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STUDENTERRAPPORT

Diagnostic and treatment challenges of patients in the Danish Primary Sector, who experience acute decline of social and cognitive capabilities due to psycho-social stress – A Literature Study

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Dansk resume / Abstract

Baggrund:
Patienter med livskriser, stresssymptomer og tilpasningsreaktioner hos patienter fylder i stor grad i primærsektoren. I 2018 blev det fundet, at 2% af befolkningen i aldersgruppen 18-65 over en 6-måneders periode kontaktede almen praksis med psyko-stress-relaterede symptomer. Konsultationer i almen praksis med mental sundhed/sygdom som årsag er ved flere studier fundet generelt mere tidskrævende og ofte udfordrende for den praktiserende læge.
Der foreligger begrænset sundhedsfaglig forskning, der lægger fokus på, hvorvidt disse patienter, der trækker store ressourcer i primærsektoren, kan tilbydes og får et tilfredsstillende forløb. Patienternes symptombilleder er i høj grad overlappende med andre psykiatriske diagnoser som andre angstlidelser og depressive tilstande. I DSAM's seneste vejledninger fra 2010 indenfor beskrives udrednings-, henvisnings- og behandlingsmuligheder for depression og angst-problematikker, herunder belastningssymptomer, men hvor godt rustet er praktiserende læger til at håndtere den store mængde af denne type patienter og deres komplekse problemstillinger, og hvilke udfordringer ser lægerne selv ift. at håndtere disse patienter bedst muligt. Der forberedes aktuelt på udarbejdning af nye kliniske retningslinjer ift. håndteringen af disse patienter, bl.a. i forbindelse med ICD-11 implementering og øget samarbejde med almen praksis og psykiatrien.
Via systematisk litteratursøgning og -gennemgang ønskes det at belyse, hvordan denne patientgruppe defineres og figurerer i studier af almen praksis, hvilke udfordringer der udrednings-, behandlings- og henvisningsmæssigt karakteriserer den, og hvorledes dette håndteres i den danske almene praksis. Fremkommer der særlige områder og problemfelter, økonomiske eller strukturelle barrierer, beskrevet i litteraturen, der kunne være grobund for forbedringer eller yderligere undersøgelser, der på sigt kunne forbedre og effektivisere den udredning og behandling, denne patientgruppe modtager?
Formålet
På baggrund af en systematisk litteratursøgning undersøges det, hvad karakteriserer patientgruppen, der søger primærsektoren i Danmark, grundet nedsat social og kognitiv funktionsevne, samt dennes udrednings- og behandlingsforløb og udfordringerne heri.
Metode
Design:
Der er foretaget systematisk litteratursøgning vha. keywords og mesh-termer i Embase, PubMed, PsycInfo. Artiklerne screenes vha. titel, abstract og gennemlæsning. De udvælges på baggrund af studiedesign, med særligt fokus på kvalitative studier indenfor området. Artiklerne systematiseres og kvalitetsvurderes vha. VAKS og CASP, og der analyseres induktiv tematiserende på det samlede litterære vidensgrundlag indenfor området.
Resultater:
Generelt beskrives det, at praktiserende læger er gode til at sætte patienternes symptomer i relation til deres livfaktorer og stressorer. Det ses, at der er en overvægt af kvinder, der søger egen læge grundet psykosocial stress, og at lægerne typisk vurderer grunden hertil som værende primært job- eller familierelateret. De praktiserende lægers udfordringer som karakteriseret i litteraturen er flerfoldige med gennemgående temaer, hvor der peges på tids- og ressourceudfordringer ift. at tilbyde bl.a. samtaleterapi og strukturende forløb. Og flere kvalitative studier peger dertil på udfordringer ift. manglende undervisning og øvelse i samtale- og kognitiv terapi samt mentaliseringsprincipper og kognitiv terapi. Dertil ses gennemgående bekymring ift. henvisningsmuligheder.
Konklusion:
Der findes et sparsomt ophav af kvalitative studier, der belyser vanskeligheder ved behandling af disse patienter i den danske primærsektor, men der er dog tendens til gennemgående temaer, hvor de praktiserende læger oplever ressourceudfordringer både ift. tid, henvisningsmuligheder, undervisning og ydelsesindretning. Det ses dog at praktiserende ofte er gode til at relatere patientens livsomstændigheder til deres aktuelle symptombillede, og de beskrives som mere tilbageholdende med psykiske sygdomsdiagnoser på den baggrund.

