG

- Belief that there are no resources to support the recognition of mental problems

"We won't diagnose psychological problems adequately until we have resources to deal with them. I realize that I don't diagnose alcohol abuse, as I have no faith that I can do anything for sufferers. However I diagnose depression well, when I have time to deal with it or a psychologist to whom the patient can go. So it will take a change in the system rather than just a few guidelines." BS

- Belief that missing physical problems is worse than missing psychological ones.

"I found certain cues useful such as dizziness. The package helped to make psychological diagnoses from these cues and strengthened the formation of psychological hypotheses. I made a number of new diagnoses of anxiety. I tried out the anxiety module with these patients who have dizziness which was superb. I moved from my own anxiety of missing a physical diagnosis to feeling empowered to make a psychological diagnosis. " RM

- Feeling overwhelmed by psycho-social problems

"Feeling overwhelmed by patient's problems. Boundary issues are important. Knowing one's own limits, accepting lack of perfection, developing a sense of humour, getting support, being patient and accepting that not everything needs to happen at once, will all help. There could be a section [in the package] on 'when it all seems just too much!'" BS

Experience with particular tools

Doctors reported on their experience with each section of the package: the checklists, flowcharts, handycards, patient leaflets and questionnaires. The experience of using the checklists and flowcharts to recognise and diagnose mental disorders has already been reported.

Handycard

The use of the handycard and other materials, for patients who could read them in an interactive manner, reportedly increased their participation in the consultation, aided the transfer of information, enhanced mutual decision making and reduced barriers to accepting the diagnosis.

> *"For a little while, her fears and concerns had vanished. Although my previous consultations were very patient-centered, I was not able to be as effective as I was using the package, and this surprised me. I was encouraged to use the package more and explore more of its strengths as well as its weaknesses. Mrs. TP had changed from being a heart sink patient to being a patient who participated fully in the management of her illness - I have just had another thought as I write this right now: the package allows patients to fully participate in the management of their condition - much more than their involvement in a patient consultation." SM*

> *"I have a patient, Mrs. AR who suffers from acute anxiety and panic attacks. She has a lot of social problems - husband left her; son on drugs; her daughter sleeping with anything that comes along; etc. I must admit she's the type of person whose IQ rises to 50 on a hot day. Nevertheless I sat her down and worked through the whole section on Anxiety with her and made a photocopy of the hand out for her. It was amazing to see her smile when she realized that she was not the only one in the world suffering from this condition. She seemed delighted that she was having the right treatment of medication and psychotherapy!" AM*

The handycards and patient leaflets when used interactively also helped to establish and not assert the diagnosis with the patient. It enabled self-awareness and insight and in addition was like having a third authoritative voice in the consultation speaking on behalf of the wider medical community.

> *"The consultation was transformed beyond my imagination. Although Mrs TP appeared to trust me as her doctor (admittedly an assumption on my part - for why else did she keep coming back to see me?), the effect of the package on her was amazing. I kept thinking: " this is like having all those specialists she has seen before, in here with me, assuring her that what I have been telling her all that time was true". The package was more than words on paper - it had authority." SM*

Patient leaflets

The patient leaflets were reportedly useful tools. They needed adaptation to the context and could be useful for both the patient and their family. The adaptation of the leaflets by the GP to his or her patients was a good learning experience. The leaflets could save time in the consultation and allow the patient to continue making sense of their problem between consultations through self-assessment. Their homework could then be discussed at the ongoing consultation.

> *"The patient leaflet has intrinsic useful properties with the questions it poses and the reflections it suggests that the patients do refer to it more than once. It is also useful to the patient to bring their completed 'homework ' back to the follow-up consultation for further counseling into their complaints and symptoms. The leaflet is also an aid in remembering what had been covered in the consult and conclusions and ideas approached. In addition it has the patient thinking more clearly as to his past situation and demonstrates a future strategy or strategies to follow. Sensible consultations with direction are the next result with a focussed determination to succeeded and the realization that success will be possible in the change of mindset engendered by the program and the leaflets." SL*

The patient's personal "progress charts" were also reported to be helpful in building insight, self-awareness and a sense of progress.

> *"Subsequently I also gave out personal progress charts. With the first ones the patients encountered difficulties with interpreting the visual analogue scale. After I corrected that problem it was easy to fill them out." SN*

Non-drug therapies such as relaxation techniques, dealing with negative thinking and problem solving were seen as potentially useful in promoting mental health in patients.

Questionnaires

The use of questionnaires to make a diagnosis was seen as coming from a research perspective and not a general practice perspective. Could this reflect the untested ideas of the people who wrote the package? Just because it works in a research project does not mean it will work for GPs. The use of self-reported questionnaires as a routine way of screening all patients was not supported. Reasons for this included, problems with literacy, language, unfamiliarity with this approach, limited time for explanations, administrative issues (copying, pencils etc) and too high a positive response rate to the general screening questions.

> *"One important thing I learnt from the above is that several patients remarked that the questionnaire should not only say "yes" or "no", there should be a "sometimes" column also...Furthermore I have learnt that only using the top few questions is too sensitive to use a s a screening test, because <u>every</u> patient had some mental problem." AM*

The use of self-reported questionnaires in selected patients may be helpful to strengthen the doctor's diagnostic certainty, to strengthen the patient's belief in the diagnosis, to cope with vagueness and complexity in the history or to save time in the consultation.

"The questionnaires were helpful in a patient who spoke English and where it was hard to get a clear picture of what was happening. The questionnaire was more structured and clear in its results. The questionnaire may help when lost in a sea of vagueness and uncertainties. Some people may focus better on a questionnaire and give clearer answers than in an interview. Maybe they do have value in the occasional patient. "BM

The use of self-reported questionnaires as a screening tool may be a useful "one off" learning experience for the GP.

Discussion

In light of the CIG findings the package was adapted and re-printed in the following format.

- A new section entitled 'mental problems' was developed (Shown in Appendix E). This is used to test the hypothesis 'mental problems' and to assess patients in the 'lobby'. This consists of a *checklist* of screening questions to test the hypothesis 'mental problems' and to enter the 'lobby', and then a *flow chart* that emphasizes a holistic assessment. The *flowchart* considers clinical, individual and contextual factors that might be contributing to the problem, with specific mention of using a genogram and a model for assessing common psychosocial problems. The assessment of sleep disorders, chronic tiredness and unexplained somatic complaints is incorporated into the *mental problems flowchart* as opposed to seeing them as separate diagnostic categories. A *mental problems handycard* was also developed which allowed the management plan to address clinical, individual and contextual issues without necessarily placing the person in a diagnostic category. The possibility of making a more specific diagnosis however is always emphasized. The *handycard* also deals with specific management advice for sleep problems, chronic tiredness and unexplained somatic complaints. A number of *patient leaflets* were re-written that allow the GP to select a combination of topics

depending on the needs of the particular patient. These include separate leaflets on:

Relaxation techniques
Dealing with negative thinking
Problem solving strategies
Sleep problems
Chronic tiredness
Unexplained somatic complaints

- The sections on depression, anxiety disorders and alcohol-use disorders were retained in their original format, but adapted for local circumstances and cultures. For example the alcohol section replaced the twelve *checklist* questions with the four CAGE questions and allowed a more appropriate way of assessing the number of drinks. The assessment of motivation and readiness to change was also included in the *handycard*.
- A new section on post-traumatic stress disorder was included.
- All the *questionnaires* and *patient leaflets* were translated into Afrikaans and Xhosa as well as English.

The experience of the CIG also showed that the relationship between GPs and the package is a crucial one in terms of motivating change or resistance. If the course is seen as a prescriptive top-down and critical approach written by specialist researchers who do not understand the realities of general practice then resistance can be expected. This was demonstrated in the UK where a national mental disorders education program was perceived as being too top-down and was rejected by GPs (Singleton and Tylee, 1996). GPs who have developed their own styles and approaches to patients may resist packages which try and tell them that 'all GPs should behave like this'. They may respond better to an approach that says 'you have decided to try and improve your practice in this area, here are some opportunities and experiences, some tools, that you can use to enable this journey. Some may be helpful, some may not be and others may need to be adapted or modified. In order to discover which are actually useful for you it may be necessary to try them out in your practice and see what happens '.

PHASE TWO: CHAPTER FIVE - INSTRUCTIONAL DESIGN AND DEVELOPMENT

INTRODUCTION

This chapter describes phase two of the study in which the findings of the CIG are incorporated into the design of a web-based distance education programme for GPs. One of the original intentions of the WHO and Sanofi-Synthélabo in creating the research fellowship was the dissemination of the adapted educational package within South Africa. This chapter describes the process of instructional design and the completed educational programme that was subsequently marketed in South Africa.

The CIG influenced the design at two different levels. Firstly the findings suggested concrete and specific changes that should be made to the materials in the package. Secondly the broader conceptual findings of the CIG shaped the ideas and vision of the program as a whole. In particular it was decided to adopt an overall structure that would be process- and not topic-based. In other words it would not follow the traditional approach of a module on depression, anxiety, schizophrenia and so on. Instead the course would follow the sequential phases of the consultation, and the process of recognition and management of mental disorders experienced in the CIG. The communication and consultation skills that are important at each phase were woven into the knowledge and skills necessary for recognition and management of mental disorders. In addition the process of learning through action and reflection, that was central to the CIG, was embedded in the educational strategy.

WHY DISTANCE EDUCATION?

The Departments of Family Medicine and Primary Care in South Africa have noted that it is difficult for many GPs to attend residential courses. This is especially true for rural doctors, who on top of their course fees, must pay for travel, accommodation and locums. At the same time the requirements of the

Health Professions Council for each doctor to attend Continuing Professional Development (CPD) and acquire a certain number of CPD points, has made it necessary for even the most isolated rural doctor to access educational opportunities.

Other countries, in implementing the WHO program, have adopted a centralised training-of-trainers. Trainers went back to their various regions and offered short courses to primary care providers (Ogel, 1998; Murphy and Mohit, 1998). Primary care providers travelled to a teaching centre for a classroom based learning experience that was often quite brief (a half or full day workshop). In the United Kingdom the ICD-10 guidelines, covered in a one day workshop, were not found to effectively change clinical practice (Upton et al. 1999). In our context we decided that distance education would increase accessibility to the course and allow a longer, more practice-based, and potentially effective educational experience. It would also allow the course to be offered nationally and to a wide variety of general practitioners.

WHY INTERNET BASED?

An analysis of the intended audience showed that of seventeen thousand GPs who are members of the South African Medical Association (SAMA) 1,657 (9.7%) submitted email addresses (Personal communication, Marilyn Myburgh, SAMA). Overall SAMA estimates that 40% of South African doctors have Internet access (Ravenhill, 1999). At the same time it was thought that, given GP's educational level, they would have sufficient capacity to use the technology as an effective learning environment. It is probable that the number of GPs having access to the Internet will continue to grow. In addition there were a number of advantages to an Internet-based as opposed to a paper-based course (Willis, 1994):

- Ability for interaction, rapid feedback and communication from student-to-student as well as from tutor-to-student.
- Ability for computer assisted instruction, for example self-assessment quizzes with automatic grading and feedback.

- Ability for the use of multi-media, such as text, graphics, audio and video materials.
- Ability to use other web-sites on the Internet as part of the learning environment.
- Availability of technical support and WebCT software at the University of Stellenbosch
- Ability for computer tracking of student's record and progress

Limitations that were considered included:

- Only GPs with access to the Internet could enroll and Internet use in other African countries is very limited (Edejer, 2000). Although a recent study in Zimbabwe found that 65% of GPs had access to Medline (Tisocki and Mufukari, 2000).
- Learners must have computer literacy and a reasonable level of proficiency.
- The course would be dependent on reliable technology, both within the faculty and with individual students.

DISTANCE EDUCATION AND EDUCATIONAL PRINCIPLES

"Good teaching is good teaching" and distance education does not have a different set of education principles from residential programs, only different methods of delivering them (Ragan, 1999). The first question therefore was not what aspects of technology should be used, but what educational principles and theory should guide the instructional design (Willis, 1994).

Attempts have been made to relate teaching models to different learning situations and to help in the decision of which model is appropriate (Knowles, 1990). The learning task in this situation was a highly complex one involving change in both recognition and management of mental disorders and was intended for general practitioners, who should have a high learning ability. In this situation Knowles recommends adult education theory and practice from

the field of humanistic psychology and based on the work of Rogers and Maslow. Carl Rogers has had a major influence on the discipline of family medicine through the development of patient-centred care and his approach to student-centred teaching parallels this in its principles and values. The application of this school of adult education theory is coherent with consultation and communication skills in general practice and with the participatory action research methodology. These core adult education principles are listed in the box below (Spencer and Jordan, 1999).

Adults are motivated by learning that:

- Is perceived as relevant to the self.
- Makes use of the previous experience of the learners.
- Is participatory and actively involves the learners.
- Is focused on problems.
- Is designed so that they can take responsibility for their own learning
- Can be immediately applied in practice
- Involves cycles of action and reflection
- Is based on mutual trust and respect.

It was intended that the development of the distance learning course should be based on these principles of adult education. These principles fall within a constructionist approach to education (Fosnot, 1996). In this approach learning is seen as "an interpretive, recursive, building process by active learners interacting with the physical and social world" (Wulff et al. 2000).

Wulff et al (2000) have considered "how the roles and interrelationships of such concepts as presence, reflection, and self-directed learning influence the learning effectiveness of Web-based pedagogy". These three principles of presence, reflection and self-directed learning, were considered key to the instructional design and are further discussed below.

Presence refers to self-awareness, being present to oneself, or psychological presence. This self-awareness should be developed and directed towards the content of the course and its activities. This should lead to development of reflectivity that enables students to learn actively from their own experience. Presence also refers to the development of dialogue within a community of learners. The web-based technology should be used in a way that supports the development of self-awareness, dialogue and interaction.

Reflection may be defined as " the learners awareness of and thinking about or mirroring to their self in an immediate manner the experiences of learning, then making meanings from those experiences, followed by organising those meanings into knowledge and / or linking them to prior knowledge structures"(Wulff et al. 2000). Self-awareness, dialogue, writing and a structured process are important for effective reflection (See Chapter 3). It is necessary to balance passionate involvement in the action with an ability to "hold it lightly". On the one hand to be immersed in and committed to the action, but at the same time detached enough to reflect on the experience. It takes time to develop reflective ability and this is a particular challenge when there is no face-to-face contact. Principles of instructional design that may enable reflectivity include (Wulff et al. 2000):

- Balancing the presentation of theoretical concepts and information with tasks that facilitate reflection, such as problem-solving, reflective writing and critical reading.
- Enabling the learners to create a reflective setting that is calm, focused and uninterrupted
- Assurance of safety and building of confidence
- Interaction with the tutor that fosters a reflective stance
- A structured process for action-reflection tasks that includes conscious steps of planning, observing, documenting and reflective writing

Self-directed learning implies that the learner takes the initiative for diagnosing their own learning needs, formulating their own goals, identifying resources, implementing appropriate activities and evaluating the outcomes of these activities (Spencer and Jordan, 1999). In essence self-directed learning "relies on the belief that knowledge cannot be transferred intact from the head of a teacher to the heads of students; rather, students construct their own knowledge by combining new information with prior understanding and previous experience" (Wulff et al. 2000). The role of the tutor moves from being the "sage on the stage" to a "guide by your side". The web-based instructional design should support such self-directed learning.

Application of educational principles to the Internet

The application of effective educational principles to the design of distance education programs has been further summarised by Ragan (1999) as illustrated in Table 5.1. This can be used as a checklist for ensuring that the novice designer, such as myself, has considered all the important areas in the design process.

Table 5.1. Guiding principles and practices for distance education. Adapted from: (Ragan, 1999).

Category 1. Learning goals and content presentation	
1.1	Learning goals should be defined as part of the instructional design and made explicit to the students
1.2	Specific instructional activities should be directed in a sequenced and structured way toward providing learners with the necessary skills, knowledge, or experiences to meet the goals and objectives of the course
1.3	Evaluation of student performance should be directed toward the measurement and assessment of the defined learning goals.
1.4	Instructional design and development support should include a wide range of services in the creation and preparation of

	instructional materials for delivery via distance education
Category II. Interactions.	
2.1	Effective learning environments should involve frequent and meaningful interactions among the learners, among the instructional materials, and between the learner and the instructor.
2.2	Social interaction between learners enrich the learning community and should be encouraged and supported throughout the instructional design
2.3	The use of electronic communications technologies should be considered as a tool for creating and maintaining the learning communities
2.4	Distance education programs should employ creative solutions to fulfill the objectives traditionally achieved via residency requirements, i.e. interactions; access to advising and academic support services and resources
2.5	To help reduce barriers to establishing social relationships, participants should be afforded the opportunity to build confidence and competence with the distance education paradigm and supporting technologies
Category III. Assessment and measurement	
3.1	Assessment methods should be congruent with the learning goals
3.2	Assessment methods should be employed as an ongoing and integral parts of the learning experience, i.e. enabling learners to assess their progress,
3.3	Assessment methods should accommodate the special needs, characteristics, and situations of the distance learner

3.4	There should be opportunity for regular feedback on the instructional design
Category IV. Instructional media and tools	
4.1	Selection of media and tools should be dependent on the learning goals and objectives
4.2	Selection of media and tools should reflect their accessibility to learners
4.3	Selection of media and tools should reflect a thorough understanding of why this technology is of "added value"
4.4	The system requires adequate preparation and support
4.5	The design must consider the diversity of learners and the different ways they may think about and use instructional media
4.6	A systematic instructional design approach should be followed and consider a wide range of technologies
4.7	Contingency plans should be made for technology-related interruptions to the program
Category V. Learner support systems and services.	
5.1	A system of technical support for learners, instructors and staff is required.
5.2	Faculty should have access to adequate support and development in the fields of IT and distance education
5.3	Support should be available 24 hours a day 7 days a week
5.4q	Regular feedback should be obtained on the success or failure of the support systems
5.5	The institution should consider any policy adjustments that are required to support distance education instructors and students.

INSTRUCTIONAL DESIGN

The program was developed following the instructional design process as outlined by Willis (1994).

The Design Stage

The first steps entitled "determine the need for instruction" and "analyze your audience" have already been discussed. Instructional objectives or outcomes for the distance education program Mental Disorders in Primary Care were established as shown in the box. At the end of the program students should:

- Be able to generate and test psychological hypotheses from relevant patient cues
- Be able to make a holistic assessment of the patient and specific psychiatric diagnoses
- Be able to prescribe appropriately, use relevant psychological therapies and refer to other resources
- Be able to use interviewing skills that enhance the doctor-patient relationship, improve recognition and management of emotional problems.
- Be more self-aware of one's own values, beliefs and attitudes towards patients with mental problems
- Know about common mental health problems in both adults and children, including emergencies, diagnostic criteria, management options, medico-legal and ethical issues.

The development stage

Create a content outline

A content outline was created based on the WHO educational package and the recommendations of the CIG. The content outline, based on the phases of the consultation, was structured into 8 modules, each of 2 weeks duration

(Table 5.2). The first column describes the communications skills required at each phase of the consultation, culminating in the need for self-awareness and stress management at the end of the consultation. These skills are addressed sequentially in the 8 modules. The second column describes the family medicine theories and principles dealt with in each module, which make sense of each phase of the consultation. These theories and principles are presented with particular application to mental disorders and make use of many insights from the findings of the co-operative inquiry group. The third column describes the practical tasks that GPs must engage with as part of their own action-reflection cycles in each module. These tasks often involve the use of specific tools from the adapted WHO Educational Package. The last column describes the focus of the self-assessment exercises in each module. Each module focuses on the GPs knowledge of a specific clinical topic.

Review existing materials

The original WHO educational package consisted of tools for use in the consultation that facilitated recognition, diagnosis, explanation, planning and management of the core mental disorders (WHO, 1998). Although these tools were significantly adapted as a result of the CIG, the idea of a printed package was retained as part of the distance learning program. The web-based instruction was designed to give the theory and rationale behind the tools, associated communication skills and to guide the learner through an action-reflection cycle in each module that required them to use and reflect on the tools in their own practice. As the WHO educational package was based on the ICD-10 Guidelines for Primary Care this was also retained as a prescribed book, on the web as well as in hardcopy. Initially I started to write review articles on each of the core mental disorders, but quickly realised this was an unecessary duplication of existing published materials. I therefore entered into negotiations with three publishers to have electronic rights to their books and to make them available on the Internet (Robertson, 1996; Allwood and Gagiano, 1997; Stein et al. 1999; WHO, 1996).

Table 5.2. Sample of the content outline.

Weeks	**Communication skills.**	**Theory**	**Action-reflection with mental health tools.**	**Knowledge**
1-2	Introduction			
3-4	Initiating the consultation.	Decision making and illness scripts	Use of a mental problems "cue card" and "questionnaires"	Depression
5-6	Exploring the doctor's agenda.	Testing the hypothesis of "mental problem"	Use of the mental problems "checklist" and key communication skills	Anxiety disorders
7-8	Understanding the patient's perspective	Making an holistic assessment	Use of the mental problems "flowchart"	Unexplained somatic complaints, chronic tiredness, sleep problems
9-10	Building the relationship, culture, and language	Making a specific diagnosis	Use of specific diagnostic checklists and flowcharts	Childhood and adolescent disorders
11-12	Explanations and planning, mutual decision making	Management of mental disorders	Use of the specific handycards and patient leaflets	Schizophrenia, emergency psychiatry, medioc-legal issues
13-14	Motivational interviewing	Basic psychotherapy for the GP	Practice skills	Alcohol, substance abuse, eating disorders, mental handicap
15-16	Self-awareness and stress	The gatekeeper: Use of resources and referral	Developing a community resource and referral network	Dementia, delirium, sexual problems

Organise and develop content

From the content outline and decisions regarding the existing materials it was possible to identify what new content should be developed. This included:

- Twenty separate topics covering the introductory material, communication skills and family medicine theory
- Eight action-reflection cycles, including task outlines and reflective journals
- A printed desktop toolkit with translation of patient orientated materials into Afrikaans and Xhosa
- Self-assessment questions for each module

Select/develop materials and methods

The primary mode of delivery for the program was the Internet and in particular the use of WebCT (Version 1.3) course management software. WebCT is a user friendly software package that enables the designer to create a course on the Internet. Specific features are listed in Table 5.3. The schematic design of the course in WebCT is shown in Fig 5.1 on page 94. An initial schematic design was attempted before uploading materials to WebCT in order to prevent chaos and confusion later on and wasting time on re-structuring materials. Even with this design the homepage became too cluttered and was later simplified. The final homepage consisted of only 6 items: getting started, course contents, communication, resource materials, self-assessment, and course tools. Each of these areas is discussed more fully below.

Getting started

The first two weeks of the course were devoted to introductory readings and tasks that were designed to help students set up their computer, familiarise themselves with WebCT and practice all the technical skills required later in the course. For example how to post a message on the bulletin board or use the quiz tools. The module also outlined the background to the course and its objectives as well as the structure and content of each module. The

introductory module also emphasised the importance of interaction and required students to introduce themselves and use the communication tools. Finally the module set tasks for the students that were designed to develop reflective capacity and journal keeping.

Course contents

Initially I wrote short word files of about 1,500 words in much the same format as a journal article. I quickly learnt that my style needed to move from lengthy

Table 5.3. WebCT tools and functions.

Welcome page	Creates an information page on the course accessible to anyone via the University WebCT site
Homepage design	Guides the user through designing and organising the homepage
Path editor	Allows you to organise your course content
Page editor	Allows you to organise each page and to link the page to other tools such as video, audio, references, questions and so on
File manager	Allows you to upload and organise all your computer files in directories, from which they can be selected. Also provides a selection of pre-determined icons.
Course management	Allows you to make a back-up copy of the course. Student management includes adding / deleting students, tracking student's progress, records and marks. This allows the tutor to monitor when a student has logged on and which parts of the course they have accessed.
Student tools	These include bulletin boards and private mail for asynchronous communication, chat rooms and whiteboards for synchronous communication as well as a calendar of course events.

linear writing, that could not easily be read in a WebCT window, to short, bite-sized interactive chunks that could link with other types of multi-media (other pages, video, URL addresses). A highly structured approach to the planning of content that could clearly identify separate conceptual chunks, see how they linked together, and how they could interact with other multi-media, was required. Students could navigate through the pages by use of a table of contents with active headings for each page as well as hyperlinks within the text. The table of contents made the content structure explicit, while the use of hyperlinks allowed the student to explore the pages non-sequentially. The use of WebCT also ensured a consistent layout and presentation of the pages. Citations were hyperlinked to the full bibliography references by use of the glossary tool. External hyperlinks (i.e. to other homepages) were kept to a minimum while internal hyperlinks were maximised (Willis, 1994). During the development stage the emerging materials were tested on the members of the CIG who gave feedback on their flow, usability and clarity.

Each module involved an action-reflection cycle. Tasks to be performed in the practice setting were outlined and learners went through a process of planning, action, observation, and reflection. The development of many of these tasks in the CIG allowed them to be 'grounded' and illustrated from practical experience. This process was written up in the form of a structured reflective journal, which was posted in their 'discussion group' bulletin board. Up to six students were allocated to one of 4 discussion groups as they entered the course. Dialogue within the discussion group was then possible with the tutor and other learners.

One challenge to the course design was how to develop communication skills at a distance when this would traditionally involve direct observation or role-play with feedback (Silverman et al. 1998). The use of video recording by each student, with review by the tutor, was considered to be practically

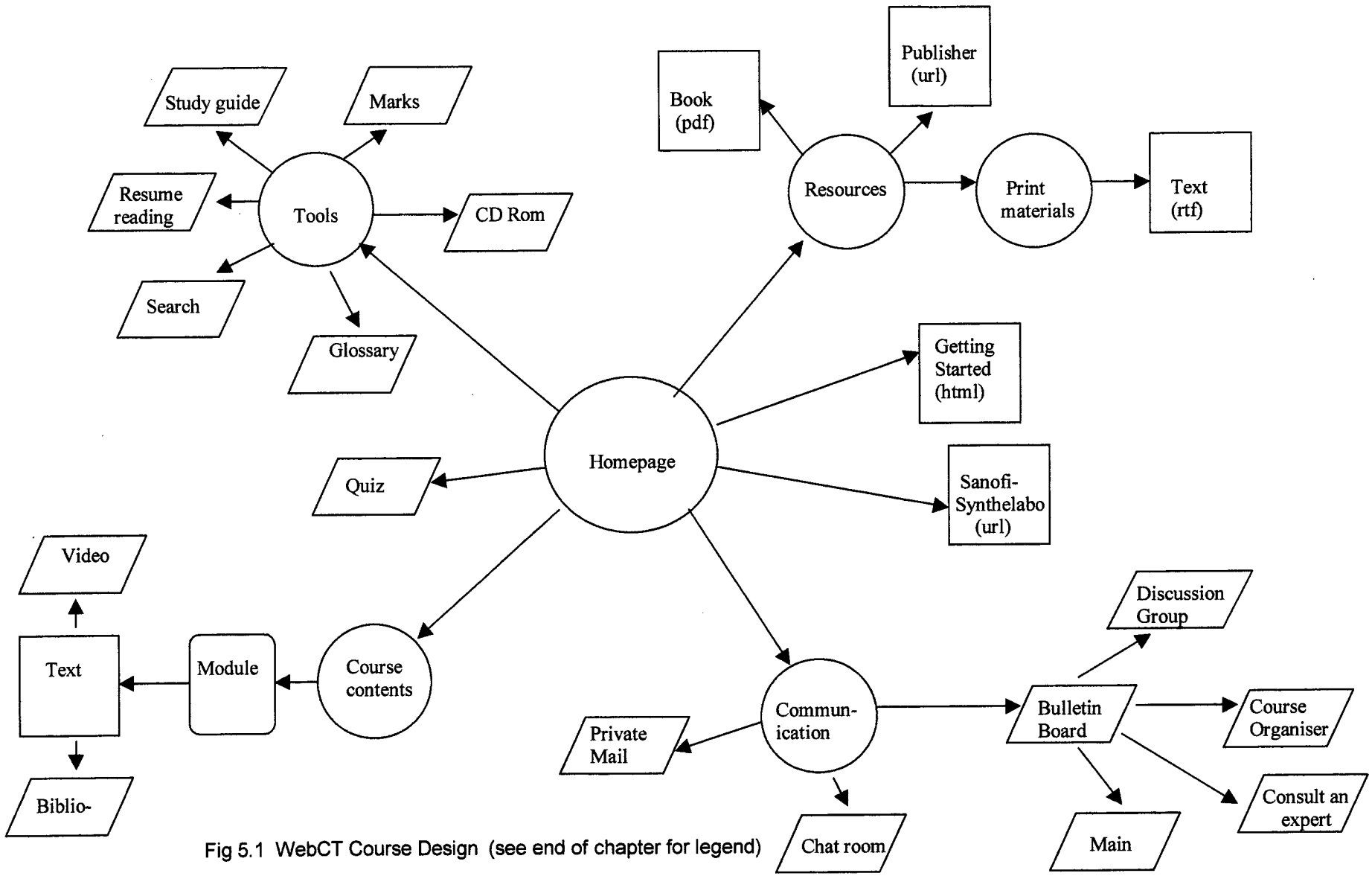
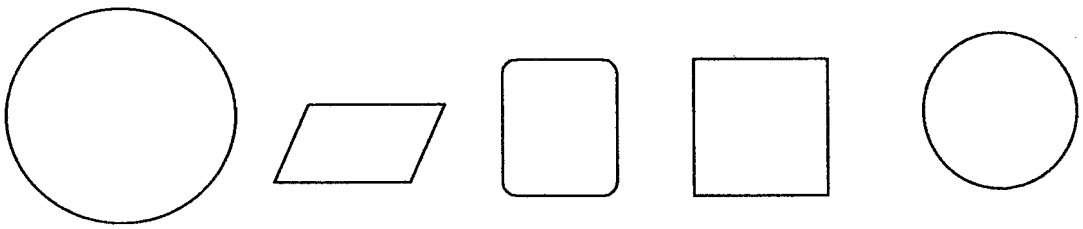


Fig 5.1 WebCT Course Design (see end of chapter for legend)

Legend for Fig 5.1:



Homepage WebCT Tool Path Single page Toolpage

Html = Hypertext markup language
Rtf = Rich text format
Pdf = Portable document format
Url = Uniform Resource Location

unwieldy and would necessitate access to high quality video cameras and equipment by each student. The use of face-to-face contact was considered, but for all the students to come on campus at the beginning of the course would negate the advantages of distance learning, would comprise the flow of the course and the cost to students would prohibit enrollment. The use of regional centres would still require considerable travel and add significantly to the overall cost of the course. It was decided therefore that the communication skills theory, delivered on the Internet, would be supplemented by video material to illustrate the skills as well as tasks to reinforce selected skills in clinical practice. It was thought that the video materials could be sent over the Internet, but the download time for even a short clip was found to be excessive. The University did not have access to software that could stream videos over the Internet and therefore it was decided that the video material would be produced on CD ROM and posted out with the printed materials. The video files were linked to the relevant pages in WebCT and could be played while on-line, as well as reviewed off-line.

Communication

I initially underestimated the importance of interaction and communication, by an assumption that this was not possible without face-to-face contact. My

ideas on this were changed by reading the distance education literature (Ragan, 1999), discussing the course with more experienced designers (Grant, 2000) and increasing familiarity with WebCT. The course design eventually included:

- Email and telephonic access to the course organiser
- Private mail within WebCT for all participants
- Membership of a discussion group (5-6 people) on a bulletin board, where tasks and reflective journals could be posted and discussed.
- Help from a mental health expert via questions posted on a dedicated bulletin board serviced by the University of Stellenbosch 'Mental Health Information Centre'.
- Help from the course organiser for technical or course related issues via a dedicated bulletin board
- Optional use of chat rooms.

Resource materials

Four books were made available in Adobe Acrobat (pdf format) after negotiation with and contractual agreements with the publishers for their electronic rights. This had the advantage of preserving the publisher's layout, while at the same time allowing the books to be searched for keywords and given electronic benchmarks for easy access. The books could be downloaded to the student's computer with the usual copyright provisos. Access to the course and therefore the books, was limited to students with user names and passwords and for the duration of the course. This required the students to also download a free copy of Adobe Acrobat to their computers. Two books were also posted in hardcopy and two books were available in hardcopy at a reduced price via a hyperlink to the publishers. All the other printed material was made available on-line in rich text format where students could adapt, modify or translate it into resources that would suit their own practice. The patient materials were posted out in English, but were also available on-line in Xhosa and Afrikaans.

Self-assessment

A self-assessment quiz, using multiple-choice and matching type questions, was developed for each module (Table 5.2). A range of content experts, mainly psychiatrists, were used to write questions on each of the topics covered by the College of Psychiatrist's Diploma curriculum. It was assumed that many GPs would like to sit the Diploma exam, but were unable to do so as they could not fulfill the entry criteria. Usually a GP would need 6-months experience in a psychiatric service before sitting the exam. By covering the factual knowledge base of the Diploma and ensuring that GPs obtained documented practical experience during the course, it was hoped that the Certificate would be recognised by the College of Psychiatrists and enable more GPs access to the Diploma exam. The quiz encouraged self-directed learning where the learner could identify areas of weakness and set their own learning goals. The course resources could then be used to strengthen knowledge in these areas. The quizzes were therefore a type of formative evaluation and could be repeated up to 5 times with the highest mark recorded. Feedback on performance in the form of a grade and written comments was given automatically by the computer.

Course tools

A series of standard WebCT tools were incorporated:

- Set up your CD Rom drive
- Generate study guide: how to select pages from the course to print or save
- Resume reading where you left off
- Search the glossary: this was used as a bibliography for the course
- Search the course content (html files) for any keyword
- View your marks and records

Printed materials

Printed materials in the form of desk-top tools were adapted from the original WHO materials as described in Chapter 4. These materials included checklists, flowcharts, handycards, questionnaires and patient leaflets for the following conditions: mental problems (including sleep problems, chronic tiredness, unexplained somatic complaints), depression, anxiety disorders (generalised anxiety, social phobia, agoraphobia, panic disorder), alcohol use disorders and, post traumatic stress disorder.

