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ORIGINAL ARTICLE

Barriers to the Treatment of Mental Illness in Primary Care Clinics in Israel

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Abstract The present study examined physicians' perceived barriers to the management of mental illness in primary care settings in Israel. Seven focus groups that included a total of 52 primary care Israeli physicians were conducted. Open coding analysis was employed, consisting of constant comparisons within and across interviews. Three major themes emerged: (a) barriers to the management of mental illness at the individual-level, (b) barriers to the management of mental illness at the system-level, and (c) the emotional ramifications that these barriers have on physicians. The findings highlight the parallelism between the experiences of primary care physicians and their patients. The findings also stress the need to attend to physicians' emotional reactions when working with patients who suffer from mental illness and to better structure mental health treatment in primary care.

Keywords Depression · Anxiety · Primary care · Antidepressants · Anti-anxiety · Physicians · Integrated care · Psychotropic · Psychotherapy

"SSRI is for us not for the patients:" Barriers to the Treatment of Mental Illness in Primary Care Clinics.

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Introduction

Depression and anxiety carry a major toll on individuals, families and society at large. This has led the World Health Organization to identify depression as the second leading cause of disability worldwide (Murray and Lopez 1996). Currently, about 10 % of primary care patients suffer from depression and as many as 7 % suffer from at least one type of anxiety disorder (Serrano-Blanco et al. 2010). Primary care providers serve as major gatekeepers in the treatment of depression and anxiety (Thombs et al. 2012). Despite the prominent role of primary care providers in the management of depression and anxiety and the various interventions employed to facilitate the treatment of mental illness in primary care (Katon et al. 2010; Vickers et al. 2013), there is a growing body of literature on barriers to adequate mental health care in primary care (Whitebird et al. 2013). The literature addresses three major types of barriers for the management of mental illness in primary care. These include barriers at the contextual level, the patient level and the provider level (Benzer et al. 2012; Schumann et al. 2012).

At the contextual level, reimbursement strategies, lack of resources and time, the stigma of mental illness (Schumann et al. 2012), inadequate care coordination and difficulties initiating referrals to mental health providers have shown to impact access to mental health treatment in

primary care (Katon et al. 2010; Kessler 2012). In contrast, integrated care, in which mental health services are provided within the premises of the primary care clinic has resulted in improved access to services and clinical outcomes (Ayalon et al. 2007; Unutzer et al. 2002). High levels of patient burden and inadequate time allocated for meeting with patients have also been shown to hamper mental health treatment in primary care (Chong et al. 2013; Rost et al. 2000).

At the patient level, barriers include the stigma of mental illness (Bell et al. 2011; Dinos et al. 2004), a general preference for psychotherapy, rather than medication (Bell et al. 2011; Kadam et al. 2001), inadequate knowledge about mental illness, the belief that depression will go away on its own (Elwy et al. 2011), a lack of trust in the primary care provider (Kravitz et al. 2011), and a somatic presentation of symptoms and a preference for a somatic diagnosis (Schumann et al. 2012). The conceptualization of mental illness in ways that diverge from the traditional bio-psychosocial model also hampers access to services (al-Krenawi and Graham 1999; Bener and Ghuloum 2011).

Finally, at the provider level, physicians have shown to have difficulties to accurately detect and diagnose depression (Coyne et al. 1995) as well as to treat mental illness, given a tendency to normalize and trivialize mental illness in comparison to other chronic medical conditions (Coventry et al. 2011). Those physicians who reported negative attitudes towards mental illness and perceived depression as a stigmatizing condition were less likely to provide adequate care (Wallace 2012). Consistently, mental health training has yielded a more adequate approach to the management of mental illness (Smith et al. 2014).

