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FAMILY PHYSICIANS' MOTIVATION PROCESS TOWARD THE DIAGNOSIS AND MANAGEMENT OF DEPRESSION

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Abstract:
Depression is a widespread disease and remarks a difficult clinical challenge for primary health care providers or physicians. Primary health care providers, namely Family Physicians (FPs), are crucial in recognizing and managing depression process. The study employed a cross-sectional survey of FPs' attitudes toward diagnosis and management, asking about their perceptions of their patient depression process. Data for the study was gathered from the FPs who were Facebook group members. 229 out of 550 FPs answered the survey questions. Statistical analysis was conducted using SPSS 24th edition. The study examined whether FPs made a significant difference between gender and years of experience in the profession. A questionnaire comprising items on a 9-point Likert scale was used to capture the perceptions and the data was analyzed using descriptive statistics and t-tests. Analysis of variance (ANOVA) was further employed to examine if the critical factors were perceived differently by FPs' experience years. The study findings presented that gender did not make a statistically significant difference. There was a significant difference between the 6-10 years of experience group of FPs, the 16-20 years of experience group, and the 21+ years group. The study showed that FPs were undecided in diagnosing and treating depressed patients. The study displayed that FPs' getting to know their patients better facilitates the diagnosis and treatment of depression. However, the study indicated that family physicians were indecisive in the depressed patients' diagnosis and treatment. It can be concluded that the success of depression processes requires the cooperation of FPs and psychiatrists. These findings suggest that healthcare policymakers should consider FPs' strategies for managing depression in the improvement of mental health services.

Keywords: depression, family physicians, diagnosis and treatment motivation

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1. Introduction

Depression is one of the most common mental disorders, which can lead to deterioration in the quality of life of individuals. In addition to being a long-term, mild, moderate, or severe illness, depression is a health problem that can affect people's families, jobs, economy, and social lives. In Europe, they make up about 10% of the population and 25% of primary care patients. In the world, more than 300 million people of all ages are trying to cope with depression (Vinogradova et al, 2019; Al Quwaidhi et al., 2018; Oöpik et al., 2006; Maurer et al., 2018).

According to recent surveys, major depressive disorders, the advanced stage of depression, affects 5% of adults. This chronic disease impacts the quality of life of individuals equal to or greater than that of ischemic heart disease or diabetes. Studies have shown that major depressive disorders constitute approximately 25% of patients who present to FPs or general practitioners with depressive symptoms. However, much attention has been drawn to about 50% of patients with depression today who do not have access to appropriate treatment and care (Josephine et al., 2015).

Previous research has documented that this disorder is become the leading cause of disability worldwide by 2030 (Ohtsuki et al., 2012). Although depression is known to be a common disease worldwide, health systems have not yet found an answer to solve the heavy burden of the disease (Bilsker et al., 2007).

However, patients can choose their doctor voluntarily, under normal circumstances, depressed patients do not always have the opportunity to see a psychiatrist. Prior research and observations have indicated that non-psychiatrists often take a role in depression's diagnosis and treatment processes. But many depressed patients do not seek help from their mental health care provider. Numerous patients with psychological problems first see their FPs or primary health care system. Many of these patients do not need special care. And the patients do not become aware of their symptoms as depression, and limited access to psychiatrists, time, and stigma prevent these patients from reaching psychiatry outpatient clinics. For these reasons, non-psychiatric doctors have to play a dominant role in the diagnosis and treatment of patients with depression (Liu et al., 2008; Yaffe et al., 2005; WONCA, 2017; Ohtsuki et al., 2012; MacCarthy et al., 2013).

Further, an estimated 60% of patients with depression find diagnosis and treatment in primary care, and people who are not psychiatrists jam 79% of their antidepressant prescriptions (Park and Zarate, 2019).