The evaluation stage

Review goals and objectives

During the development process I attended a workshop on distance education by Janet Grant from the Open University (Grant, 2000). This provided a useful checklist for designers of distance education (Table 5.4). I will briefly discuss each of these 14 questions in relation to the design of this programme and my learning as a novice designer.

(1) The need for improvement in the recognition and management of mental disorders by primary care providers forms the underlying basis for the educational programme and this issue has already been discussed in Chapter 2. The specific educational needs of GPs in relation to the WHO package has also been explored in the co-operative inquiry group. The purpose of this research can itself be partly understood in terms of adapting the educational programme to meet the learning needs of GPs.
(2 / 3) In the design of the programme a number of clear objectives were set as listed on page 88, although these were only fully conceptualised as a result of Grant's questions.
(4) The course was timed as a 16-week course, but the need for definite deadlines within the course and explicit cut-off dates to guide the distance learner was learnt from Grant.

(5) The need to test the web-based materials as they were developed rather than leaving this until the first students enrolled was useful and on realising this I made an attempt to test the materials with members of the co-operative inquiry group. This testing was however limited in its scope.
(6) Support for the learner was provided in a number of ways, by the course organiser through the bulletin boards, telephone and email. Administrative support was provided from the Department of Family Medicine in the form of a part-time assistant. Technical support was provided by the Universities' IT and UniEd departments, but when required was accessed via the course organiser. Clinical support was provided by the Department of Psychiatry at Stellenbosch University who were accessed through the Mental Health Information Centre (MHIC). The MHIC serviced the 'consult an expert' bulletin board in WebCT.
(7) Feedback on learning was given by the course organiser and tutor via the bulletin boards, the need for prompt and specific feedback was emphasised by Grant.
(8) The incorporation of action-reflection cycles was a key feature supporting the idea of active learning.
(9) The assessment of the programme is of course the focus of this research study. The assessment of the GPs is described below on page 100.
(10 / 11) Interaction with the tutor and other students was allowed via a series of bulletin boards as described on page 95. The central importance of this communication and interaction however was also learnt from Grant.
(12) The self-sufficiency of the course in terms of content and resources is described on page 89. The course did not leave GPs having to surf the net for suitable resources.
(13) The feasibility of the programme was achieved by the coming together of a number of factors. These factors included the starting point of the WHO Educational Package, the funding of my time and development of the programme by Sanofi-Synthelabo and the commitment of the University to support WebCT and distance education.
(14) The initial course fee of R1,200 for a 16-week course was heavily subsidised and therefore, for the GPs enrolled in this initial course, represented good value for money.

Table 5.4. Questions to ask about quality in distance education

1. Was there a needs assessment?
2. Are the objectives stated?
3. Are they my objectives?
4. Is it timed?
5. Has the course been tested?
6. Is there support for the learner?
7. Is there feedback on learning?
8. Does it encourage active learning?
9. Is there an assessment?
10. Is there interaction with tutors?
11. Is there interaction with other learners?
12. Is it self-sufficient?
13. Is it feasible for me?
14. Is it value for money?

Develop an evaluation strategy

There is no summative evaluation as part of the course, but in order to be certified students must complete all the self-assessment questions and successfully complete all the action-reflection tasks. At the end of the course students receive a certificate from the University of Stellenbosch, 40 CPD points from the Health Professions Council, accreditation towards sitting the Colleges of Medicine's, Diploma in Psychiatry and credit for 1 module in the new Masters Degree in Family Medicine degree at the University of Stellenbosch.

The evaluation of the program itself is described in the following Chapters 6 and 7.

The revision stage

After the course design was completed and the first learners enrolled, the design was subjected to a quality assessment. A recently published review "Quality on the line" recommended 24 benchmarks that could be used as standards for this quality assessment (Pittinsky and Chase, 2000). The following issues were highlighted:

- The need to back-up and copy the course in case of technological failure
- The experience of this program can help the University establish support and training to guide faculty more clearly through the web-based instructional design process
- The administrative roles and interactions between the Universities departments involved with distance education need to be clarified and rationalised

MARKETING AND ADMINISTRATION

The development of the program required a multi-disciplinary team of people (Mooney and Bligh, 1997) who, although they did not meet together, were co-ordinated by the author. This team included technical and multi-media experts, educational design experts, content experts, graphic designers, and administrators. The course was marketed through the medical journals and by a mailing list from the SAMA to GPs with email addresses. Information and registration was also available on the Internet.

The University of Stellenbosch provided educational support through its UniEd Department, and administrative support through the Division of Distance Education, Registrars Office and the Department of Family Medicine and Primary Care. The roles and responsibilities of these various departments towards the instructional design and administration was difficult to understand and reflected a lack of overall clarity within the faculty towards distance

education courses. The initial course fee was heavily subsidised in order not to deter people from enrolling. The entire design process took 15 hours a week over a 7 month period and cost R136,000. It was estimated that one tutor could comfortably co-ordinate and interact with up to 20 students and therefore this was set as the ceiling for enrollment in the first course. The first group of students were enrolled in August 2000 and it was planned to repeat the course twice a year from 2001.

PHASE THREE: CHAPTER SIX - RESEARCH METHODOLOGY FOR EVALUATING THE DISTANCE EDUCATION PROGRAM

INTRODUCTION

This chapter describes the methodology of action inquiry that was used in phase three of the study to evaluate the Internet based distance education program. The rationale for using this methodology, within an emancipatory-critical paradigm, has already been discussed in Chapter 3. This phase of the research project, dealing with the distance education program, had the intention of further adapting and refining the distance education programme for South African GPs. As with the co-operative inquiry group the action inquiry was designed to explore the relationship of the GPs to the educational process. In this inquiry the initial questions that I attempted to explore were:

- What expectations did the GPs have of this educational experience?
- How did the GPs use the materials on the web?
- What happened when they engaged with the action-reflection cycles?
- What changes took place in the GPs through this experience?

Twenty-one GPs registered for the course. Two of these GPs did not start the program and 6 dropped out of the program early on, the remaining thirteen GPs all completed the program. The demographics of the nineteen GPs who started the program and contributed qualitative data are shown in Table 6.1. Many of the private GPs in rural towns were also involved in the public sector as district surgeons or in the local district hospital.

Table 6.1. Demographics of the general practitioners

Initials	Age	Province	Practice setting
FY	38	Western Cape	Metropolitan, public health centre
KH	38	Western Cape	Rural town, private practice
KL	34	Western Cape	Rural town, private practice
HB	46	Western Cape	Rural town, private practice
CN	26	Western Cape	Rural town, regional hospital
HJ	32	Western Cape	Metropolitan, private practice
ML	50	Western Cape	Rural town, private practice
VB	41	Western Cape	Metropolitan, NGO
SN	27	Western Cape	Rural town, regional hospital
GM	36	Western Cape	Metropolitan, private practice
JB	30	Eastern Cape	Rural town, private practice
KI	X	Eastern Cape	Rural town, district hospital
SP	48	Eastern Cape	Rural town, district hospital
HC	50	Eastern Cape	Rural town, private practice
SRP	52	Kwazulu-Natal	Metropolitan, private practice
JU	37	Kwazulu-Natal	Rural town, district hospital
AM	48	Kwazulu-Natal	Metropolitan, private practice
SS	38	Mpumalanga	Rural town, district hospital
SE	40	Gauteng	Metropolitan, private practice

NGO = Non-government organisation

ACTION INQUIRY

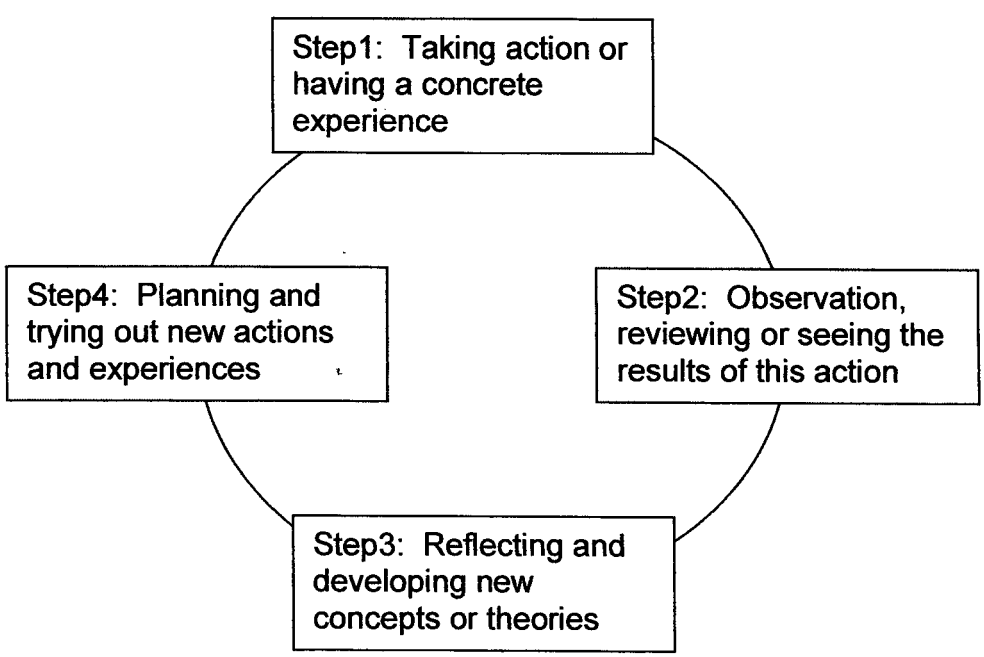
Action inquiry has been used to develop business and organisational leadership as well as in quality assurance processes. Reason (1994) defines action inquiry as:

> "[It] is concerned with the transformation of organisations and communities towards greater effectiveness and greater justice...[It] addresses outcomes (measured empirically), and the quality of one's

own attention (monitored by meditative exercises as one acts). Further, action inquiry addresses the question of how to transform organisations and communities into collaborative, self-reflective communities of inquiry."

In this research project action inquiry is used in an educational setting. In the same way that the co-operative inquiry group involves a cyclical process of action and reflection within a participatory *group*, action inquiry involves the *individual* in a cycle of action and reflection. This individual's consciousness is both deeply engaged in the action of the moment and yet simultaneously able to stand back and adopt a reflective stance. In the context of this research process I was deeply engaged with organising the Internet course as well as tutoring and facilitating the GPs and yet simultaneously standing back to analyse and reflect on the experience of myself and the course participants. This can be summarised as "questioning in the midst of action"(Reason, 1994).

The process of action inquiry can be represented as an action learning cycle (Zuber-Skerritt, 1997):



This cyclical process can be seen as having both 'single-loop learning' and 'double-loop learning'. Single-loop learning detects and corrects errors without challenging or changing the underlying values or concepts. Double-loop learning detects and corrects errors that require changes in the underlying values or concepts (Argyris and Schon, 1974).

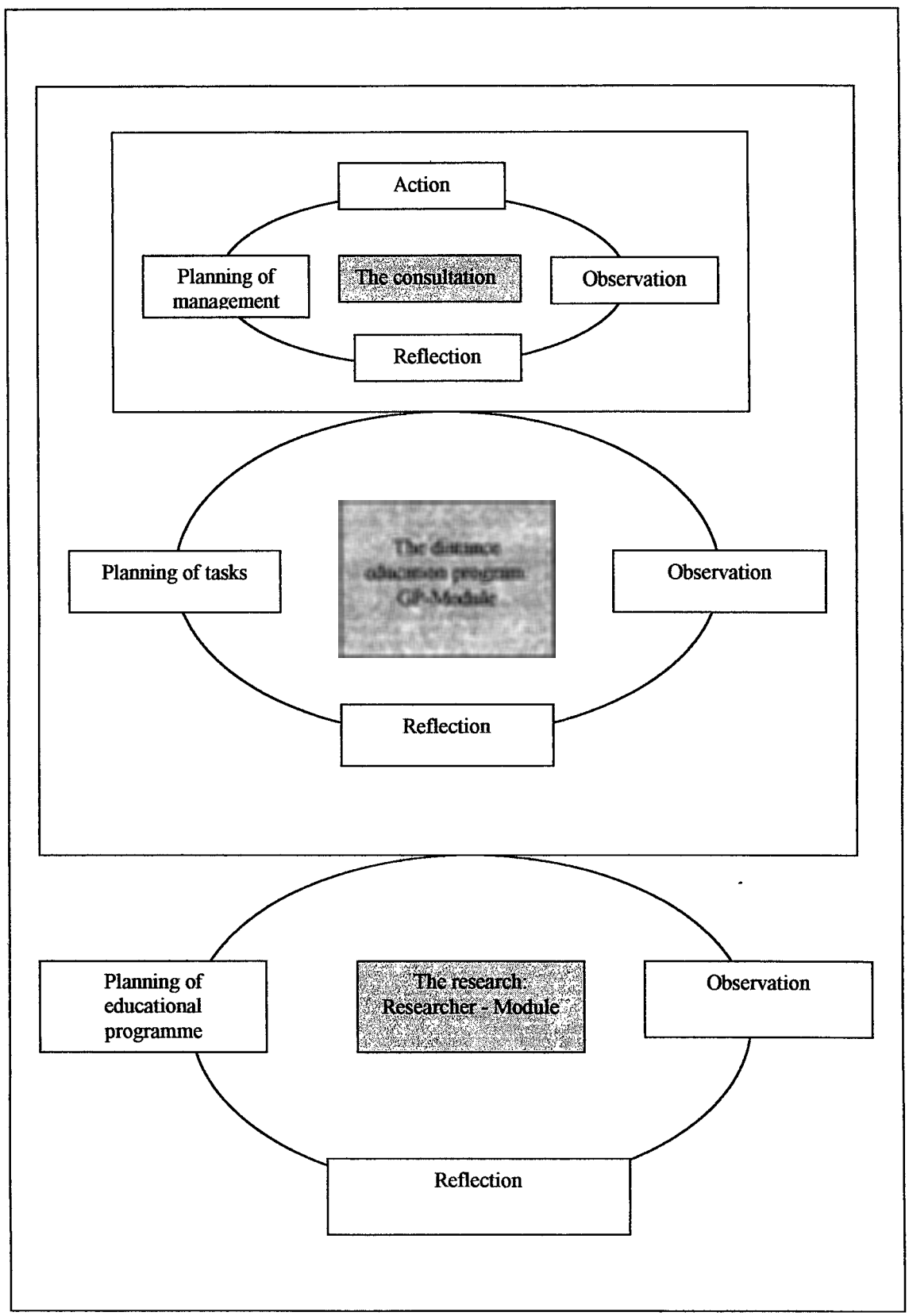
Argyris states that effective action inquiry or learning requires double-loop learning or as Torbert put it "an upstream swimming process of questioning assumptions and repeatedly re-framing the game we are playing" (Fisher and Torbert, 1995).

The action learning cycle requires the person to develop four different styles or roles: activist, reflector, theorist and pragmatist. The activist is the person immersed in the experience, the reflector is the person observing and reviewing this experience, the theorist is the person developing new conclusions and concepts from this reflection and the pragmatist is the person planning specific and concrete changes and new actions (Zuber-Skerritt, 1997).

As outlined in Chapter 5 the educational theory and instructional design of the Internet based course involved the GPs in a series of action learning cycles. Each of these cycles required the GP to engage with the course materials on the web and in their consultations with patients. At the end of each of these 8 cycles the GP was required to submit a reflective journal that described what they had planned to do, what happened, and what they had learnt from reflecting on this experience. From my perspective the course as a whole, as well as each module within it, can be seen as action learning cycles where the journals submitted by the GPs acted as their main mode of reflection and my main means of observation. This process is represented diagrammatically in Fig 6.1 and shows how action learning cycles were taking place at 3 levels.

Level1:	The consultation: Patient and the GP
Level2:	The distance education program: GP and the Module
Level3:	The research: Module and the Researcher

Fig 6.1: Three levels of action inquiry.



For the researcher each action-learning cycle provided an immediate opportunity for single-loop learning and the correction of errors or mistakes in the course, whereas the action-learning for the course as a whole provided an opportunity for double-loop learning and a re-consideration of the underlying design, theories and concepts.

The journals submitted by the GPs therefore had two functions. Firstly they were a significant part of the GPs own learning cycle and secondly they provided qualitative data that as a researcher I could analyse and reflect upon to explore what was happening in the relationship between the GPs and the educational programme. I will now describe the process of qualitative data analysis that I followed.

Qualitative data analysis

At the end of each module the GPs posted their journal on an electronic bulletin board. Altogether 92 journals were posted and received. The journal was then saved to a directory on my hard drive and printed out. Each journal was coded with the module (i.e. J1 = Journal for module 1) and the initials of the GP who wrote the journal (i.e. J1HC). An example of a journal is shown in Appendix F.

As soon as possible after the GP had posted the journal the printed copy was read and notes made in the margin. As a tutor these notes could relate to clinical questions that the GP raised, such as the use of Antabuse in patients with alcoholism. Where necessary these clinical questions were posted on the 'consult an expert' bulletin board where the Mental Health Information Centre could read and respond to the question. Other notes related to the style of writing and reflective stance taken by the GP. It was necessary as part of the course to develop reflectivity in the GPs and to give feedback on the process that they had followed. Typical feedback might address the need to ground their learning in descriptions of actual consultations and patient encounters, the need to be more concrete and specific in their reflections or the need for

clarification of their meaning. This feedback was given immediately to the GP in order to enhance their reflectivity in subsequent modules. Initially I was hesitant to give this feedback to the GPs as I felt that they had signed up for a course on mental disorders and not reflectivity. Discussion with my research consultant, however, enabled me to become more direct and specific in this feedback and I came to appreciate that not only was reflectivity necessary for effective learning and useful qualitative data, but was also an attribute that therapists require in their healing relationships with patients. An example of feedback given to the GPs is shown in Appendix G.

Initially I filed the journals according to the individual GPs, but at the start of the course this way of ordering the material made it seem too thin and insubstantial. I therefore re-ordered the material by collating all the equivalent journals together (i.e. all the journals for module 0 together). After reading the materials I labelled the text with codes in the margin that related to possible initial categories. On the computer I then cut and pasted the text into a matrix with 4 columns:

Column1: Code for the journal (i.e. J1HC)
Column2: The text
Column3: Personal feelings, reactions and questions about the text
Column4: An initial category for analysing and giving meaning to this section of text

When all the journals for that module had been cut and pasted into the matrix I printed it out and worked from it to write a reflective summary for that module. The initial categories were sometimes clarified or changed in this process. This reflective summary was then posted on the course organisers bulletin board in WebCT and the GPs asked to read and give feedback on whether the summary did justice to their experience and learning. Following discussion with my research consultant I realised that my initial reflective summaries were not tentative enough and not sufficiently grounded in the actual journals and the individual voices of the GPs. Subsequently I used more direct quotes in the summaries and identified the voices speaking, as

well as drawing people's attention to areas of contradiction or confusion. Examples of the matrix and subsequent reflective summary are shown in Appendices H and I respectively.

During this process I began to feel that I was not sufficiently in tune with the individual GP's intentions and personal journeys. By analysing the journals together for each module the journey of each person through the course was obscured. Therefore I re-ordered the journals for each individual GP and analysed the journals for each GP in a different way using an approach to analysis developed by Meulenberg-Buskens (see page 52 Chapter 3). Although my overall analysis continued to be structured according to modules this parallel process enabled me to become more aware of what themes and issues each individual learner was dealing with.

Once the initial analysis process was complete I had 8 provisional reflective summaries. I now returned to the beginning and re-wrote the reflective summaries adding in additional material from journals that were handed in late and where necessary changing the style of the writing as I have already explained. Following this I analysed the eight summaries for common themes and condensed them into 3 documents entitled:

- Themes regarding the recognition and management of mental disorders
- Experience with Internet based materials
- Experience with desktop tools in clinical practice

These three documents represented the final step in the analysis. The documents were then read alongside the original research questions and the material reformulated and interpreted with regard to these questions. A single document was then created that presented the final themes and concepts. This document forms the basis of the research findings in Chapter 7.

QUALITY AND ACTION INQUIRY

The 'trustworthiness' of this action inquiry can be considered under the following headings:

- Reflectivity of the researcher
- Respondent validation
- Peer review
- Documentation and thick description
- Fair dealing
- Transferability

Reflectivity of the researcher

Action inquiry relies on the ability of the inquirer to be "questioning in action". The trustworthiness of the research will therefore depend on the extent to which the research instrument, in this case myself, is able to operate in this dialectical cycling between the action of running the course and the questioning of it. As I hope has been clear during this thesis the development of this ability in myself has been a continuous and probably never ending process. In this action inquiry it was relatively easy to separate out my roles as activist (tutor and course co-ordinator) from my role as reflector (analysing and reflecting on the qualitative material). My preconceptions as a researcher were discussed in Chapter 3.

Respondent validation

As already described the reflective summary of each set of journals was posted on the bulletin board and feedback requested from the GPs. In addition feedback on their journals was offered to the GPs individually by messages on the bulletin boards and meeting them in an Internet-based chat room. Material from the feedback and interaction as well as the chat rooms was used to assist in the analytical process.

Peer review

Meulenberg-Buskens a research consultant and expert in the field of qualitative and participatory research was contracted to supervise the research process and review its quality. Her feedback and comments were useful in guiding the process and are mentioned in the text.

Documentation and thick description

The conclusions of the action inquiry should not simply be stated or asserted, but the thesis should show how these conclusions were established. Each step of the way should be clearly described and any underlying assumptions or methodological decisions clarified. The reader should be able to hear the original voices and context speaking in the document and see how these led the researcher to his or her conclusions. The steps in the process are described above and examples of each step given in the appendix.

Fair dealing

All the GPs who registered for the course should be treated fairly in the analytical process. In particular all those who failed to complete the course were approached to discover why they had dropped out and whether this could shed light on a different perspective. This could also be seen as a type of 'deviant case analysis'.

Transferability

At the end of the day the thesis should present its findings in such a way that the reader can clearly transfer those findings that are relevant to their own context.

DISCUSSION

The journals provided a huge amount of qualitative data, which was useful in exploring the experience of the GPs with each aspect of the course. Although the GPs gave little feedback on my reflective summaries there was a useful amount of dialogue around the individual feedback on their journals and at the end of the course 3 GPs met separately with the principal researcher in a chat room to discuss their experience. The chat room discussions were also saved as documents for qualitative analysis. This study did not attempt to provide triangulation of methods where the same phenomenon is explored by collecting data from different sources (Malterud, 2001).

All the GPs who dropped out of the program were followed up to determine their reasons. The main reason for all these GPs was a lack of time to participate in the program due to the pressures of clinical practice or other competing responsibilities. One GP was involved in a motor vehicle accident, which prevented her from continuing. None of the GPs reported withdrawing because of problems with the course material or use of the Internet.

One issue that needs further discussion in this action inquiry is the extent to which the GPs participated in the research. Clearly the level of participation and collaboration was far less than in the co-operative inquiry group. The main intention of the GPs was to complete the educational programme and not to participate in an action inquiry. The intention of the course organiser to engage the GPs in an action inquiry process was made explicit in the introductory module. As the means of observation for the principal researcher, namely the reflective journals, was also one of the key means of learning for the GPs, there was no difficulty in combining the two agendas. However it could be argued that the GPs did not have the option of refusing to participate in the research as this would invalidate their completion of the educational programme. In practice none of the GPs expressed an objection to the dual purpose of the journals, but the issue of whether fully informed consent was possible should be highlighted.

This issue also raises paradigmatic concerns as the emancipatory-critical paradigm stresses participation as one of the key values in the 'research process' (see Table 3.1 page 25). The depth of participation by the GPs in the research process was limited in this phase of the study. Can this research therefore still be regarded as action research or does it have more in common with the attributes of the interpretative-hermeneutical paradigm? At the level of the 'relationship with the research reality' the process involved cycles of action and reflection by the course organiser / principal researcher with changes planned, made and observed during the educational programme. For example the format and style of the reflective summaries and the nature of the feedback given to the participants was changed siginificantly during the research. On this basis the methodology still falls within an emancipatory-critical perspective. At the level of the 'researched person' and the 'view of truth' the methodology was more in tune with an interpretative approach where the experience of the learners was interpreted by the researcher and a coherent analysis made of the qualitative data. The methodology used in this phase of the research illustrates how paradigms can be "combined or triangulated within a research project" and researchers do not have to believe in "theoretical monism, epistemological absolutism and paradigmatical ethnocentrism" (Smaling, 1992).

PHASE THREE: CHAPTER 7 - RESULTS: EVALUATION OF THE DISTANCE EDUCATION COURSE

INTRODUCTION

This chapter presents the findings of the action inquiry, which seeks to explore and learn from the GP's experience of the distance education programme. The process of qualitative data analysis and the way in which this final document was developed is described in Chapter 6 pages 108 to 110. The findings that emerged from the process of qualitative data analysis are presented as a number of themes:

- What expectations did the GPs have of this educational experience?
- How did the GPs use the materials on the web?
- What happened when they engaged with the action-reflection cycles?
- What changes took place in the GPs through this experience?

1. What expectations did the GPs have of this educational experience?

The expressed learning needs and intentions of the GPs were:

- To update knowledge, especially for mature GPs, whose undergraduate training was many years ago. These GPs had recognised that mental disorders are a common part of general practice and therefore important.
- To have greater insight into and confidence in managing patients with mental disorders
- To obtain CPD points
- To prepare to sit the College of Psychiatrist's Diploma Exam
- To develop an existing special interest in mental disorders
- To enable the GP to perform a special role in managing mental disorders within the district health system i.e. running a psychiatric clinic

- To improve skills in communication, diagnosis and management, including counselling or psychotherapy.
- To prepare (vocational training) for independent practice and to make oneself "more marketable" in the future
- To take advantage of distance education programs, especially in more rural practice, as compared to residential programs.
- To explore and deepen a commitment to cross-cultural issues and the bio-psycho-social model.

Overall GPs were more interested in developing an approach to recognition and management of mental disorders and in building their confidence in this area. The development of a practical approach in the consultation was more valued than extensive updating of knowledge for specific conditions. Updating of knowledge may pre-dispose to the development of an approach, but in itself was not the main learning need. This probably reflects the nature of general practice where the skilled GP must make sense of undifferentiated conditions and identify urgent and serious cases. This emphasis by the GPs on developing a practical approach validated the emphasis on this in the instructional design. This practical approach needed to be time-efficient as well as effective and was clearly linked to the development of confidence and willingness to address mental problems in the consultation.

"If I could go deeper into her mental complaint with more experience of mental disorders, I could probably do more for her in less time. I would like to be more comfortable with these patients." J0ML

"I really need an organised, easy to use system to refer to." J0KL

"I was not sure that I should treat this patient, firstly because I am not confident enough to treat him,,," J0SRP

The learning needs and intentions of the GPs in registering for the course were coherent with the pre-determined outcomes. The similarity of the GP's intentions and the intentions of the course, prepared the way for a useful educational experience.

2. How did the GPs use the materials on the web?

2.1 Content of modules

The practical focus of the materials on the process of recognition as well as the learning of diagnostic criteria was appreciated as being relevant to general practice:

> *"The course material and resource material was adequate. As a primary care practitioner it is more important for me to be able to pick up these cues than to know the DSM-IV criterias. This is why I find this relevant to my practice and there were no technical problems." J1AM*

Specific comments included the need to include material on the follow up of patients with schizophrenia and for material on *dagga* abuse. No major problems were experienced with the course materials. They were found to be relevant, user friendly and practical.

> *"I found the course material very useful and the flowcharts very handy in a busy practice." J2ML*

One GP in an urban private setting had the opinion that the course materials in the module dealing with language and culture were more useful for rural practitioners:

> *"I observe that there is a big difference in your approach, use and reflection on the course materials depending on your dominant practice*

population. I see mostly middle to high income white and black patients who speak English / Afrikaans fluently so I rarely have a problem with language...The course materials reflect more on the rural practitioner, but I suppose the problem of recognising mental disorders in this patient population is much greater so I will accept that." J4HJ

Some GPs would have liked more emphasis on psychotherapy, although it was not clear what exactly they meant by this.

"I wish psychotherapy could have been covered in one of the modules of this programme." J0SS

2.2 Resource materials: books

Doctors found the ICD-10 Guidelines, in hardcopy, useful as a resource in the consultation. Drawbacks included the absence of PTSD and a lack of information on medications.

"I found the ICD 10 booklet very useful to refer to, to make a specific diagnosis... reading through the ICD 10 I missed PTSD a diagnosis that does come to mind every now and again - why would it have been left out?" J4KL

"While these guidelines [ICD 10 book] might not really fulfill the needs of a GP in terms of medication and medical treatment options, I found it to be most useful in terms of counselling patients and their families." J4SN

Some people found it more useful to have the hardcopy of the books rather than the Internet version. People preferred to read longer materials in hardcopy and not electronically.

"I have received the 2 recommended handbooks, which facilitates the reading a lot." J2FY

The two Handbooks were found to be too superficial as resource materials and a more extensive textbook would have been better.

2.3 Use of technology and interaction on the Internet

Some initial confusion was experienced with use of the Internet and computers, but was easily resolved with help from the course organiser or by the learners themselves. The main problem was attaching items to the bulletin boards.

"The only problem I have had is my lack of knowledge of the computer system but after many hours surfing the temporary Internet files and numerous calls to friends I think I am finally winning." J1FY

"I found the course materials difficult to access initially, mainly because I had to work 'on-line' a lot. Also I'm not to clued up on all cutting , pasting, file transfers etc." J1GM

"The course was an eye opener. I never thought it was possible to use Internet for such an extensive process of learning." J7AM

"I don't know a lot about computers and the fact that I did the whole course on my own shows that the technology was excellent, because I didn't have any problems, the course was accessable and if you had problems you could ask Bob and there was no further problem." J7CN

The interaction with the course organiser was useful, but there was little interaction with each other through the discussion bulletin boards. Likewise only three people took up the offer of meeting in the chat room. It seemed that

the time required to do the reading, quizzes and journals within the 2 weeks did not allow much spare time for interaction with each other. The time needed to do all the course work was more than anticipated. There was also little response to the reflective summaries.

> *"We have been able to come so close yet being physically so far away from each other." J7FY*

> *"After initial problems with the technology it worked very well. It was my first experience communicating with a bulletin board, a truly wonderful way of communicating, I am just so impressed with a distance-learning course that can accomplish so much." J7HC*

> *"The communication with the course organizer and the feedback was great." J7SS*

> *"It is really difficult to chat with other students - there simply is no time to do so." J7JB*

> *"I found that I required more than the 4 hours, maybe 6 hours [a week]" CRFY*

2.4 Quiz

The quizzes were useful, although there were some errors in the computerised marking that were corrected during the course. The feedback given to the leaner with each question was useful. Some of the quiz questions on more formal psychiatry were not perceived as relevant to general practice.

3. What happened when they engaged with the action-reflection cycles?

This section will present the qualitative results in 2 parts:

- Experience with the desktop tools
- Experience with communication skills

3.1 Experience with the desktop tools

3.1.1 Commitment to practical action

Trying out new ideas and skills could generate personal feelings of irritation and tension.

> *"Personal feelings towards a 'new' process is not always positive, but in this case the chapter clearly pointed out my own mistakes, turning me into a more 'user-friendly' doctor." J2KL*

> *"... The course material seems to get better as we progress in the course and very easy to use, once the initial barrier of starting the new task has been overcome." J4FY*

For others it was difficult to remember to carry the materials with them and use them in the consultation:

> *"When starting with the tasks I was not very 'with it', somehow I forgot to put the checklist on my desk, then I got into the trap of seeing patients 'quickly' without delving deeper into their symptoms." J2FY*

Several people had difficulty finding what they saw as good "cases". This was especially in module 6, which dealt with simple psychotherapeutic techniques.

> *"Sometimes it is difficult to select or have the right patient for the weeks "topic"... There is not always time to get back to the patients to see what their reactions was." " J6JB*

> *"Unfortunately (?) I have not yet encountered a good "case patient", but would like to describe an incident of some months ago.." J6KL*

> *"The patients I have described were all seen in the 1st week of the module and there did not seem to be suitable patients in the second week." J6HC*

> *"It is difficult to match a specific patient in a specific time frame. I often come upon a patient realising that the specific problem has not been addressed and is scheduled for the weeks to come. I would have preferred to have a birds eye view to the whole course and then perhaps focussing on specific problems coming from specific situation." J6JB*

> *"I then phoned some of my old patients, that I felt would benefit from this programme to make appointments. This was not done to exclude any new patients, but it was done so that I could have enough subjects to use the interview techniques on." J6AM*

This problem may be because the topic is being too narrowly interpreted and relevant patients inadvertently excluded or because the module is too short to generate sufficient experience. Maybe the modules should be longer - 3 or 4 weeks. However for some GPs the apparent lack of patients seemed to be an excuse for not grounding their reflections in actual experience, they preferred to react theoretically to the materials

"I find that I often do not see relevant patients during the specific two weeks, but that I can reflect retrospectively on prior consultations. Maybe the best format will be to just describe your feelings or such regarding the module, giving your opinion on the subject whether you had a consultation or not." J4HJ

One doctor decided to keep a logbook of the patients for later recall of their problems and to help with reflection.

3.1.2 Reflection and use of journals

The format of action-reflection cycles was supported:

"I find the format of the course very useful; some input, tasks to do in one's practice, then reflection on the experience." J1HC

The writing of the journal itself was part of the reflective process:

"I have only just now, by writing the journal, realized how useful the checklists actually are." J2FY

For some the format of the reflective journal became repetitive and started to irritate as it felt like writing the same thing every time.