The present study is focused on the challenges associated with the treatment of mental illness in primary care clinics in Israel. The uniqueness of the Israeli system stems from its universal coverage, which allows for equal access to services to all members of society (Shirom and Gross 2002). Moreover, there is an explicit expectation that mental health services will be integrated in primary care by 2015 (Tvivian Mizrachi 2007). Hence, there are already active forces in place, such as educational training and interventions for the management of mental illness in primary care. The present study was conducted in the Clalit Health Services. This is the largest Health Maintenance Organization (HMO) in Israel, which insures about 4 million Israelis (roughly 52 % of the Israeli population; 70 % of those over the age of 65). All physicians employed by the Clalit receive written guidelines about the identification and management of mental illness in primary care. Social workers are available for consultation in some primary care clinics, but psychiatric or psychological consultations are available only in specialty mental health clinics and at the present time are not considered standard services. Given the potentially important role of the primary care provider in the management of depression and anxiety in primary care and the limited research attention given to this role, this study is specifically focused on the primary care providers' perceptions.

The study focused on physicians from the three population groups, which broadly represent the three largest groups in Israeli society: veteran Israeli Jews, Israeli Arabs and new immigrants from the former Soviet Union (FSU). Although by no means are these three population groups homogenous, each shares its own unique characteristics. Veteran Israeli Jews represent the largest and most established and advantageous population in Israel. Israeli Arabs, on the other hand, constitute the largest minority in the country, comprising about 20 % of the population (Central Bureau of Statistics 2014). This group tends to report higher levels of mental distress compared with the general population (Kaplan et al. 2010; Levav et al. 2007), but is the least likely to use psychotropic medications (Ayalon et al. 2011). Immigrants from the FSU also represent a unique group. They arrived in Israel during the late 1980s–early 1990s of the twentieth century, and constitute about 14 % of the general population, but 20 % of those 65 and older (Central Bureau of Statistics 2006). Similar to Israeli Arabs, immigrants from the FSU also report high levels of mental distress, they tend to use high levels of psychotropic medication relative to veteran Israeli Jews (Ayalon et al. 2011). Given documented differences across the three population groups, in the report of mental distress and the use of mental health services, we decided to explore potential differences and similarities across these three population groups in relation to their beliefs and attitudes concerning depression and anxiety. The present study is focused on similarities in the responses of physicians concerning potential barriers for the management of mental illness in primary care. Two additional papers based on the same dataset, explored the unique characteristics and needs of Israeli Arabs (Ayalon et al. 2014) and immigrants from the FSU (Dolberg et al., under review).

Methods

The study was approved by the Helsinki (Institutional Review Board, IRB) committee of the Clalit Health Services. The overall aim of the study was to compare attitudes and beliefs about the treatment of depression and anxiety in primary care among three population groups: veteran Jews, Israeli Arabs and immigrants from the FSU. Although the three population groups do have points of interaction, there is a tendency for Jews from the FSU to

actively seek consultation from physicians who are immigrants from the FSU. Similarly, Israeli Arabs are most likely to receive services from Israeli Arab physicians. We conducted focus groups with patients and primary care providers. For the present study, only findings from focus groups with primary care providers are discussed.

The rationale for using focus group methodology rather than individual interviews stems from our interest in public views concerning depression and anxiety. Focus groups provide a relatively efficient way to obtain perceptions, attitudes and beliefs of a relatively large number of participants over a short period of time. It is particularly useful when participants are not sure about their feelings concerning certain issues, as it allows them to form an opinion while listening to others. Focus groups may also develop into a group discussion in which many nuances of the issue are revealed (Morgan 1997). Primary care physicians were recruited by a direct approach made by the investigators of this study (KK, IB, SF, & MG), who hold managerial positions in the Clalit Health Services, which is the largest HMO in Israel. All physicians were employees of the Clalit Health Services. All the clinics that participated in the study were public clinics which offer on the same premises nursing, administrative, physician and pharmacy services. Each clinic cares for about 3,000–6,000 patients. Solo and independent (private) clinics were not included. The number of patients per physician ranged between 800 and 1,600.

Procedure

Overall, seven focus groups with primary care providers were conducted. A total of 52 physicians were interviewed. In sampling participants, we attempted to recruit physicians of varied expertise (family medicine, internal medicine, general/no specialty) and age range. Table 1 summarizes the characteristics of the participants in the focus groups.