Diagnostic and treatment challenges of patients in the Danish Primary Sector, who experience acute decline of social and cognitive capabilities due to psycho-social stress – A Literature Study

Steen David Sønderby

Introduction:

Patients, who consult their general practice during psycho-social stressful periods of their life or following a stressful event, due to symptoms of stress, physical or mental, are a significant portion of the patient population in the primary sector of the Danish health system. It has been found that 2% of the Danish working population, defined as 18-65 year of age, sought their primary physician at least once due to psychological stress over a time-period of six months.[1] Often, the problems and symptoms these patients present such as cognitive difficulties, anxiousness, sleep difficulty, or physical discomfort[2] are not quickly or easily dealt with in a general practice setting, and several studies have indicated that the average time spent per consultation with patients with mental issues or concerns is significantly longer.[3],[4] than consultations of a purely somatic nature.

These patients and their symptoms often straggle the line between different diagnoses if they indeed qualify for one. Diagnoses influence and reflect which treatment and referral-options are available to and chosen by the general physician. And very commonly patients getting treatment for psychological stress in a general practice have one or more co-existing psychiatric diagnoses, which further impact the treatment and patient outcome. This is estimated as being the case for approximately half the patients (48%).[5]

The diagnostic criteria for several mental illnesses have been reassessed in the upcoming ICD-11, which is set to be implemented in 2022. This will among other things have significant influence in how stress, anxiety, depression and adjustment disorder are indexed and understood.[6] Further work and studies in how best to handle and treat these patients in general practice, as well as determining if they are indeed all in need of a clinical diagnosis, should hopefully follow in the future. In Denmark there are currently two sets of guidelines from the society of general physicians (DSAM) focused on the diagnostic program and treatment of anxiety disorders[7] and depression[8], respectively, both from 2010. Currently work is set to prepare a new unified set of guidelines dealing with stress, anxiety and depression, which is expected to be finished in 2022.[9]

This study aims to elucidate what tasks this diverse group of patients pose in the Danish primary sector to the general practitioners and how this is characterized in the medical literature. To this aim the relevant knowledge in the literature is thematically systematized and assessed. To gauge the difficulties and challenges general practitioners experience with this group of patients a sub focus has been chosen on the qualitative studies performed in the field directly dealing with this.

Method:

Data sources:

All relevant studies were identified in a systematic literature search.

The final search was conducted on December 15th, in the databases PubMed, Embase and PsycInfo.

For inclusion, the studies had to describe and deal with the treatment of patients with psycho-social stress-symptoms encountered by a general practitioner in Denmark.

The search strategy consisted of several different mesh/index terms and keywords/text words which were combined with the use of Boolean operators "AND" and "OR". The mesh terms regarding mental states were: "Stress, Psychological", "Psychological Distress", "Mental Disorders", "Depression", and text words were "Distress", "Mental disorder*", "Mental disease*", "Mental ill*", "anxiety", "depress*". These were combing with the following mesh terms and keywords for the specification of the Danish Primary Sector. Mesh terms: "General Practice", "General Practitioner", "Physicians, Family". Text words: "General practi*", "Family physician*", "General physician*" as well as the text words: "Danish", "Denmark". When using Embase, the search was narrowed slightly through exclusion of findings containing the term "conference abstract". No restrictions were applied concerning the year of publication or language.

Study Selection:

The process of study selection consisted of elimination of duplicates across the search, as well as exclusion of ineligible studies. Studies were considered ineligible if they did not examine patients with symptoms of psycho-social stress in a general practice setting in Denmark. Studies were excluded if they were primarily dealing with severe mental disorders outside of the affective/anxious-spectrum (F30-49) and/or severe somatic co-morbidities. Studies were also considered ineligible if they primarily examined children and/or geriatric patients.

The following information was extracted from the abstracts chosen for full-text screening:
Type of study; indexed in qualitive studies, validation studies, clinical studies, literature, cohort and incidence studies.

The performed systematic literature search identified 2081 studies. (Figure 1) 776 duplicates were removed resulting in 1305 for further screening. Of these 1069 were excluded by title, resulting in 236. Of these 152 were removed by abstract, resulting in 84 full text screened for inclusion in the present review. Of the 236, 27 were qualitive studies and of these 15 were selected for full-text quality assessment via CASP[10] and VAKS[11]. None of the included qualitative studies were considered to have any significant or methodological flaws, though some had relatively small, limited samples and some report on the same samples, but following the example by Noyes-Popay (2007)[12], none were excluded on this basis, judging that they could still benefit the general analysis.