"I must confess though I find the patterns and formats of these journals repetitive and boring. Maybe something more structured or not structured at all could have been a better option." J4SS

"Performing the tasks were easy and a good learning experience but to be honest the repetitiveness of the journal format is getting to me. I feel as if I am writing the same journal every second week. Is it only me, or do other course participants feel the same?" J4KL

"I also think that one tend to repeat yourself in the reflective journals, but the concept of doing this is still important to reconcile the module's impact or not on your practice." J4HJ

"I must admit that it is easier to practise the techniques in my practice than to write all these journals! I would be more positive towards these journals if they would be a bit different and not all the same each week." J7JB

This problem may partly be addressed by varying the format and structure of the journals between modules. The journals were designed to enable reflection on the part of the learner as well as provide qualitative data for this research. In future the format of the journals will not have to meet both these demands. The complaint however also tended to come from GPs who failed to engage with the tasks in their own practice. A lack of real experience with using the tools may lead to a lack of reflection and difficulties with completing the journal. GPs who were more committed to the tasks and appeared to have greater reflectivity were more positive about the journals. This method of learning therefore may be of more value to GPs who are open to change and experimentation and with more reflective skills. This also points towards the need to identify and assist people early on in the course to overcome resistance to action and to develop their reflectivity.

3.1.3 Development of the cue cards

The consensus of the GPs on the common cues for mental disorders in general practice is given below:

Verbal cues:

Pain syndromes: Headache, neck pain, 'neck veins', 'ndinomxadi', muscle pains and cramps, backache.

Chest symptoms: Chest pain, tight chest, palpitations, shortness of breath, choking retrosternal feeling.

Abdominal symptoms: Choking feeling in epigastrium, 'umbelini', 'something moving in the stomach', epigastric discomfort, weight changes, nausea, cramps, change in appetite, unexplained vomiting, menstrual problems

Mental symptoms: Tiredness, insomnia, sleeping too much, poor memory,

Sensations: dizziness, 'something in hair or scalp', tingling around mouths and hands, itching excessively, 'inkantsi', 'something crawling under the skin', sweating, dry mouth, tremor, tearing or sensitivity of eyes

Mode of communication: Explaining the same thing over and over, many different complaints in different parts of the body, urgency to explain symptoms as if saying 'doctor please take note', minor or irrelevant complaints, excessive worry about health, repeated visits with non-specific complaints, asking for a disability grant, long standing unexplained symptoms with normal findings

Non-verbal cues:

Facial expression: sad, troubled, pained, poor eye contact / looking down, 'bewildered look'

Posture and movement: moving slowly, defensive body language (crossed legs and arms), fidgeting, sitting on edge of chair, tremor, seeks chair in corner, doorknob hesitation,

Emotional state: crying, agitated, irritated, impatient,

Type of speech: speaking slowly, incessant speech, poor communication

General appearance: physical neglect, unkept, sweaty, traditional mourning dress

Contextual cues:

Financial problems
Relationship problems: marital problems, divorce, lives alone,
Family problems: 'troubled kids', teenage pregnancy, new baby,
Problems at school
Problems at work
Substance abuse in family:
Physical or sexual abuse in family or history: rape
Community problems: high levels of crime, violence, theft, poverty
Recent loss: bereavement, loss of job, loss of home / relocation, loss of pregnancy / TOP,
History of mental illness
Problems with health in self or family: HIV, serious illness or operation

The list of cues was seen as dynamic and changed with the experience. The exercise of constructing a list of cues reportedly increased awareness of them in the consultation. The actual list itself was not usually referred to in the consultation, but the list acted as an internal mental prompt or script. As a result the cues for the hypothesis 'mental problem' were more clearly assimilated and constructed in the doctor's mind. Recognition of and consideration of mental disorders was reportedly increased.

> *"Patients with mental disorders will in most instances not complain of a problem in the mind but will present with a physical complaint as an 'entry ticket.'...I was pleased to notice that I had been able to pick up mental problems using simple cues that I had ignored in the past. It is a*

sadness that I realise that through the years in practice I may have been missing so many mental illness," J1AM

"Had the cue of generalised body aches not spelt 'mental disease' she might have left with some analgesics and vitamins!" J1SN

"This consultation confirmed a long suspicion I had that some patients applying for disability are depressed, perhaps an "exhaustion" depression brought on by a desparate financial situation." J1HC

"Recognising mental problems can be a diagnostic challenge in some cases, but I think the practitioner's 'mental cue card' grows with time and experience sending one's thoughts automatically into the mental direction. (Subconsciously recognising certain symptoms and signs.) It is not practical to refer to a list of cues during the consultation. The list can serve as a reminder every month or so." J1KL

The likelihood of physical cues was reinforced:

"Mental illness will masquerade as a physical complaint in most instances. We need to keep this on our minds at all times." J2AM

3.1.4 Use of the questionnaires

Between 20 - 40% of patients screened positive to the depression questionnaire and the task increased awareness of how common mental disorders are among primary care patients. There was reluctance by some learners to use the questionnaires as a screening tool and a desire to rather use the questionnaire, within the doctor-patient relationship, once trust had been established.

"I found that most patients are not ready to talk about their mental problems on the first or even the second or third consultation. I'm

therefore planning to use the questionnaires when the patient starts to talk more freely and the possibility of a mental problem seems likely. ... the bulk of my patients are very anti-forms, so I decided against general screening for now." J1HJ

"I have learnt to be more alert to the cues from the patients, often the patients do not want to talk about their problems, maybe they are not aware that we can help. I find that I have to ask all my patients about their emotional and psychosocial wellbeing and I have to be persistent until slowly they are able to talk about themselves... I found that I have to establish rapport with my patients first " J1FY

Some learners did use the questionnaire as a screening tool, either for consecutive patients or a certain number each day. The presence of clinic staff who could administer the questionnaire made this possible i.e. nurse, receptionist, interpreter. Other learners introduced the questionnaire as a screening tool at the end of the consultation once rapport was established. Most learners used the questionnaire as a selective case-finding tool. Once the possibility of a mental disorder came up in the consultation the patient was asked to complete the questionnaire.

The reason for this difference between learners was not obvious and was not related to a private or public setting. Maybe the doctor made an initial judgement that patients would be upset by the task or feared that the task would undermine the doctor-patient relationship. It was noted that some patients are slow to talk about mental problems as it is seen as a "sign of weakness" (J1HJ) and may resist a mental health label for their illness.

Barriers to the use of the questionnaires included illiteracy, language, additional time to consult patients who completed a questionnaire, patient's fears about confidentiality, cultural insensitivity in some of the questions and discomfort by some doctors in using tools in the consultation:

"However there was a problem with the sexually orientated questions. In some patients, especially the older patients, my assistant had to ask me to administer that part myself. I couldn't ask some of these questions myself to some of my elderly patients. I felt they would embarrass some of these patients." J1AM [Zulu doctor and patient]

"Some of the patients was quite astonished when I gave them the questionnaires. They wanted to know what the purpose was, if it will be handled confidentially, some could not read and some could not understand the language. After some explanation there was no hesitation." J1CN

"I was told by some they felt uncomfortable completing it in open waiting room as heading is clearly readable from a distance." J1KH

"I think I felt more uncomfortable than the patients. It seemed to me patients thought I did not know how to proceed on my own." J1KH

Positive aspects of the questionnaires included:

- They were "quick and easy to use"
- They saved time in the consultation
- They helped make a diagnosis
- They facilitated the introduction of mental health as an explanatory model into the consultation

"I did however find the questionnaires very helpful, as well as the information leaflets. They enable one to enquire about the most important issues and also to share important information in a short space of time. I found the task interesting and sometimes a diagnostic help." J1KL

Many doctors were surprised by hidden psychological issues:

"A 23 year old Xhosa lady was referred to the OPD from the antenatal clinic for treatment of a UTI. I took her medical history, examined her and prescribed the pertinent medication, I did not perceive any cues, and at the end I asked her to fill in the questionnaire. To my surprise she screened positive -she said to me that she had been thinking of ending her life." J1FY

"The one patient was given a questionnaire to complete by mistake! (He actually brought his son with a URTI) - I ended up with a father with lots of questions and a possibility of depression - what must I do?" J1JB

This goes against the belief that one can predict who has a purely physical problem. It also created some tension in what the most appropriate response should be when this was not the presenting problem.

"I still don't know when and if the patient wants to be labelled or treated for a mental problem - especially if they didn't present it to you themselves." J1JB

For some this led to the conclusion that ideally emotional and psychosocial factors should be considered in all patients.

In conclusion this task reinforced the idea that the use of screening questionnaires is not practical for GPs due to issues with the patients, doctors and organisational systems. However they are useful as case-finding tools when the GP has the hypothesis of 'mental disorder'. This task appeared to be a useful educational experience in increasing awareness of the prevalence of mental disorders in primary care.

3.1.5 Use of mental problems checklist

Most learners found the two checklists useful, sometimes combining elements of them both (See Appendix E).

> *"I used the Khayelitsha questions in half the patients and the WHO checklist in the other half. I found the Khayelitsha list was more appropriate to my practice." J2AM*

The concept of testing the general hypothesis 'mental problem' after recognising possible cues was reported to be useful and gave a sense of structure in approaching the issue. In addition this approach was reported to be more practical than traditional approaches based on complex diagnostic criteria or psychiatric models of assessment.

> *"It is not simple to recognise mental health problems, however by using these structured questions it makes it easier to arrive at a diagnosis with some certainty. The mini-mental state examination is not well suited for the busy practices we find ourselves in...Also keeping the DSM-IV criteria within easy reach is not possible. In most instances this is what makes most GPs to be uncomfortable in dealing with mental disorders." J2AM*

> *"Having a specific structure of questions, e.g. looking for the mental cues and building one's questionning around that, makes the diagnosis of psychiatric conditions much easier. I found the WHO question list adequate for pointing the direction and did not really need to add any more questions." J2KL*

> *"The questions to test the hypothesis of mental problems works very good in my consultation as a quick screening test." J7CN*

> *"I have found the mental problem checklist very useful to screen patients where I suspect a 'deeper' problem than just a physical*

problem. The other screening questionnaires helped me to identify a more specific problem e.g. depression. I became much more aware or tuned into the possibility of mental problems." J7HC

Some questions were frequently positive (loss of energy / chronic tiredness) and were not seen to discriminate well between those who really had a problem and those who did not.

"Loss of energy and chronic tiredness also feature as an almost certain 'yes' so I have to be careful when I ask these questions." J2HJ

The addition of PTSD was supported:

"I was surprised at the prevalence of PTSD in our patient population. I never used to enquire about this but will not leave it out again. An example of this is a young girl who presented with non specific abdominal complaints but who revealed after use of the Khayelitsha list that she was raped 2 months ago and has been suffering from severe anxiety, decreased sleep and hyperarousal." J2SN

One doctor reformulated the checklist as a circular diagram to help her internalise it:

"I made a handycard - circle with four parts. It's easier to remember. Depending on the patient in front of me I would formulate a questions to understand the major criteria." J2JB

One doctor used another diagram with a patient to show how mental problems co-exist and to gain acceptance of the assessment.

"Using the diagram of the 6 most common mental problems I could show her that the symptoms tallied up to a diagnosis of depression and

anxiety... She ended up understanding her problem and why taking more analgesics are not helping" J2KH

3.1.6 Use of mental problems flowchart

The flowchart provided a practical and useful systematic approach to the assessment of mental problems, but needed to be internalised by the GP (See Appendix E).

"Although I suspected a mental problem at the beginning the flow chart made me to think about and eliminate medical conditions and medications before considering a mental disorder. Working in this systematic manner ensures nothing is left behind." J3AM

"Using a checklist and a flowchart makes it a less daunting task. Lack of availability of good instruments such as these is one of the things that make GP practice difficult." J3AM

"The mental problem flowchart gave me a systematically approach to access this patient. On questioning he agreed that he was taking a two-hour nap after lunch and went to bed after the seven o'clock news! No wonder he wanted stronger sleeping tablets - he was awake every night at twelve!" J3JB

"Regarding the mental flowchart, I actually did not use it as such, it was lying on my desk, I looked at it between patients and tried to internalize it and use it in the context of the consultation." J3FY

"The mental flowchart helped a lot to put structure to the consultation. Quick referral to it helped me not to leave out important areas of questioning. It is however, impractical to apply the flowchart word for word. For me it is simply a 'referring note'." J3KL

It helped doctors gain insight into the value of a more holistic assessment and to integrate this into their usual consultation style.

> *"I realise that till now I have not seen the patient's problems in their proper context. Being able to identify the problems and the different disease without the holistic situation is insufficient. In most cases this resulted in an unsatisfactory encounter, incomplete treatment and relapse. I also now see that being able to identify all the relevant problems not only aids in the diagnosis, but is crucial in successful treatment." J3KH*

Time was still a constraint.

> *"During this module, I was much more aware of the need to explore all issues with a flowchart in a systematic way. I found myself enthusiastic about each consultation, but still found time a constraint." J3HC*

Doctors reported a more holistic or bio-psycho-social assessment of the patient as being necessary for more effective diagnosis and treatment.

> *"I think the most important aspect I learned from the exercise was to look at the holistic picture, and not to 'zoom' in on the possible medical reasons for every complaint." J3KL*

> *"The 3 simple questions about 'ideas, fears and expectations' put to a patient, often wraps up a consultation in a very short time space and helps to satisfy the patient's needs (and thus have a happy patient leaving the room.)" J3KL*

> *"We see many patients with thick files, many investigations have been done, with no answers. All these patients have all these somatic complaints and are referred from one department to another. A good psychiatric or psycho-social evaluation is needed rather than all these*

special investigations. All of our doctors at EB Hospital should actually do this course, because these mental health problems are being neglected." J3CN

"When I use mental problem flowchart in various patients, it is interesting that most patient's illnesses are associated with either individual or contextual aspects. I am currently treating a 27 year old woman who was suffering from 'chest pain', 'headache' and 'palpitation'. On using the genogram and on doing a three stage assessment, her symptoms were found to be related to her husbands murder." J3SS

"This journal made me realise how important a holistic approach is, especially the three-stage assessment...I also love to use the genogram because it can give you a better and bigger understanding of your patient, and I think they love it too, because you are actually interested in them as a whole." J7CN

One doctor also felt it important to ask routinely about previous consultations with *sangomas* or *inyangas*.

3.1.7 Use of the genogram

Some doctors were already using genograms, whereas for others it was a new idea. Doctors varied from trying to use it with every patient, to using it on 2-3 per day or only those with known mental or family problems. All the doctors found the genogram practical to use in the consultation.

The doctors found the genogram useful for a variety of reasons:

- To reveal family structure, dynamics and patterns of behaviour

"Interesting was that these themes played themselves overtly and covertly out in the way each individual behaved. The role of alcohol in complimenting this behaviour was highlighted throughout her genogram" J3JB

- To make the doctor feel more confident in approaching psychosocial issues

"You must communicate to the patient that you are competent enough to handle his / her problem. A genogram is especially handy for this purpose." J3VB

- To take a fresh look at issues in patients who have been 'coming for years'

"The patients were really surprised as why we are so much interested in their family history. There was new information gathered from the old patient in the practice. We found extended families, divorces, family fights, foster children, adopted children, and families torn apart by violence. It was amazing to see these stories unfolding in front of my eyes." J3AM

"I myself find it very useful in spite of the fact that I knew my patients very good because I am practising in the same area for almost 23 years." J3ML

- To go beyond the usual medical history

"The conversation veers in a new direction which explores points that a usual medical history would not." J3FY

- To assess patients with other medical problems - not just mental problems i.e. cardiovascular risks, retinoblastoma

"I did not just complete the genogram for mental problems. I found it very handy for other diseases such as cardio-vascular problems." J3KH

- To reveal undetected (by doctor) or unconscious (to patient) stressors

"The index patient was the eldest daughter (20 years old) of a single parent family. This time she came for abdominal pains. As I drew the genogram I found the following: Her mother had been widowed since 1993 and her father dies while suffering from a mental illness. Her brother (19 years) has been admitted to a hospital earlier this year for an acute psychotic illness. One of the aunts is suspected of using witchcraft on the rest of the family. After the husband died there was bitter infighting for the inheritance." J3AM

"She could not identify any of these stressors no matter how obviously they may seem. She gained insight into her problem and is on a SSRI presently and trying to piece all the parts of her life together." J3KH

- To help with explaining problems and motivating change to the patient

"It also helped me explain some problems and influences to patients. They could follow this easily." J3KH

Problems included:

- Complicated families with re-marriages and extended families made drawing the genogram time consuming and complex
- Fears about opening up a 'can of worms' and never ending the consultation
- Time needed to draw a full genogram

"I don't seem to get through to him, he is so focused on his BODY, I have not dared to do a genogram on him for fear of never getting him out of the consulting room." J3FY

3.1.8 Use of MAPP

The need to handle psychosocial problems better was one of the learning needs expressed by GPs at the beginning of the course. To deal with the fear of not being able to fix psychosocial problems:

> *"A lack of confidence is difficult to hide especially if the patient is persisting and difficult; but I'm working on it! Psychosocial problems are far more common than I expected!" J3JB*

and

> *" oh no, I have to kill psychosomatic symptoms again." J0KL*

> *"It is still not easy for me to communicate with the patients, because a big part of the population we work with have the common triggers like unemployment, financial problems, domestic violence and ALCOHOL problems. I don't always know how to solve their problems or what advice to give them." J1CN*

The model for approaching psychosocial problems (MAPP) was reported to be helpful:

> *"I was also very glad to see that I was not expected to cure these social problems, because sometimes I feel so overwhelmed by all their problems. It feels as if you want to run away. Number 6.6 of this module [MAPP] really meant a lot to me." J3CN*

> *"Patients realise that the doctor cannot always fix the problem, but they appreciate a 'sounding board.'" J7VB*

3.1.9 Use of specific diagnostic checklists and flowcharts

For some doctors it was helpful to have the materials physically on the desk as a prompt, but for others there was a need to memorise or internalise the materials to the point that they were not referred to in the consultation. This was to reduce any negative impact on the doctor-patient relationship by using them as a doctor-centred list, by breaking the flow of the consultation, or maybe implying the doctor needed help to know what to do.

> *"The lists and charts are easy to understand, but I feel the doctor should know the basic framework by heart. Personally I do not feel comfortable paging through a file in the middle of the consultation. I think this has a negative impact on the doctor-patient relationship." J4KL*

> *"The checklists and flowcharts are a great asset, but I tend to agree with KL that it is mostly unpractical to use it during the consultation but very helpful to reflect on the consultation afterwards." J4HJ*

The specific checklists were reported to be practical and helped build the GP's confidence in making a diagnosis:

> *"These tasks gave me the confidence of approaching any mental illness with a set format that makes sure that nothing is missed during a consultation." J4AM*

> *"I felt very good about reaching a specific diagnosis and exploring the nuances of a particular disorder." J4FY*

> *"For the first time I now feel more confident in mental health to make a specific diagnosis." J4HJ*

Some patients however were still difficult to categorise:

> *"The lady who complained of hearing voices could not be categorised within any of the given diagnoses. She was not psychotic. There was no history of previous hospital admissions for these symptoms. There was no history of substance abuse. Her normal daily routine was not yet affected to any extent by the voices. She was not consulting me primarily for the voices but for an URTI. " J4AM*

The checklist for anxiety disorders created most comment:

> *"I found that I diagnose a fair number of patients with depression but no patients with anxiety disorders or PTSD. I think I need to concentrate on anxiety disorders and PTSD, I fear that I am still missing these disorders." J4HC*

One doctor worried that the diagnostic checklists did not include all the formal criteria used in research, especially for anxiety:

> *"The completeness bothered me a bit but I think these checklists were probably devised to prompt you into thinking about a specific disorder rather then to be complete diagnostic criteria...I found that reading the diagnostic criteria for the common diseases in the DSM-IV helped a lot...some of the checklists seemed quite vague. For instance the diagnosis for agoraphobia no mention is made of the patient avoiding the situation." J4SN*

Further study is needed to explore whether the difficulties with anxiety disorders are due to a lack of recognition of the cues or a mis-match between the given categories of anxiety and the realities of general practice.

3.1.10 Use of handycards

The handycard, unlike questionnaires or leaflets, was a new concept to the GPs. They initially resisted the idea but when it was used found it helpful.

> *"I had to overcome my scepticism - I believed that the approach was too sophisticated for my patients and that they were not interested in so much detail. I was proved correct a couple of times, but I was also wrong on a number of occasions...My notes indicated that he could possible have an alcohol use disorder. I decided to 'take the bull by the horns' and use the handycard to discuss the issue with him. ...Reflecting on this story I am surprised and impressed at the way in which the handycard paved the way for the discussion. " J5VB*

> *"I thought this will take a lot of my time and it did in the beginning, but later I got more comfortable using it as part of my consultation and I realised it was actually easier explaining the problem by going through the handycard than trying to do it in my own words." J5CN*

The handycards were useful too in gaining the patient's acceptance of the diagnosis:

> *"The handycards are very important to me in a patient with an established diagnosis. Patients feel much more at ease and they will accept your diagnosis more frequently if you can show them a factual 'document' describing your diagnosis. If they can identify with it you have a compliant patient." J5HJ*

> *"I saw the handycard in this circumstance as a second opinion..." J5ML*

> *"I find it sometimes difficult to explain a disease or a psychiatric problem to a patient, but with the handycards and leaflets it was much easier and I think the patients also appreciated the leaflets, because*

they could take it home and try to explain to their family as well. I really got some good feedback on these tasks." J7CN

Some felt uncomfortable with referring to a card in front of the patient:

"My opinion is still that it is not practical to refer to a card several times during the consultation. I regard the cards to be more of a study aid for myself." J5KL

3.1.11 Use of patient leaflets

The patient leaflets were used without adaptation in their current format and were given to specific patients - they were not used as information for the general public. The English, Afrikaans and Xhosa versions were used by different GPs. The leaflets were useful in a number of ways:

- They could act as an authoritative voice in the consultation and could facilitate acceptance of the diagnosis by the patient.

  "The information leaflets are very handy, especially in helping to convince some patients that their symptoms are in fact psychological... It makes a huge difference when they see a document from a university that confirms the GP's viewpoint!" J5KL

  "We used the leaflet as a guideline for discussion and I found their scepticism decrease after seeing all these abstract things in print." J5SN

- They provided information to the patient

- They also helped to reinforce and remind the patient of the key messages after the consultation:

  "[it] was very handy to give for the patient to confirm the right diagnosis was made and to familiarise him with the symptoms and signs of the problem, as well as handy tips like the writing of his 'story'." J5JB

  "The leaflets is a resource that the patient can refer to afterwards and don't have to try and remember what the doctor tried to describe to him." J5ML

- They were useful in self-assessment, although the progress charts in the leaflets were of less practical use and required more motivation for the patient to use. It was suggested that another tool for follow up and maybe a rating scale in the records could be useful instead:

  "I have not had much success in getting patients to complete the progress charts." J5KL

  "I found that the information on the leaflet was enormous. It took quite sometime to go through. The section on keeping the progress record was a bit hard to explain. But once the patient found out that he was going to monitor his own progress it became very exciting." J5AM

  "The part of the explanation and what the family should do was much appreciated by the patients, but the record progress was a bit neglected...Maybe the reason was that I followed them up too early and that I should explain more what the purpose of keeping the records were." J5CN

- The leaflets could be therapeutic when the self-help suggestions were followed:

"I also gave him the leaflet to take home. When he follow up I were surprised that he had indeed find a friend to share his experience with - the friend was also in a car accident recently - although not as dramatic as my patient. The leaflet was helpful to him in re-formulating the event. When he was re-writing the event himself he came to the realisation that there was not anything he could do to prevent the dramatic accident and that alone meant a lot to him." J5JB

- The leaflets could also be useful in illiterate patients if there was a literate family member in the house.

"There were no problems with my patients using the leaflets and where literacy was a problem there were kids in the house which helped with reading." J5ML

However other GPs expressed doubts about this.

"I have some doubts about the suitability of the handouts for illiterate patients but would like to use them on more patients and get feedback from them." HC

There was a need to translate the leaflets into more languages, although other members of the health care team could be used to translate the leaflets:

"They were not translated into Zulu. To those who could not use English I asked my receptionist, whom I had briefed thoroughly on these materials, to go through the leaflet with them again after I had seen them. Those that would say they had someone at home who could read and understand English they could be given a leaflet to take home." J5AM

- The leaflets could be used as homework between consultations to save time and also strengthened the doctor-patient relationship.

"The homework I gave the patient and his willingness to do it, showed me that he was eager to get better and to give his co-operation." J5JB

"Information leaflets cut down on the time spent giving such information to the patient." J5AM

There was also a need to get more feedback from patients on how they found the leaflets:

"I have not yet had any feedback on the patient leaflets." J5HC

but the feedback that was received, was positive:

"I also thought that it will be paper wasted to give the patients the leaflets, but some patients gave good feedback and told me I were the first doctor to give them such an explanation and that they actually understood their illness better after reading through it. Their families were also impressed, because they also could understand what was going on with their family member." J5CN

"I am surprised and impressed at the ... interest the patient displayed in the content and his response to the 'homework' in the patient leaflet." J5VB

3.1.12 Motivational interviewing

Motivational interviewing appeared to help some doctors to adopt a more comfortable stance towards behaviour change in their patient's and in particular enabled them to tackle alcohol use disorders.

"I found the concept of stages of change very useful, to categorise patient into the stages and to approach the problem accordingly." J6HC

"The part on motivational interviewing I found to be excellent and I'm really trying to practice it in my consultation. The fact that I realise that patients go through stages of change made it more easy to motivate, because previously I would have become angry immediately if they don't want to listen. Now I am more relaxed about their problem and respect their decision, but I will keep on informing them about the dangers of smoking for example." J7CN

"I feel much more confident in dealing with patients with alcohol abuse / dependency." J7HC

"Through the understanding the 'stages of change' and recognising the stage the patient is in, I no longer shy away from confronting situations requiring drastic changes in life-style e.g. alcohol -drug related problems, obesity, non-compliance, but initiate discussion on the issue. I also no longer expect an instant response - I have become more patient." J7VB

" My feelings regarding decision making has changed during this module. Firstly I thought that I had to give the patient solutions to problems, now I know that it's best for the patient to try and find his or her own solutions, with information and professional help if necessary."

"I feel more confident in handling this part, especially after I realised that patients go through stages of change and that you must respect that and wait for the patient to move to the next stage." J6CN

"This is something I have struggled with for a while. Motivating patients to stop drinking / smoking was a headache because there is such a thin line between doing nothing and telling patients what to do. Recognising the stage of readiness seems to be the perfect answer to guiding these decisions." J6SN

"My feelings did change from not wanting to offend the patient by confrontation and reluctance to be involved, to positive attitude." J6KH

"I feel that module 6 enabled me to in future handle the alcohol problems much more effectively and in a structured manner." J6KL

On the other hand one GP found:

"To me motivational interviewing and specifically the stages of change model is probably even more difficult or time consuming [than cognitive-behavioural therapy and others]... I don't think you as a doctor (and probably a stranger as well) would do any better [at convincing the patient there is a problem]. You will even struggle convincing some patients on more medical subjects like HPT and NIDDM...They listen to what you say, accept it, but doesn't know how to implement it in their daily lives." J6HJ

"I've also seen quite a few patients straight out of rehab who immediately starts to drink again at home. They then come to you for help but what's next (usually they have been to rehab 2-3 times before), I've had patients on rehab in Libertas Hospital drinking while they're there! One of my patient's brothers is slowly but surely drinking himself to death (already has liver failure). He knows it but he's not "ready to change", will probably never be. Your chances to be a motivation / influence as yet another person telling him what he already knows but doesn't want to change are very slim indeed and it will take just as much effort and time as psychotherapy (Isn't it just another word for the same thing?) That why I say the patient must get to your rooms in a ready to change state. Then you will have effect with your motivational interviewing! Up to then the patient will either deny that there is a problem or ignore you like they did the rest of the family.." J7HJ

The other GPs were positive in terms of giving them a useful approach and gave many examples where it had positively helped the patient:

> *"We had another consult a week after and she had already lost 2Kg." J6SN*

> *"Together we decided that she would only be allowed to smoke one cigarette an hour, not before 08h00 and not later than 18h00. She told me that it really helped her - her daughter was also helping her." J6JB*

> *"At this juncture I suspected that Mr P was in the 'contemplation ' phase. I suggested he give the situation some serious thought, gave him the patient leaflet and other literature and made a follow-up appointment for the following week. At the follow-up consultation, Mr P informed me that he wanted to change his drinking habits." J5VB*

> *" Having been down that path before, I decided it was time to confront her with the real issues once more and told her that I thought her real problem was her alcoholism, and asked her whether she had read the leaflet. She responded well to this prompt and told me that she wanted to do something about it, but was scared of the DTs, her husband had also mentioned that she was drinking too much and it was affecting her relationship. She asked whether she could be admitted while she detoxifies?? Maybe over the Xmas period, as she will have her mother in law with her who can then look after the children? Am happy to find that she seems to be in the "ready to change" state." J6FY*

Motivational interviewing was learnt in the context of alcohol use disorders. The handling of patients with alcohol use disorders produced more discussion than any other condition and this seemed to reflect the difficulty GPs have with these patients.

" The other patient I would like to mention is one I have described in a previous module. He was taken through the complete process, from initial consult, detox, in-patient rehab, networking after discharge to attendance of AA meetings and follow-up after relapses. Despite all our joint efforts, with big input from employer, he is still in the wilderness. Initially I took this failure very personal, but subsequently have adjusted.You can lead a horse away from the water, but if he is thirsty……. " J6KH

3.1.13 Problem solving approach

Although very simple this approach was found to be useful:

"I fully agree with the 4 guidelines for problem solving. It is excellent! I used it a lot and the patient definitely benefits from the perception shift." J6HJ

"I explain to her that she should use my problem solving leaflet and we went through it…The nurse went home and told her husband that she approach me. He then agreed to be sent for [alcohol] rehabilitation." J6ML

"Next she needed to brainstorm solutions to cut down her drinking until the admission: stop drinking immediately, stop buying alcohol, mixing wine and soda water instead of gin. She decided to do the last one." J6FY

"Managing some patients will need 'to go an extra mile' and for that one needs commitment and motivation himself. Skills for comprehensive assessment, negotiation and exploring various alternatives are pre-requisite for success in motivation." J6SS

3.1.14 Relaxation techniques

A number of GPs tried these out for themselves and found them effective, but they preferred the shortened version:

> *"I tried out the relaxation technique and the breathing exercises…I experienced a little resistance from myself …I had to remind myself, a few times, not to cut it short and when I did it all the way, I ended up nearly asleep!! So it definitely relaxes! I rather prefer for myself the quick relaxation routine.." J6FY*

> *"I started using the techniques in my own life first, because I found it difficult to guide patients in definite techniques and I haven't been there myself." J6CN*

> *"I have benefited immensely from applying some of these techniques in my life." J6AM*

They were also given to patients and found to be useful:

> *"The young girl I told you about had such good results with the relaxing exercises that she is helping mates during the exams." J6ML/fb*

However these techniques were quite foreign to some patient populations:

> *"Culturally my patient population [Zulu] is not used to counselling, relaxation technique etc. Many of them rather expect 'pill'." J2SS*

3.1.15 Dealing with negative thinking

Much less was said about this and the response was more ambiguous. The technique was difficult for the GPs and therefore also difficult to recommend to the patients:

"I read through the negative thinking handout several times but somehow never started my thought diary." J6HC

"I wonder if a negative thinking patient will put in so much effort [as myself], if even I was forgetting to complete it." J6JB

"I found the part on negative thoughts to be excellent and have been using it in my own life with great effect." J6SN

"She has a big problem with negative thinking and this module's combined principles helped to give a new perspective on a lot of things." J6HJ

3.2 Experience with communication skills

Some learners gained self-awareness of their tendency towards a more closed / doctor-centred style.

"It does feel a bit awkward at first to start paying attention to what you thought comes naturally during an interview. It's like paying attention to how you are breathing. Down the line I realised that I may have thought I was conducting the interviews correctly but suddenly it appears as if I have been shortchanging my clients during the consultations." J2AM

"I recognised myself in the DR CENTRED video!" J2KL

"I realised that till now I have often side-tracked myself with my old approach. Very often I didn't allow the patient to guide me and I tried to charge the bull in the china shop. This must be a reason for some door knob endings." J2KH

Listening to the patient's narrative with an open questioning style and facilitative responses was reportedly useful for patients to present their problems fully, in context, and to express their feelings.

> *"Patients are eager to volunteer information relating to the context of their illness and we ought not to be afraid to pose these questions routinely." J2AM*

> *"Also listening to her I heard what she was trying to tell me and not just what I wanted to hear. Previously I diagnosed her symptoms as what I wanted to fit into my preconceived algorithm of headaches." J2KH*

> *"Once I began picking up on cues and allowing the patient to talk, it was as if a tap had been opened. Suddenly a lot of patients were confiding in me and allowing themselves to express their emotions." J2VB*

It was better than an interrogatory style in obtaining relevant information quickly and easily.

> *"I found that by leaving the patient to finish his / her narrative and with the encouragement of facilitative responses I obtained more information, easier and quicker than if I had to 'interrogate' the patient." J2FY*

Although time was constantly stated as a limiting factor this was not confirmed in practice:

> *"Although initially I was slightly dubious, I was soon convinced that there is more than enough time to allow each patient to tell their story." J2VB*

> *"I also realised it actually takes longer asking all the [closed] questions, rather let your patient do the talking, while you listen." J2CN*

"Proper communication is not time consuming." J7VB

One drawback to this approach was allowing patients to digress away from the point [from the doctors perspective!].

"Open questions sometimes invited a very elaborated response. 'Seeing that I am here now and have the opportunity I better complain of everything that bothered me since the last time I saw a doctor 2 years ago!'" J2AM

Awareness of interruptions by the doctors was heightened and how asking for clarification can also act as an interruption.

"I wanted to kick myself sometimes when it took a lot of encouragement to get the patient to answer only to interrupt to give an opinion or clarify something." J2HJ

Closed questions were used more when under time pressure and when the clinical problem was "clear" to the doctor. They could also be used to force patients into a preconceived diagnostic box. Patients were accustomed to a closed questionning style and needed encouragement to tell their story.