FPs consider diagnosing, treating, and caring for their patients with depressive and anxiety disorders an important task, though the way FPs diagnose and treat depressive and anxiety disorders is often not in line with current medical standards (van Rijswijk et al., 2009). Some studies have suggested that there is no standard mechanism and understanding that FPs and psychiatrists use when diagnosing depression in patients. Meanwhile, FPs do not choose to directly use the diagnostic guidelines and rating scales created in psychiatry. In addition, studies have confirmed that many

patients with depression present to FPs or primary health care centers with somatic symptoms. These somatic symptoms are intense symptoms of depression, and FPs sometimes have difficulty explaining these symptoms medically (Annette and Fosgerau, 2014).

Previous research has confirmed that general practitioners or FPs do not see enough patients with depression, they treat too few patients. Besides, previous studies have revealed that FPs underdiagnose or over-diagnose, or under-treat. However, FPs claim that diagnoses made in psychiatry clinics, disease diagnosis guidelines, and rating scales are invalid in primary care and cannot be used in general practice (Davidsen and Fosgerau, 2014). Not only the number of patients with depression is quite high worldwide, but also the diagnosis, evaluation, and treatment of these patients are burdensome. However, obstacles weaken the diagnosis and treatment of depression by FPs, developments in depression screening tools, pharmacotherapy, and counseling approaches provide hope for positive results (Cabana, Rushton, and Rush, 2002). Even though about 25% of the patients who apply to FPs are depressed, the skills used by FPs in diagnosing and treating depression may differ from the standards used by psychiatrists. But the frequency of depression has emerged as an important motivating factor for FPs, patients with depression increase the workload of FPs. This result leads FPs to define this area as problematic (Oöpik et al., 2006).

Although there are intervention efforts to improve the standard of care, such as the training of FPs and the dissemination and implementation of guidelines to help diagnose the disease, they do not indicate very positive results, especially in terms of patient outcomes (van Rijswijk et al., 2009). As a result, many descriptive studies have confirmed FPs' knowledge, confidence, attitudes, and current practices in depression of recognizing and managing and perceived barriers in the care of depressed patients (Liu et al., 2008).

Relatively little information exists regarding the behaviors and attitudes of FPs toward diagnosing patients with depression and the treatment processes of depression in Turkey. To help fill these gaps, we experienced the attitudes and behaviors of family randomly assigned FPs.

2. Methodology

The study used a cross-sectional questionnaire on FPs' attitudes toward diagnosis and treatment and asked about their perceptions of depression. We collected the data from FPs who were members of a Facebook group working in Konya, Turkey. We invited all FPs to participate through an invitation to the Facebook site. The invitation included a link to the Google Drive online version of the survey. 229 people from 550 Facebook FPs completed the questionnaire.

Participation was voluntary and anonymous, with no financial incentives submitted to increase enrolment. The questionnaires were arranged for FPs after

reviewing the national and international literature on the diagnosis and treatment of depression.

The final questionnaire consisted of 24 items designed according to FPs' attitudes and behaviors toward depression diagnosis, management, and treatment. Items were rated on a 9-point Likert scale ranging from 1 (strongly disagree) to 9 (strongly agree).

We translated each questionary item into English and back into Turkish. The questionnaire was pilot tested with (n=15) to examine for possible misinterpretation of questions, instructions, and response format. The researchers made only minor changes to the final version of the questionnaire.

Factor analysis was applied to determine the main factors of the question items used to reveal FPs' attitudes toward depression and its treatment.

An independent-samples t-test was conducted to compare the factors scores for females and males.

We tested whether there was a significant difference in the scores between the factors according to the years they worked in the FPs by using the Anova test and performed a post-hock test to understand which factor(s) caused the difference.

All data were analyzed with IBM Statistic Version 20 and run at a significance level of 0.05.

3. Results

Of 550 FPs, 229 (45.8%) completed the questionnaire. Of the study participants, 103 were female (45%), and 126 were male (55%). FPs had 27 (11.8%) years of professional experience between 1 and 5 years, the number of FPs between 6 and 10 years of experience was 35 (15.3%), the number of FPs between 11 and 15 years of experience was 27 (11.8%), 16 the total number of FPs with a professional year of 21 years or more was 110 (48%).