Interviews followed a funnel approach starting from a broad question, asking participants to discuss their thoughts about depression and anxiety, followed by more detailed questions, asking participants to discuss their treatment options for depression and anxiety as well as challenges to and facilitators of mental health treatment. When barriers were mentioned they were probed using general mechanisms, such as "tell me more," "is this unique to a particular population group", etc. Appendix provides a detailed overview of the interview guide.

Analysis

We started the analysis by open coding with no prior hypotheses concerning the nature of the codes. To reach a smaller number of meaningful thematic categories, we conducted constant comparisons, looking for commonalities and differences within each interview and across interviews (Miles et al. 2014). Next, selective coding was employed. At this stage, we selected specific themes of

Table 1 Characteristics of focus group participants

	FG1 ($n = 7$)	FG2 ($n = 6$)	FG3 ($n = 10$)	FG4 ($n = 9$)	FG5 ($n = 10$)	FG6 ($n = 4$)	FG7 ($n = 6$)
Population group							
Veteran Israeli		6			10		
Former Soviet Union	7		10				6
Israeli Arab				9		4	
Age (mean [SD])	46 [5.6]	46 [9.4]	54 [8.1]	41 [6.8]	45 [6.3]	48 [8.1]	45 [9.9]
Women	5	4	10	0	8	0	5
Specialization							
Family	5	6	5	9	10	3	6
Internal	2		2				
General (no specialty)			3			1	
Religion							
Jewish	6	6	8		10		4
Christian				1			2
Muslim				7		4	
Other	1		2				
Mental health training	2	1	3	2	0	3	1

Number of physicians in each focus group is reported for categorical variables and mean (standard deviation, SD) for continuous variables. Numbers may not sum up due to missing values

relevant content to present a coherent storyline concerning perceived barriers to the treatment of mental illness in primary care (Corbin and Strauss 1990). Findings that alluded to differences across the three population groups (e.g., veteran Israeli Jews, immigrants from the FSU and Israeli Arabs) are discussed in detail elsewhere (Ayalon et al. 2014; Dolberg et al., under review). The present study stresses some of the commonalities identified across groups. Analysis was conducted by LA, a clinical psychologist with over 10 years of experience in qualitative research. Two focus group interviews were further analyzed by graduate social work students. The additional study authors (family physicians, a social worker and a nurse), each with more than two decades of experience in primary care, actively participated at the stage of selective coding.

Results

Three major themes emerged: physicians' perceived barriers to mental health management at the individual level, perceived barrier to mental health management at the system level and the emotional ramifications that these barriers have on physicians. There was some parallelism between the description made by physicians of their own experiences in treating patients who suffer from depression and anxiety and their description of their patients' experiences. Throughout the results section, we demonstrate this parallelism and the identification of physicians with their patients as reported by physicians. Direct quotes from the interviews are provided for illustrative purposes.

Barriers at the Individual-Level

These can be largely classified as barriers associated with the diagnosis of mental illness and the treatment of mental illness. In both cases, according to physicians, the barriers stem from: perceived inadequate awareness, skills, knowledge, information or training and limited or no interest in pursuing further action. Physicians discussed the importance of awareness, skills, information and training in their ability to diagnose and treat mental illness and at the same time expressed their ambivalence with regard to diagnosing and treating mental illness. According to physicians, these challenges were interchangeably present at the physician- as well as at the patient-level.

The Diagnosis of Mental Illness

Recognizing that one suffers from mental illness is the first necessary step prior to offering any treatment alternative. The uncertainty and ambivalence associated with reaching a diagnosis of mental illness is clearly expressed in the following statement: "…most of the time we [physicians] diagnose with very limited opportunity for consultation. We decide on our own, and usually have a certain question mark attached to a mental illness diagnosis" (FG3).

Awareness of mental illness was identified as the first step that has to be taken prior to offering a diagnosis or treatment alternatives. However, awareness was often portrayed as being limited not only among patients, but also among physicians: "And there are some primary care docs who have no awareness [of mental illness]" (FG2). Similarly, patients too were perceived as lacking awareness of mental illness: "if physicians and patients had awareness [of mental illness] then treatment would have been easier" (FG4).