"The old patients in the practice had different reactions like "I don't know if I must say more" or "I don't really know if you need to know such and such" ... I think they reacted like this because they are used to the doctor-centred approach." J2AM

"When I began using the facilitative responses to encourage the patient to tell their story, I found that I needed to prod them quite substantially. At first they seemed hesitant to talk, but I persisted and discovered that often the main complaint was left for last." J2VB

Open questions were useful when the problem was "in doubt" or "vague". The use of summarising was found to be positive, both as a means of structuring the consultation "when a lot of talking was taking place" and for ensuring that the patient's perspective had been understood.

> *"I found the internal summary to be most helpful. This has nearly eliminated the dreaded doorknob syndrome." J2SN*

Allowing patients to tell their story or "vent feelings in an apparently secure milieu" (J1GM) was experienced as therapeutic and this more open and facilitative style "started the healing process" J2VB.
Learners also recognised the importance of asking patients their concerns about their symptoms.

The importance of the doctor's own personal feelings was also identified as an important factor in determining the communication style.

> *"The first patient also brought home to me the importance of the doctor's state of mind. Initially I was certainly not in the mood to see the patient, let alone attend to a 'mental problem'." J2HC*

Problems of language have already been mentioned, although the translation of materials was a useful way of overcoming this. The translator can be another barrier to recognition and assessment:

> *"I believe that a translator in this environment is not very effective as they translate in their own way and many problems the patient does not want to disclose to two people, and maybe the fact that the translator was a friend was a barrier for him to tell me that something else." J3FY*

> *"I'm very excited to try the Xhosa versions of the questionnaire and to learn the most appropriate questions to confirm my suspicions." J0HC*

"I also find the Xhosa translation of the depression questionnaire very useful. I am able to ask questions around feelings, self-esteem, guilt and suicidal thoughts now while before I felt unable to ask these questions…Previously I felt quite disempowered to deal with mental problems cross-culturally. The material has now helped me to have contact on a deeper level with my Xhosa patients." J4HC

While most people aspired to a more mutual and participatory decision making process it seemed that patients often expected a more paternalistic approach.

"In regard to decision making, I often hear: "well you are the doctor, you decide". Which makes me feel like an ant, having completely missed the point with that particular patient. The answer irritates me tremendously." J5FY

"I definitely prefer the mutuality style of consultation but I think I need to be sensitive to patients who prefer a more paternalistic approach. I think patient may experience me as uncertain 'You are the doctor, you decide.'" J5HC

"What I found interesting was that on the video the doctor gives the patient leaflet information and says you can use it for self assessment if you are interested…I thought this was part of the prescription. Shouldn't the clinician be firm on his recommendations?" J5AM

"A few patients seemed to dislike me discussing my thoughts with them - it made them nervous and doubtful about my abilities - but they were in the minority." J5VB

However with other patients

"Most patients will accept your opinion more readily if they feel that you are not dictating, but involving them in the decision making process." J5HJ

"..you can be sure that they have done a lot of reading on the subject. With the availability of the Internet this has increased even more..." J5HJ

It seems that patients from poorer communities in the public sector not only get a more doctor-centred approach, but have come to expect it? Is this a vicious circle where the lack of time, language and cultural barriers on the one hand combine with the patient's less informed and educated starting point and expectations of the doctor as an authority figure, to strip them of participation in decision making? Does a willingness to let the doctor decide imply a lack of questions or need for information as well? Are patient's intimidated and willing to accept that this is how the public medical system works or genuinely not interested in participating in the decision?

"The "seekers" put us through a minor oral examination no doubt about that, whereby the "avoiders" are often intimidated by the hospital environment, the bossy staff to ask anything, although they would like to obtain more information or have information that they can understand." J5FY

"So often patients have a door-handle response of "doctor, what is really wrong with me?" and so often I don't know!" J5HC

"I was surprised how illiterate patients respond to the 'deeper' questions in the depression questionnaire." J5HC

It seems that on the one hand doctors need to be able to offer a range of roles and to be able to engage in a participatory relationship, while at the same time being alert to those who are genuinely uncomfortable with it. Maybe if we aspire to and offer a more participatory option the patients who are intimidated

and disempowered will have the opportunity to choose a different type of relationship?

> *"As the course progresses I realize how paternalistic I am in my approach to the patients. This is partially due to the patient profile I have been exposed to and to time constraints, but it is also because I have never learnt (I didn't realize I lacked them) the skills necessary for "mutuality"." J5VB*

This may also be compounded by the different health beliefs and explanatory models that the patient and doctor are using.

> *"Especially the more illiterate patient wants to know what is wrong and so often in primary care the symptoms and signs are non-specific. Patients often have a specific view like "I have ulcers" or "the child has sores (amaqakuva) inside". Do I also use these terms to explain to patients? In my book an ulcer is an ulcer when it has been confirmed by gastroscopy. To explain dyspepsia can be quite difficult "too much acid in the stomach", it is so much easier to agree that there is an ulcer!" J5HC*

Most of the doctors found the communication skills useful either in developing more effective skills in the consultation or in terms of consolidating prior training with a focus on mental disorders. For a few doctors this produced dramatic changes in their consultations and connections with patients:

> *"The communication skills I still need to work on and improve, but has made a considerable difference, was so used to dominating the interview that I frequently led the patient up the wrong garden path, just so long as I was in control. Too often I decided what the problem was and didn't take the patient's feelings into consideration. I hope to talk less, more sense, and listen more..."J7KH*

"From the outset it was obvious that I sorely lacked the communication skills which encourage patients to discuss their psychosocial problems. I have worked hard at rectifying this, using the skills taught in this course..."J7VB

"The course has made me recognise that I had a paternalistic approach to the patients. Since becoming aware of this I have made a concerted effort to change. This has allowed the patients to relate to me on a different level and the whole tone of the consultation seems to be more relaxed. The patients have noticed the different style and more and more of them are giving me a glimpse into their world. It is vastly different to mine and I now find it easier to understand why so many of them have what I used to term "vague symptoms". Since the start of the course so many patients have cried in my consulting room - something that did not happen often before." J7VB

The doctor-patient relationship was also affected by cross-cultural issues:

"I would like to make a comment about the video on witchcraft. We all know our patients consult traditional healers, as a Christian, I am compelled to warn them about this demonic habit. I am not judging them morally, just warning about the consequence of divination. We were created by God and should rather seek our healing there." J4KH

"I enjoyed the video material on witchcraft and inyongo. I have to grapple with these issues daily in my practice. I have to warn my patients daily about the dangers of laxative abuse. However the big problem is that after they use these things they feel better." J4AM

3.3 Barriers to effective care

Through reflecting on their experiences in the action-reflection cycles the GPs also identified a number of barriers in their various settings which impeded the

process of recognition and management. GPs will need to overcome or at least minimise these barriers if they are to effectively participate in the course and develop a practical approach to mental problems. These barriers may relate primarily to the GP, the patient or the health system:

Barriers that relate to the GP included:

- Language - preventing adequate communication

  "But how to help a patient whose language you don't speak and who will probably not be able to afford the treatment." J0HJ

  "At this point our communication broke down, the translator was not available and I asked her to come back the following week." J1FY

- Insufficient personal skills and confidence

  "The problem at this stage is that after identifying the problem - what do I do? It is not practical or always the solution to merely start every patient with a possible depression on medication." J1JB

Barriers that relate to the health system included:

- The need for continuity of care was seen as a major factor in enabling or disabling an approach to mental problems. Continuity increases knowledge of and insight into a particular patient, builds trust and rapport and disclosure of sensitive problems. Continuity can be used to assess and manage complex problems in a time-efficient manner over a number of visits. Questionnaires and leaflets can be used between visits. If the health system cannot provide continuity of care, especially in the public sector, then the potential for recognition and management of mental

problems is significantly diminished. Continuity of care in the health system may be as important as effective communication skills in the GP.

"No consultation is ever meaningless as with every one you get to know your patients more, so as to make you more sensitive to subtle complaints in the future." J0HJ

"Because of the nature of the practice in the public hospitals, the continuity of care remains a challenge for a patient-centred approach." J0SS

"I have learned that sometimes it takes a long time to gain the patients trust or confidence." J0FY

"I cannot spend half-an-hour with a patient - although I often do - due to enormous workload. So, once I have established that the patient is suffering from a mental disorder, I like to hand out the leaflet and questionnaire and ask the patient to return a couple of days later." J0FY

"I am experiencing a problem with follow up of patients, are they returning and another doctor sees them or are they not returning? I suspect that some of my patients get seen by my colleagues, and then get swallowed by the system, until by chance, I see them again." J4FY

"Once the hypothesis of mental problem has been made it is not so easy to slot the patients in a certain category. I find that the checklist helps a lot in establishing an initial diagnosis, the different disorders overlap and further consultations are needed to pinpoint the mental disorder." J2FY

- Cost - not able to afford treatment in private practice

"I usually treat most of my patients myself, but in this case [Xhosa patient no medical insurance] the lack of good communication as well as financial problems prompted the referral to the clinic." J1HJ

- Limited resources in the area

"I felt overawed, frustrated, knowing time restraints, as well as limited resources available in our town. My capability (or rather incapability) to handle this did nothing to improve my feelings." J0KH

"You can only recognise what you know, but by the same measure it is of little value to diagnose without being able to treat effectively." J2KH

"The other problem is the treatment. The following options are available: imipramine, social worker, the church, family and friends. Maybe after this course I shall have some more options?" J1CN

- Frequently "time" is stated as a major barrier to effective care and also a limiting factor in the tasks. The need to balance the time given to assessment of an individual patient and the time needed to cope with the overall workload was a source of personal stress. The GPs attitude towards the consumption of time by mental problems was also affected by the doctor's ambivalence towards these conditions.

"Time pressure was a factor. I have only an hour to do the clinic; was already late and there were many patients." J0HC

"On some days...I found that the limited time factor plus our frustration and the frustration from the patients that have been waiting for up to 8 hours was very disruptive and the receptivity of patients and myself was definitely not ideal..." J4FY

"I must be honest it did take more time, especially if the patients wants to discuss the questionnaire and not their problems!!" J1JB

"It is impossible to do a proper consultation of this kind in the designated 15 minutes. This adds to personal stress, knowing that the next patient is waiting." J1KL

Barriers that related to the patient included:

- Low education levels and illiteracy in patients

"But unfortunately only a few of my patients were educated. For the others I could not use them [patient leaflets]" J0SS

- Patient's inability to express emotional issues

"The main issue for me was that this patient had difficulty communicating her feelings and emotions." J0FY

- Patient's resistance to be labelled mentally ill

"And then there is the fact that a lot of the patients might not come back, frightened to be labelled as a patient with a mental disorder." J0FY

"I think a lot of patients still think they are crazy or not really sick when you make the diagnosis of depression, so they shy away from that line of questioning. On the other hand, most patients love being asked if they are anxious or stressed..." J2HJ

3.4 Personal resource directories

One of the tasks in the final module was to create a personal directory of community resources and options for referral. For some GPs this was simply a case of updating an existing resource or making explicit resources already known. For others it helped them to explore a wider range of resources to help

in managing their patients. Although time was a constraining factor this late in the course most GPs found this a useful exercise.

> *"Time was a big problem for me, I could not get all the information in time to put it on the computer before tomorrow morning..." J7CN*

> *"Regarding the resources directory, everything is more or less in place for medical-aid patients.." J7HJ*

> *"I actually find it interesting to put it all together, it seems that over the last few months a fair amount of networking has been happening. I'll be adding on in the future to this list." J7FY*

> *"The task was interesting - I actually added a few names to my current list of common referrals." J7JB*

> *"Mental health resources are few and far between in a rural area like ours but I still found it a useful exercise." J7HC*

4. How did GPs change during the distance education program?

4.1 Learning a new approach - change in practice

While change in clinical practice was not measured empirically, the approach to recognition and assessment was reported to be relevant and useful in practice. This approach included awareness of cues, screening for the presence of mental problems, holistic assessment in the 'lobby' and the consideration of a specific diagnosis. For some this was a new approach to assessing patients with mental disorders whereas for others the course made them conscious of skills that they had already been practicing. This insight

allowed GPs to be more reflective and to make conscious choices of particular skills or techniques.

> *"I tend to know and use most of the principles explained here on a daily basis, so there was no need for preparation. It was insightful to see the process explained in this correct order though as I mostly used it "on instinct" previously." J6HJ*

> *"I recognise a patient with a mental disorder with ease now, my confidence regarding the management has also increased substantially. When I see a patient that gives me a cue towards a mental problem, I talk to the patient to try to elicit and psychosocial problem and then I screen him/her with the mental problem checklist and take it from there. I find that all the material from the course is very good. I use the questionnaires a lot, followed by the handycards and the ICD-10 book. " J7FY*

> *"A lady whose husband died of heart attack two weeks earlier on consulted me for chest pains. This complaint had been listed earlier on as a cue for mental illness. I started with open ended questions to clarify some of the issues she had raised. I went on to assess her using the mental disorders checklist. Although she responded positively to some of the questions she could not be categorised definitely into one of the disorders. After excluding physical problems I decided to manage her for stress and possibly an adjustment disorder in the 'lobby' of the practice." J7AM*

> *"This course also provided a framework and a method to handle most of the mental problems I see. This empowers me to not only help myself, but also my patients." J7KH*

A good example of integrating all the course materials together in a patient:

"She was a 60-year-old lady, visiting her daughter for a few days. She came to see me, (according to her the only doctor in 10 years), with a terrible headache, marked anxiety and a big amount of stress...If I were not doing this course I would not have helped that patient effectively. She told me that her previous encounter with a doctor a few years ago only lasted a few minutes. The consultation was a disaster. Taking into account that contextual facts play an important role in recognising mental problems, I used the flow diagram to test the hypothesis of mental problems, and revealed a lot of anxiety and underlying depression. The questionnaire was useful to make the diagnosis of depression easier. She was ready to change because she told me so! She admitted that she was neglecting her health these years and that she had trust in me and that she would follow any advice I would give her. I gave her a voltaren and celestone injection for the marked muscle spasm and unbearable headache. I also gave her a TAD and ponstan capsules. She told me a few sessions later that she had not felt this good in years. She was eager to change, as one can expect it was much easier to practice relaxation techniques, change a diet and even negative thoughts (she told me that the writing down of her thoughts helped her) than to stop smoking. The patients appreciate having a leaflet to take home.." J6JB

Changes in management were reported on less than changes in the approach to recognition, but a broader range of therapeutic options appeared to be developed:

"Yes, I did change. I would try more psychotherapy in future rather than just giving drugs." J6ML/fb

"I must admit that I have changed because I acquired through the course more knowledge and understanding especially to treat alcohol." J7ML

4.2 Changes in attitude and perspective

GPs struggled with whether patient's problems were physical or mental. Two diagnostic models appeared to be at work. The first model saw mental disorders as diseases in a bio-medical framework that must be diagnosed. In this model problems are either physical or mental, physical disorders are emphasised, and mental disorders are seen as uncommon and severe. Some of the GPs appeared to shift in their beliefs regarding this:

> *"There is nothing like 'nothing wrong in this patient'. Often we are unable to recognise his / her problem following traditional paradigm of assessment." J1SS*

> *"The first achievement was to have proper awareness about the presence of mental illness in general practice. As a GP I am usually used to rush for making a diagnosis and 'try to sort out the patient's physical problem'. Module 1 was an eye opener to me to know that I, like many other GPs was missing many patient's inner diagnosis.' J7SS*

> *"We see many patients with thick files, many investigations have been done, with no answers. All these patients have all these somatic complaints and are referred from one department to another. A good psychiatric or psycho-social evaluation is needed rather than all these special investigations." J3CN*

> *"She screened positive but due to her physical unwellness I decided to leave our discussion until after her next visit when we will have the Xray report and the rest of the tests back." J1FY*

> *"Most importantly it had a great impact in awareness in the extent of mental disorders in my practice. When I used to think of bipolar illness, major depression, schizophrenia, manic episodes etc. Now I also think*

of many other conditions like sleep disorders, GAD, unexplained somatic complaints etc." J7SS

"Previously I had the idea that mental disorders are part of a special group of people who fit in the DSM-4 category, not necessarily a young healthy adult with insomnia." J7JB

In the second model all illness is seen as having an impact on the person's physical health, psychological health and context. In this model it is not necessary to separate the physical from the mental but to consider and assess them simultaneously in a systems approach.

"It became evident to me that, through three stage assessment, allowing patients to express their feelings and through mutual participation in drawing the genogram [one can] enhance the diagnostic ability to a great extent." J7SS

"In this case it showed that a systems approach including genograms are useful in patient assessments." J7AM

"This journal made me realise how important a holistic approach is, especially the three stage assessment." J7CN

"The course makes me to explore that mental health should be seen in a broader context, family members, friends, a household, workplace etc." J7ML

However, even in the realm of psychiatry there was a need to separate conditions into physical and social. Recent advances in neurophysiology have also enabled mental disorders to acquire a bio-medical explanation.

"The contextual aspect brought out quite a lot of information especially when trying to separate between social problems and chemical depression." J1SN

"I modified the depression leaflet by including a drawing of a synapse to explain the chemical basis of the illness. While patients may not remember all the jargon, some actually know a bit about the illness and I think that it helps the patient understand that this was not something they brought onto themselves, but that there is a scientific reason for their feelings." J5SN

Mental problems were found to be more common than previously thought and greater awareness of mental disorders was experienced.

"Mental problems especially depression is more common in general practice than I previously thought." J0SS

"Module 1 was an eye opener for me to know that I, like many other GPs was missing many patient's inner diagnosis." J7SS

"Although I am aware of the high incidence of physical violence, sexual abuse as well as drug and alcohol related problems in this community, I often forget to formulate a psychological hypothesis." J0VB

"But suddenly something came to my mind which has never happened in my previous encounters with this patient - this patient must be having major depression and I had never recognized it in any of my previous encounters." J0SRP

"To my surprise nearly a third of the patients that I asked to complete the questionnaire screened positive. My attitude has changed completely and I find that I need to include the CAGE questions in my medical history." J1FY

"Mental problems are more common than I expected, in patients I didn't expect!! I had to open my eyes and mind and be less afraid to ask patients about their feelings." J1JB

GPs reportedly changed their assumptions about who could develop mental disorders.

"It also shows that mental problems can arise at any age and I must not assume that young people are immune to life stressors." J0VB

GPs reported that there was an increased willingness to ask about mental problems - in particular alcohol problems.

"Due to the high incidence of alcoholism in our area, I have stopped asking about this. It has now become part of my history again." J1SN

GPs reported more empathy and appeared less judgemental towards their patients:

"I was dismayed at the frequency of domestic violence, regular exposure to traumatic events and ongoing subjection to extreme life stressors. I am realising that I don't really know or understand the circumstances under which my patients live - they are vastly different to my own." J1VB

"Patients are not malingers, they give definite "cues" when they are experiencing psychosocial problems and they desparately need the doctor to recognise and act on them." J7VB

"Insights into my own attitudes and beliefs, yes, I find myself relaxed and tolerant with other peoples ideas and beliefs, not judgemental and I seemed to get closer to a large number of patients. I feel that I have found a field of medicine that I enjoy and want to persue." J7FY

GPs reported more confidence in handling mental disorders through having a clear approach to follow in the consultation:

> *"I have learnt that mental health problems contribute to over 50% of my family practice…My practice has changed during the course in the sense that I am now more aware of mental problems and the course made me more confident to handle more problems myself." J7ML*

> *"I am no longer intimidated by psychosocial problems in my patients." J7AM*

> *"I have become much more aware but also more confident in dealing with mental problems in primary care." J7HC*

> *"I feel gradually more confident now that I don't have to run away from many of the psychiatric conditions I may encounter in the practice." J4AM*

The course also enabled learners to grow and develop in themselves:

> *"The best thing about this course is getting to know myself, being able to improve my strong points, discard the bad and acquire plenty of new skills." J5VB*

> *"I benefited as much as my patients - I learnt a lot about myself and feel I have grown emotionally. I have become less judgemental - not only of my patients, but of people in general." J7VB*

> *"The course has strengthened my belief of a need to look after my own health." J7AM*

> *"I did the stress resistance test and found to be excellent resistance to stress…I think it was the journal on relaxation skills that helped me." J7CN*

"I also learned something about my own mental health stand by the grace of God and by that alone." J7KH

"I now know that I am also vulnerable to stress and that I cannot expect to relate in exactly the same way each day - I am less hard on myself. I also realise that my standards are not necessarily the standards others set for themselves and are not necessarily correct." J7VB

SUMMARY

The GPs gave detailed feedback on how they used each of the desktop tools and how these could be adapted to make them more useful. The majority of the GPs engaged with the action-reflection cycles, although they experienced some tension around the process of change and found the reflective journals too repetitive. GPs responded well to the material and tasks on communication skills and showed a depth of insight and change in practice that was unexpected. GPs experienced some initial technical problems with the Internet but quickly adapted to this environment and found it to be an effective learning process. Interaction between students was limited and this needs to be addressed. The learning needs and intentions of the GPs were largely synergistic with the programme and emphasised skills in recognition and management more than simply acquisition of knowledge. A number of barriers to effective learning and change in practice were identified. In addition the dilemma that GPs face in balancing bio-medical or bio-psycho-social models of illness was highlighted. GPs reported significant changes in their approach to patients with mental disorders, their assumptions, attitudes and beliefs as well as in their ability to recognise and manage patients.

CHAPTER EIGHT - DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

"... the primary purpose of action research is not to produce academic theories based on action; nor is it to produce theories about action; nor is it to produce theoretical or empirical knowledge that can be applied in action; it is to liberate the human body, mind and spirit in the search for a better, freer world." (Reason 2001)

In this quotation Reason alludes to the essential emancipatory nature of action research, and the impact that this has on the participants and their communities. It is not possible to experience this dimension fully in a written thesis, however this chapter will attempt to outline the different types of knowledge that are contributed by this research. This new knowledge and knowing will be discussed under 3 headings:

- The development of methodology
- The action findings
- The theoretical findings

The development of methodology

Action research is a relatively new approach in the field of medicine, although it is well established in the fields of education, management and social sciences. One feature of this research has been the novel development of and application of action research methodologies in the field of family medicine and medical education. The adaptation of the co-operative inquiry group to the development of educational materials and the use of action inquiry to explore the way that GPs engage with the distance education programme illustrates how these methods may be useful to other medical researchers. I believe that this way of doing research 'with people' rather than 'on people' will be of particular interest to the discipline of family medicine. In his opening address to the 16th World Congress of Family Doctors on May 14th 2001 the US

Surgeon General, Dr David Satcher, listed four key roles for the family physician in the 21st century. The third of these was to bridge the gap between science, practice and policy. The methodology of action research, by closing the theory-practice gap, is ideally suited to this task and this study complements the steps that Macaulay et al.(1999) have already taken in embracing this approach. These methodologies have been fully discussed in Chapters 3 and 6 respectively and only the key points are summarised here.

Within a paradigmatic discourse action research can be said to fall within an emancipatory-critical paradigm (Smaling, 1992). Although there were undoubtedly various pragmatic reasons for choosing this paradigm, I have argued that given the goal of this research was to produce a practically useful educational programme, this was the most sensible approach. The characteristics of this paradigm, from an ontological viewpoint, sees man as an emancipator and epistemologically there is a consensus view of truth. From an axiological perspective there is a desire to realise a particular view of life and society, for example in the liberation of oppressed communities. Methodologically this paradigm has its own concepts of quality that in relation to the co-operative inquiry group have been defined as: alignment with purpose, ownership of the inquiry process, reflectivity, genuine participation and collaboration, commitment to practical action and experience, documentation, transferability and construction of practical knowledge. Within this methodology both quantitative and qualitative techniques can be used as appropriate.

The main issue that we struggled with in the co-operative inquiry process was the effect of starting the action-reflection cycle with a pre-determined action - to use the WHO educational package. Much of the initial resistance to using the WHO package and divergence of the personal and research inquiries, within the thematic concern of improving recognition and management of mental disorders, can be ascribed to this. However by continually refocusing the group with the purpose of this research these initial problems were largely overcome by the end of the 6-month action-reflection spiral.

In the action inquiry process, that evaluated the distance education programme, the principle of participation and collaboration in the inquiry was limited due to the registration of GPs who were mainly concerned with an educational and not a research agenda. The use of reflective journals as both the main mode of learning for the GPs and of observation for the researcher placed limits on the achievement of fully informed consent, as GPs were unable to complete the course without providing data for the research. Nevertheless none of the learners expressed concern with the research agenda, which was explicitly stated.

According to Malterud (2000) the reflectivity of the researcher is an important standard or measure of quality and is affected by both his or her preconceptions and metapositions. In this study I have attempted to account for my preconceptions and 'subjectivity' by discussing this explicitly in Chapter 3. My background as a family physician is rooted in a patient-centred clinical method and commitment to a holistic approach to the patient. This has undoubtedly been part of my positioning as a researcher in this study. The way in which I have balanced action and reflection throughout the study has been discussed fully in the methodology. This is what Malterud (2000) refers to as the researcher's metaposition or strategy for creating adequate reflective distance from the study setting.

Another important concept is that of transferability, which refers to the extent to which the study findings can be applied beyond the context of the study. The context of this study has been described, but may be summarised as that of general practice in both the public and private settings in South Africa and spanning both primary and secondary levels of care. The context of the co-operative inquiry group was limited by the lack of rural GPs and absence of the district hospital setting. The GPs came from urban and peri-urban settings within both public and private practices. In the action inquiry however more than half the GPs came from rural settings with both primary and district hospital levels represented. This study therefore can report on the experience and learning of GPs from the majority of typical settings in South Africa. It may be difficult however to transfer the findings to other primary care providers

such as the clinical nurse practitioner. It may also be difficult to transfer some of the findings to other countries where web-based education is limited by a lack of technological infrastructure. Many of the theoretical findings as they relate to educational strategies and models of the consultation, presented below, will I believe be possible to transfer to general practice contexts elsewhere.

The process of knowledge construction for the co-operative inquiry group and interpretation and analysis for the action inquiry have I believe been clearly and systematically described. The quality criteria used to assess the validity of both the co-operative inquiry group and action inquiry have also been clearly listed and discussed in the chapters on methodology.

Action findings

One of the strengths of an action research study is that the results are already implemented in the research. In this case the research has resulted in a distance education programme that in itself is a practical validation of the usefulness of the research. This programme is the first formal introduction of the WHO programme into Africa and the first time, internationally, that the programme has been adapted for web-based distance education. For those who read this thesis the course may be found at http://learn.sun.ac.za and guest access obtained by using the user name and password 'bobguest'. The print materials may also be viewed on the website.

The action inquiry resulted in a number of specific recommendations of how the distance education course should be furthered adapted and changed. These are listed in the box below:

1. The action-reflection cycles were a useful learning experience, but the format of the journal needs to be changed to make it more stimulating and varied. In order to accomplish this the journal will be replaced by:

- A structured logbook of all patient encounters with mental disorders. This can be analysed both qualitatively and quantitatively by the learner during the course and reported on in their journal.

- A structured feedback form at the end of each module on the course materials, separate from the journal.

- A variety of structures for the reflective journals, that change with the different tasks.

2. The modules should be lengthened to allow time for more exposure to relevant "cases", especially in module 6 that deals with therapeutic skills. An increase from 2 to 3 weeks per module should be considered, or at least a reallocation of the available time between modules.

3. The interaction of students with each other was also limited by the amount of time required for the course each week. This interaction can be enhanced by creating group tasks as well as individual tasks and by the creation of safe, confidential and tutor-free communication within a virtual 'student bar'.

4. The study time of 2-4 hours per week was an underestimate and 6-8 hours per week is more realistic.

5. The questionnaire is a useful tool for case-finding in general practice, but its use, as a screening instrument was not supported.

6. The materials should be further translated into other languages such as Zulu and Sotho.

7. The program should include more material on substance abuse (dagga) and the follow up of schizophrenic patients.

8. The program should use books that have more in-depth material than the Handbooks. In 2001 Oxford University Press (Southern Africa) will publish a Textbook of Psychiatry and this would be a suitable replacement.

9. The books were more useful in hardcopy than electronic pdf files and in future should be mailed out with the printed material.

10. Clearer instructions are required on how to save and attach files in the bulletin boards.

11. The use of private mail and chat rooms was of little practical use and can be omitted in future courses.

12. The checklist for anxiety disorders needs to be clarified and more detail added to distinguish the different conditions.

13. The material on motivational interviewing needs to be reviewed, particularly the distinction between brief motivational interviewing skills for general practice, included in this program, and training in more comprehensive techniques.

Theoretical findings

A recent review of mental health services research in Southern Africa found no articles written by primary care providers, who were not specialised in psychiatry (Thom, 2000). Therefore this study is unusual in being conducted by a family physician and from a primary care perspective. Furthermore the reported adaptation and evaluation of the WHO programme in other countries has been primarily by mental health specialists. When the WHO educational package was evaluated by South African general practitioners in a co-operative inquiry group a number of specific changes were made as summarised in the box below:

1. A new section entitled 'mental problems' was created. This section incorporated sleep problems, unexplained somatic complaints and chronic tiredness, which were dealt with as discrete diagnoses in the original materials. It included a mental problem checklist and flowchart for assessment as well as a handycard for explanations and planning. A number of leaflets were written that could be combined as required and did not relate to any specific diagnosis:
   - Relaxation techniques
   - Problem solving
   - Dealing with negative thinking
   - Sleep problems
   - Chronic tiredness
   - Unexplained somatic complaints
2. The remaining WHO materials were adapted for local cultures, circumstances and languages.
3. Post traumatic stress disorder was added as a new condition and a checklist, flowchart, handycard, questionnaire and patient leaflet created.
4. The final package therefore dealt with the following conditions: mental problems, depression, anxiety disorders, alcohol use disorders and post traumatic stress disorder.

When this adapted WHO package was incorporated into a web-based distance education programme the experience of the GPs with this programme can be interpreted using two conceptual frameworks. These conceptual frameworks are presented below and can be understood as the "analyst's reading glasses" (Malterud, 2001) in the sense that these are the lenses through which I attempt to make sense of the research findings. The first conceptual framework, which attempts to make sense of the GP's beliefs, attitudes and reported experience of change, is taken from the work of Argyris and Schon (1974). This conceptual framework also builds on the concept of the bio-medical, reductionistic versus a bio-psycho-social, holistic clinical method (de Villiers, 2000). The second conceptual framework attempts to make sense of the relationship between the educational programme and the

different phases of the consultation. This second conceptual framework is presented as a model of the consultation and although the content of this model is constructed from the findings of this research, the design or layout of the model mirrors that of the patient-centred clinical method as presented by de Villiers (2000).

In the first conceptual framework Argyris and Schon (1974) discuss theories of action, which try to explain how thought and action are inter-related. Behaviour is seen as a consequence of the theories of action held by the person. It is possible to differentiate between the "espoused theory of action" and "theory-in-use". The espoused theory is the theory to which he or she gives allegiance and which is communicated publically, the theory-in-use is the theory that actually governs his or her actions. The theory-in-use contains assumptions about self, the other, the situation and consequences of actions. Our theory-in-use is associated with various governing variables, which are regulated and maintained. The actions that result from the theory-in-use tend to shape the behavioural world within which they occur in such a way that the theory-in-use is positively reinforced. The theory-in-use can be construed from the actions and practices of the person observed. The following discussion focuses on the theory-in-use that I construed from the reported practice and reflective journals of the GPs as well as the findings of the co-operative inquiry group. How can a theory-in-use be changed? Usually this happens through the surfacing of major dilemmas that force a revision of the theory-in-use. These dilemmas may be due to growing awareness of incongruity between the espoused theory and theory-in-use, inconsistency between the governing variables and the theory-in-use or increasing ineffectiveness of the governing variables.

How can this help in understanding change in the GPs? In both the co-operative inquiry group and the action inquiry the theories of GPs towards patients with mental disorders may be construed. These beliefs and attitudes were characterised by a fear of missing physical problems, a fear of being overwhelmed by mental problems, a belief that patients with mental problems may be fooling the GP or malingering, a belief that mental problems are

usually severe and uncommon, a belief that patients with mental problems are difficult and that there is not enough time to address these psychological issues. Many of these beliefs and attitudes among GPs have also been reported in other research as discussed in Chapter 2. At the start of the course therefore many of the GPs were operating with a theory-in-use that I have labelled model 1 (Table 8.1).

During this educational experience GPs reported changes in their beliefs and attitudes. These changes were characterised by a new belief that mental disorders are common, frequently missed, and present in all parts of their practice population. GPs also reported less judgement and rejection of these difficult patients while at the same time a new confidence in assessing and managing them. This new confidence was related to having developed a more systematic and holistic approach to recognition, assessment and management. I have labelled this new theory-in-use as model 2 (Table 8.1).

One interpretation of this is that in a typical consultation with a patient who has a mental disorder the GP, operating in model 1, becomes frustrated because the problem does not fit into his theory-in-use. As a result he experiences tension that is characterised by a low sense of effectiveness with this patient and little control over the problem. Instead of questioning his theory-in-use he rather maintains the status quo by labeling the patient as "difficult" and resolving the dilemma by saying to himself that the patient is a "malingerer", or "neurotic" or that there is not enough time to deal with these issues. As a result the patient is rejected. Another possible outcome is that the GP continues to seek a solution within the frame of his theory-in-use and this may lead to multiple physical investigations or referral. A consequence of this is that mental problems remain hidden and undetected.

Models 1 and 2 can be related to the current discussions in family medicine about the most appropriate clinical method for GPs. Model 1 relates more to the bio-medical, doctor-centred, paternalistic clinical method and model 2 to the bio-psycho-social, patient-centred, and shared clinical method (de Villiers, 2000). These ideas are also shown in Table 8.1. Doctors are trained in a

Table 8.1. Models of GPs theories-in-use.