Table 1 shows the demographic figures.

Table 1: Demographic characteristics of the study sample

	Gender	N	Mean	Std. Dev.	Std. Err. Mean
Patient's motivation	Female	103	7.4903	1.27461	.12559
	Male	126	7.3823	1.35762	.12095
Involvement in treatment	Female	103	6.7184	1.58657	.15633
	Male	126	6.7667	1.57089	.13995
Confidence	Female	103	7.4417	1.44389	.14227
	Male	126	7.1548	1.43870	.12817
Confidence in FPs' skills	Female	103	5.7476	1.67999	.16553
	Male	126	5.4656	1.58217	.14095
Barriers	Female	103	7.0801	1.50661	.14845
	Male	126	7.2421	1.19287	.10627
Facilitators	Female	103	7.0816	1.17471	.11575
	Male	126	6.6984	1.41529	.12608

The mean scores of the items in each factor were also categorized as strongly disagree, disagree, moderately disagree, slightly disagree, undecided, slightly agree, moderately agree, agree, and strongly agree. The mean of the first factor was 7.43, the mean of the second factor was 6.74, and the mean value of the third factor was 7.28. The mean of the fourth factor was 5.59, the fifth factor was 6.79, and finally, the sixth factor was 6.87.

Table 2 shows the factor items and their means.

Table 2: Factor items, means and standard deviations

Factor 1
19. *"I am persuasive in referring my patients who I think have depression complaints to a psychiatrist."* (7,45; SD: 1.440)
18. *"I can motivate depressed patients to seek treatment."* (7,63; SD: 1.595)
12. *"I counsel and advise my patients with depressive symptoms."* (7.28; SD: 1.840)
9. *"Open patient-physician trust relationship with my patients; makes my depression diagnosis process easier."* (7,45; SD:1.593)
21. *"I make suggestions to the patients I have diagnosed with depression in solving their problems."* (7,27; SD: 1.726)
11. *"When I am not busy, I can spend more time with my patients with depression symptoms."* (7,41; SD: 1.937)
Factor 2
20. *"I should be able to prescribe antidepressants for patients diagnosed with depression."* (6.75; SD: 2.514)
15. *"I support the participation of FPs in treatment other than patients with symptoms of major depression."* (7,07; SD: 2.135)
1. *"Depression is an important health problem that is usually treated by non-psychiatric physicians."* (4.86; SD: 2.403)
22. *"I support a standard psychometric screening test prepared by the Ministry of Health to guide doctors in primary health care services."* (7.57; SD: 1.831)
6. *"The fact that I have known my patients for a long time and the patient-doctor trust relationship facilitates me in diagnosing my patients with depression."* (7.47; SD: 1.685)
Factor 3
7. *"I can easily ask questions to my patients about their psycho-social conditions."* (7.57; SD: 1.578)
8. *"After talking to my patient, I can easily assess whether he or she has depression."* (7.00; SD: 4.915)
Factor 4
14. *"I have special skills and knowledge in communicating with patients with depressive symptoms."* (5.86; SD: 1.883)
10. *"I use my methods in diagnosing those I suspect of depression among my patients."* (5.64; SD: 2.189)
24. *"I rely more on my practical knowledge in diagnosing and treating depression than written sources."* (5,28; SD: 2.207)
Factor 5
16. *"Time pressure prevents me from dealing with my patients' psychological problems."* (7.51; SD: 1.891)
23. *"My patients suffering from depression experience a potential fear of the stigma associated with a psychological diagnosis."* (6.98; SD: 1.872)
13. *"Each patient's unique, dynamic situation makes it difficult to follow general guidelines for the diagnosis and treatment of depression."* (6.64; SD: 1.817)
17. *"I support that FPs should receive training in psychotherapy."* (7.55; SD: 2.145)
Factor 6
2. *"Depressive disorders are quite common among my patients."* (6.37; SD: 1.882)
3. *"Depression and physical illnesses occur simultaneously; they should be followed up and treated together."* (6,55; SD: 1.881)