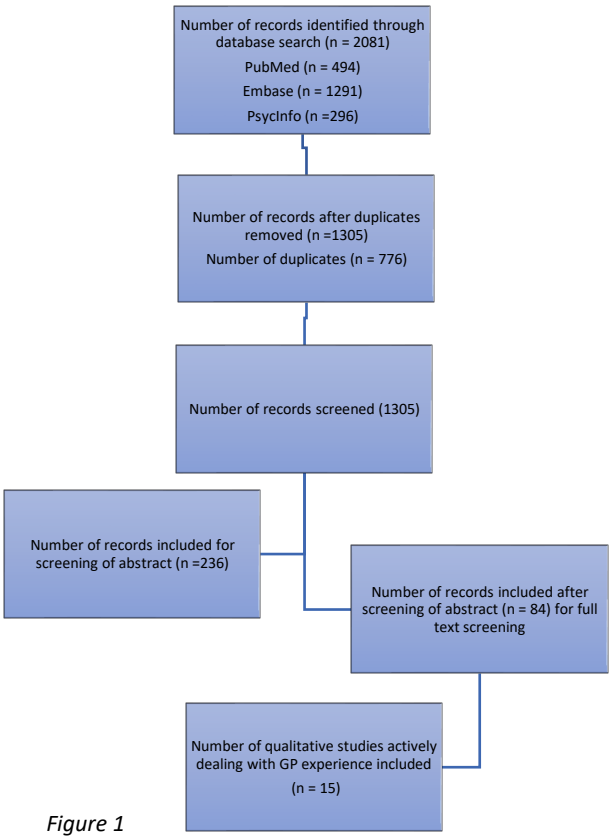

Figure 1

Results:

84 studies were selected for full text screening for inclusion. Of these 15 qualitative studies were deemed to be actively dealing with GP experience of treatment of the chosen patient group. These are summarized in table 1 below.

Title	Author	Year
How do general practitioners experience providing care to refugees with mental health problems? A qualitative study from Denmark.	Jensen, Natasja Koitzsch Norredam, Marie Priebe, Stefan Krasnik, Allan	2013
GPs and involuntary admission: a qualitative study.	Jepsen, Britta Lomborg, Kirsten Engberg, Marianne	2010
Enactments and experiences of 'enhanced interprofessional communication' in collaborative care - a qualitative study.	Overbeck, Gritt Brostrøm Kousgaard, Marius Davidsen, Annette Sofie	2019
Barriers and facilitators to using a web-based tool for diagnosis and monitoring of patients with depression: a qualitative study among Danish general practitioners.	Krog, Mette Daugbjerg Nielsen, Marie Germund Le, Jette Videbæk Bro, Flemming Christensen, Kaj Sparle Mygind, Anna	2018
'It takes some time to get into the rhythm – and to slow the flow of thought': A qualitative study about experience of time and narrative in psychological interventions in general practice	Davidsen, Annette Sofie Reventlow, Susanne	2010
Experiences of barriers to trans-sectoral treatment of patients with severe mental illness. A qualitative study.	Davidsen, A S; Davidsen, J; Jønsson, A B R; Nielsen, M H Kjellberg, P K; Reventlow, S	2020
How does the general practitioner understand the patient? A qualitative study about psychological interventions in general practice.	Davidsen, Annette Sofie	2009
The work and challenges of care managers in the implementation of collaborative care: A qualitative study.	Overbeck, G Kousgaard, M B Davidsen, A S	2018
Screening and brief intervention for excessive alcohol use: qualitative interview study of the experiences of general practitioners.	Beich, Anders Gannik, Dorte Malterud, Kirsti	2002
Who needs collaborative care treatment? A qualitative study exploring attitudes towards and experiences with mental healthcare among general practitioners and care managers	Møller, Marlene Christina Rosengaard Mygind, Anna Bro, Flemming	2018
Patients' perspectives on antidepressant treatment in consultations with physicians.	Fosgerau, Christina Fogtmann Davidsen, Annette Sofie	2014
What is depression? Psychiatrists' and GPs' experiences of diagnosis and the diagnostic process.	Davidsen, Annette S Fosgerau, Christina F	2014
Talking therapy as part of the general practitioner's normal working day	Davidsen, Annette Sofie	2010
Narratives about patients with psychological problems illustrate different professional roles among general practitioners.	Davidsen, Annette Sofie Reventlow, Susanne	2011
General practitioners' and psychiatrists' responses to emotional disclosures in patients with depression.	Davidsen, Annette Sofie Fosgerau, Christina Fogtmann	2014

Table 1

To investigate the qualitative studies and findings in the field, they were thematically examined through data driven, inductive analysis.[1314] Recurring themes in these studies emerged, regarding difficulties and challenges encountered by the GPs in handling this group. These themes are summarized in table 2 and thematically explored below.
Methods used in the included qualitive studies were diverse and included interviews, focus group interviews and videotaped consultations.