Model 1	Model 2
Physical disorders are more important than mental disorders and should not be missed Patients symptoms are either due to a physical or a mental disorder Mental disorders are severe and relatively uncommon i.e. psychosis, bipolar disorders There is not enough time to deal with mental problems It is difficult to be sure that a patient has a real mental disorder	Physical and mental disorders are both important and should be assessed at the same time Illness usually has both physical, mental and contextual aspects Mental disorders and problems of living are common A systematic and holistic approach can help with time constraints Mental disorders can be positively and confidently identified
Bio-medical clinical model Doctor-centred consultations Unilateral decision making Doctor as curer Technical skills	Bio-psycho-social clinical model Patient-centred consultations Mutual decision making Doctor as healer Communication skills

culture that legitimizes, values and skills them in the diagnosis and management of physical and bio-medical problems. The emphasis is on therapeutic interventions and technical skills applied to a relatively passive patient. This culture also sees the mind and body as separate. There is a belief that the physical and psychological are separate diagnostic categories and problems must be placed in one or other of these containers. In addition traditional hospital based training often exposes students more to severe psychiatric disorders. Recent research into neurotransmitters and genetics is

giving mental disorders a "physical" or chemical persona that allows the diagnoses to be legitimized in the bio-medical culture. I would argue therefore that our training and enculturation as doctors prepares us more to operate primarily in model 1. I would propose however that the recognition and management of common mental disorders, so called sub-threshold conditions and problems of living, especially in poor communities, requires a different approach and a different theory-in-use, characterised as model 2.

The materials originally produced by the WHO are more consistent with a model 1 theory-in-use. They emphasise diagnostic categories and a bio-medical model with diagnosis and treatment. In my view the traditional undergraduate curriculum, including psychiatric training, has also tended to support a model 1 theory-in-use with an emphasis on the more severe hospital-based psychiatric disorders. In this way many GPs in South Africa may have been programmed to be ineffective in the recognition and management of mental disorders in primary care.

What may be needed is a fundamental shift in the theory-in-use accompanied by changes in the underlying assumptions and governing variables. It is possible that such a change can happen spontaneously through the surfacing of major dilemmas and an ability to learn from experience. However the purpose of education and training is to facilitate this change in a wider number of people and with less of a convulsive process.

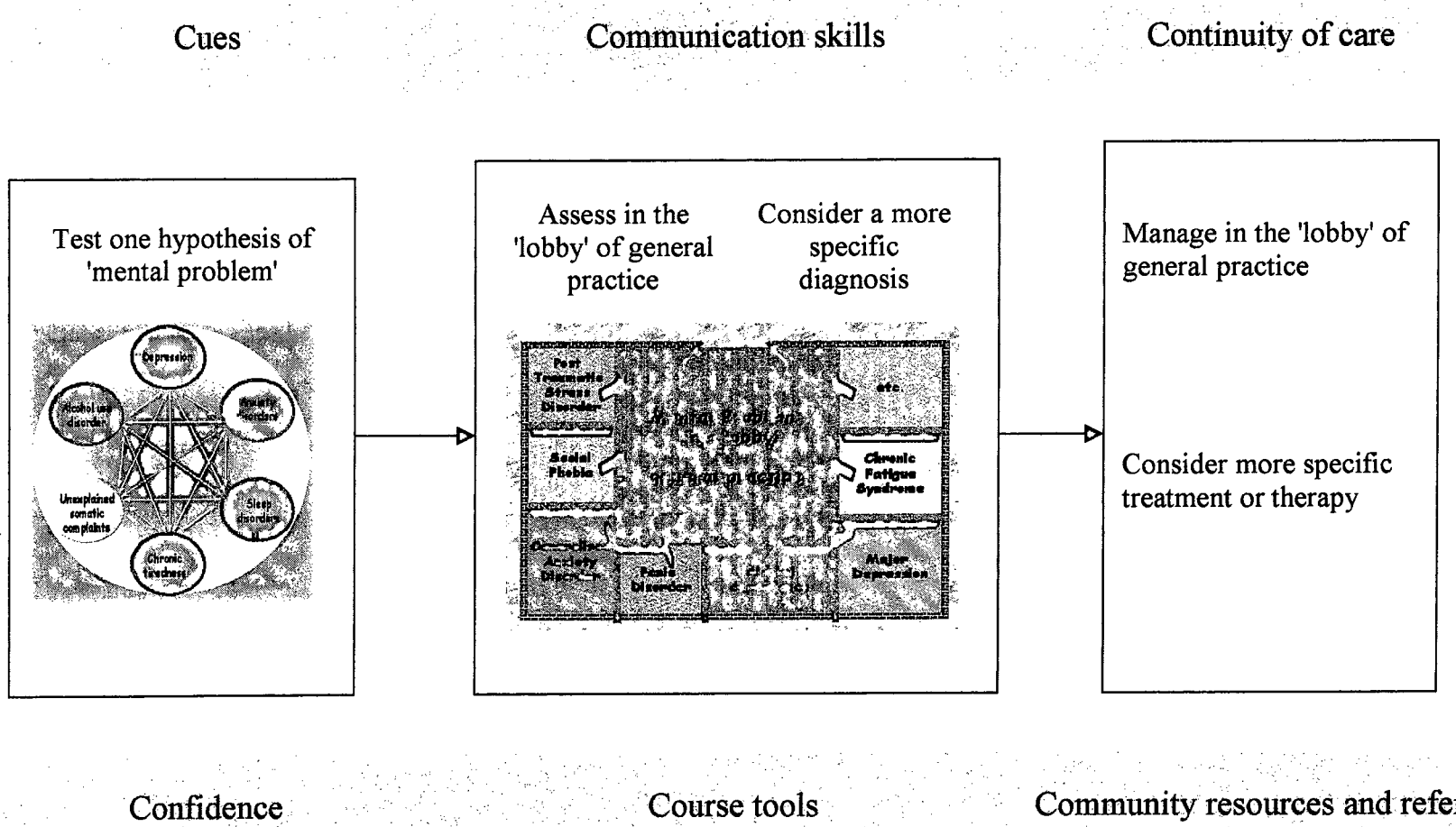
Therefore education programmes should not primarily be about learning diagnostic categories, as the original WHO materials suggest, but about enabling GPs to move from model 1 to model 2. Updating knowledge was a pre-disposing factor in enabling GPs to change their practice rather than an end in itself. How was the course effective in doing this? As moving from model 1 to model 2 requires a change in underlying assumptions and beliefs with regard to mental disorders these changes should be seen as fundamental to the shift required. The grounding of the course in actual clinical practice with action-reflection cycles enabled GPs to be faced with real life inconsistencies and incongruities and a safe environment within which to

reflect on this. The course provided GPs with an alternative theory-in-use to make sense of these dilemmas and a series of simple tools that facilitated change from model 1 to model 2. These tools were not used permanently, but as approaches consistent with model 2 that could be internalised and integrated into a new theory-in-use. GPs were not coerced into using or adopting the materials, but allowed to adopt, reject or modify all the materials. This was particularly important in reducing resistance. The course was less effective where GPs failed to engage with the materials in their actual practice and resorted to giving their theoretical opinions divorced from actual experience. From this it can be seen that the two most important factors in the learners was an openness to change and a willingness to test the materials in their actual practice.

The second conceptual framework is shown in Fig 8.1. This attempts to make sense of the relationship between the educational programme and the different phases of the consultation. The consultation in this model is assumed to be with a patient who has a mental disorder, which needs to be recognised and managed. This model also provides a conceptual framework that can guide educational design, teaching and learning in this area. Desktop tools that can be used in the consultation have been developed to support each step within this model. The model is also consistent with the patient-centred clinical method and communication skills that have been shown to be effective in general practice (Silverman et al. 1998). This consistency is also important, as I believe it highlights the inappropriate recommendation by psychiatric texts of a separate clinical method for use by GPs (Baumann, 2001). This psychiatric clinical method, while being useful in patients with severe psychiatric disorders in a hospital context, is I believe not useful for the bulk of patients with common conditions such as depression and anxiety disorders in primary care. I also believe that GPs will find it easier to integrate new skills into a model that is consistent with a clinical method that can be applied to all patient encounters

At the top and bottom of the model I have defined 6 governing variables for

Fig 8.1. Educational model for the recognition and management of mental disorders



effective recognition and management. These may be remembered as the 6 "C"s. Previous recommendations for the training of primary care providers also highlight some of these governing variables, for example the need for good communications skills, continuity of care and knowledge of community resources (Goldberg and Gater, 1996). This study however confirms the importance of these factors and goes further by showing how these recommendations can be integrated into a model of the consultation that is practically useful for general practitioners. This study also shows how specific educational tools and strategies can be created to support each part of this consultative process.

The six "C"s of effective recognition and management of mental disorders in primary care:

Cues: Preparing to recognise mental disorders

GPs may fail to recognise mental disorders because of deficiencies in their prior training and experience that have not led to the formation of psychological "illness scripts" that are relevant to general practice. An illness script is an internal mental construction that GPs use to recognise clinical conditions. It is a combination of data from patho-physiological knowledge, the experience of many previous cases and of their practice population (Schmidt et al. 1990). By making GPs more conscious of the presenting cues and allowing them, through experience with identified cases, to incorporate these cues into new "illness scripts" the course can prepare the GPs to better recognise mental disorders. This step highlights that it is not sufficient to learn diagnostic criteria divorced from how these conditions present within the undifferentiated symptomatology of general practice. In addition, although research projects have used screening questionnaires to measure the ability of GPs to recognise mental disorders, this study does not support their use as a clinical strategy for improving recognition. A consensus of important cues for mental disorders was developed from the experience of the GPs as shown on pages 124 - 126. In addition a single illness script for 'mental problems' was developed. This single hypothesis gave GPs a way of considering mental

problems in the consultation alongside other physical hypotheses. This single hypothesis gave GPs a sense of confidence and efficiency, and was easily incorporated into the consultation.

Communication: Enabling the recognition and management of mental disorders

The experience of GPs in this course (pages 151 to 158). supports the literature that shows that effective communications skills are a pre-requisite for effective recognition of mental disorders (Goldberg and Huxley, 1992). The course suggested that it is possible to learn communication skills at a distance without any face-to-face contact by a combination of theory, video illustration and practical tasks. This was unexpected as traditionally communication skill training involves direct observation and feedback. These communication skills can be naturally extended into therapeutic skills such as brief motivational interviewing and problem-solving

Continuing care: Enabling the assessment and management of mental disorders

The experience of GPs in this course highlighted the importance of continuity of care, especially in situations of high workload, in enabling time-efficient and effective consultations that support a progressive approach to assessment and management. The assessment process for mental disorders may take several brief consultations in situations of high workload and will be disrupted by a break in the continuity of care. It is a challenge to the managers of the health system to nurture continuity of care. The main barriers for South African GPs to change their practice in this area were identified on pages 158 - 162.

Confidence: A pre-requisite for change

One of the main themes to emerge from the GPs was a need to feel confident in their approach. GPs were not willing to engage with problems where they

felt out of control. GPs needed simple tools and relevant information to make them feel safe in both the process of recognition and management. As already discussed this shift in confidence can also be understood in terms of changes in the GP's underlying beliefs and attitudes.

Course tools: Facilitating change

The provision of simple desktop tools that could independently strengthen each of the steps in the process of recognition and management was useful in supporting change, maintaining confidence and facilitating the internalisation of a new model 2 approach.

Community resources and referral:

The final task in the course on identifying a local resource directory strengthened the GPs ability to assist patients with a wide variety of mental and psychosocial problems. In addition the absence of specialist support inhibited GPs from recognising conditions that they felt unable to handle.

The method:

In the centre of the model the process of recognition and management is presented. While this is shown as a linear and progressive process in reality the steps may be blended together and GPs may cycle back to earlier steps when necessary. The recommendation of a biopsychosocial approach and the teaching of specific diagnostic criteria and therapies is not a new finding (Novack et al. 1989). However the concept of testing one hypothesis of 'mental problem' and the practical application of this is a unique contribution. The concept of the lobby as an explicit and acceptable step in the process of recognition, assessment and management is also new although in the desk top tools it has been formulated along the lines of the three-stage assessment and plan as described by de Villiers (2000).

Testing the hypothesis 'mental problem'

GPs suggested and confirmed that this is a useful and practical approach to recognition of the common mental disorders in primary care. The six most common disorders are initially considered as one hypothesis due to their significant overlap in presentation and co-morbidity. In the mental problem checklist a number of case-finding questions were developed to test the hypothesis.
It allows a psychological hypothesis to be explored quickly and efficiently at the same time as physical ones, without the need to consider a host of different conditions. In this respect it enhanced the confidence of GPs in their ability to address mental problems. It was not seen as a diagnostic outcome per se but as a stepping stone in the process of recognition and assessment.

Assessment in the lobby of general practice

The concept of the lobby was also suggested and found to be useful. The lobby is an open assessment and management area where patients can be seen holistically without necessarily labeling them with a specific psychiatric diagnosis. This recognises the nature of general practice that handles uncertainty, sub-threshold and sometimes unclassifiable conditions. The GP can make sense of these patients and legitimately manage them without trying to force them into a diagnostic box. The mental problem flowchart, which incorporates the use of a genogram and approach to psychosocial problems, is used to support a clinical, individual and contextual assessment. The ICD-10 Classification system either does not recognise this aspect of general practice or provides diagnostic categories such as 'adjustment disorder' that are practically unhelpful for both the patient and GP. In addition the concept of the lobby allows local expressions of emotional distress or so called culture bound syndromes to be accepted without necessarily needing to impose an ICD-10 diagnosis.

Considering a more specific diagnosis

Part of assessing the patient holistically in the lobby is to consider whether a more specific clinical diagnosis should be made. Conceptually they would then enter a side-room where further diagnosis and specific treatment or therapy can be planned. Ideally these diagnoses should lead to specific evidence-based interventions that the GP can offer to the patient. Each diagnosis has a questionnaire, diagnostic checklist and flowchart to enable case-finding.

Management

All patients in the lobby can be managed holistically by considering the clinical, individual and contextual aspects of their problem(s). A mental problem handycard was developed to assist with this. In particular an approach to managing psycho-social problems is required. A number of generic leaflets were written to address common problems and non-drug therapies. Patients with a more specific diagnosis can in addition be offered more specific interventions. A handycard and patient leaflet to assist with explanations, planning and management, supported each specific diagnosis.

Implications for future education and research

The action research methods developed here should be explored further in relation to other common dilemmas of general practice that require closure of the theory-practice gap and change in clinical practice. For example, how to improve the care of diabetic patients, how to enable young women to negotiate safe sex practices with their partners, how to improve adherence to TB treatment. In particular the development of a South African network of participatory action researchers in the field of health should be considered. There may also be place for a Handbook that describes these methodologies and gives local examples.

The action research findings will be reported back to the WHO and incorporated into the design of the next edition of their program 'Mental Disorders in Primary Care'.

The action research findings with this course on mental disorders are now being used to develop a Masters Degree in Family Medicine by web-based distance education at Stellenbosch University. The learning of key family medicine skills and theory in an integrated way within a clinical topic has been adopted as a key design element.

In addition the preparation of undergraduates to recognise and manage mental disorders in primary care may require a different approach to that currently taken. The type of skills required may be best learnt in a community based setting and with tutoring from family medicine as well as psychiatry (Goldberg and Gater, 1996). The incorporation of the findings of this study into the training of undergraduate students should be considered by the Medical Faculty at Stellenbosch University.

The purpose of this research was to adapt the WHO materials and develop practically useful educational materials for GPs in South Africa. In the final analysis however, managers and planners will want answers to the following questions. Was there any change in the recognition and management of mental disorders? Were the outcomes of the patients improved as a result of this course? These questions are not addressed in this research which focused more on the process of the educational encounter and how to improve the educational experience for GPs. One strength of this research study is that the findings have already been implemented as part of the research process in the creation and modification of a web-based distance education programme. The next step in the research journey could be to further evaluate this programme in a clinical trial within the empirical-analytical paradigm. This empirical research could measure and quantify outcomes such as changes in recognition and management of mental disorders by GPs as well as patient outcomes.

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Mental Disorders Checklist

Depression

Yes

I. Low mood / sadness.....❑
II. Loss of interest or pleasure .....❑
III. Decreased energy and/or increased fatigue.....❑

If YES to any of the above, continue below

1. Sleep disturbance .....❑
   difficulty falling asleep
   early morning wakening
2. Appetite disturbance.....❑
   appetite loss
   appetite increase
3. Concentration difficulty.....❑
4. Psychomotor retardation or agitation .....❑
5. Decreased libido .....❑
6. Loss of self-confidence or self esteem .....❑
7. Thought of death or suicide.....❑
8. Feelings of guilt.....❑

Summing up

Positive to I,II or III and at least 5 positive from 1 to 8. .....❑
all occurring most of the time for 2 weeks or more.
Indication of ***depression***.....❑

Anxiety

Yes

I. Feeling tense or anxious?.....❑
II. Worrying a lot about things? .....❑

If YES to any of the above, continue below

1. Symptoms of arousal and anxiety?.....❑
2. Experienced intense or sudden fear unexpectedly or for no apparent reason?
   Fear of dying .....❑
   Fear of losing control ...❑
   Pounding heart .....❑
   Sweating .....❑
   Trembling or shaking ....❑
   Chest pains or difficulty breathing.....❑
   Feeling dizzy, lightheaded or faint.....❑
   Numbness or tingling sensations.....❑
   Feelings of unreality.....❑
   Nausea .....❑
3. Experiences fear/anxiety in specific situations
   leaving familiar places .....❑
   travelling alone, e.g. train, car, plane .....❑
   crowds confined places/ public places ...❑
4. Experienced fear/anxiety in social situations
   speaking in front of others .....❑
   social events.....❑
   eating in front of others.....❑
   worry a lot about what others think or self-consciousness?.....❑

Summing up

Positive to I or II and negative to 2,3 and 4:
Indication of ***generalized anxiety***.....❑
Positive to I and 2: indication of ***panic disorder***.....❑
Positive to I and 3: indication of ***agoraphobia***.....❑
Positive to 1 and 4: indication of ***social phobia***.....❑

Alcohol Use Disorder

I. No. standart drinks in a typical day when drinking?____
II. No. of days/wk. having alcoholic drinks?____

If above limit, or if there is a regular / hazardous pattern, continue below

1. Have you been unable to stop, reduce or continue your drinking?.....
2. Have you ever felt such a strong desire or urge to drink that you could not resist it?
3. Did stopping or cutting down on your drinking ever cause you problems such as:
   the shakes .....❑
   being unable to sleep .....❑
   feeling nervous or restless....❑
   sweating.....❑
   heart beating fast.....
   headaches.....
   fits or seizures.....
4. Have you ever continued to drink when you know that you h problems that can be made worse by drinking?.....
5. Has anyone expressed concern about your drinking, for exam your family, friends or your doctor?.....

Summing up

If I x II is 21/wk or more for men or 14/wk or more for women, then possible ***alcohol problem***.....
Positive to I and any of 1-5, then likely ***alcohol problem***.....

Functioning & Disablement

I. During the last month have you been limited in one or more of the following activities most of the time:

Self care: bathing, dressing, eating? .....❑
Family relations: spouse, children, relatives?.....❑
Going to work or school? .....❑
Doing housework or household tasks? .....❑
Social activities, seeing friends? .....❑
Remembering things? .....❑

II. Because of these problems during the last month

For how many days were you unable to fully carry out your usual daily activities?.....____
How many days did you spend in bed in order to rest?.....____

Always check for Depression / Stressful situations / Anxiety

Sleep Problems

Yes

I. Have you had any problems with sleep?

Difficulty falling asleep ☐
Restless or unrefreshing asleep ☐
Frequent or long periods of being awake ☐
Early morning awakening ☐

If YES to any of the above, continue below

1. Do you have any medical problems or physical pains? ☐
2. Are you taking any medication? ☐
3. Do any of the following apply?
   drink alcohol, coffee, tea or eat before you sleep? ☐
   take day time naps? ☐
   experienced changes to your routine e.g. shift work? ☐
   disruptive noises during the night? ☐
4. Problems for at least three times a week? ☐
5. Has anyone told you that your snoring is loud and disruptive? ☐
6. Do you get sudden uncontrollable sleep attacks during the day? ☐
7. Low mood or loss of interest or pleasure? ☐
8. Worried, anxious or tense? ☐
9. How much alcohol do you drink in a typical week - (number of standard drinks / wk)? _____

Summing up

Positive to any of 1,2 or 3: ☐
cosider management of the underlying problem
Positive to 4 then indication of ***sleep problem*** ☐
Positivee to 5 consider ***sleep apnea*** ☐
If positive to 6 consider ***narcolepsy*** ☐
Positive to 7: consider ***depressive disorder*** ☐
Positive to 8: consider ***anxiety disorder*** ☐
If weekly drinking is more than 21 standard drinks for men and more than 14 for women, consider ***alcohol use disorder*** ☐

Always check for Depression / Stressful situations / Anxiety

Chronic Tiredness

Yes

I. Do you get tired easily? ☐
Tired all the time? ☐
Easily tired out while performing every day tasks? ☐
Difficult to recover from the tiredness, despite rest? ☐

If YES to any of the above, continue below

1. Do you have any medical problems or physical pains? ☐
2. Are you taking any medication? ☐
3. Low mood or loss of interest or pleasure? ☐
4. Worried, anxious or tense? ☐
5. How much alcohol do you drink in a typical week (number of standard drinks / wk)? _____
6. Are you doing too much at home and/or work? ☐
7. Do you fail to set time aside for leisure activities? ☐
8. Have you been having problems with sleep? ☐

Summing up

Positive to I: indication of a ***fatigue problem*** ☐
Positive to any of 1 or 2: ☐
Consider management of the underlying problem
Positive to 3: consider ***depresive disorder*** ☐
Positive to 4: consider ***anxiety disorder*** ☐
If weekly drinking is more than 21 standard drinks for men and more than 14 for women: consider ***alcohol use disorder*** ☐
Positive to 6 or 7: consider ***lifestyle change*** ☐
Positive to 8: consider ***sleep problem*** ☐

Check for multiple doctors and negative test results / Dramatic presentation / Attention seeking / Unusual symtoms

Unexplained Somatic Complaints

Yes

I. Have you been bothered by continuing aches or pains or other physical complaints for which a cause has not been found (e.g. Nausea / vomiting / diarrhoea / shortness of breath / chest pain / headaches / abdominal pain)? ☐

If YES to any of the above, continue below

1. Have you seen more than one doctor for these problems? ☐
2. Have you seen any specialists about these problems? ☐
3. Have you experienced these pains or different physical problems for longer than 6 months? ☐
4. Low mood or loss of interest or pleasure? ☐
5. Worried, anxious or tense? ☐
6. How much alcohol do you drink in a typical week (number of standard drinks /wk)? _____

Summing up

Positive to I and also to at least one positive form 1 to 4 and negative to 5, 6, and 7: ☐
consider ***unexplained somatic complaints disorder.***

Functioning & Disablement

I. During the last month have you been limited in one or more of the following activities most of the time:

Self care: bathing, dressing, eating? ☐
Family relations: spouse, children, relatives? ☐
Going to work or school? ☐
Doing housework or household tasks? ☐
Social activities, seeing friends? ☐
Remembering things? ☐

II. Because of these problems during the last month

For how many days were you unable to fully carry out your usual daily activities? _____
How many days did you spend in bed in order to rest? _____

Flow Chart Assessment Guide

(To be used with ICD-10 PC)

Depression

Common symptoms:

Low mood, sad, blue, loss of interest, guilt or low self worth, disturbed sleep, disturbed appetite, agitation or slowing down, fatigue, pain, hopelessness and helplessness.

↓

Medical conditions:
Organic illness: neoplasms, arthritis, endocrine disorders, chronic infectious diseases, chronic medical conditions e.g. heart problems, diabetes etc

↓

Use of medications:
Beta blockers, antihypertensives, contraceptives, corticosteroids

↓

Tense / worried / anxious → Anxiety card - F41.1

↓

Alcohol use disorder → Alcohol use disorders card - F10

↓

Life events / loss → Adjustment disorder card - F43.2

↓

If still depressed treat with antidepressants. (adequate dose and period)

Anxiety

Common symptoms:

Worry chest pain, numbness, tension, dizziness, breathlessness, light headedness, sweating heart pounding, muscle aches, stomach pains, tremors

↓

Medical conditions: e.g. Thyrotoxicosis

↓

Use of medications: e.g. Methylxanthines and beta agonists

↓

Depressed mood Anhedonia → Depression card-F32#

↓

Alcohol use disorder → Alcohol use disorders card- F10

↓

Life events / loss → Adjustment disorder card- F43.2 Bereavement disorders - Z63

↓

Sudden episodes of extreme anxiety → Panic disorder - F41.0

↓

With avoidance behaviour in public, crowded or open spaces → Agoraphobia-Phobic disorders - F40

↓

Long lasting anxiety symptoms → Anxiety card - F41.1

↓

Extreme fear of being judged → Social phobia - Phobic disorders - F40

Alcohol Use Disorders

Common symptoms:

Drinking above acceptable levels
Comorbid disorder depression / anxiety suspect
Medical examination + biochemical tests, family history

↓

Male GE 21 standard drinks/wk
Females GE 14 standard drinks/ wk

Physical, psychological and social problems Pregnancy → Alcohol use disorders card-F10 (Harmful use)

↓

Loss of control strong desire tolerance withdrawal symptoms → Alcohol use disorders card-F10 (dependence)

Flow Chart Assessment Guide

(To be used with ICD-10 PC)

Sleep Problems

Common symptoms:

Difficulty falling asleep, frequent or long periods of being awake, early morning wakening, restless or unrefreshing sleep

↓

Lifestyle:
Exercise before sleeping, day-time naps, changed routine, partner snoring, drinking coffee, eating immediately prior to sleeping.

↓

Medical conditions:
Heart failure, pulmonary disease, pains, diabetes mellitus

↓

Use of medications:
steroids, theophyilline, decongestants, some anti-depressant drugs, alcohol use

↓

Rarer sleep conditions:
Narcolepsy, sleep apnea

↓

Depressed mood Anhedonia → Depression card- F32#

↓

Alcohol use disorder → Alcohol use disorders card - F10

↓

Tense, worried, anxious → Anxiety card - F41.1

Chronic Tiredness (Neurasthenia)

Common symptoms:

Tired all the time, tires easily, tired despite rest

↓

Lifestyle:
Doing too much or too little

↓

Medical conditions:
Infectious hepatitis, glandular fever, influenza, diabetes, heart failure

↓

Use of medications:
Hypnotics, sedating anti-depressants, anti-histamines, steroids

↓

Not sleeping properly:
Sleep apnea → Sleep problems card -F51

↓

Depressed mood Anhedonia → Depression card - F32#

↓

Tense, worried, anxious → Anxiety card - F41.1

↓

Alcohol use disorder → Alcohol use disorders card- F10

↓

Low energy, irritable → Chronic tiredness - F48.0 (Neurastfhenia)

Unexplained Somatic Complaints

Common symptoms:

Nausea,vomiting, abdominal pains, headaches, chest pains, difficulty in breathing, skin rashes

↓

No medical conditions to explain complaints

↓

Depressed mood Anhedonia → Depression card F32#

↓

Tense, worried, anxious → Anxiety card - F41.1

↓

Alcohol use disorder → Alcohol use disorders card- F10

↓

Unexplained somatic complaints- F45

The assessment guide for Unexplained Somatic Complaints should be used in close conjunction with the other cards wherever applicable (e.g. Depression, Anxiety, Alcohol Use Disorder, Sleep Problems)

ICD-10 PC:
Questionnaire for

Depressive Disorder

During the ***last month*** have you had any of the following complaints most of the time for at least two weeks.

If yes, please check or mark the relevant box.

I. Have you been feeling sad, blue or depressed ? ..... ❑

II. Have you lost interest or pleasure in things that you enjoyed previously ? ..... ❑

III. Have you been feeling your energy decreased and/or you are tired all the time ? ..... ❑

If YES to any of the above, continue below

1. Have you been experiencing any problems falling asleep or waking up much earlier than before? .....❑

2. Have you lost your appetite or have you been eating much more than usual ?..... ❑

3. Any difficulties concentrating; for example, listening to others, working, watching TV, listening to the radio ?..... ❑

4. Have you noticed any slowing down in your thinking or moving around ? ..... ❑

5. Has your interest in sex decreased ? ..... ❑

6. Have you felt negative about yourself or lost confidence ? ..... ❑

7. Have you thought of death, wished that you were dead or tried to end your life? ..... ❑

8. Do you often feel guilty? ..... ❑

I. During the *last month* have you been limited in one or more of the following areas most of the time:

- Self care: bathing, dressing, eating ? ..... ❑
- Family relations: spouse, children, relatives ? ..... ❑
- Going to work or school ? ..... ❑
- Doing housework or household tasks ? ..... ❑
- Social activities, seeing friends, hobbies ? ..... ❑
- Remembering things ? ..... ❑

II. Because of these problems during the *last month:*

How many days were you unable to fully carry out your usual daily activities ? ..... _____

How many days did you spend in bed in order to rest?..... _____

Mental Disorders in Primary Care

Depression

Common symptoms

Mood and Motivation

- Continuous low mood
- Loss of interest or pleasure
- Hopelessness
- Helplessness
- Worthlessness

Psychological

- Guilt / negative attitude to self
- Poor concentration/memory
- Thoughts of death or suicide
- Tearfulness

Physical

- Slowing down or agitation
- Tiredness / lack of energy
- Sleep problems
- Disturbed appetite (weight loss/increase)

- Difficulties carrying out routine activities
- Difficulties performing at work
- Difficulties with home life
- Withdrawal from friends and social activities

Depression is common and treatable

Depression ***does not*** mean weakness
Depression ***does not*** mean laziness
Depression ***does*** mean that you have a medical disorder which requires treatment

Common triggers

Psychological

Major life events

- recent bereavement
- relationship problems
- unemployment
- moving house
- stress at work
- financial problems

Other

- family history of depression
- childbirth
- menopause
- seasonal changes

Illness

- infectious diseases
- influenza
- hepatitis
- chronic medical conditions
- alcohol and substance use disorders

Medications

- antihypertensives
- H2 blockers
- oral contraceptives
- corticosteroids

What treatments can help?

Both therapies are most often needed

Supportive therapy for:

- stress/life problems
- patterns of negative thinking
- prevention of further episodes

Medication for:

- depressed mood or loss of interest / pleasure for two or more weeks and at least four of the symptoms mentioned earlier
- little response to supportive therapy (counselling)
- recurrent depression
- family history of depression

About medication

Effective
works better and faster than other methods

Treatment plan
must be strictly adhered to

Drugs
- ➤ are not addictive
- ➤ interact in a harmful way with alcohol
- ➤ improvement takes time, generally 3 weeks for response

Side effects
must be reported, but generally start improving within 7-10 days

Progress
- ➤ same medication should continue unless a different decision is taken by the physician
- ➤ medication should not be discontinued without physician's knowledge
- ➤ in case a drug is not effective, another drug may be tried

Time period
medication to be continued at least 6 months after initial improvement

Ongoing review
is necessary over the next few months

Increasing time spent on enjoyable activities

- ➤ Set small achievable, daily goals for doing pleasant activities
- ➤ Plan time for activities and increase the amount of time spent on these each week
- ➤ Plan things to look forward to in the future
- ➤ Keep busy even when it is hard to feel motivated
- ➤ Try to be with other people/family members

Problem solving plan

Discuss
problems with partner/family members, trusted friend or counsellor

Distance
yourself to look at problems as though you were an observer

Options
to work out possible solutions to solve the problems

Pros & Cons
examine advantages and disadvantages of each option

Time frame
to examine and resolve problems

Action plan
for working through the problems over a period of time

Review
progress made in solving problems

Changing attitudes and way of thinking

"I will always feel this way, things will never change"

Instead

"These feelings are temporary. With treatment things will look better in a few weeks."

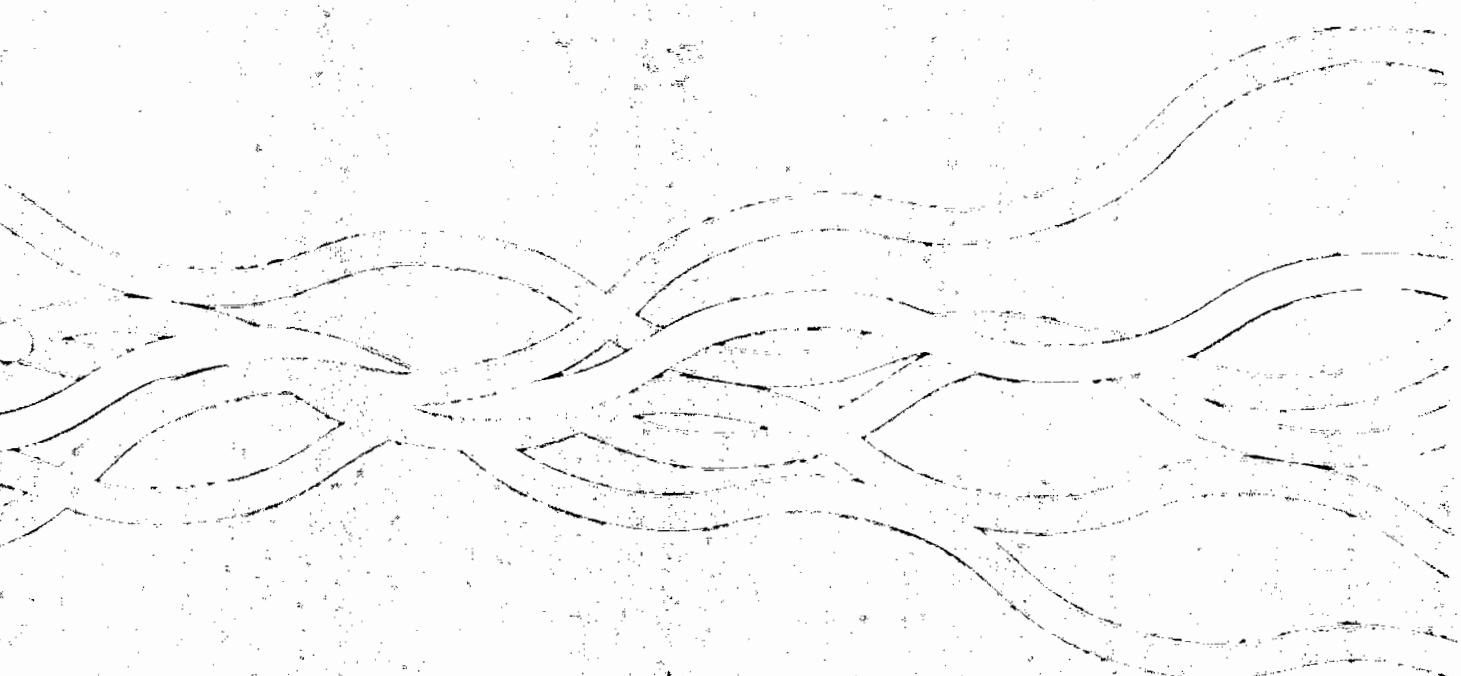
"It's all my fault. I do not seem to be able to do anything right"

Instead

"These are negative thoughts that are the result of depression. What evidence for this do I really have?"