In addition to awareness, inadequate knowledge and training were identified as potential obstacles to the diagnosis of mental illness in primary care. This is clearly reflected in the following statement:

> Assessment is a tool. We don't have similar tools to the ones used in diagnosing somatic conditions, such as X-rays. Only a conversation. Q & A. and the prior mental health experience of the physician. Not every young physician can make a diagnosis. (FG2)

An additional barrier to the diagnosis of depression and anxiety in primary care was identified as having a limited or no interest in pursuing the issue further: "Physicians do not want to diagnose (with mental illness). They do not want to enter this corner. If you diagnose depression you have to take it very seriously. You have to involve many people…" According to physicians, this was true also for patients who actively refrained from having a diagnosis of mental illness documented in their chart: "some patients (who suffer from mental illness) seek private consultation as they do not want, under any circumstances, to have a diagnosis documented in their chart" (FG1).

The ramifications of charting a diagnosis of mental illness were seen as severe for both the patient and the physician. Physicians expressed a concern about making a mistake and misdiagnosing a patient as depressed. Moreover, even if the diagnosis correctly reflected the patient's mental state, it was portrayed as carrying substantial ramifications not only because of the stigma it carried, but also because of its legal implications. The dilemma of whether or not to document mental illness in one's medical chart is clearly illustrated by the following statement: "This is something that is always in the background [charting a diagnosis of mental illness]. A dilemma. To write a diagnosis of mental illness or not to write. How much to write, how to write. Whether to offer medical treatment" (FG5).

The Treatment of Mental Illness

Similarly to the case of diagnosing mental illness, physicians identified various challenges at the individual-level that were associated with the treatment of mental illness in primary care. Lack of knowledge and inadequate training in the field were seen as major obstacle for the treatment of mental illness in primary care. Many physicians referred to psychotropic medication as the only available alternative they could offer a patient. Psychotropic medications were viewed by physicians as a means to ease patients' suffering by offering them a concrete treatment with proven efficacy. At the same time, psychotropic medications were also viewed as a means to ease physicians' burden as the ability to give an easily administered and potentially efficacious treatment reduced the number of visits to the clinic and the neediness of the patients, "SSRI is a solution not for the patients; it is a solution for us. It [mental health treatment] takes a long time, follow ups, repeated exams, I agree. You have to give a pill that shuts their [patients'] mouth" (FG7).

In light of their limited mental health knowledge and tools, many physicians were unsure of their role as providers of mental health treatment, given their realization that medication is not the only option and should often be supplemented by psychotherapeutic services, which cannot be provided under current conditions of the primary care system:

> The biggest vacuum I felt was when I treated the easier cases. Because I felt authentic enough and I knew how to diagnose (mental illness). I knew the patient suffers from depression and was not suicidal. I knew what med I should start with and maybe even second line, but what's next? What are we doing together now? I started learning all this only when I took a special course on mental health treatment… What I was missing was the consultation and the follow up parts. Not the early diagnosis and the initiation of treatment (FG2).

Ambivalence was evident not only with regard to diagnosing patients with mental illness, but also with regard to treating them. Ambivalence was partially attributed to inadequate training or knowledge in the field of mental illness as well as to lack of interest or a general discomfort to treat patients who suffer from mental illness:

> I am not ashamed to say it, if you don't want to treat mental illness. Doesn't know how to. Don't have the tools. No problem- just refer elsewhere. The problem is that we are even afraid to think about this [treatment of mental illness]. Because this is something that requires a lot of strength a lot of energy, a lot of follow-up (FG4).

The interdependence between providers and patients and the strong ambivalence with regard to mental health treatment at the patient-level was also described by physicians. Possibly, at least some of the ambivalence with regard to the treatment of mental illness expressed by physicians stems from their patients' ambivalence and vice versa: "I have a patient with minor depression and anxiety. I have already spoken with her many times about taking psychotropic meds. She doesn't want this. She says, 'I will manage on my own'" (FG2).