6. *"The fact that I have known my patients for a long time and the patient-doctor trust relationship facilitates me in diagnosing my patients with depression."* (7.47; SD: 1.685)
4. "*Depressed patients use primary health care services more frequently than others."* (6.48; SD: 2.235)
5. *"Because clinicians do not know the patient well enough, patients are more likely to share personal information with FPs."* (7.47; SD: 1.808)

Factor analysis findings showed six factors. These were Factor I (Items 9, 11, 12, 18, 19, and 21) Patients' Motivation, Factor II (Items 1, 6, 15, 20, and 22) Involvement in treatment, and Factor III (Items 7 and 8) Confidence, Factor IV (Items 10, 14 and 24) Confidence in FP's Skills, Factor V (Items 13, 16, 17 and 23) Barriers, Factor VI (Items 2, 3, 4, 5 and 6). They were named Facilitators.

The Independent sample t-test results were between male (M=7.38, SD=1.35) and female (M=7.49, SD=1.27) scores findings did not make a significant difference.

Regarding continuous variables, there was a significant difference between the factors according to the years of work of the PFs participating in the study. The findings referred that only there was a statistically significant difference at the $p<.05$ level in "confidence in FPs skills" scores ($F(4.224) = .77$, $p= .54$). According to the post-hock test Tukey results, there was no significant difference between the 1-5 group and the other groups and between the 11-15 group and the other groups. There was a significant difference between the 6-10 group and the 16-20 and 21+ years group. There was no significant difference between the 21+ group and the other groups.

Internal consistency estimates demonstrated good reliability for each of the key theme areas (.89).

4. Discussion

This study aimed to reveal the readiness, motivation, and problems of FPs in depression diagnosis and treatment.

The generally accepted approach is that psychiatrists diagnose and treat depression and prepare guidelines for general physicians in the diagnosis and treatment stages. Although this is the general approach, FPs try to diagnose and treat most depression patients worldwide (Davidson & Fosgerau, 2014).

For FPs, a depressed patient may be more problematic than a somatic patient, and depressed patients take longer to treat. Since diagnosing depression is time-consuming and requires more clinical effort, FPs' ability to diagnose and treat depression is directly related to the depression illness education they have received (Ööpik et al., 2006).

Psychiatrists use clinical impressions and intuitions for diagnosis and treatment methods. In the primary health care system, the diagnosis and treatment process of patients with depression can be problematic. Although psychiatrists consider depression and depression symptoms as primary targets, general practitioners often have difficulty distinguishing depression from reactions to living conditions (Davidsen & Fosgerau, 2014).

Effective management of depression requires FPs to educate patients about treatment options and possible side effects, initiation of pharmacotherapy or psychotherapy, and consistent follow-up. Approaches such as discussing their condition and current problems with patients and prescribing necessary medications when necessary are supported by a modern evidence-based systematic to the disease. Referring depression in adults to a specialist or treating the patient effectively often requires antidepressants with psychotherapy (Vinogradova et al., 2019).

The findings indicated that the close relationship of FPs with their patients facilitated the diagnosis and treatment processes of depression. FPs thought that although family physicians had enough motivation in the management of depression, time constraints and lack of sufficient information about depression were obstacles. FPs neither confirmed nor disapproved that depression was usually treated by nonpsychiatric physicians.

4.1 Patient's motivation

Previous research about elderly patients with depression has shown that most patients preferred going to their family doctor rather than seeing psychiatrists, which is the troublesome route (Yaffe et al., 2005). Our study revealed that family physicians effectively motivate patients diagnosed with depression to seek treatment. In addition, the findings showed that family physicians provide counseling and advice to their patients with depressive symptoms and that the open patient-physician trust relationship with their patients facilitates the depression diagnosis processes. FPs stated that when they were not busy, they could spend more time with their patients with depression symptoms, and they could ask questions about their psycho-social status. The study showed that FPs are highly motivated to deal with depressed patients.