Depression

Depression is an illness
It is common and treatable



Depression

Depression is an illness - it is common and treatable

Depression ***does not*** mean that you are weak or lazy. it is a ***medical*** disorder like hypertension, diabetes or arthritis that requires ***medical treatment.*** It can occur at any age and can be overcome with ***medical help.***

What is depression?

Many people use the word depression to describe feelings of sadness and loss.These feelings often pass within a few hours or a few days. During this time people are able to carry out their normal activities. The medical illness called ***depression*** is different from transient feelings of sadness. In ***depression***, as a medical disorder, sad feelings are felt much more intensely and for a longer period of time. It can be disruptive to your work, social and family life.

Depression can also affect people in many other ways. Common symptoms are:

- ➤ Disturbed sleep
- ➤ Changes to appetite
- ➤ Physical aches and pain
- ➤ Lack of energy or motivation
- ➤ Irritability and intolerance
- ➤ Feelings of guilt
- ➤ Loss of concentration

What may trigger depression?

It is known that there are biochemical changes in the brains of depressed patients. There is also evidence that if your first degree relatives suffer from depression, you are at a greater risk of having depression. For many people, depression is triggered by stressful events, alcohol or drug use. However, in some people there is no obvious trigger. Think about your situation - was your depression associated with one of the triggers listed below?

If so, put a check beside it. If not, and you are aware of some other trigger, write it in the space provided. It would help to discuss this with your doctor, your family and friends.

Possible triggers

- ➤ Moving house _____
- ➤ Divorce or separation _____
- ➤ Death of a loved one _____
- ➤ Long term alcohol use _____
- ➤ Certain medications _____
- ➤ Dissatisfaction or conflict at work _____
- ➤ Widowhood _____
- ➤ Chronic physical illness _____
- ➤ Being a victim of a crime or an accident _____
- ➤ Serious injury or illness in the patient or a loved one _____
- ➤ Low self-esteem _____
- ➤ Loss of job _____
- ➤ Poverty _____
- ➤ Unemployment _____
- ➤ Chronic drug use _____
- ➤ Seasonal changes _____
- ➤ Loneliness _____
- ➤ Marital problems _____
- ➤ Childbirth _____
- ➤ Unsatisfactory relationships with family or friends _____
- ➤ Unprepared social and cultural changes (immigration) _____
- ➤ Others (specify) _____

How to overcome depression

1 Identify your symptoms of depression - In the last month

Symptom Severity Form	*Not at all*	*Mild*	*Moderate*	*Severe*
Feelings of sadness				
Loss of interest or pleasure in activities previously enjoyed				
Lack of energy/tiredness				
Poor/disturbed sleep				
Putting on/losing weight				
Poor concentration / forgetfulness				
Slowness				
Restlessness				
Decreased libido				
Physical aches/pains				
Believing that you are no good				
Feelings of hopelessness				
Thoughts of harming oneself (death)				
Feelings of guilt/self blame				

2 Identify problems in your life

Everybody experiences problems in life and sometimes these can trigger depression. List the problems which you think triggered your depression . What were the things that bothered you before you became depressed?

e.g. *Going through divorce, unhappy work environment*

Discuss your list with your doctor and/or counsellor, family member or a trusted friend.

3 Working out a strategy to deal with problems

Often problems that never get resolved can trigger depression. Are you putting your problems off because you cannot find any easy solutions to them? Maybe with the help of your doctor and/or your counsellor and the support of your family and friends you can try to work out some of your problems. Think of the problems you have listed previously. We suggest that you work through each of them using the following strategy.

Discuss the problem(s) with a trusted family member or friend.
Then ***write*** down what you believe to be the major difficulties of solving it.

e.g. *Problem: Unhappy work environment*
Major diffuculty of solving it: Difficulty in finding a new job

Work out ***options*** for dealing with the problem(s)
Then ***write*** down your options.

e.g. *Leave the job and than look for a new one*

What do other people think?

You shouldn't leave your job before finding a new one

Decide on a ***step by step action plan*** for working through the problem(s).The final solution can seem over whelming. Plan the steps that you need to take to solve the problem and than set realistic time targets to achieve each step.

Action	*Date*
e.g. *Start looking for a new job*	*Tomorrow*

Examine the progress made in solving problem(s). At each step, review your progress and discuss this with your doctor and/or counsellor or with a trusted family member or friend.

Progress review	*Date*
e.g *Boss responded positively*	*6/6/97*

4 Identify routine and pleasant activities

Think about your daily routine activities before you were depressed and write them below. Now think about those activities that you enjoyed and those that you would have liked to have done and also write them down,

Before becoming depressed

My routine activities	*Pleasant activities*	*Activities I wanted to do*
e.g. *Grocery shopping*	*Going to a restaurant*	*Reading*

5 Increase routine and pleasant activities

Once you have identified your daily routine activities and pleasant activities with the help of your doctor and/ or counsellor you can slowly try to return to your routine and also try to do some of the pleasant activities you enjoy. At the beginning of each week you can choose activities from your "daily routine" list and "pleasant activity" list and build them into your day.

Remember, it is important to do these activities even when you do not feel like it.

6 Identify those areas of your life that are positive

When you are depressed it is easy to lose sight of those things that you value in your life. Think about life before depression. What did you value and what was special? Make a list of them.

e.g. *Family*
Children
Work
Sport
Music

Having identified those areas of your life that are positive, discuss them with your doctor and/or counsellor.

7 Identity negative thinking

When people are depressed they tend to think negatively about themselves, events and their future. Negative thinking can also trigger depression and slow down recovery. Have you noticed differences in the way people think about events? Some people are mostly positive while others are negative. Can you relate to any of the examples below?

A colleague was promoted at work rather than you....

Person A	**Person B**
She is more experienced	I will never get promoted
She has been here longer	I am not appreciated
She has the necessary skills	I am not liked
It will be my turn next time	I am worthless
Disappointment	*Prolonged unhappiness*

Remember the success of your treatment depends on how hard you work to change your negative way of thinking.

Here are some more examples of negative thoughts or beliefs. Mark the statements that apply to you

- ❑ If someone does not like me it means that there is something wrong with me
- ❑ If I get criticised it means that I am wrong
- ❑ If I make a mistake that means that I am stupid
- ❑ Things always and will always go wrong for me
- ❑ I cannot handle it when things go wrong
- ❑ To be a good person I have to be nice to everyone
- ❑ I am a bad person if I hurt someone
- ❑ If I show emotion it means that I am weak
- ❑ If my partner leaves me it means that I am worthless
- ❑ If I do not get asked out it means that I am not liked
- ❑ I can never overcome my problems
- ❑ I have failed in the relationship,I did something wrong

8 How do you change the way that you think

It is likely that you have been thinking in a negative way for sometime now. It will take a lot of practice to change these ways

Remember you can learn to think more positively and this will make a huge difference in your life.

Here are some suggestions:

First , ask yourself *"Is what I believe TRUE?"*

- It will be useful to consult someone outside the situation for their opinion
- Ask yourself if everyone would have the same belief in this situation
- Examine other possible explanations for the event occurring

Second, counter each negative/unreasonable thought with more realistic ones

- These should be opposite to the unreasonable belief
- They should be realistic statements
- There should be as many counters as possible

Now, read the following example and work out your own examples using the same format. You can do this with the help of your doctor and/or your counsellor.

Example:

The example below shows how negative and positive thoughts lead to different reactions to the same situation.

SITUATION: Was not chosen for job

Unreasonable/negative thoughts:
- Just as well I didn't get the job, I would have failed at it anyway
- I am no good/stupid
- I am a failure
- I should give up
- I will never succeed

Resulting feelings: Worthlessness, depression.

Now lets look at the same situation from a different angle

Reasonable/positive thoughts:
- Many people do not get the job they want
- I need to practice some interview techniques
- I am not a failure, I have achieved many good things in the past
- I will not get anywhere by giving up
- If I persevere I can succeed
- I have succeeded in the past and I will continue to succeed

Resulting feelings: Disappointment, but enthusiasm and hope

Now you can work through your own examples. Write down a situation that has made you unhappy and any negative thoughts you may have had and the resulting feelings. Next you may write the counter positive thoughts and the new resulting feelings.

Remember it will take time to change the way you think and feel.

Keep a record of progress

As part of treatment it is often useful to record how you feel and also to plan and record activities that you do. This will help you keep track of your progress.

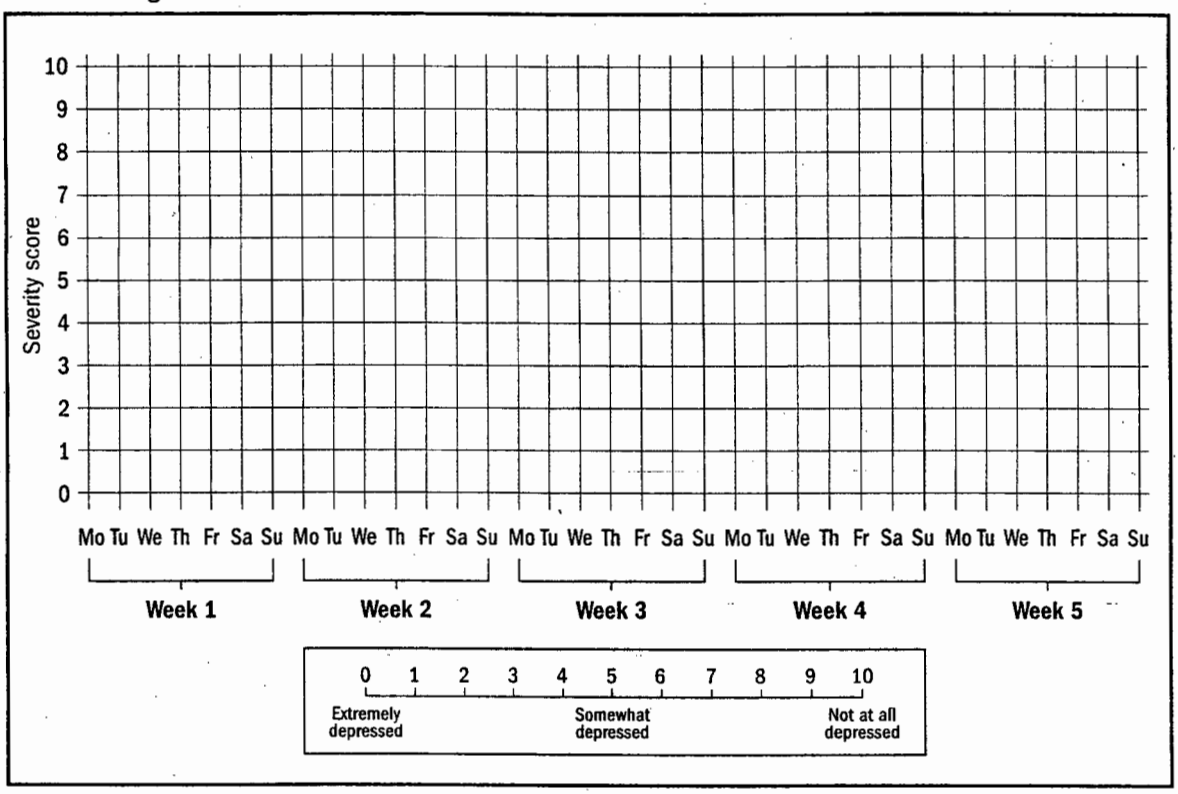
Use the Symptom Severity Form and Personal Progress Chart to monitor your mood and symptoms. Give yourself an overall rating of how you feel each week.

Remember to:

1 Choose items from your activity lists and build them into each day using the weekly activity planning form
2 Every week think about how you feel and rate each of your symptoms on the symptom severity form
3 Each week mark your overall depression rating on the personal progress chart

Overall rating of how you feel

Personal Progress Chart



How to avoid recurrence of depression

- ➤ it is very important that you follow your physicians advice
- ➤ take your medication as directed without skipping any days
- ➤ never reduce or stop taking medication without first talking to your doctor
- ➤ identify your negative thinking habit and change them to positive one

Assess your symptoms regularly and consult your physician and/or counsellor if you have any problem.

Finally

- ➤ Doing the exercises when you are depressed can be difficult.
- ➤ It might be useful to work through them with a trusted friend or family member.
- ➤ If you need extra help you can always talk to your doctor and/or your counsellor.

You can overcome your depression.

APPENDIX B: SUMMARY OF PLANNING MEETING FOR CO-OPERATIVE INQUIRY AT BEGINNING OF CYCLE 2 23/10/99

Further reflections from 16/10/99 and the week before this meeting.

SG:

Uncertain where to start using the package. Went back to using the questionnaire. Found the package and the patient divided his attention during the consultation. Still unfamiliar with the package. How to blend the patient centred flow with this highly structured package. Story of patient with a sleep disorder / sexual problems / depression. Story of pt in Khayelitsha with alcohol problem. Pt appreciated the extra effort taken and being engaged with the package. Didn't need the package so much in the private practice where communication was easier and flowed well. In Khayelitsha the flow was impeded by language barriers, patients finding it difficult to understand the questions, needs a different approach. When the flow is going well the package may be intrusive. When not sure about the diagnosis or confused the package may help bring clarity. When uncertain gave guidance. Compare private practice with Khayelitsha and use of the package.

SN:

Felt uncomfortable using the package with new patients. Better with follow up visits. Story of a patient with anxiety. The package provided a sort of external authority that helped the doctors explanation and gave the patient an insight into their problem. "It means there are other people having the same thing." Normalised the experience as a recognised diagnosis. Not such a problem to explain the symptoms in depression as with anxiety. But even here the package helped to reinforce the doctor's opinion.

SG:

Reaction to SN – beware of using the package as a "power tool" to manipulate the patient and brow beat them to your viewpoint.

RM:

Has an assistant who rigidly follows guidelines and tells the patient "You must do..." and "You have...." Such a person's approach might misuse the package to be too rigid and inflexible. Too doctor centred.

SM:

What is the package actually? Is it an educational tool or a practical tool? Is meant to interfere with the dr-pt relationship? Is it meant to educate the dr and be discarded or to become the way a dr relates to the pt? Saw that it is intended to be adapted to the country, to the culture and to your own individual practice. Good to see it like this.

BM:

Maybe for example the process of developing the questions that work in your practice for these concepts is more important to the educational effect than prescribing the outcome i.e. the actual questions you should ask. Package is generic but not without values / viewpoint – it is dr centred exploring the disease categories. It says nothing about the dr-pt relationship and the communication. Research has shown this to be an important aspect of recognising mental health disorders. This is a shortcoming.

SG:

The fact that it doesn't prescribe a particular style or approach allows the doctor to integrate the information into his own way of relating. If the pt centred approach has been shown to increase recognition and improve management then this needs to be included in the program eventually.

AM:

Maybe need two separate interventions. The one about mental health that you can integrate into your style and the one about the kind of style – relationship that is effective.

BM:

Saw the interconnectedness of the 6 conditions and thought that it made sense to see them as one hypothesis. Developed a list of 7 questions to use in Khayelitsha that could test this one hypothesis of "mental disorder". Found that these questions worked like a dance. Each question opened up a new area of the patient's story and context. The consultation danced between exploring this new information and going back to the checklist. It may be important to develop these questions for each person in their unique practice setting. IMB suggests reading up on "argumentation"??? On reading about chronic tiredness saw that once you have stripped away depression, anxiety and other conditions there is no convincing treatment, management is aimed more at not mis-managing the patient. Is it helpful to make this diagnosis? Package doesn't have an approach to exploring the patient's issues, context, and problems. Could include tools such as the genogram, MAPP.

NM:

Likes the superficial approach of the package as its simplicity does not make you feel intimidated. You can master it easily. Infact you may already know more than the package in some areas. Not overwhelmed or made to feel inadequate. The use of the package then makes you aware of the need for further learning. Gives you the feeling that you already know something and therefore you are willing to use the package. If it made you feel I know nothing then you want to push the package away.

Questions and actions for second co-operative inquiry cycle. 23/10/99

General comments:

Don't be afraid to dissemble and reassemble the package contents and structure. Cut, paste, edit, translate, and play around with it.

Try to make your question(s) as specific and focused as possible. You may want to further refine and add to your questions and action plan.

Document your experience so that you can "show" what happened. Describe what happened, write the story, allow people to enter into your experience. Many of us have "told the stories" during the meeting of patient encounters and experiences. This needs to be captured in a written format. It may be easier to do this soon after the experience while it is still fresh – preferably the same day.

Reflect on your experience and document what you have learnt. Do this in a way that you "establish" your conclusions based on your experience and do not just "assert" what they are over and over. Need to show how your experience established these conclusions.

I would suggest that we stay in touch with each other using the list server (coopinquiry@listbot.com) and send some of our key stories and reflections each week to share with each other as we go along. These will then form a record in the archive. I will be able to stay in touch by accessing the list server from the UK.

BS:

How can the package save consultation time and not take up more?

Adapt self-report questionnaire into a tool that empowers the patient to bring up difficult issues in the consultation. Signals the doctor's willingness to address

these issues. With all patients? Selected patients? Will bring up too many issues? How will you then use the package if patients respond to this invitation?

SM:

How can this doctor-centred package be incorporated into a patient-centred consultation?

Formulate a set of general questions to test the hypothesis "mental health problem" and try it out. Incorporate these questions within the consultation and use them as required. If necessary focus in on a specific disorder after this. Maybe also look at a similar process of adaptation and incorporation of the other materials in the second half of the consultation?

AM:

How to put the package into practice?

Read and modify the materials to be suitable for teaching GPs, asking questions to patients, teaching GPs new approaches to patients, useful patient leaflets. Try out the package in my practice. Document and reflect on this experience.

NM:

How can the package be used by SA doctors?
Will revisit this question and make it more focused and specific.

Does the package empower or disempower GPs?

Will use the other topics in the package one by one and reflect on the experience. Excellent research attitude, but need to reformulate and focus the question.

RM:

Why are GPs still missing mental health problems?
This broad question relates to the underlying motivation of the people at WHO who wrote the package. A more focused and specific question is:

Does the package help me with picking up psychological cues and testing these alongside physical hypotheses? How to adapt it to enable this to happen?

Use the various tools and change them to enable this process to happen.

FC:

How can I enhance my ability to recognise and manage mental health disorders in my practice? How can I measure this?

To internalise the package contents, filter-rephrase-modify them, and try them out and document – reflect on the experience. To keep track of my detection rate and follow up patient's outcomes over the few weeks.

SG:

How do I optimise the usefulness of the package in terms of recognition and management? How to integrate the package into the consultation with minimum interference and maximum benefit?

Dissemble and re-assemble the package in a format that can be integrated with my consultation style and clinical method. To use the patient's symptoms or cues as the starting point. Develop general screening questions, photocopy handouts and ICD-10 questionnaires. To document and reflect on the experience.

SN:

What will my colleagues think about the package?

To share the package with my colleagues and document their thoughts, feelings and reactions.

How to use the package to enable my patients with mental disorders to accept that this is the cause of their symptoms?

To use and adapt the handycards and education leaflets. To document and reflect on whether they are helpful in enabling this process.

SL:

The package has information that is accepted by the patient and doctor – how to make this more easily introduced into the consultation?

How to gauge the outcomes of the consultation – was the patient's needs or expectations fulfilled?

One action would be to introduce an open question regarding mental disorders or problems in the practice questionnaire and in those who respond positively use this as an entry point into using the package. Maybe add other specific actions?

BM

How to make the contents of the package relevant to patients in Khayelitsha and to my clinical method?

To re-formulate the package in the following structure: cue card (build a list of common cues used by patient's in Khayelitsha that may signal a mental health problem); hypothesis testing card (a list of 7 questions that can be used in the consultation to test the hypothesis "Is this a mental health disorder?"); mental disorder cards (one card per disorder that summarises how to make a more specific diagnosis, includes interactive material and prompts on management); psycho-social card (ways of exploring the patient's psycho-social problems i.e. genogram, MAPP); patient leaflets (adapt for Khayelitsha). To try out the adapted materials to see if they work in my clinical method and if the patient and I find them useful. Document and reflect.

APPENDIX C: SUMMARY OF REFLECTIONS OF CO-OPERATIVE INQUIRY GROUP AT THE END OF CYCLE 2 ON 28/11/99

Introduction: One word feeling round and program for the day

Each person share their experience and personal reflection followed by group clarification

Break

Each person to make sense of what they have learnt as a result of the group feedback - by means of a target diagram, FAI, writing etc.

Insights and new knowledge is summarised using the target model with group discussion

Break

Discussion of the way forward, documentation, new cycle, Christmas

Each person develops new questions and actions using the same process as before

Sharing of new questions and clarification

Closure

Feedback 28/11/99

SL:

Used the module on USC with a GP meeting in Seapoint. They did not have an approach to this or way of making a diagnosis and found the approach in the package useful.

Patients have found the module on USC very useful. Particularly the handycard. You can see the satisfaction, the relief of the patient. Still positive and feeling better on telephonic follow up. Used sections 1,2,3,5 and 6 of the handycard. Seeing the symptoms and explanation in print seemed to help people unblock and accept the drs explanation. They identified with the written material and felt more comfortable with the explanation. Were then able to give more attention and acceptance to the dr. Did not use the pt leaflet as people seemed satisfied with the diagnosis and explanation. Stories?? Provides a diagnosis / category that helps the patient and doctor "I've got a recognised problem called USC."

Pt interest and acceptance may mirror the drs belief in the package contents?

Only focused on one sheet. Didn't explore related or underlying issues e.g. Depression, anxiety, alcohol. Should have had more follow up. Beware of using USC as a catch all category for somatic complaints, which have other explanations.

FC:

Found the package itself too stiff to use directly in the consultation. Internalised the content and concepts of the package by reading and re-reading it and used the framework and approach within the consultation. Internalisation led to a feeling of empowerment in the doctor in the sense that it legitimised an approach, gave a sense of aligning with an approved approach. The facts were not new but the skeleton of the package / the approach was empowering. Need to align with the approach and then see what is useful. What is the skeleton / approach? Found the section on USC most useful. Management approach gave more clarity in terms of what the options are. Tends to refer a lot to the psychologist. Beware of physical disorders that mimic mental i.e. patient with thyrotoxicosis.

Some people have used the package as a triad dr-pt-package whereas others have internalised the package and it is in a sense hidden in the consultation within the doctor.

SN:

Used the package as a tool and to engage patients. Going through the questions with the patient sitting side by side. Also used the genogram. Found that the package was empowering, going through the sheets with the patient led to a greater acceptance of the diagnosis, patients recognised their problems / symptoms. Used the checklist mainly. Used the section on USC and found patients were satisfied. Enhanced trust and disclosure. Why? Used the package as a "special treat" with some patients. Maybe these patients were picking up on this positive attitude from the doctor? Punished others by not using the package.

RM:

Found certain cues useful e.g. Dizziness. Helped to make psychological diagnoses from the cues. Strengthened the formation of psychological hypotheses. Made a number of new diagnoses of anxiety. Tried out the anxiety module with these patients who have dizziness- "superb". Used the pt education leaflet. Moved from my own anxiety of missing a physical diagnosis to feeling empowered to make a psychological diagnosis. Took time 20-30 mins – couldn't use it routinely. Chronic tiredness worked well – checklist, reassurance, tips on what to do were helpful. Patients thank you at the end. Gave an explanation of

illness that was satisfying. The explanation was more helpful than prescribing. Worries about missing physical problems were re-enforced by the psychiatrist.

SM.

Did not develop the questionnaire and did not use the package with patients.

BS:

Did not develop or use the screening questionnaire. Found that she resisted the idea when it came to doing it. Resists the rigid approach of questionnaires and lists of questions. Finds the process of the consultation, the relationship, and the communication most important. The package honours the doctor's agenda of reaching a diagnosis, but does not honour the patient's agenda or the interaction between the dr and pt. Would almost use the package as a punishment with patients! The disorders themselves are very interlinked and the working category may actually be "emotional distress" with practical decisions such as "Needs antidepressant / Does not need" part of the decision making process rather than a more defined diagnosis. The knowledge should serve the purpose of the consultation. If the purpose is to make a diagnosis then the package is aligned with this. The approach of the ICD-10 is to try and place each patient within a distinct category. However the management recommendations are often very similar and overlap. If the purpose is healing of the patient then it may not be necessary to always box the patient in a category. The package is coming from a bio-medical mechanistic perspective and not a systems perspective.

SG:

Attempted to develop the package as a usable tool and integrate it into the consultation. Found that it was not helpful to use directly at the beginning of the consultation, but later on once the patient's narrative had been heard it was useful to confirm the diagnosis and to assess severity. On using the checklist several patients turned out to have a more severe depression than thought. Helped to clarify diagnosis and severity and guide treatment. Reassuring to dr that all issues covered. Acted as a prompt to the dr that everything was covered. Handycards were useful in the handover as it gave the patient a chance to elaborate on their symptoms and problems. Found that giving the pt leaflet and a good explanation cut down on the need to prescribe antidepressants. Skimming through the package "allowed patients to take up what they wanted.". Local idioms important such as "hearing bad news." Using the package as a general guide but varying its application with the language, literacy and educational level of the patient. The more I used the package and became familiar with it the more useful it became. Even having the package on the desk increased recognition and awareness of mental problems.

AM:

Will ask AM to circulate his document on the list server.

Where are we now in terms of our research with the package? What have we learnt about the package? What has happened to change our attitude to the package?

1. People have moved from a feeling of resistance to the package to a feeling of acceptance and finding it useful in a wide variety of different ways. How has this happened? One of the reasons seems to be a change from seeing the package as a rigid prescription of how a GP should approach a patient to seeing it as an agent for change or an educational tool-kit that can enable a GP to develop further whilst retaining their own preferred style and approach. From seeing it as a time-consuming and stifling series of steps and questions to selecting out certain parts that can be used directly in the consultation or internalised into the internal dialogue of the GP during the consultation. From seeing it as a threat to one's own philosophy and approach developed over several years as a GP, in a particular context, to a tool that can enable the person to develop further within their own space. From resistance, threat, irritation to acceptance, excitement and involvement. It is likely that many GP's when confronted with the educational package will react with resistance even though they have chosen to do the course and presumably want to change. What can we learn from our experience that may help people move from resistance to acceptance? Simply becoming aware of our resistance and recognising it may have helped to move beyond it.

2. People have used the package in a wide variety of ways, which have all enhanced recognition and management. Some have used the cards directly with patients, some have re-formulated the screening questions and developed new materials, some have internalised the framework of the package, and some have used it as a prompt during the consultation. While the basic facts and knowledge are not new the internalisation of the package may have enabled an internal re-structuring of this data, making new connections, developing clearer approaches to problems, making the management and diagnostic options more conscious, giving a sense of internal completeness that all had been covered. The checklist and handycard seem to have been the focus of most attention. The flow chart and patient leaflets less so – why is this? The educational program should allow people to play with and use the package in a variety of ways and find what works best for them, as long as it is aligned with improving recognition and management of mental health disorders.

3. How useful are the research designed categories of mental disorders in GP? In practice the GP may be using categories such as "emotional distress" or "needs /does not need antidepressants"? A parallel to this are the categories "LRTI" "Bronchitis" "URTI" "Flu" "Pharyngitis" where the main issue is often "Needs / Does not need antibiotic"? Emotional distress may merge depression-anxiety-somatic symptoms. In terms of hypothesis generation we seem to have decided that a combined hypothesis of "mental disorder" may be useful. On the other hand the specific categories in the package have international recognition and have been tested in research settings. Are we just being sloppy in not making a specific diagnosis? There is a body of evidence that finds depression and anxiety symptoms often are mixed. Do we want to manipulate patients into categories that don't quite fit? To what extent are the separate categories linked to different management strategies, which make them practically useful for deciding on therapy? How should we address this issue?

4. There is a need to adapt the concepts to local language and expressions of emotional distress. Within the SA context it may be necessary for course participants to each do this for their own situation as these situations are so diverse.

5. The patient leaflets have been useful and should be adapted to the local context and languages. Not much comment made about them?

6. The package can be useful at all phases of the consultation, but the part that is most useful varies from GP to GP.

#enhances generation of psychological hypothesis from cues i.e. Dizziness.
#enables doctor to test a psychological hypothesis with more confidence
#empowers doctor to have confidence in making a psychological diagnosis
#enables patients to accept a psychological explanation and label for their problem. "unblocks the patient" – use of the handycard.
#reduces need to prescribe as the explanation and non-drug therapy may be enough.

7. The doctor-patient relationship, communication skills have been shown to be very important in recognising and managing mental disorders and by members of the co-op inquiry group, but have not been addressed in the printed package.

8. The issue of time is an important one for the GP. Does this package make the GP more efficient in their use of time? This issue must be addressed in the program. It may be that whilst using the package and learning from it this will take more time but once the learning has been internalised and integrated into the smooth flow of practice the consultations will be more efficient. Better

picking up of cues, reasons for the visit, quicker testing of psychological hypothesis, less time spent on unnecessary examination and investigations.

9. The use of the screening questions as a general combined screening questionnaire for all patients was not helpful in that all patients were positive and the questionnaire was too sensitive. The use of the specific questionnaires has not been found helpful as well due to language and literacy barriers. The use of questionnaires seems to meet with resistance maybe because there use is foreign to the usual style of GP. They may be more useful in a research setting than a normal GP consultation. The screening questions may be more useful when used selectively to test the hypothesis "mental disorder" with a patient.

10. Many SA GP's have difficulty with follow up consultations and continuity of care due to patient's financial constraints, distance from the clinic or lack of a system for appts / seeing the same doctor. Being realistic it may not be possible to do everything in one consultation, but one consultation may be all you have in many situations. How to address this issue?

What have we learned through the process as GP's in relation to mental health disorders? What has happened to change us as GP's?

Improving recognition of disorders has been of more importance to me than the management. Maybe because of working in Khayelitsha with barriers of language and culture and feeling that I am not picking up cues or diagnosing patients as often as I should. I have learnt:

- A clearer approach to recognising and assessing patients with alcohol problems. Developing a pathway or an approach enables you to choose to go down it as you are not so worried about getting lost or stuck.
- Developed questions in the local language and idioms that I feel hold water in Khayelitsha. More willing to ask these questions that make sense to the patients. Need to have formulated how to ask about the various concepts.
- Developed the concept of a general hypothesis "mental disorder" and a list of useful screening questions to try. Part of developing a pathway. New idea.
- Have a better sense of the diagnostic options, categories and connections between them. Not such a mystery.
- Becoming interested in finding patients with mental problems because I feel that I have a pathway and some skills to help.

What has helped me is:

- Reading the materials and making connections with family medicine theory. Doing the literature review.
- Interviewing local people about their experience with local language and culture.

- Reflecting on my own encounters, describing them and reflecting on what happened.

What do we need to get there?

Need to reflect more on our experience and some of the questions that are still hanging:

- How did we move from resistance to acceptance?
- What about the flow charts and patient leaflets?
- How do we resolve the issue of useful diagnostic categories?
- What can we say about adapting the package and adding to it?

I feel that we have had a wealth of experience but have not reflected on that experience with sufficient skill to unlock fully what we have actually learnt. How can we develop this reflective stance better – the writing workshop will help us.

We need to document more carefully what we have done, what our reflections were and our learning.

At this point I don't feel that another round of action will help unless we can switch on our ability to reflect and our ability to document the process. We need to be more aligned with the purpose of the research and ask the right questions – maybe these ones above will help. I think that time spent writing on our experience may lead to discoveries and reflection.

Continue using the materials and documenting encounters with patients.

Enlist the help of the co-op inquiry group in producing the video materials. Bring in some others too.

APPENDIX D: EXAMPLE OF A PERSONAL PORTFOLIO THAT SUMMARIES ONE PERSON'S INQUIRY AT THE END OF THE 6 MONTHS.

MY JOURNEY – WORKING WITH A CO-OPERATIVE INQUIRY GROUP TO ADAPT THE WHO PACKAGE ON "MENTAL DISORDERS IN PRIMARY CARE" TO BECOME AN EFFECTIVE EDUCATIONAL TOOL FOR SOUTH AFRICAN GPS.

Cycle 1: 18/9/99 – 16/10/99

I entered the process for personal gain:
(a). To network with colleagues "who think like me" i.e. family doctors.
(b). To avoid the frustration of academic isolation. This was an opportunity to get in touch with BS of UCT, BM of US, SM the "THE PERSON" of the academy of family practitioners and SAMA, SG, an extremely knowledgeable colleague who fits like a glove in both the public and the private sectors etc. etc.
(c). I hope to get stimulated to do some publishing of interesting conditions that we encounter and manage at primary care level, and lastly,
(d). Perhaps the process would make me take an interest in managing patients with mental ill health.

