Although perceptions of mental illness have changed for the better over the past years, for reasons unbeknownst, mental health issues remain a lingering taboo. This has led to many mental illness sufferers feeling side-lined, isolated, ashamed and worthless; fearing being labelled as a liability or "mental". This can pull the final trigger for those teetering on the mental health ledge. After all, our brain is another part of our body - so why shouldn't we talk freely about it, just like we would talk about a broken bone?

This article aims to explore the role of the primary care physician in the management of such an important health aspect.

WHAT ARE THE NUMBERS?
According to the World Health Organisation (WHO), mental disorders are the greatest contributors to chronic conditions affecting the European population. Depression tops the list - it accounts for 11% of all 'years lived with disability' (YLDs), making it the leading chronic condition in Europe. Anxiety disorders account for 4% of YLDs. Rates for mood disorders in women are significantly higher when compared to men (33.2% vs. 21.7%).

WHO highlight the contributing role of GPs as follows:
• 74% of countries report that GPs identify and refer people with severe and enduring mental health problems
• 52% report that GPs diagnose such disorders
• 40% report that GPs also give treatment.

MANAGING DEPRESSIVE DISORDER IN PRIMARY CARE
General practitioners provide a "person-centred, continuing, comprehensive, and coordinated whole-person health care to individuals and families in their communities". Given that GPs tend to know their patients and families on a more personal level, patients might feel more comfortable to open up with their GP about any problems encountered. Physicians might fall into the trap of inquiring only about physical symptoms and attempt to treating them; without exploring whether there are any causes to these symptoms apart from somatic ones, such as mood disorders, resulting in depression going undiagnosed. A study by Simon et al. showed that 69% of patients diagnosed with major depressive disorder presented to primary care solely with physical symptoms. These might include chest pain, joint pain, limb pain, back pain, gastrointestinal symptoms, fatigue, psychomotor activity changes and appetite changes.

In 2015 Strakowski and Nelson came up with a seven-key component strategy which can be employed in the primary care setting when managing a patient with depression:

Comprehensive assessment
Several validated and effective screening tools have been developed in order to identify and measure the severity of depressive symptoms; a popular choice being the nine-item Patient Health Questionnaire (PHQ-9). This questionnaire may be filled out by the practitioner or the patient himself, and is not only used in the initial stages of management, but also as an effective tool in assessing response to management. It addresses whether each of the nine DSM-IV criteria for depression such as anhedonia, poor appetite and thoughts of self-harm were present over the two weeks prior to the compilation of the questionnaire and scores each criterion from 0 to 3; 0 meaning that the features were not present, whilst a score of 3 indicates that the features were present nearly every day. A total score of less than 10 might indicate that conservative treatment should be applied such as counselling, relaxation strategies and exercise; on the other hand, a score greater than 19 indicate severe depression and medical treatment should be employed.

Ongoing safety evaluation
During this stage, suicide risk should be addressed. It is vital to identify any potential risk factors and protective factors. Patients tend to avoid bringing up this subject unless asked directly. The highest predictor of self-harm or suicide is a previous attempt. Protective factors include a good support system such as family, and in certain cases, religion. Furthermore, alcohol and drug use should be enquired about since these may be resorted to by patients passing through a difficult period in their life, and they are depressogenic in themselves, resulting in the patients spiralling into a hazardous vicious cycle.
Setting treatment goals
Setting realistic treatment goals is crucial, whilst adopting a biopsychosocial approach, and this should be done hand in hand with the patient together with family or other supportive figures. The fears and concerns of the patient should be explored and any potential stressors exacerbating the situation should be identified. Furthermore, one should explore what the individual wants to achieve, since this will also direct what type of treatment is chosen.

Agreed upon treatment plan to meet goals
NICE recommends that the management of depression should be in a stepped care approach, that is, the least burdensome treatment which achieves effect, even if it is just watchful waiting, should be employed. Furthermore, it reports that a significant proportion of patients recover without any medical interventions. In mild to moderate depression, one may opt to resort to conservative measures such as sleep hygiene and active monitoring, or else step up to psychological therapy, one form of which is cognitive behavioural therapy (CBT). CBT, pioneered by Ellis and Beck in 1962 and 1970, respectively, refers to interventions that aim to change maladaptive cognitions leading to a reduction in emotional distress and problematic behaviour. In cases of more severe symptoms, anti-depressant treatment is recommended; 1st line treatment recommended by NICE is SSRIs. Medications may be employed in conjunction with psychological interventions. It is of vital importance to discuss that these medications take three to four weeks for the full effect to be exerted and potential treatment side-effects should be mentioned. In severe cases, or where suicide risk is high, referral to specialist care or services should be sought promptly.

Good support network
Fighting depression is no easy task; patients may often succumb to their feelings of hopelessness and helplessness, and both medications and behavioural interventions take a fair deal of time for their effects to be evident. It is therefore important to support these patients through frequent follow-up visits, which can eventually be spaced out if the patients are responding well to treatment or interventions. Apart from ensuring that patients have a good support network from friends and families, they can also be referred to special entities and organisations.

Mood monitoring
As part of the management of depressive disorder, Dr. Strakowski suggests the use of mood charting where patients record their mood and depressive symptoms on a daily basis. Apart from involving the patients actively in his own management, patients would have a graphical representation of how they are responding to treatment. Furthermore, it can guide the physician in terms of treatment, since when asked how they are doing, “patients tend to report how they have been feeling over a period of time based on how they are feeling at that specific moment”, which can be misleading.

Create meaningful appointments
As already mentioned, organising regular follow-up appointments is of vital importance. Through these appointments, mood charting may be monitored and reviewed, suicidal risk re-assessed, and compliance to treatment ensured. Drug and alcohol use should always be enquired about. Another important issue is treatment side-effects especially those related to sexual dysfunction, a common side-effect with SSRIs which patients might be hesitant to report. What is more is that general health measures should always be supported; these include a good balanced diet, exercise and sleep. In cases where patients do not seem to respond to treatment, then ideally specialist advice or referral should be sought.

CONCLUSION
The pivotal role of the primary care physicians in relation to the management of several mental health disorders throughout our community remains, to this very day, undisputed. Physicians also have an important responsibility in assuring that what has, for a long stretch of time, been considered by many as a lingering taboo, will be shelved as something of the past; thus ascertaining that patients feel that they can enjoy the same level of treatment and support as for any other physical illness. Although remaining a recurring challenge, this paradigm shift now seems much more attainable than a few years back. The primary care physician must be looked at by patients as their pillar of strength, their very one individual upon whom they can rely on, no matter the circumstances. This will ensure that patients have enough trust in the former so much so that they feel safe confiding in them the daily challenges they face and consequently seek help.

REFERENCES