Barriers at the System-Level

Two major obstacles were identified at the system-level. The first concerned the limited time available for patient visits and for consultations with mental health providers. According to physicians, the designated time per session is rarely enough to provide adequate care for those who suffer from mental illness. Consistently, the designated time allotted to physician consultations is also too limited and does not provide a true opportunity for consultation and support. A second obstacle was identified as inadequate sources of informal (by family and friends) and formal support (by mental health providers) for patients and physicians alike.

Time as an Obstacle for the Management of Mental Illness

The limited time allotted for patient appointments was identified as a major obstacle to adequate mental health care. According to physicians, the large caseload they deal with and the limited time designated to each patient take a toll on the quality of care they provide and largely determine the therapeutic tools they use or refrain from using: "unfortunately, because the system is so burdened, we switch to meds" (FG3).

According to physicians, the limited availability of primary care physicians has major implications for the care of patients who suffer from mental illness. Many believed that adequate care required ongoing attention and longer appointment time that truly allow for the development of trust and empathy in the relationships. The interdependence between patients and physicians was clearly reflected by the fact that physicians identified limited time not only as a barrier to their therapeutic relationships with their patients, but also as a barrier to their own ability to obtain support and guidance when treating patients who suffer from mental illness:

> They (management) extended the amount of time to see a patient from 10 to 12 minutes, but still the

> majority of the population is being treated in large public clinics. So what's the advantage? The advantage is that I work next to a social worker, next to a nurse. But I cannot sit with them. There is no time designated for that…When will I sit with a psychiatrist and talk to him? When will I sit with the nurse that works in the room next to me? (FG2).

Inadequate or Absent Support as an Obstacle to the Management of Mental Illness

Two major sources of support at the system-/structural-level were identified as lacking: informal support by family or friends and formal support by professional mental health providers. In both cases, an inadequate or absent support system impacted not only the patient's mental health, but also the physician's ability to treat the patient adequately. The ambivalence concerning the adequacy and availability of informal sources of support was perceived as being not only within the domain of physicians, but also within the patients' domain. This clearly attests to potential parallelism in the experiences of physicians and their patients as perceived by physicians,

> When they [patients] are depressed, they perceive it as a personal failure, that they couldn't deal with things alone and this is why they come to us. And then to involve the husband, the mother, the father, the sister, the friends, this is disapproved most of the time (FG2).

Consistent with the view of informal support as a potential resource (even though not always available) for patients and physicians alike, so was formal support viewed as a potentially helpful tool that was currently in very limited availability. Having a psychiatrist available for consultation was seen as a way to improve the overall services provided to patients with mental illness. A psychiatrist was viewed as potentially being able to assist the patients directly, by seeing the more severe cases, but also indirectly, by consulting the physician and assisting him or her with the appropriate selection of psychotropic medication and with monitoring symptoms. Indeed, in the few clinics that had psychiatric consultation available, physicians reported tremendous gains.

Nevertheless, physicians clearly acknowledged various barriers that prevent them from obtaining adequate sources of formal support. The disjointed nature of services and the fact that psychiatric and psychological services are not offered within the same premises were portrayed as affecting the quality of care provided to patients: "There is a tremendous fear from going to a different clinic that they [patients] do not know or are unfamiliar with. I believe that if it [mental health services] were inside the clinic they [patients] would have come" (FG2).

Communication difficulties with other providers and in particular with psychiatrists were seen as additional factors that hamper services. Many physicians expressed strong negative feelings when describing their strenuous relationships with psychiatrists:

> With most psychiatrists that we [physicians] tried to work, they were very authoritative. It was unbearable for us. They were unwilling to listen: 'We [psychiatrists] said something and you do that'. As if you [physician] got an order-'do and do not argue.' It did not fit the way we [physicians] wanted things to happen. We wanted to have an opportunity to ask questions (and interact collegially) (FG2).

Communication difficulties between physicians and mental health providers were seen as impacting not only the ability of physicians to seek consultation, but also the ability of patients to receive adequate treatment:

> I try to offer what is out there (in terms of mental health treatment), but the truth is that the relationship between the primary care clinic and the mental health clinic is quite loose. I don't know. We have to hear from patients about the length of lines and the difficulties obtaining an appointment or (to learn from patients) who is on the team over there [in the clinic] (FG2).