Before the first meeting of the group on the 4/9/99 I went through the package once. My impression was that it was not going to help me in my endeavour of getting interested in the management of mentally distressed patients. I saw the package as a memory jogger for those who had allowed themselves to rust (sic). At the risk of sounding arrogant, my feeling was that I had never really had a problem with identifying metal anguish illhealth in a patient, especially after I had received further training in Family Medicine. My problem however, had always lied with the management of these patients. Often after diagnosis I would refer the patient to the social worker, psychologist or psychiatrist for further management. This was because I did not have a working approach and therefore I experienced management as a long and unrewarding drag. So, I reasoned, if the package was not going to help me what then would be the incentive for proceeding with the group? Anyway BS and SG are already my friends and SM is my neighbour! As for BM ... well, I surmised, life is tough. The other thing is: I do not need more CPD points. I have already got so may that I would sell points to two other doctors and still be left with enough to recertify!

I was with a sceptical mood that I attended the first meeting "to see what would unfold". I had done my homework entailing reading the package, articles on PAR and on reflection. I had also done an exercise on previous experiences with dealing with mentally ill patients.

The group was amazing – all sceptics like myself! I was in the wrong camp ... or was it the right camp? Issues raised by the group with nodding all the way were

for example ... "the package is too simplistic"; "it does not mention anything that we already do not know" and I specifically said, "the package lacks holistic care". Regarding our experiences with patients I related the story a story about Mrs. F, a patient with schizophrenia. Mrs. F has cancer of the left breast. She refused all forms of treatment offered at GSH. She is now sitting with a huge fungating and ulcerating mass. In her breast which she expects me to manage! I was beginning to resent Mrs. F and in fact earlier that week I had expressed my reluctance to continue seeing her to the psychiatric nurse "because I had arranged umpteen appointments and transport to take her to GSH and she had always let me down by refusing to go". As I was relating the story the obstacle in my dysfunctional relationship with this patient became clear to me ... I had never attempted to enter Mrs. F's mental-world and understand where she was coming from. My excuse (sub-consciously) was that she was attending psychiatry. This compartmentalization of care with the psychiatrist being the "mind-doctor" and me being the "body-doctor" needed to be modified.

The members of the group were then paired to tell each other about our understanding of the PAR. As my partner and I were talking, I was liking what I was hearing about the PAR ... honesty, sharing, open-mindedness, no judgement of others, opportunities, team work, freedom to explore ... all positive things. Maybe, I wondered, there was something for me in the group ... if nothing more than to change my "stinking attitude" (sic) and to acquire training in the PAR.

The homework that I had determined for myself at the end of the session was to use the package on patients with alcohol disuse problems and to explore their environment using genograms. By doing genograms I was hoping to identify support structures for the patients. I did not like the definition of alcoholism provided in the package (men: more than 3 standard drinks/day and women: more than 2 standard drinks/day). I instead used the CAGE definition. For documentation I planned to photocopy notes from the folders of the patients and to keep a journal for reflections.

My first patient was Mr. E, a 42 year old man who is a "ceiling and partition fitter" by profession. He is now unemployed because of alcohol abuse. He presented with epigastric pains after an alcohol binge. The diagnosis was gastritis with a differential of acute pancreatitis. He responded to antacids and a pethidine injection and was able to give me a little bit more history about himself before discharge. What struck me as I was paging through was the numerous times that I had seen him in Triage for trauma related problems but I could not remember his face. I was also flabbergasted by the fact that I had handled him purely biomedically – the family physician that I profess to be! Mr. E readily admitted to having an alcohol problem and said he had been planning to do something about it. When I enquired after his family the hard-faced expression was replaced by an angelic softness. He agreed to come back for follow up with his wife.

On follow up the genogram which was constructed mostly with the information given by Mr. E's wife. It revealed marital disharmony attributed to by Mr. E's lifestyle of alcohol abuse and usage of hard substances. Mr. E hardly knew his children. Only his wife knew their ages and the grades that they were doing at school. Mr. E expressed that he was ashamed of that and he had been unaware how estranged he had been with his family.

The package was used to go through "Common Psychological and Physical Symptoms of Alcohol Abuse" and "How to Reach Target Goals".

When they left Mrs. E thanked me profusely for the opportunity given to talk about her concerns. I felt I had made a breakthrough. Follow up appointment was given.

My next patient was EZ, a 30 year old unemployed polio victim who walks with elbow crutches. He had a teddy bear (huggable) personality. EZ complained of "fat legs" for a month. He said he was having difficulty with squeezing his feet into his orthopaedic boots. On examination I found him to have a huge myopathic heart and he was in cardiac failure. It has only when I drew the genogram that it dawned to me that he was consuming a lot of alcohol on a daily basis. EZ lived with relatives who were all employed. Every morning when the other family members went to work he visited a shebeen down the road with the intention of playing cards and pool with the other customers. He said he was offered alcohol beverages frequently and never refused them. EZ is an intelligent patient and it was easy to convince him to stop taking alcohol altogether because I made it clear that it was poisonous to his heart. I have not met his family members due to their job commitments but I understand his friends from the shebeen are now supportive. They even organised transport for him to come to the hospital. EZ is now doing well on medication.

The other patients with alcohol abuse problems presented in a disguised way e.g. unemployment, repeated trauma, elevated INR (a measure of thinness of blood) and gouty attacks. Previously I never asked patients of Moslem religion about alcohol use lest I offend those who were teetotalers. Since using the package I do and I have been surprised on many occasions.

The package is useful on guiding the patients on how to lessen alcohol consumption. However, I have found it lacking in information on how to assist a patient to totally stop alcohol intake.

Cycle 2: 23/10/99 – 28/11/99

Whilst I was mainly focusing on patients with alcohol related problems, I was also seeing patients with anxiety, sleep disorders, unexplained body pains and chronic tiredness. I found it very difficult and awkward to use the package on patients that I was seeing for the first time. Once I had established a relationship

with a patient and thought about suitable sections in the package that would help the patient then it was easy for me to introduce the package in the consultation. Between the patients' visits I would often familiarize myself with the package.

During this period I saw Mrs. P, a 38 year old patient that I had known for about three years. She suffered from anxiety and had been investigated to exclude organic causes. Out of desperation because she was not getting better and because of pressure from the patient I referred her back to GSH. The re-investigation drew a blank.

In the past, before the package, when I pulled out Mrs. P's folder, my heart would sink. This time I was eager to see her. Together with Mrs. P sitting next to me we read "The Common Symptoms of Anxiety". I then turned to the first page, which read "Anxiety is common and treatable". I think what I then saw was an expression of hope, belief and acceptance on Mrs. P's face – you have to see that yourself to understand what I mean. I have subsequently had the same experience with the same patients who suffer from anxiety. In fact anxiety has now become my pet subject. I find it gratifying to manage because the patients show improvement quickly after the acceptance of the diagnosis. I am also amazed by how common it is in both men and women.

There are also patients with anxiety disorder that I saw in private practices. There I found it a bit of a challenge to manage because the patients did not know me. It became very uncomfortable for me to start asking personal matters. It was also difficult to try and squeeze everything in one session of +- 15 minutes, as continuity by myself is not guaranteed. Out of desperation I asked one patient what he would want me to do for him. He said he wished I could remove his fears especially the fear of getting a heart attack. This was a learning experience for me. I now often ask directly "what are your fears?" or "what would you like me to do for you?" The answers that I get are mind blowing. A patient who had a strained relationship with her only son said to me " I want to be able to tell my child that I love him ... I find it very difficult to show him that I love him ... I find it easier to shout him".

Some of the patients that come to my mind are the elderly. Mrs. Z, a 70 year old grand mother presented with general body pains. On physical examination there was nothing objective to find. Looking through her folder, she had no chronic medical conditions. Of concern was the multiple recent hospital visits. Mrs. Z denied social stresses. My gut feeling told me to explore because in my book there is no patient who present with nothing. A genogram revealed that she was staying with her son, his wife and their two year old child. When I enquired about their relations, she started crying ... and then everything came out. She said she was exhausted and upset because her son and his wife recently told her that she was going to be looking after their daughter for one more year before she could go to crèche'. It was trying for her to look after a boisterous two year old alone during the day. She said she could not even take a nap during the day because

she was apprehensive a child could injure herself while she was asleep. Mrs. Z did not want to tell her children this lest she alienates them. Following counseling we agreed that the children needed to be told. We both phrased a non-accusing letter requesting them to relieve her of this duty. The letter did miracles, the children put the child in crèche' and even asked a neighbour to keep an eye on Mrs. Z during the day. All along the children were not aware that their mother was getting old and frail. Needless to say, the unexplained somatic symptoms disappeared.

Mrs. Z's story had a "mirror-of-me" effect on me. I also have a child who is looked after by my 71 year old mother. Although there are also relatives who helped with the child my mother is the one who is mainly responsible. The very same evening that I saw Mrs. Z I phoned my mother and demanded to know how exactly she felt about looking after my child. She reassured me that my concerns are unfounded and said "tell those people in Cape Town that the child belongs to the whole family".

Another old lady that I saw recently was also in her 70's. she complained of " a painful thing under her arm. On examination it was an innocent skin tag. I told her categorically that she was hiding something from me. Yes, she agreed, the roof of her house that damaged tormented her by tornado. The councillors had promised to arrange for the repair work to no avail. The family live on her pension. Mrs. Sam was worried about the coming winter rains. We decided to write a letter to the ward councillor. If nothing comes out of this the Social worker said she will refer her to the NGOs that may help her.

Some of the other patients that I saw had a mixture of depression, insomnia, anxiety, unexplained somatic complaints and/or alcohol dependence. There were also various ways where the mental illnesses were expressed e.g. low self esteem, obesity, poor appetite, etc. etc. in all cases I found the genograms useful. Most households were shown to be dysfunctional. Where there was marital disharmony it became difficult to assist as the spouses (mainly husbands) refused to come for counseling. I am only seeing one couple at the moment. My partner also refuses to go for counseling when we have problems!

I introduced the package to my colleagues and they seem to be impressed first time. The two who actually used it said they liked the approaches of "Chronic Tiredness" and "Unexplained Somatic Complaints". One colleague especially liked giving out the copies of the "Personal Progress Chart" for the patients to fill them out between their visits. She had found this to be a powerful tool to get the patients involved in the management of their ill health. She also said an unexpected spin-off was that the whole family seemed to get involved with the completion of the charts.

Subsequently I also gave out personal progress charts. With the first ones the patients encountered difficulties with interpreting the visual analogue scale. After I corrected that problem it was easy to fill them out.

Cycle3: 11/12/99 – 22/01/00

I have always enjoyed our gatherings as a group because even though we were meeting for "serious staff" the atmosphere was always informal and nonthreatening. Our group worked well as a unit and thanks mostly to the leadership of IMB who is full of fun and wit. I was therefore not in a mood to attend the writing workshop given by a stranger (Dorian Haarhof). Why didn't IMB or BS give it?

The Saturday of the workshop was particularly hot and I was feeling lethargic because of this. It was the day when I made up my mind that I was going to get myself a car with an air conditioner. I was very irritable because I felt I should have been at home rather travelling in the sun to some workshop. The workshop was unfortunately a necessary evil – BM had made that clear in his indirect no nonsense way!

At the workshop we started off by analysing a text on "Hanna's kist" – a beautiful story. It was interesting to listen to the varied interpretations of the story by members of the group.

We did a lot of creative work like speed writing and blind writing. We reflected on things that we had done and gave feedback to the group. We also did a lot of hearkening.

The workshop gave me confidence that I could write. Dorian emphasised that writing should be embodied i.e. life needs to be breathed into stories. That is why when you read of good authors you feel as if they are talking directly to you.

It is also ironic that Dorian was the one who made it clear to me how our work was going to be presented in the end. He said we should look at the PAR as an 11 course meal with each one of the participants writing their own story and relating their own experience of the process. It is this analogy that has made it easier for me to write about my own journey. I wish we could have had the workshop much earlier!

Cycle 4: 22/0100 – 03/00

Soon after the group's last meeting in January, our chief medical officer mentioned that she saw the PAR-groups' picture in the SAMJ. She asked me share with the other doctors "what you are doing with BM?". This led to me presenting to my colleagues about our research. I amazed myself about my clarity about the process of the PAR! Basically the talk was about our objectives,

where we were and where we were going. The new doctors wanted to try out the package and so our CMO made photocopies of the package for everyone.

The feedback from the doctors has been very disappointing. Most of them said they had no time to use the package. They felt the black and white photocopies were not as stimulating as using the colour coded package. The former was also easier for navigation. As mentioned before, the task of using the package with private patients was daunting.

The one patient in private who comes to my mind because I felt we had one effective session was Mrs. IS. She presented with chronic headaches that were of tension type. Mrs. IS's facial expression was concerning and I decided to explore using the internalised information from the package. She had symptoms of depression but was not suicidal. The genogram revealed that she had a 17 year old son who was a gang member and was using hard substances. The son was "always fighting with his father". Mrs. IS's marriage was "dead" and the couple is spending most of their energy on "trying to get the child right". Mrs. IS said she was not aware that she was suffering from depression. Fortunately Mrs. IS said she had psychiatric services at her workplace and I referred her for further management. Mrs. IS liked the idea of a family conference.

Summary

This summary is compiled mostly from my reflections.

The more I use the package, the more I experienced its power as a clinical tool in identifying and managing mental illnesses.

The process has given me confidence. The proverbial "fear of opening a can of worms" has become a thing of the past.

It is difficult to measure patient-satisfaction. However, I have a feeling that I have satisfied many patients since starting to use the package than before. My recipe' is quite simple: I follow the principle of family medicine (e.g. easy accessibility and provide continuity) and I explore the patient's environment. A patient who feels heard is a joy to manage.

This reminds me of Mrs. H, a schoolteacher who is in an abusive relationship she presented with unexplained somatic complaints and on probing, I found her to have a very low self-esteem. She said her husband of ten years was always criticising her in front of her children and others. The criticism was for example about her appearance, her cooking and her role as a mother. In the process of counseling it was revealed that her main problem was negative thinking especially about herself. Guided by the section in the package that says "changing attitudes and ways of thinking" I have been helping the patient to retrain her mind to think positively. For example, she had a thought of "I feel

useless" and she changed the thought to " I am not useless, I have an important purpose in life. I teach children and I am raising two children well".

The exercise that I also find to be useful for the patient and for myself is slow breathing which is described under the section of "Anxiety". This exercise is employed for any situation when "things are getting too much".

Using the package has built trust in my relationship with patients. Mrs. R is a patient who suffers from dysthymia. The source of this is her husband's infidelity. Her husband has refused counseling in the past three years and Mrs. R has been adamant that she wants to keep her marriage for religious reasons. Basically I felt stuck with this patient because there was no progress and she did not want to be refereed to other health providers. Therefore the introduction of the package was a welcome tool for me. We worked using the section of "Coping Skills". Somewhere along the line our relationship gained more depth. For the first time Mrs. R revealed the real issue. She did not mind that much that her husband had a girlfriend but the problem was that the girlfriend was from another religion and this was scandalous in her community.

Contrary to my previous experiences using the package has become a time saver. The process of patients accepting their diagnosis is much quicker than before and using the progress charts encourages patients to own the healing process. One of my patients said she is more in touch with herself since she started completing the progress charts. The package also engages me, the carer to become focused albeit in different ways for each patient.

The package encourages individualistic care. I have found, for example, that five patient with anxiety disorder have been managed differently because their genograms revealed that they had different issues.

Several learning needs emerged during the process. The one that I have mostly difficulties with is managing sexual issues. I am not sure that I will be happy to play the role of a sexologist!

09 March, 2000.

APPENDIX E: MATERIALS FOR 'MENTAL PROBLEM' SECTION OF NEW PACKAGE

Mental Problems Checklist

These questions can be used to test the hypothesis of "mental problems?" The questions were developed in the context of Khayelitsha a Xhosa speaking township.

1. Are you thinking too much ? .....
2. How are you sleeping at the moment? .....
3. Do you feel exhausted or tired even when you are not working hard? .....
4. Do you feel sad or like crying for no reason ? .....
5. As a person there are things that you enjoy doing – do you find that you no longer enjoy these things? i.e. listening to music or going out with friends. .....
6. Do you sometimes have the feeling as though you are going to hear bad news? .....
7. a) Have you ever felt you should cut down on your drinking? ..... ❑
   b) Have people annoyed you by criticising your drinking? ..... ❑
   c) Have you ever felt bad or guilty about your drinking? ..... ❑
   d) Have you ever had an eye-opener first thing in the morning to steady your nerves or to get rid of a hangover? ..... ❑
8. Have you experienced traumatic events that made you feel extremely threatened or endangered? Or witnessed someone else in this situation? .....

If positive to any one further assessment may be required – see Mental Problems Flowchart

*If positive to **2, 3, 4, 5** then consider **depression.***
*If positive to **1, 2, 6** consider **anxiety disorders.***
*If positive to **7** consider **alcohol use disorders.***
*If positive to **8** consider **post traumatic stress disorder.***

These questions can be used to test the hypothesis of "mental problems?" The questions are taken directly from the ICD-10 Classification.

1. Low mood or sadness?.....
2. Loss of interest or pleasure? .....
3. Decreased energy and / or increased fatigue?.....
4. Have you had any problems with sleep? .....
5. Feeling tense or anxious?.....
6. Worrying a lot about things? .....
7. a) No. of standard drinks in a typical day when drinking?
   b) No. of days / wk having alcoholic drinks?

If positive to any one of these questions further assessment may be required – see Mental Problems Flowchart.

*Positive to **1, 2, 3** or **4** consider **depression***
*Positive to **5** or **6** consider **anxiety disorders***
*If **7** is 21/wk or more for men or 14/wk or more for women consider **alcohol use disorders***

Mental Problems Flowchart

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Clinical

Consider whether other *medical conditions* could be causing the symptoms

Consider whether the symptoms could be a side-effect of *medications*

Consider possible *lifestyle factors*

Consider whether the person has a more *specific mental disorder*

Individual

Ideas: "What do you think might be causing the problem?"

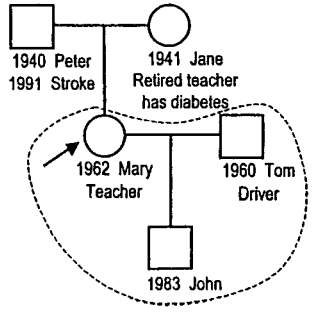
Fears: "What was the worst thing you were thinking it might be?"

Expectations: "What were you hoping we might be able to do for this?"

Context

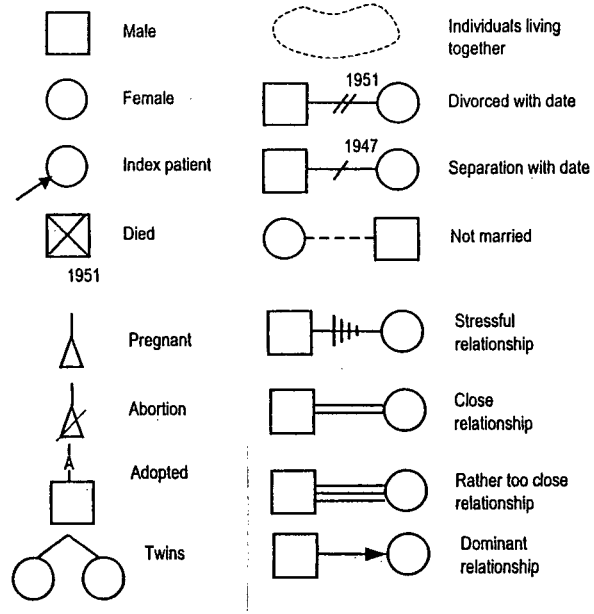
Consider the key *areas for psychosocial problems*

Consider a *genogram* to explore the family "Who else is at home with you?"



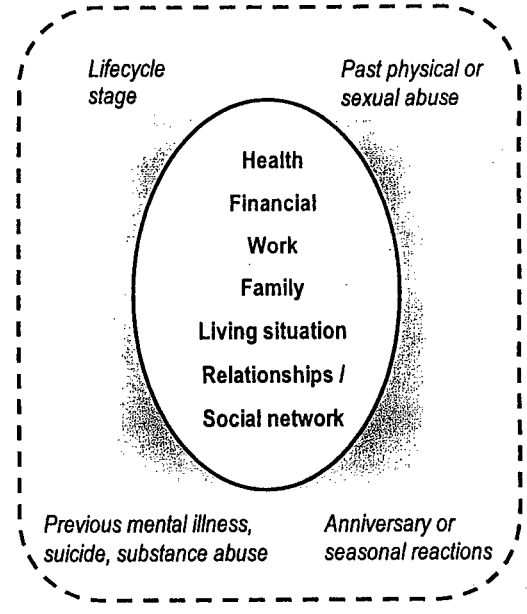
Rules of the genogram:

1. Draw a skeleton genogram at the first visit and fill in only the information needed at that point.
2. At future visits, add information as needed and as you have time.
3. At least three generations should be drawn.
4. Write date of birth rather than age.



Key areas for psychosocial problems

Items inside the oval represent patient's current life situation. Items outside the oval identify historical influences that may be relevant



Mental Problems Flowchart

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Sleep problems

Difficulty falling asleep, frequent or long periods of being awake, early morning wakening, restless or unrefreshing sleep

↓

Is there a medical problem or pain that interferes with sleep? .....❑

- *asthma, heart failure, arthritis, indigestion, backache…*

↓

Are there any medications that might affect sleep? .....❑

- *theophyilline, steroids, decongestants, some anti-depressants*

↓

Are there lifestyle issues that may affect sleep?.....❑

- *drinking alcohol, coffee, tea or eating before sleep*
- *taking day time naps*
- *changes in routine – i.e. shift work*
- *disruptive noises at night*
- *overcrowding*

↓

Consider a more specific mental disorder?.....❑

- *Depression, anxiety, PTSD, alcohol disorder.*

↓

Consider a more specific sleep disorder......❑

- *Has anyone told you that your snoring is loud and disruptive?* ***Consider sleep apnea***
- *Do you get sudden uncontrollable sleep attacks during the day?* ***Consider narcolepsy***

Chronic tiredness

Tired all the time, tires easily, tired despite rest

↓

Is there a medical problem that may cause tiredness?....❑

- *Anaemia, infectious hepatitis, glandular fever, influenza, heart failure, diabetes…*

↓

Are there any medications that might cause tiredness? .❑

- *Hypnotics, sedating anti-depressants, anti-histamines, steroids*

↓

Are there lifestyle issues?.....❑

- *Doing too much at home or work*
- *Doing too little*

↓

Consider a more specific mental disorder?.....❑

- *Depression, anxiety, PTSD, alcohol disorder.*

↓

Consider chronic fatigue syndrome? .....❑

- *Severe disabling fatigue of at least 6 months duration, present for at least 50% of the time and affecting both physical and mental functioning. Other symptoms such as myalgia, sleep and mood disturbance may be present.*

Somatic complaints

Nausea, vomiting, abdominal pains, headaches, chest pains, difficulty breathing, skin rashes…

↓

Is there a medical problem that might explain them?.....❑

- *Arthritis, peptic ulcer, asthma, angina …*

↓

Are there any medications that might cause them? .....❑

↓

Are there lifestyle issues? .....❑

- *Occupational factors i.e. musculoskeletal problems*

↓

Consider a more specific mental disorder?.....❑

- *Depression, anxiety, PTSD, alcohol disorder.*

↓

Consider a somatoform disorder if there are:

- *Many physical symptoms without a physical explanation*
- *Frequent medical visits in spite of negative investigations (often to more than one doctor, specialists and emergency departments)*
- *No other specific mental disorders*

sanofi~synthelabo

Mental Problems Handycard

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Patients with 'stress', 'nerves' and 'psychosocial problems' are common in general practice. Often a more specific diagnosis is not possible or helpful. Sometimes it may take more than one consultation to fully assess the situation, but management is still required.

Clinical:

- Treat or investigate possible underlying medical problems
- Stop or change any medication that may cause symptoms
- Look for any specific mental disorder
- Consider what other medication may be helpful
- Explain and give information about underlying lifestyle issues

Consider the need for ***relaxation techniques***

Individual:

Discuss the patient's ideas, concerns and expectations as part of your explanation, information and mutual decision making

Consider the need for help with ***negative thinking***

Context:

With the patient, consider what help you can practically offer e.g.

- On-going consultations (supportive doctor-patient relationship)
- Involvement of other counsellors, social agencies or support groups
- Application for specific grants or support
- Family conference
- Talk with the employer

Consider the need for a ***problem solving approach***

Mental Problems Handycard

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Help with sleeping problems

Benzodiazepines should only be used for up to 14 days as they have a risk of dependence. Beware interaction with alcohol and daytime drowsiness.

Paying attention to sleeping habits rather than medication is the best approach. Sleep hygiene may be useful:

- Exercise regularly, but not just before bedtime
- Avoid sedatives (e.g. alcohol) just before bedtime
- Avoid stimulants (e.g. caffeine, nicotine) just before bedtime
- Eat only a light snack just before bedtime
- Relaxing routine (e.g. hot bath) just before bedtime
- Ensure that the room is quiet and comfortable
- Use bed only for sleeping and sex
- Avoid daytime napping (except in the elderly)
- Get up at the same time each day (even if tired)
- Don't watch the clock after going to bed
- If not asleep within 20 minutes, do low energy activity in another room (e.g. reading) until tired

Non-benzodiazepine hypnotics and antidepressants may be useful in primary insomnia.

Sleep apnea, narcolepsy or other sleep disorders will need referral.

Help with chronic tiredness

There are no effective medications specific to fatigue. Activating antidepressants (e.g. fluoxetine) are sometimes helpful.

In **chronic fatigue syndrome** a graded exercise programme and cognitive-behavioural therapy may be helpful. Gradually increase the level of physical activity

A little activity 1 or 2 times a week

- *i.e. walking*

Daily activities – not much effort

- *i.e. fast walking, shopping, cleaning*

Activities that makes you out of breath for 20 minutes or more, 3-5 times a week

- *i.e. jogging*

Help with somatic complaints

Explanation of the links between emotional stress and physical symptoms is important. Acknowledge that the physical symptoms are real.

In a somatoform disorder:

- Try to avoid unnecessary diagnostic tests or prescribing a new medication for every symptom
- See the patient regularly, rather than waiting for them to come
- Antidepressant medication (e.g. amitriptyline 50-100mg a day) may be helpful in some cases (e.g. chronic headache, atypical chest pain)
- Focus on managing the symptoms and the patient's functioning, not on discovering a diagnosis
- Give specific reassurance
    - *This does not mean that there is nothing wrong*
    - *You are not going to develop serious illness*
    - *The symptoms are real but they are not caused by physical disease*
- Relaxation techniques and dealing with negative thinking may help
- Increasing levels of physical activity may help
- Avoid recurrent referral to specialists. Patients are often offended by referral to a psychiatrist.

Relaxation skills

Learning how to relax is necessary for mental health in all people. For some people, who have a particular problem with anxiety, stress or tension, learning to relax may be essential. Specific relaxation techniques can be learnt.

The relationship between mind and body is well illustrated by relaxation. Many aches and pains in the back, neck, shoulders and elsewhere are the result of tension. The pains themselves are then another source of worry and often the reason to go to the doctor. Similarly, sleep problems may be due to "thinking too much" and being unable to relax at night.

Step 1: Preparing to relax

There are many methods or types of relaxation skills. No one method is proven to be more effective and it is probably a matter of personal choice which one to use. It is important however to stick with one approach and to practice it on a daily basis. For example deep muscle relaxation, yoga or meditation. Deep muscle relaxation is described below.

You will need about 30 minutes a day and should choose a time that suits you best. Learn at your own pace, don't pressurise yourself. Settle yourself in a warm and comfortable place. Loosen any tight clothing. You could lie down on your back and close your eyes or sit comfortably with your eyes open.

Tune into your breathing. When relaxed you will breath with your stomach moving in and out. If all the movement is from your chest then you are less relaxed. You can place a hand on each to help you become aware of what is happening. Tell yourself to "let go" as you breathe out.

When you are settled, start to go through the muscles one by one.

Step 2: Practice

The basic exercise: Turn your attention to your hands. When you are ready, tighten up all the muscles in both your hands. Clench your fists, and hold the tension while you count slowly to three, then let the tension go. Feel the tension drain out of your fingers, and let them come naturally to rest. Each time you breathe out allow your hands to become heavier. Let the blood circulate right to your fingertips, as you feel more and more deeply relaxed.

Once you have finished move on to the next muscle group.

The muscle groups:

- *Hands*: Clench the fists. Now, let go.
- *Arms*: Tighten the upper and lower arms together (without the hands)
- *Shoulders*: Raise your shoulders as if they could touch your ears
- *Feet*: Screw up your toes
- *Front of legs*: Point your foot away from you, so that it is almost parallel with your leg
- *Back of legs*: Flex your feet upwards, stretching your heels down
- *Thighs*: Tighten them while pressing your knees down into the floor
- *Bottom*: Clench your buttocks together
- *Stomach*: Hold you stomach muscles in tight
- *Lower back*: Press the small of your back into the floor
- *Chest*: Breathe in, hold your breath and tighten all your chest muscles
- *Shoulders*: Breathe in, hold your breath and raise your shoulders as if they could touch your ears
- *Neck*: Stretch you head up , as if your chin could touch the ceiling
- *Neck*: Bend your head forward until your chin reaches your chest

- *Mouth and jaw*: Press your lips together and clench your teeth
- *Eyes*: Close them up tight
- *Forehead and scalp*: Raise your eyebrows as if they could disappear
- *Face*: Screw all the muscles up together

This exercise goes from your hands to your shoulders and then from your feet up to your head. The exact order is not important.

When finished, enjoy the sensation of relaxation and tune in again to your breathing.

When relaxed you may find it helpful to mentally focus on relaxing images. Make a list of places or situations that you find calming or relaxing and imagine these when your muscles are relaxed. Gently bring your attention back to these relaxing images if worries start to intrude.

Do not leap up too quickly or you may feel slightly dizzy and undo the benefits of the exercise.

It may help to record the instructions on a tape and play this in the background or have relaxing music.

Step3: Application

But how can you apply this in normal life? You can't practice deep muscle relaxation while driving a car or looking after children.

Shorten the relaxation exercise. As you master the exercise you will be able to shorten it and still obtain relaxation. You may want to concentrate on only a few muscle groups, or only on those that feel tense. Develop the ability to practice the shortened version more frequently during the day when you are involved in your usual routine.

Practice in difficult situations. Try to use the exercise in different positions and situations. While sitting, walking, washing up. Try to use the exercise in situations that make you tense. Become aware of increasing tension and catch it early.

An example of a quick relaxation routine:

1. Tune into your breathing. Take one deep breath in, hold it, then tell yourself to let go as you breath out. Breath naturally for a while, repeating the instruction to let go with every outward breath.
2. Tense up and then relax a single muscle group such as your hand, foot or stomach. When you let go, try to let all the unnecessary tension slip away.
3. Drop your shoulders

Step4: Develop a relaxed attitude

1. Adopt a relaxed posture. When sitting consciously adopt a relaxed posture. Not sitting tense on the edge of your chair or constantly fiddling.
2. Stop rushing about. Consciously go more slowly, you will probably achieve just as much.
3. Make a habit of doing the things you find relaxing. These may be peaceful things, such as reading or listening to music, or strenuous things, such as cycling or running.
4. Seek out pleasures and treats. Enjoyment and relaxation are connected.
5. Give yourself breaks. Take short breaks during the day, talk to a friend for example, as well as longer breaks and holidays.

Controlling your breathing

Over-breathing

In some people over-breathing increases the physical symptoms of anxiety and panic.

It is natural to breathe more quickly and more deeply when afraid because this prepares the body for action. Over-breathing however (hyperventilation) leads to unpleasant sensations that add to the feelings of panic. These sensations include feeling short of breath, dizzy, sweating and tingling in the hands and feet. It feels like you are not breathing enough. The natural response is to breathe in more, but this just makes the problem worse. The best solution is to slow down your breathing. Over-breathing and its effects can be controlled by learning how to breathe calmly.

The following slow breathing technique should be practiced many times when you are not anxious, so that you can use it effectively when you have symptoms of panic or anxiety. Practice twice a day for a week, until you feel comfortable with the exercise, before using the method during a panic attack.

1. Breathe in slowly through your nose to the count of 3 seconds ("one hundred, two hundred, three hundred")
2. When you get to 3, slowly breathe out through your mouth to the count of 3 seconds.
3. Pause for 3 seconds before breathing in again.
4. Put a hand on the stomach to see if it moves up and down when you breathe. You should aim to move your stomach more than your chest when you breathe. Your breathing is more relaxed when you move your stomach more than your chest.

Breathing into a paper bag

If you are not able to control your breathing during a panic attack it may help to breath into a paper bag.

1. Use a paper and not a plastic bag. Make sure there are no holes.
2. Hold an empty paper bag tightly over your mouth and nose with both hands.
3. Breathe in and out for a maximum of 10 breaths, this should reduce the sensations caused by over-breathing.

☑ *Depression and Anxiety Support Group*

- This is a not-for-profit organisation that aims to provide educational material, to support self-help and to improve access to health care. There is a network of support groups and counsellors throughout South Africa. Books, tapes, pamphlets and brochures are also available. Referral to experts and free medical treatment may be offered where appropriate.
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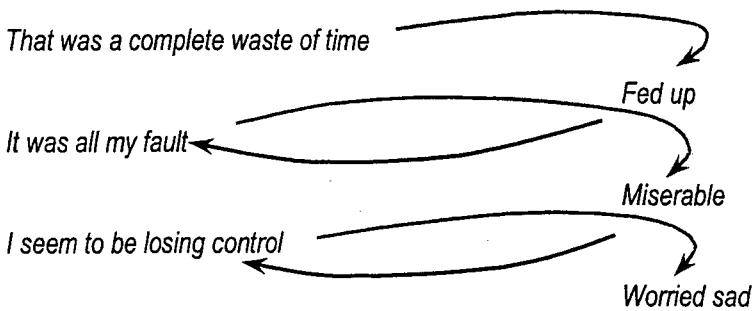
Dealing with negative thinking

Every situation or problem has a number of ways of seeing it. We all tend to choose a particular viewpoint and see this as the only "right" one. Our moods and ways of seeing things are linked together. For example negative thoughts lead to negative feelings, which increase negative thoughts in a downward spiral.