In agreement with previous studies, in the present investigation, FPs felt patients trusted them more than unknown psychiatry physicians. The generally acknowledged assumption is that the intimate relationship between FPs and their patients positively affects patients' motivation for depression treatment. Awareness of the duty and responsibility of FPs is among the impelling elements patients prefer. Since depression is a prevalent disease in primary care, the physicians' commitment to their patients meets a need in the treatment processes of patients. Thus, FPs strengthen the patient's health and the doctor-patient relationship in depression's successful treatment (Ööpik et al., 2006).

4.2 FPs' involvement in treatment

Although the prevalence of depression among FPs or general practitioners is lower than in psychiatry, FPs want to be involved in the diagnosis and treatment processes of depression. These doctors are at high risk of being misdiagnosed or underdiagnosed. They are general practitioners or FPs and cannot limit their focus to a well-defined number of disease symptoms, but must deal with the various problems and symptoms presented by patients (Davidsen and Fosgerau, 2014). Ööpik et al. (2006) state that many family physicians consider it their duty to manage the diagnosis and treatment process

of depression. These physicians have declared that they are ready to treat these patients and perform this action in their daily work. Our study revealed that FPs saw depression as a critical health problem. However, FPs did not approve of the idea that non-psychiatric physicians treated depression. However, the study did not support the work of Ööpik et al. The study indicated that FPs were undecided about depression as a disease treated outside of specialist physicians, although FPs deal with depressed patients.

The findings of our study did not sufficiently support FPs to participate in treatment other than patients with major depression. The fact that FPs have known their patients for a long time motivates their willingness to participate in treatment. Previous studies have shown that although most family physicians are interested in identifying and treating the problems of patients with depression, they are often dissatisfied with the quality of the services they provide (Clatney et al., 2008). Vinogradova et al. (2019) said that more than half of the participating FPs could assess their patients' psycho-emotional states and possible disorders quite well after talking about their patients' emotional problems.

FPs acknowledged the difficulty distinguishing depression from normal sadness and sometimes lacked knowledge, time, and additional support resources such as specialist psychologists. FPs have difficulty balancing supporting and empowering patients with depressive symptoms and actively treating patients with depressive disorders (Warmenhoven et al., 2012). In addition to all this workload, interview techniques and findings used by FPs show that, unlike the interviews used by psychiatrists in standard psychiatry interviews, some FPs underdiagnose and overdiagnose depression. Generally, FPs use procedures to identify depression based on an algorithm to rule out long-term patient-doctor history, relationships, and other diagnoses. Therefore, the methods used by this and similar FPs differ from the techniques used by psychiatrists (Schumann et al. 2011). The findings of our study exposed that family physicians supported a standard psychometric screening test to be prepared by the Ministry of Health.

McNaughton's (2009) study has revealed that most primary care physicians are willing to begin medication therapy for patients with depression. At the same time, FPs state that although they are willing to observe these patients, they cannot provide effective and adequate psychotherapeutic treatment due to time constraints, lack of knowledge, or inexperience. Our study findings stated that FPs supported a standard psychometric screening test prepared by the Ministry of Health to guide physicians in primary health care. In addition, our study was compatible with previous studies that FPs should be able to prescribe antidepressants to patients diagnosed with depression. However, our study did not strongly confirm that physicians could prescribe medication for patients with depression. Although FPs support prescribing for depressed patients, FPs prescribe antidepressant medication for only 8% of depressed patients followed up to 12 months. Most of these doctors have found their education on depression inadequate. Besides, physicians have stated that they receive less education (81.6%) about depression compared to other diseases (Liu et al., 2007). In addition, Mulango et al. (2018)

have noted that more than half of FPs find antidepressants generally inadequate for depressed patients' treatment. In addition, nearly two-thirds of FPs believe that most depressive illness improves without medication. Many FPs think that they agree that patients with depression should see a psychiatrist.