Stigma and the need for confidentiality were additional issues that were seen as impacting the ability of physicians to seek consultation from other mental health providers: "You cannot treat depression like all other conditions. About high blood pressure, for instance, you could speak in the corridor. Not about depression" (FG4). The ambivalence about seeking psychiatric help because of the stigma assigned to mental illness was also perceived as a concern of the patients: "There is a concern about seeing a psychiatrist. When they [patients] need to go they ask, 'what am I crazy?'" (FG5).

The scarcity of services served as an additional barrier that hampered the potential reliance on other mental health providers. Both patients and physicians had no one to turn to for help when the patient suffered from mental illness. This again impacted not only the patients, but also the physicians:

> They [patients] come one-two days after they started on a new medication and report side effects. The psychiatrists are not really available. You have to wait a month to see one. And they are also not available for us [for consultation]. So that I could have potentially picked up the phone and told the psychiatrist about the side effects…there is no one

> to talk to…there is no address [for us or for the patients] (FG2).

The Emotional Ramifications of Caring for Patients with Mental Illness

At times, the identification of physicians with their patients resulted in parallel emotional experiences. Some physicians reported experiencing depression and anxiety when caring for their patients who suffer from mental illness. This idea is clearly expressed in the following statement: "Depression and anxiety are quite common. Quite common among many patients. Prevalent even among us [physicians]" (FG3).

In addition to depression, anxiety and fear were also common among physicians: "You need to enter the soul of the person who sits in front of you and in the beginning it is very scary and difficult" (FG4). Physicians explicitly spoke about treating the less severe or complicated cases and referring out more difficult cases from which they are 'afraid'. Reportedly, treating patients with mental illness was a major source of aggravation for physicians: "Those who treat depressed patients suffer from anxiety. Because they have patients waiting outside the office. He [physician] is stressed out with time. He has home visits, a family. His own problems" (FG7).

Sense of powerlessness which is so prevalent among depressed and anxious patients was also expressed by physicians who cared for patients who suffered from mental illness: "I remain powerless, because I have no way to treat patients, other than give them meds" (FG3). A similar idea was expressed in a different focus group:

> I came home every day powerless and I felt as if they (patients) were pouring on me more than I could take. It's a terrible feeling. That you are left with no power. I felt like a rag (FG7).

Some physicians also reported a sense of loneliness in their care for patients with mental illness: "Psychiatrists do not want to treat double illness and this leaves us [physicians] very lonely, which is one of the hardest problems of treatment" (FG5).

Discussion

Past research has shown that the presence of a mental health care manager and the availability of mental health consultation and support for physicians and patients alike have improved clinical outcomes and access to mental health care in primary care in the United States (Vickers et al. 2013). These features are currently lacking in the Israeli system, which aims to integrate mental health services into primary care by 2015 (Tvivian Mizrachi 2007). Therefore, it is not surprising that the physicians interviewed described multiple challenges associated with the management of depression and anxiety in primary care. These challenges refer to patient-level barriers, which concern the diagnosis and treatment of mental illness in primary care and system-level barriers, which include the limited time available for patient visits and the inadequate informal and formal support available for patients and providers, alike. Somewhat unexpected was the identification of physicians with their patients' experiences and the parallelism in patients' and physicians' experiences, including negative emotional reaction as a result of treating patients who suffer from mental illness.

A major finding concerns physicians' description of the prescription of psychotropic medication as a default, which does not always reflect clinical indication. Recent reports have questioned the role of psychotropic medication for the management of mild to moderate depression (Fournier et al. 2010) and have noted at best, a mild effect for severe cases (Kirsch et al. 2008). Past research has also documented that patients prefer seeking help from their primary care physician, but desire psychological counseling rather than medication (Dwight-Johnson et al. 2000). Nevertheless, medication continue to be the first line of treatment, with one out of five primary care patients in Israel receiving anti-anxiety or anti-depressive medication (Ayalon et al. 2011). This clearly attests to the need to reconstruct mental health treatment in primary care clinics in Israel so that it will allow for greater flexibility in terms of mental health services. For instance, greater availability of psychological, psychiatrics and social work services in the clinics could potentially improve access to care and might better meet patients' preferences.