You can choose to see things in a different way. If you think differently, this can help your mood and increase more positive or realistic thoughts. Dealing with unrealistic or irrational thoughts is important for everybodys mental health. If you suffer from depression, anxiety or post-traumatic stress disorder it may be especially important to change the way that you think or see things.

Some strategies may help you to become aware of your negative thought patterns and to change them.

The thought diary

A thought diary is a record of your feelings and associated thoughts on a daily basis. You should make an entry at least once a day, but more frequently is better. Identifying the situation and your feelings, will help you remember the exact thoughts that you had. Ask yourself 'What went through my mind at the time?'. Thoughts include all the content of your mind – beliefs, attitudes, ideas, images, dreams. *For example*:

Situation	***Feelings***	***Thoughts***
➢ *Be specific*	➢ *There may be more than one*	➢ *Keep the different thoughts separate*
Travelling to work	Sad	I've made the wrong decision about accepting this job. There's nothing I can do to change it.
Sitting at home after work	Depressed	I'm all on my own I don't have any friends.

The more you use the thought diary the more you will become aware of your thoughts and thinking. If a relatively small event provokes much stronger feelings that you think it should, it may be because this situation has some special meaning to you. For example the reaction may have made sense in the past when you were a child, or when something happened to you, but does not fit the facts of the present situation. Maybe there is a pattern of reactions from your family or past events?

Negative thinking

There are many ways of thinking that are especially likely to make you feel bad. Review the list below and identify the "negative thinking" that most applies to you.

☑ 1. *Predicting the worst*

Predicting the worst outcome. Every symptom is a sign of serious illness, every frown a sign of rejection.

- "If I make a mistake, I will lose my job." ,
- "My heart is beating so fast I must be having a heart attack."
- "Everything is bound to go wrong."
- "I won't be able to cope on my own."

☑ 2. *Generalizing*

Assuming that because something happens once, this means it will always happen.

- "I never seem to say the right thing."
- "I always blow it at the last minute."

☑ 3. *Exaggerating*

Exaggerating the importance of negative events.

- "I'll never get over it."
- "If I can't get this right, I might as well not bother."
- "If you can say that, then our relationship means nothing at all."

Rejecting good things as if they did not count.

- "Getting this contract doesn't mean anything at all."
- "I was just lucky."
- "She only said that to make me feel better."

☑ 4. *Mind reading*

Believing that you know what others are thinking. Taking things personally.

- "She knows I've made a mess of this."
- "They all think I am stupid."
- "He doesn't like me."
- "They didn't ask me because they don't like me." "You're criticizing me."

☑ 5. *Taking the blame*

Taking responsibility when it is not yours.

- "It's all my fault."
- "They'd be happier if I was a better mother."

☑ 6. *Emotional reasoning*

Mistaking feelings for facts.

- "I'm sure they've had an accident."
- "I love her so much she's bound to feel the same."

☑ 7. *Name calling*

- "I'm bad"
- "I'm stupid"

☑ 8. *Wishful thinking*

Supposing things would be better if only they were different.

- "If only I were ...younger...thinner...smarter...not the way I am."

Look out for the following words in your thoughts, which are often not true or which place you under tremendous pressure.

Should:	"I should have done better"
Must	"I must not make a mistake"
Have to	"I have to keep this relationship going"
Ought	"I ought never to be angry"
Always	"I always have to clear up after you"
Never	"I'll never change"
Nobody	"Nobody ever notices me"

Changing your thinking

Keep the thought diary for a few weeks. Then take each thought one at a time and search for alternative points of view or other ways of thinking that would make you feel better.

Thoughts	***Alternative points of view***
➢ *Take one at a time*	➢ *There may be more than one*
I've made the wrong decision	It seemed the right one at the time
	It's too soon to tell
	I probably think that because I am feeling so bad
I am a failure	I am not a failure.
	I have achieved many good things in the past
I am sure they know that I am anxious and my fork is shaking	It is unlikely that they have noticed my anxiety

Questions that may help you discover alternative viewpoints:

- Questions about thoughts. What other points of view are there? How would someone else think about this? How else could I think about it? How would I think about this if I were feeling better?
- Questions about reality. What are the facts? What is the evidence? How can I find out which way of thinking fits the facts best?
- Questions about negative thinking. Could I be making a mistake in the way I am thinking?
- Questions about coping. What is the worst that could happen? How bad is this going to get? What can I do when that happens? How can I get help?

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Problem-solving approach

Problems of living are common and may cause physical symptoms such as headaches, muscular pain or sleep problems. Commonly problems of living occur in the following areas:

- *Relationships*
- *Work*
- *Finances*
- *Family*
- *Living situation*

Identify the problem

It is helpful to discuss your problems with a trusted friend, family member or counsellor. After discussion, try to write down exactly what the problem is. Try to be as specific as possible. For example 'Not having a job' or 'My husband drinks all the money' is better than "I have no money'.

Think of solutions

Take one of the problems and 'brainstorm' possible solutions. Do not judge your solutions however silly they sound, just keep writing them down. Do not judge what is realistic or possible at this stage. Make a list of all your ideas. It may help to distance yourself from the problem. For example ask yourself "How would I advise a friend with a similar problem?".

Taking S.T.E.P.s

☑ *Select a solution*

Go through the list and look at all the pros and cons of each suggestion. Select the solution that is most acceptable, realistic and feasible.

☑ *Try it out*

Work out in detail what it involves to do this and take the necessary action. Set a realistic time frame or deadline for this.

☑ *Evaluate what happens*

Did this solution work? Was it helpful? Often it will help but not completely. Should you persist with this or try a different solution?

☑ *Persist until you feel better*

You may be on the right track, but need to go further. You may need to persist. After some time you may need to go back to the beginning and identify more problems. Having solved part of the problem the other aspects may become clearer.

Four guidelines for problem-solving

1. Do not waste time on problems that cannot be solved: shift your focus
2. Tackle one problem at a time
3. Work on changing yourself, not on changing others.
4. Consider whether doing nothing, at least for the time being, and learning to accept the problem, would be helpful.

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APPENDIX F: EXAMPLE OF A PARTICIPANT'S REFLECTIVE JOURNAL FOR MODULE 5

Reflective journal: module 5

Please complete your reflective journal using the main headings below. The questions below the headings are designed to stimulate your writing and give you some structure for the journal.

Planning: How did you prepare?

How did you prepare to use the handycards?

Most of the patients seen and diagnosed as having either of one of the conditions were recalled so that they could be evaluated further and their treatment commenced. Some that were not seen before were first evaluated by using checklists, questionnaires and flowcharts; then we moved to handycards when there were positive diagnoses. The handycards were placed within easy reach so as not to raise any anxiety in the patient by frantically searching for the appropriate material while the patient wait in anticipation what is going to happen next.

How did you prepare the patient leaflets to use in your practice?

The patient leaflets were going to be discussed and given to the patient at the end of the consultation. They were not translated into Zulu. To those who could not use English I asked my receptionist, whom I had briefed thoroughly on these materials, to go through the leaflet with them again after I had seen them. Those that would say they had someone at home who could read and understand English they would be given a leaflet to take home.

Observation: What happened?

Describe what happened when you used the handycards. Describe one or two consultations.

The handycards were very useful in giving explanation to the patients as to what was happening to them.
It became easy for the patient to identify some of the common symptoms that she/he had forgotten about. It gave hope to the patient when she would discover

that she was having just another illness that could be treated and not that she was to blame for the way she was feeling.
Going through the common triggers showed the patients that their situation was not unique and that there are many people who may be going through similar circumstances.
That these conditions will respond to supportive therapy and medication made the treatment contract acceptable to all the patients.

A 38 year old lady who works at a financial institution as a section head presented with a problem of forgetfulness, inability to cope at work, sleep disturbances, tearfulness and lack of sexual pleasure. Depression was diagnosed after going through the relevant checklist and flowchart with her. The trigger was a recent bereavement. She had recently lost her 9 month old baby under suspicious circumstances. Stress at work was fuelling the depression, as it is one of the recognised triggers according to the handycard. The available treatment options were offered to her (supportive therapy and medication). Follow up consultations were arranged with her. A patient leaflet was also given to her. I told her that I expect feedback on whether the leaflet was helping her at the next consultation.

Describe what happened when you used the patient leaflets. Describe one or two patients who used the leaflets.

I found that the information on the leaflet was enormous. It took quite sometime to go through. The section on keeping the progress record was a bit hard to explain. But once the patient found out that he was going to monitor his own progress it became very exciting. We had to advise the patient to keep the leaflet in a plastic cover so that it could last for some weeks without being spoiled.

A 47 year old-divorced man who is a process engineer in a paint manufacturing plant has been recently diagnosed with a TB and an underlying HIV infection. He lives with his 15 year-old daughter. He had been successfully treated for the alcohol problem in the past after being referred by his employers to SANCA as it was already interfering with his performance at work. I found out from his daughter, who had come to see me for an URTI, that he had relapsed. No one had noticed this at work because he had started drinking about 3weeks ago after being booked off from work by the chest clinic as he was very week. I then phoned him and asked if I could go and see him at his house just to check on how he was

recuperating and to give him his hypertension treatment prescription that he hadn't collected from the surgery for 3months.During the visit I was able to raise the question of alcohol with him easily because there were a few empty beer bottles in the passage leading to his bedroom. We then went on to discuss all the dangers of alcohol (that he already knew). I then told him that incidentally I had a leaflet in my car that could help if he was motivated to discontinue. (I had not carried the leaflet with me when I went into the house as I felt that would give away the discussion I had had with his daughter). He was thankful for the visit I had paid him. I felt that I would make a big impact on his alcohol problem because I had seen him at his house. I arranged to see him in my surgery so that we could explore further the possible triggering factors e.g. stress that may be a result of the HIV and TB diagnosis.

Reflections: What did I learn from this experience?

What did you learn about explanations, giving information and mutual decision making with your patients?

I learnt that;
- giving information is a major part of a consultation.
-information leaflets cut down on the time spent giving such information to the patient.
-an informed patient is an ally to the therapist/doctor and not an adversary.
-information can be given in packages to allow the patient to assimilate the information.
-compliance is much better with informed patient.

What was your personal reaction to these tasks - your feelings and thoughts? Did these change during the module?

I am glad that I have participated in such an eye-opening exercise. Some of the information that I was sharing with the patients was new to me also. My confidence in dealing with these disorders is increasing.

How did you find the course materials? Were they easy to follow and use? Were they relevant to your practice? Were there any technical problems?

The course materials were quite good. They were easy to use. What I found interesting was that on the video the doctor gives the patient leaflet information and says you can use it for self-assessment if you are interested. Also when a psychological consultation is recommended the same is said. I thought this is part of a prescription. Shouldn't the clinician be firm on his recommendations?

If you changed, modified or translated your patient leaflets share this with the other people on the program by posting it on your group's bulletin board.

When your journal is finished please also attach it to your group's bulletin board.

APPENDIX G: EXAMPLE OF FEEDBACK TO STUDENT

Reply | Quote | Save

[Prev Thread] [Next Thread] [Prev in Thread] [Next in Thread]

Article No. 342: [Branch from no. 323] posted by **Bob Mash** on Tue, Nov. 21, 2000, 11:54

Subject: re: Journal.4

Dear , Thanks for your journal 4. A few comments:

I enjoyed the patient story and was impressed with the continuity of care over several weeks. I was also glad to see that the leaflet and personal progress chart was useful to him.

I found your reflections to be a bit brief. You comment on the course materials, but I was left wondering what did you learn? how did you change? what did you get out of the experience yourself? I was of course very glad to see your positive reaction to the course and course materials. Can you maybe reflect a bit more on this. Ideally your reflections should be based on your experience with the course materials and patients in your practice and should be both concrete and specific in themselves and in their relationship to this experience.

Best wishes Bob.

[Prev Thread] [Next Thread] [Prev in Thread] [Next in Thread]

APPENDIX H: EXAMPLE OF A MATRIX USED FOR QUALITATIVE DATA ANALYSIS OF MODULE 5

Code	Text	Reactions	Provisional Category
J5JB	I had a look at all the handy cards and patient leaflets once again – interesting to see all the new information that one see if you read through it again. I decide to keep the leaflets in my own consulting room, as to give it for the right patients – and having control over it.		Use of tools
	After telling his own "story" the patient clearly felt better, especially after having a "name" for his problem. The patient leaflet was very handy to give for the patient to confirm that the right diagnoses was made and to familiarise him with the symptoms and signs of the problem, as well as handy tips like the rewrighting of his "story". The homework I gave the patient and his willingness to do it, showed me that he was eager to get better and to give his co-operation.		Tools - effect
	It was interesting to me to see that patients are eager to know the aetiology of their illnesses and the prognosis of it. I am often so glad that I could make a fairly accurate diagnosis and prescribe the right treatment that I had forget about what the patients want to know !!		Comm skills
J5FY	I familiarized myself with the handycards and put them all at the front of the folder, ready to take out and use with the patients. The patient leaflets I have on top of the desk. I have been giving them out since the beginning of the course.		Use of tools
	In my opinion, all patients "want" information, it is just the depth that varies. The "seekers" put us through a minor oral examination no doubt about that, whereby the 'avoiders' are often to		Comm skills

	intimidated by the hospital environment, the bossy staff to ask anything, although they would like to obtain more information or have information that they can understand. I think that as doctors we should be able to talk to patients from different cultural backgrounds, at their levels , without patronising. I did not elicit previous knowledge and beliefs, but I do ask if the patient has any questions and I often employ chunking and checking and repetition. The other skills for recall I still need to assimilate. I have tried hard not to tell patient information while the sister is taking blood or the patient is dressing. There are still plenty of skills that need improving., In regards to decision making, I often hear: "well, your are the doctor, you decide". Which makes me feel like an ant, having completely missed the point with that particular patient. That answer irritates me tremendously. On the other hand, if the patient wants to get involved, it is very gratifying for both, the patient and myself, and usually a smiling patient leaves the consulting room. My thought did change during the module, at first I thought I was good at conveying info, explaining and at decision making, but now I know that their is a lot of scope for improvement.		
J5HC	I kept the folder with the handycards handy in my consultation rooms. I work in two consultation rooms so this takes a bit of organization for a disorganized person like me! I printed out the Xhosa version some of the patient leaflets.		Handycard
	I have not yet had any feedback on the patient leaflets. I hope I will be able to report back later. I have some doubts about the suitability of the handouts for illiterate patients but would like to use them on more patients and get feedback from them.		Leaflets
	I was surprised how illiterate patients respond to the "deeper" questions in the depression questionnaire.		Quests used in Xhosa
	I found that I could really relate to the course material. I have always thought that I am not doing well in the 2nd half of the consultation. So often patients have a door-handle response of " doctor, what is really wrong with me?" and so often I don't know! Especially the more illiterate patient wants to know what is wrong and so often in primary care symptoms and		Comm skills

	signs are non-specific. Patient often have a specific view like " I have ulcers" or " the child has sores (amaqakuva) inside". Do I also use these terms to explain to patients? In my book an ulcer is only an ulcer when it has been confirmed by gastrocopy. To explain dyspepsia can be quite difficult, " too much acid in the stomach", it is so much easier to agree that there is an ulcer! I have been very aware of suggestions made in the course material to improve my skills at the second half of the consultation and have tried them out. I especially find it useful to ask the patient if they need more information. I definitely prefer the mutuality style of consultation but I think I need to be sensitive to patients who prefer a more paternalistic approach. I think patients may experience me as uncertain; "You are the doctor, you decide". On the other hand patients need to get used to this mutuality just like patients need to get used to a more patient centered approach. So many patients come in and just start undressing immediately or say; "dis my kop en my maag" and then keep quiet!		
	I have had fewer patients with "mental" problems this week. I am still waiting for patients with PTSD and anxiety!		Anxiety disorders
J5HJ	THE HANDYCARDS ARE VERY IMPORTANT TO ME IN A PATIENT WITH AN ESTABLISHED DIAGNOSIS. PATIENTS FEEL MUCH MORE AT EASE AND THEY WILL ACCEPT YOUR DIAGNOSIS MORE FREQUENTLY IF YOU CAN SHOW THEM A FACTUAL "DOCUMENT" DESCRIBING YOUR DIAGNOSIS. IF THEY CAN IDENTIFY WITH IT, YOU HAVE A COMPLIANT PATIENT. I EXPERIENCED THIS BEFORE WITH ALLERGIC RHINITIS PATIENTS THAT HAVE TO USE A STEROID NASAL SPRAY LONG-TERM. PATIENTS ARE IMMEDIATELY APPREHENSIVE WHEN YOU MENTION THE WORD STEROID. THEY HAVE HEARD ABOUT ALL THE HORRIBLE SIDE EFFECTS AND DO NOT KNOW HOW THIS WILL AFFECT THEM. FOR THIS REASON I KEEP A COPY OF A PROMOTIONAL CARD USED BY THE NASONEX REPS WHERE IT SHOWS A HISTOLOGICAL SLIDE OF THE NASAL MUCOSA IN CHILDREN BEFORE AND AFTER USING THE PRODUCT FOR 12 MONTHS. THIS USUALLY WINS THEM OVER.	More useful in private practice? Literate patients? Consumerist patients?	Handycard

	.		
	THE PATIENT LEAFLETS ARE VERY MUCH SUITABLE FOR MY PRACTICE AND I'M NOT GOING TO CHANGE THEM. IF I DO GET A PROBLEM PATIENT I WILL MODIFY IT PRN. EVERY ONE OF MY PATIENTS WHO ARE STARTING OFF ON THERAPY OR ARE NEARING A FINAL DIAGNOSIS WILL GET ONE. I WILL KEEP FROM MAKING THEM AVAILABLE SAY IN THE WAITING ROOM AS PATIENTS OFTEN READ ONLY WHAT THEY WANT TO READ AND MAKE THEMSELVES FIT A DIAGNOSIS. IT IS OFTEN VERY DIFFICULT TO PUT THIS RIGHT AFTERWARDS.		Leaflets
	IT IS VERY TRUE THAT YOU HAVE TO HAVE INSIGHT INTO THE PATIENTS KNOWLEDGE OF A CONDITION. YOU WILL SAVE YOURSELF A LOT OF EMBARRASSMENT. IF IT IS A DISEASE AFFECTING ONE OF THEIR FAMILY YOU CAN BE SURE THAT THEY HAVE DONE A LOT OF READING ON THE SUBJECT. WITH THE AVAILABILITY OF THE INTERNET THIS HAS INCREASED EVEN MORE AND YOU CAN BE SURE THAT FOR THE MOMENT THE PATIENT WILL BE A SPECIALIST ON THE SUBJECT! IN ADDITION I CANNOT AGREE MORE THAT YOU HAVE TO FIND OUT EXACTLY WHAT YOUR PATIENT EXPECTS OF YOU. IN A PATIENT THAT IS VERY STRONGLY HOMEOPATHICALLY INCLINED IT WILL DEFINITELY BE THE WRONG IDEA TO MENTION STANDARD MEDICATIONS EARLY IN YOUR CONSULTATION. I OFTEN SEE THIS WITH ANTIBIOTIC USE. MOST PATIENTS WILL ACCEPT YOUR OPINION MORE READILY IF THEY FEEL THAT YOU ARE NOT DICTATING, BUT INVOLVING THEM IN THE DECISION MAKING PROCESS AND LEAVING THE OPTION TO DECLINE TO THEM. OBVIOUSLY THERE WILL BE SITUATIONS WHERE THIS IS NOT POSSIBLE AS EXPLAINED IN THE TEXT	HJ is just commenting on the text and from a theoretical perspective. Not convinced he is speaking from using the materials in his practice or doing the tasks in his practice.	Comm skills
J5KL	I prepared in the usual way - kept the file ready on my desk to refer to handy cards when necessary. My opinion is still that it is not practical to refer to a card several times during consultation. I regard the cards to be more of a	Authority voice of tools	Use of tools

	study aid for myself. The information leaflets (and questionnaires) are very handy, especially in helping to convince some patients that their symptoms are in fact psychological. Some of my patients believe strongly that they have a physical problem and I find it difficult to convince them that their somatic symptoms are caused by, for instance, anxiety. It makes a huge difference when they see a document from a university that confirms the GP's viewpoint!		
	I have not had much success in getting patients to complete the progress charts. Maybe one should rather put a copy of it in your patient's file, and then have an objective way to chart his/her progress during follow-up consultations - I have not yet done this myself.		Leaflets
	I found module 5 on a whole good and very relevant to our practice. Although schizophrenia is not a casual diagnosis in our private practice, we see a number of psychiatric patients in the state system and have to make decisions about their treatment (neuroleptics).	Schizophrenia is more imp for him. Some reservations about mod 5?	Materials
	I also agree that the "mutual decision making system" leaves the patient better informed and more satisfied. (Unfortunately time is the one factor that often throws the system out the back door!) This goes for all consultations and not only psychiatry.	Opinion not from task	Comm skills
J5KH	I prepared for this module by reading through the handycards and patient leaflets kept both in my consulting room for references. Although I have read through both before I still needed to refer to cards at times. The leaflets were all excepted well by the patients and were of great help. I found that I also needed to do some reading from textbooks on subjects, like ME/Chronic fatigue.	Needed more on CFS	Tools
	I learned about the value of mutual decisions, the effect on compliance as well as patient satisfaction. It also is about shared responsibility and respect and understanding. It also sets you free from unrealistic expectations found that in the past I didn't give enough relevant information. The handout was very well received, provided much information and saved me time.	Are people's reflections really related to their experience as shown in their stories?	Comm skills
	I did feel less threatened than I thought and		Personal

	learned new skills in communication.		reaction
J5ML	THE HANDYCARDS LIES ON MY DESK. I USE THE CARDS TO GO THROUGH THE MENTAL PROBLEM AFTER IDENTIFYING THE PROBLEM EG. DEPRESSION. BECAUSE I HAVE MAINLY AN AFRIKAANS PRACTICE I GOT LEAFLETS FROM WEBCT IN AFRIKAANS.THERE WERE NO PROBLEMS WITH MY PATIENTS USING THE LEAFLETS AND WHERE LITERACY WAS A PROBLEM, THERE WERE KIDS IN THE HOUSE WITCH HELPED WITH READING.		Use of tools
	. I REALISE THAT THIS WAS THE IDEAL PATIENT TO USE THE HANDYCARD AND TOGO THROUGH IT AGAIN. I SAW THE HANDY CARD IN THIS SURCUMSTANCE AS A SECOND OPINION AND IT WENT AS FOLLOWS; WE AGAIN WENT THROUGH THE SYMPTOMS AND SHE ADMITS THAT THERE WERE STILL A LOT OF THEM WITH HER. THE TABLETS, IN THIS INSTANCE WERE AMYTRIPTILINE AND SHE ADMIT THAT SHE IS FEELING BETTER.		Use of handycards
	PATIENTS DO NOT TAKE IN ALL A DOCTOR IS TELLING THEM. SOMETIMES PATIENTS IS TELLING ME STORYS ABOUT OTHER DOCTORS EXPLANATION OF ILLNESSES AND JUDGING FOR WHAT I HEAR I COULD NOT BELIEVE THAT THE PASIENT TRULY REFLECT WHAT THE DOCTOR WAS TELLING THEM. THE LEAFLETS IS A RESORSE THAT THE PATIENT CAN REFER TO AFTERWORD AND DON'T HAVE TO TRY TO REMEMBER WHAT THE DOCTOR TRIED TO DESCRIBE TO HIM. BY READING THROUG THIS LEAFLETS THE PATIENTS FEEL MORE CONFIDENT THAT THE DOCTOR MADE THE RIGHT DIAGNOSIS AND THE LEAFLETS ACT AS A SECOND OPINION.		Leaflet
	I THINK THE COURSE MATERIAL IS OUSTANDING, AND PATIENTS RECEIVED IN A GOOD ATTITUDE.		Materials

APPENDIX I: EXAMPLE OF A REFLECTIVE SUMMARY FOR MODULE 5

Reflective summary - Journal 5

Handycards

In general there was less comment on the handycards than the leaflets. Does this mean they were not used as much or were not as useful? Did people resist using them? It seems that the handycard was a new concept to the GP, unlike questionnaires or leaflets, they initially resisted the idea but when it was used found it helpful.

> "I had to overcome my skepticism - I believed that the approach was too sophisticated for my patients and that they were not interested in so much detail. I was proved correct a couple of times, but I was also wrong on a number of occasions...My notes indicated that he could possible have an alcohol use disorder. I decided to 'take the bull by the horns' and use the handycard to discuss the issue with him. ...Reflecting on this story I am surprised and impressed at the way in which the handycard paved the way for the discussion. " VB

> "I thought this will take a lot of my time and it did in the beginning, but later I got more comfortable using it as part of my consultation and I realised it was actually easier explaining the problem by going through the handycard than trying to do it in my own words." J5CN

The handycards were useful to in gaining the patient's acceptance of the diagnosis;

> "The handycards are very important to me in a patient with an established diagnosis. Patients feel much more at ease and they will accept your diagnosis more frequently if you can show them a factual 'document' describing your diagnosis. If they can identify with it you have a compliant patient." HJ

> "I saw the handycard in this circumstance as a second opinion..." ML

and also as a way of raising the possibility of alcohol abuse:

> "I decide to 'take the bull by the horns' and use the handycard to discuss the issue with him." VB

I wonder if they are useful as a prompt or guideline to the doctor? KL though felt uncomfortable with referring to a card in front of the patient.

> "My opinion is still that it is not practical to refer to a card several times during the consultation. I regard the cards to be more of a study aid for myself." KL

I wonder if they have limited usefulness in non-English speaking patients and illiterate patients? Any experience with this?

Patient leaflets

The patient leaflets were used without adaptation in their current format and were given to specific patients with the condition - they were not used as information for the general public. Different GPs used the English, Afrikaans and Xhosa versions. The leaflets seemed useful in a number of ways:

They could act as an authoritative voice in the consultation and could facilitate acceptance of the diagnosis by the patient.

> "The information leaflets are very handy, especially in helping to convince some patients that their symptoms are in fact psychological... It makes a huge difference when they see a document from a university that confirms the GP's viewpoint!" KL

> "We used the leaflet as a guideline for discussion and I found their scepticism decrease after seeing all these abstract things in print." J5SN

They provided information to the patient and also increased the patient's self-awareness. They also helped to reinforce and remind the patient of the key messages after the consultation:

> "[it] was very handy to give for the patient to confirm the right diagnosis was made and to familiarise him with the symptoms and signs of the problem, as well as handy tips like the writing of his 'story'." JB

> "The leaflets is a resource that the patient can refer to afterwards and don't have to try and remember what the doctor tried to describe to him." ML

The progress charts in the leaflets were not of much practical use or required more motivation for the patient to use:

> "I have not had much success in getting patients to complete the progress charts." KL

> "I found that the information on the leaflet was enormous. It took quite sometime to go through. The section on keeping the progress record was a bit hard to explain. But once the patient found out that he was going to monitor his own progress it became very exciting." J5AM

> "The part of the explanation and what the family should do was much appreciated by the patients, but the record progress was a bit neglected... Maybe the reason was that I followed them up too early and that I should explain more what the purpose of keeping the records were." J5CN

It was suggested that a tool for follow up and maybe a rating scale in the records could be useful instead. Maybe we should develop such a tool and allow the GP to identify key target symptoms? Any thoughts?

The leaflets could also be useful in illiterate patients if there was a literate family member in the house.

> "There were no problems with my patients using the leaflets and where literacy was a problem there were kids in the house which helped with reading." ML

However other GPs expressed doubts about this.

> "I have some doubts about the suitability of the handouts for illiterate patients but would like to use them on more patients and get feedback from them." HC

There was also a need to get more feedback from patients on how they found the leaflets, but the feedback received was positive

> "I have not yet had any feedback on the patient leaflets." HC

> "I also thought that it will be paper wasted to give the patients the leaflets, but some patients gave good feedback and told me I were the first doctor to give them such an explanation and that they actually understood their illness better after reading through it. Their families were also impressed, because they also could understand what was going on with their family member." J5CN

> ""I am surprised and impressed at the ... interest the patient displayed in the content and his response to the 'homework' in the patient leaflet." J5VB

Has there been more feedback from patients subsequently?

The leaflets could be used as homework between consultations to save time and also strengthened the doctor-patient relationship.

> "The homework I gave the patient and his willingness to do it, showed me that he was eager to get better and to give his co-operation." JB

> "Information leaflets cut down on the time spent giving such information to the patient." J5AM

There was a need to translate the leaflets into more languages, although other members of the PHC team could be used to go through the leaflets:

> "They were not translated into Zulu. To those who could use English I asked my receptionist, whom I had briefed thoroughly on these materials, to go through the

> leaflet with them again after I had seen them. Those that would say they had someone at home who could read and understand English they could be given a leaflet to take home." J5AM

The leaflets and approach to mutual decision making did not work well in acutely disturbed patients.

> "Obviously the patient was (and still is) a high risk for suicide. Although the patient apparently looked in touch with reality and receptive to information, she was indeed not in a state of normal thought process and rational decision making." J5SS

The leaflets could be therapeutic when the self-help suggestions were followed:

> "I also gave him the leaflet to take home. When he follow up I were surprised that he had indeed find a friend to share his experience with - the friend was also in a car accident recently - although not as dramatic as my patient. The leaflet was helpful to him in re-formulating the event. When he was re-writing the event himself he came to the realisation that there was not anything he could do to prevent the dramatic accident and that alone meant a lot to him." J5JB

Communication skills for the second half of the consultation

While most people aspired to a more mutual and participatory decision making process it seemed that patients often expected a more paternalistic approach.

> "In regard to decision making, I often hear: "well you are the doctor, you decide". Which makes me feel like an ant, having completely missed the point with that particular patient. The answer irritates me tremendously." FY

> "I definitely prefer the mutuality style of consultation but I think I need to be sensitive to patients who prefer a more paternalistic approach. I think patient may experience me as uncertain 'You are the doctor, you decide.'" HC

> "What I found interesting was that on the video the doctor gives the patient leaflet information and says you can use it for self assessment if you are interested...I thought this was part of the prescription. Shouldn't the clinician be firm on his recommendations?" J5AM

> "A few patients seemed to dislike me discussing my thoughts with them - it made them nervous and doubtful about my abilities - but they were in the minority." J5VB

However with other patients

> "Most patients will accept your opinion more readily if they feel that you are not dictating, but involving them in the decision making process." HJ

> "..you can be sure that they have done a lot of reading on the subject. With the availability of the Internet this has increased even more..." HJ

It seems that patients from poorer communities in the public sector not only get a more doctor-centred approach, but have come to expect it? Is this a viscous circle where the lack of time, language and cultural barriers on the one hand combine with the patient's less informed and educated starting point and expectations of the doctor as an authority figure, to strip them of participation in decision making? Does a willingness to let the doctor decide imply a lack of questions or need for information as well? Are patient's intimidated, willing to accept that this is how the public medical system works or genuinely not interested in participating in the decision?

> "The "seekers" put us through a minor oral examination no doubt about that, whereby the "avoiders" are often intimidated by the hospital environment, the bossy staff to ask anything, although they would like to obtain more information or have information that they can understand." FY

> "So often patients have a door-handle response of "doctor, what is really wrong with me?" and so often I don't know!" HC

> "I was surprised how illiterate patients respond to the 'deeper' questions in the depression questionnaire." HC

It seems that on the one hand doctors need to be able to offer a range of roles and to be able to engage in a participatory relationship, while at the same time being alert to those who are genuinely uncomfortable with it. Maybe if we aspire to and offer a more participatory option the patients who are intimidated and disempowered will have the opportunity to choose a different type of relationship?

> "As the course progresses I realize how paternalistic I am in my approach to the patients. This is partially due to the patient profile I have been exposed to and to time constraints, but it is also because I have never learnt (I didn't realize I lacked them) the skills necessary for "mutuality"." VB

This may also be compounded by the different health beliefs and explanatory models that the patient and doctor are using.

> "Especially the more illiterate patient wants to know what is wrong and so often in primary care the symptoms and signs are non-specific. Patients often have a specific view like "I have ulcers" or "the child has sores (amaqakuva) inside". Do I also use these terms to explain to patients? In my book an ulcer is an ulcer when it has been confirmed by gastroscopy. To explain dyspepsia can be quite

> difficult "too much acid in the stomach", it is so much easier to agree that there is an ulcer!" HC

One doctor modified the depression leaflet to include a bio-medical explanation. This may help the patient to see it as a disease that they have developed rather than a personal weakness or something they brought on themselves. Does this also make the doctor more comfortable to be back in a bio-medical model?

> "I modified the depression leaflet by including a drawing of a synapse to explain the chemical basis of the illness. While patients may not remember all the jargon, some actually know a bit about the illness and I think that it helps the patient understand that this was not something they brought onto themselves, but that there is a scientific reason for their feelings." J5SN

Other issues

HC found that he does not seem to see many patients with PTSD and anxiety in his practice - is this a lack of recognition, a remarkably mentally healthy community (!), or a mismatch between the concepts of anxiety disorders in the ICD-10 and the symptoms provided by patients? Or?

KL commented that those working in the state system may have a need for skills in managing the follow up of patient's with schizophrenia - is this not adequately addressed - should there be a tool for this?

KH found that he needed to do more reading around the topic of ME/Chronic fatigue in the textbooks - were the books provided on-line adequate for this or a bit thin?

For me one of the most wonderful reflections on the interaction with the course was:

> "The best thing about this course is getting to know myself, being able to improve my strong points, discard the bad and acquire plenty of new skills." VB

If this is happening I am a happy man!