The study of palliative patients has revealed that doctors rarely prescribe antidepressants or stimulants. In this study, FPs have state they frequently encounter depressive symptoms in palliative care patients. FPs have reported feeling competent in diagnosing and treating depression in palliative patients. FPs rely heavily on their cumulative knowledge to determine whether these patients have normal sadness or depression. Although they acknowledge the difficulty distinguishing depression from ordinary boredom, they sometimes lack knowledge, time, and additional support resources such as specialist psychologists (Warmenhoven et al., 2012).

FPs are closely involved in depression diagnosis and treatment of similar problems. Despite this, family physicians are not satisfied with the health services they provide. Clatney et al. (2008) have exposed that FPs state that they can treat very few of these patients.

4.3 Confidence

Previous studies have indicated that most psychiatrists rely on their clinical judgment and instinct. However, patients with depression have stated that these patients rely on their FPs' support, worry less, and have reduced stress (Warmenhoven et al., 2012).

Another study of FPs has said that FPs rely more on clinical judgments than depression guidelines. Other studies have also indicated that they find FPs more reliable in their practical knowledge and clinical judgment than depression tools. In addition, depression tools emerge as a supportive aspect of FPs' decision-making and treatment processes (Warmenhoven et al., 2012). Our study findings supported previous studies that FPs could with ease ask the questions they wanted to their patients with suspected depression. FPs felt more confident in asking their patients questions. FPs stated that they could effectively diagnose after meeting with their patients. A study of depressed elderly chronic patients showed that these are more likely to suffer from depression and are more likely to trust their FPs than other doctors. At the same time, the self-confidence of FPs is also high (Al Quwaidhi et al., 2018).

Although our study and some researches have indicated that many FPs feel an encouraging responsibility to recognize or manage depression, FPs emphasize that lack of knowledge reduces self-confidence in family physicians. Previous studies and our study have shown that more than half of family physicians do not know the names of commonly used antidepressants, even though FPs are self-sufficient in diagnosing and managing patients with depression (Liu et al., 2008). A previous study has shown that FPs express uncertainties in their knowledge of psychotherapy and strategies to prevent depression recurrence, defined as considerable hesitation in their assessments (Gallo et al., 2002). One study also stated that as the proportion of FPs who feel adequate about their knowledge increases, the number of those who think psychiatry physicians should

use psychotherapy increases. FPs realize that Cognitive Behavioural Therapy, applied during the treatment of depression, requires a long-term training process (Yıldız Sunay and Akkuş, 2018).

4.4 Confidence in FPs' skills

Previous studies have shown that FPs are ready to manage the process of patients with depression. The study has revealed that FPs have never used a guideline for assessing the risk of depression in approximately 50% of their patients (Annette, Davidsen, and Fosgerau, 2014). FPs think needing additional training. In a similar study, most doctors have expressed that their education on depression is insufficient, and they have less education on depression regarding other diseases (Liu et al., 2008; Oöpik et al., 2006). Our study showed that FPs were undecided about using their methods when diagnosing depression. They also hesitated to trust their practical knowledge of depression diagnosis and treatment more than written sources. The findings supported some studies on confidence in the skills of FPs. Previous studies have indicated that most FPs are not confident in managing patients with depression. The same study has introduced that insufficient training of FPs limits helping patients with depression (Liu et al., 2008). Inadequate training of primary care physicians makes it difficult for FPs to provide a safe treatment process for patients with depression (Broers et al., 2006). Meanwhile, previous research has shown that physicians rely on their ability to diagnose and manage depression but with inadequate training (Harman et al., 2002).

Some studies have found that only half of the physicians are confident in diagnosing depression, more than one-third are self-confident in managing depression with pharmacological treatment, and few are confident in providing non-pharmacological intervention. These studies have shown that depression assessment guidelines are necessary to reduce underdiagnosis and avoid overuse and unnecessary harmful effects of pharmacotherapy (Mulango et al., 2018; Davidsen and Fosgerau, 2014).