Stress, anxiety, depression and fear that are so often experienced by patients who suffer from mental illness were also conveyed by their primary care physicians. Consistently, a sense of loneliness and powerlessness, which characterizes patients, who suffer from mental illness (Cacioppo et al. 2006; Ross and Mirowsky 2013), was also articulated by their primary care physicians. Both physicians and patients were portrayed by physicians as being highly ambivalent about the diagnosis and treatment of mental illness. According to physicians, both patients and physicians were lacking adequate awareness and knowledge concerning mental illness and both had limited access to external support.

The term parallel processes is used to describe the therapist's enactment of features of the relationship of the therapist with the patient in other settings and relationships (Tracey et al. 2012). This term could potentially be used to describe the parallelism in physicians' description of the

management of mental illness in primary care. A related dynamic term which could be used to describe the experiences portrayed by physicians is projection identification (Kernberg 1987; Mendelsohn 2012). Accordingly, feelings or thoughts that are too difficult for the patient to hold onto are projected on the therapist, who unconsciously reacts to these objects of identification. Although both terms have been widely used in the psychodynamic literature, they have hardly been explored beyond the psychotherapeutic context (Jiménez et al. 2012; Kljenak and Parikh 2012; Muskin and Epstein 2009; Smith 1984). Hence, although mental health providers receive extensive training, which among other things helps them explore their own reactions to their patients and the impact that the treatment of patients with mental illness has on them, physicians in the present study had no such training. Given the limited literature on the topic (Jiménez et al. 2012; Kljenak and Parikh 2012; Muskin and Epstein 2009; Smith 1984), this neglect likely is not unique to Israel. Hence, a major implication of the present study concerns the need to attend to physicians' mental reaction when working with patients who suffer from mental illness. Other recommendations are consistent with current knowledge and stress the importance of locating mental health providers within the primary care clinic (Chomienne et al. 2011), allowing for easy consultation between primary care physicians and other mental health providers and facilitating the reliance on a care manager (Katon et al. 2010; Roy-Byrne et al. 2010; Von Korff et al. 2001).

Despite its strengths, the study has several limitations that should be noted. First, although we had interviews from both physicians and patients, we decided to focus the present study only on data derived from physicians' interviews. This was done in light of the richness of the interviews and the limited scope of this paper. This choice does not allow for firm conclusions about the potential parallelism between physicians and their patients. In addition, because of the richness of the data, we decided to emphasize in this paper the similarities among physicians from the three population groups, rather than the differences. For further discussion of findings concerning differences and unique challenges of the various populations, the reader is referred elsewhere (Ayalon et al. 2014; Dolberg et al., under review). Given the fact that focus groups were heterogeneous in terms of physician specialty, we decided not to pursue potential comparisons between internal, family and general physicians. Future research will benefit from further exploring potential differences associated with physician specialty. Another potential limitation of the present study stems from the subjective nature of qualitative research and the limited ability of this type of design to reach broader generalizations about the population studied. To overcome the subjective nature of qualitative research, selected interviews were analyzed by different coders. In addition, the findings were further reviewed by providers who represent the populations that were the focus of this study and their feedback was incorporated. Direct quotes from interviews are provided to allow the reader to judge the accuracy of our assertions. Finally, some of the terms used to describe the findings, such as projection identification or parallel processes are of theoretical importance, but are not easily operationalized or measured.

Nonetheless, despite its limitations, the study is important because it provides an in-depth understanding into some of the challenges faced by physicians who treat patients who suffer from mental illness in primary care. The findings are particularly important in light of recent changes in the mental health system in Israel, which is currently undergoing the integration of mental health treatment into primary care.

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Appendix: Interview Guide

Tell me your thoughts about depression and anxiety
How does the society in which you live perceive depression and anxiety?
What would you have done had you suffered from depression or anxiety?
What are some of the common ways to deal with depression and anxiety?
What are some of the advantages and disadvantages associated with using these various ways?

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