Themes:	Number of qualitative studies dealing with it
Time	8
Referrals and collaboration	7
Diagnostic challenges and screening tools	8
Training / education	5
Financial considerations and remuneration	4

Table 2

Themes:

To synthetize the results and findings in the literature regarding challenges in general practice common themes were extracted and explored across studies. Several themes and challenges are narratively interconnected and overlapping and are presented as such.

Time

Several studies note how mental illness is very time-consuming for the general practitioner, which can influence what treatment is offered. Many practices have a setup with many short consultations and appointments allowing them to see and treat a high number of patients. Davidsen et al. (2010)[15] characterizes how several general physicians during periods of high patient- or workload in their practice describe a tendency to more readily refer patients with psychological stress, adjustment disorder or other affective disorders to psychologists or specialized psychiatric treatment, instead of opting for their own sessions of talking therapy, and as Davidsen et al (2010)[16] finds: "*If time was short, talking therapy was always the ting that was ditched, since the physician prioritized the biomedical tasks. Talking therapy is thus not a natural and integrated part of the general physician's work."*
Davidsen et al. (2015)[15] do, however, note a strength of general practices in relation to time. Described as "*longitudinal time*", it as seen as particular specialty that patients consult their general practice again and again, over and over throughout the years for a variety of reasons, and during times of poor mental well-being they will often frequent their general practitioner in a repeated manner which can help offset the time constraints of the individual consultation, establish a trusting rapport, and allow the general practitioner to follow and monitor any progress or deterioration of the patient's symptoms and condition closely.
Lack of time and resources in the general practice to administer talking therapy is a recurring theme described in the qualitative studies as Møller et al. (2018)[17] likewise describe several GPs that would welcome increased implementation of collaborative care between general practitioners and specialists in psychiatry, due to the time-consuming nature of treatment of patients, which have mental health issues, but do not meet the criteria for referral to ambulatory treatment in the regional psychiatric system in Denmark. However, many GP are also concerned about the additional time that would have to be spent on organization and coordination to implement Collaborative Care would swallow any otherwise freed time and resources.

Referral options and collaboration with specialists

Referral options or lack thereof are viewed as a limiting factor of optimal, efficient treatment in several studies, with Møller et al. (2018)[17] noting that general practitioners *"see a growing need for improved referral options for this patient group"*, with many expressions frustra-

tions with long-wait list to both private psychologists and regional psychiatric ambulatories. Møller et al. (2018)[17] is one of several recent studies that have described how new approaches to treatment of this group of patients have been tested and implemented in the Danish primary sector. Since 2014 Collaborative Care have been tested in four regions of Denmark. Through this new system, patients debuting with symptoms of anxiety or depression in general practice get a coordinated treatment plan from the beginning through a Care Manager designated from the region's Psychiatric Unit, usually a nurse, who coordinate between the GP and licensed Psychiatrist. A few completed studies have reported promising, positive findings in Denmark – with a high level of patient satisfaction and shorter duration of depressive symptoms as result of the mental illness.[18] It was found in Møller et al. (2018)[17] that many general practitioners were mostly interested in more collaboration concerning severe mental illness such as schizophrenia and *"did not see a need for enhanced collaboration with specialised (sic) psychiatry on patients with mild/moderate mental problems. For this patient group, they requested a fast track to high-quality treatment in cases when usual care fails."* And studies have found room for improvement regarding Collaborative Care, with Overbeck[19] noting that general practitioners would like more flexibility in referrals, since a criteria for patient inclusion in collaborative care is a single set diagnosis by the general practitioner, where the GP often notes a mixture of psychological symptoms compatible with multiple diagnoses, such as anxious disorders, depression and PTSD as well the GP being less inclined to place a diagnosis on symptoms that could be seen as a natural reaction to life circumstances. More studies are evaluating on the efficacy and quality of this program with expected results in 2021.