4.5 Barriers

Although non-psychiatric physicians play an important role in depression treatment, defining and managing depression can be challenging (Liu et al., 2008). FPs find it difficult to balance supporting and empowering patients with depressive symptoms and actively treating patients with depressive disorders (Warmenhoven et al., 2012). Our study observed that FPs viewed each patient's unique and dynamic situation, their fear of stigma, as a barrier to diagnosis and treatment. It is a fact that stigmatizing makes difficult the management of depression (Alanazi et al., 2022). In addition, our study emphasized that family physicians who did not receive psychotherapy training created an obstacle in the diagnosis and treatment.

According to the WHO, a challenging barrier to effective treatment for depression is misjudgment and often the inability to diagnose depressed people (Lim et al., 2014).

However, there are still difficulties in identifying and treating these problems for FPs. FPs generally declare difficulty accessing mental health professionals for consultation or referral (McNaughton, 2009).

One study has shown that more than one-third of the participants find that time constraints are a limiting factor in depression management. While most PFs refer patients with depression to specialists for counseling or medical treatment, nearly one-fifth of the sample also refer patients to their homes or traditional healers to pray (Mulango et al., 2018). Our study findings supported the previous research that time pressure prevented family physicians from dealing with depressive patients adequately.

FPs have difficulty concluding the underlying cause of patients' somatic complaints and force patients to perform a physical examination before confirming the diagnosis of depression (Leff et al., 2017). Findings have shown that many somatic complaints create diagnostic difficulties (Oöpik et al., 2006). These diagnostic difficulties may lead to prolonging the disease diagnosis and treatment processes. Despite the efforts to educate patients, communities, and medical professionals, stigma remains a primary barrier to mental illness diagnosis and treatment (Park, Zarate, 2019).

4.6 Facilitators

Our study findings indicated that the patients were more likely to prefer FPs and gave the personal details of patients because clinicians did not recognize the patient adequately. The study also stated that the high number of patients with depression complaints from FPs occurred as a facilitating factor for FPs to diagnose and treat the disease. In addition, the fact that depression diseases were together with physical symptoms and that FPs had known their patients for a long time facilitated the diagnosis and treatment processes. Research findings have almost confirmed that patients with depression use primary health care services more frequently. Our research findings supported other studies on helping factors in depression diagnosis and treatment by FPs. Previous research has stated that family physicians have a long-term relationship with their patients, which would help determine patients' behavior from normal sadness (Warmenhoven et al., 2012). In addition, FPs emphasize that knowing their patients' résumés is an available assessment in determining the patient's disorder (Davidsen, Fosgerau, 2014).

A trusting relationship between FPs and their patients facilitates patient evaluation. Combined with professional competence expands the credibility of physicians for patients. The patient's trust in the FPs gives hope and puts the patient's doctor in a privileged position (Hudon et al., 2013). Early diagnosis and effective treatment of depression in primary care would increase the patient's quality of life. The patient density in secondary and tertiary care and the financial burden on the patient and the country's budget would decrease (Yıldız, Sunay, and Akkuş, 2018).

This study reveals that FPs, who are an essential part of the health system in Turkey as well as many countries, take a heavy responsibility for the recognition and treatment of patients with depression. For this reason, this study is crucial in revealing

FPs' perspectives on the diagnosis and treatment processes and contributing to health policymakers and family physicians to perform these processes more comfortably.

Although our research had a relatively small sample size, we think that it would contribute to filling the scientific gap regarding the FPs' perspectives on patients with depression in Turkey.

5. Conclusion

Despite the limitations, the study raises important issues. FPs had persuasive skills in referring patients with depression to treatment. The close relationship between the patient and the FPs facilitated the diagnosis and treatment processes of depression. Even so, FPs stated they had skills in managing symptoms other than major depression treatments. They thought that the guidelines that would guide the diagnosis and treatment of patients would support FPs. The findings of our study indicated that increasing the cooperation between primary FPs and mental health professionals would expand the success in depression diagnosis and treatment. Ultimately, healthcare policymakers should consider FPs' strategies for managing depression in the improvement of mental health services.

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Conflict of Interest Statement

The authors declare that they have no conflict of interest related to the study or preparation of the manuscript.

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