Diagnostic considerations and screening tools

A number of studies[20,21] have focused on the validation of different screening tools for depression and anxiety such as Hamilton, MDI and CMDQ in a general practice setting, since there have been wonderings if physicians have a tendency to overdiagnose mental illness, especially regarding depression.[22] The majority of patients with diagnosed depression are treated exclusively in general practice. Davidsen et al. (2014,1)[4] deal with the difference between how general practitioners and psychiatrists interpret and diagnose these patients. The study notes significant differences in how these subsets of physicians understand depression and patients, focusing on how many general practitioners consider a purely psychiatric approach reductionist, which fails to take into account the present life circumstances of the specific patient, and its broached that many GPs often find it difficult to label and diagnose a condition or illness which was mixed with social issues. A tendency was expressed where psychiatrists take a more generalized, illness-centered approach to depression, whilst general practitioners are more apt to focus more on the individual patient and their life traumas, stressors and social situations.[4] It's speculated that the general practitioners often had a closer understanding of these specific social, somatic and medical factors due at least in part to a time aspect, where they get to know the patient over many years.[13] Thereby indicating a split between understandings of depression, where GPs are perhaps more apt to view depressive symptoms as natural in persons and patients exposed to stressors and traumas, compared to a more disease-model oriented view by psychiatrists. It is likewise noted by Davidsen et al. (2014)[13] that the GP has as strength in their ability to more readily examine the patient somatically and allay the patients fears or conceptions that something might be physically, and thus overcome many patients' subconscious or conscious resistance to a mental diagnosis.

A study by Jensen et al. (2013)[23] dealing with care of refugees with mental health issues notes the possible extra significance of this in the case of refugees, since findings suggests general practitioners have the experience that refugees sometimes have an difficulty separating physical symptoms and psychological problems. It is also found that general practitioners note themselves more conscious of possible trauma history and difficult life circumstance with this group.

It was found in Lykkegaard et al. (2020)[5] that twice as many women as men sought their GP with psychological stress, and it was suggested that treatment and referral patterns are to some degree dependent on the gender of the patient. Men with psychological stress symptoms were more frequently treated with medicine, both in regards to antidepressants, but especially regarding benzodiazepines or Z-drugs, whereas women were more likely to have and period of sick leave and slightly more likely to receive a referral to a psychologist and/or receive talking therapy in the general practice. This correlated with how GPs assessed causality of the patients' psychological stress. A tendency was found that psychological stress was most often assessed as being caused by work or family-related factors, with other areas of life being less frequent, with there being a propensity for psychological stress to more frequently be caused by work regarding female patients, while men seemed to be more disposed to psychological from factors outside their work. It was considered multifactorial in approximately a third of the cases. Treatment choices were to a degree associated with what was considered the cause of the psychological stress, insofar as sick-leave was more often recommended when the primary cause was seen as work-related, referral to a private psychologist when it was family-related, and prescription of medicine when it was related to a somatic illness. Davidsen et al. (2014)[4] noted that there is often a discrepancy in how general practitioners and psychiatrists evaluate the patients mental state based on the GP's understanding and consideration of the patients' present life circumstances, medical and family history and social network.

Training and education

Davidsen et al. (2008)[24] also notes how a key component effecting choice of treatment in a general practice setting is how comfortable the GP is in using talking therapy. Several physicians expressed concerns that they had not received sufficient education and formalized training in handling talking therapy and were therefore reluctant to initiate it. Likewise, supervision could be sparse. Davidsen (2009)[25] likewise makes assertions that some general practitioners could benefit in more focus on mentalization training and education and that facilitation of this is not an uncommon request. A similar point is again made by Davidsen et al. (2014)[26] a few years later in a study, comparing the responses by GPs and psychiatrists to emotional disclosures, where she finds GPs more empathetic in their responses and physiatrists more rational and focused on clarifying symptoms, though the study finds that some GPs can often be unreflective in their empathy, failing to elaborate or deepen the patient's narratives or symptoms. But moreover, a significant point found in both Møller et al. (2018)[17] and throughout different studies by Davidsen et al. (2011)[27] is that the degree to which general practitioners handle patients with psychological stress or mild mental illnesses themselves through talking therapy or repeated regular consultations if often quite dependent on the preferences and personality of the physician himself or herself since the field of general practitioners is diverse with and their foci the same across somatic and mental illness, and that the Danish system can enable this.

Financial considerations

As noted by Lykkegaard et al. (2020)[5] in Denmark, psychologist care is partly remunerated if the patient is diagnosed with depression at all ages, whereas this is only the case with anxiety-diagnoses until the age of 38, raising wonderings whether the GPs are incentivized on

behalf of the patient to give the diagnose depression more frequently and allowing for more referrals to psychologists with this diagnosis. Many patients do, however, have private health insurances, often through work, which covers mental health, and in recent years young adults have on a trial basis had the opportunity of receiving referral to psychologists free of charge for certain diagnoses, which is set to continue and be expanded to cover a wider age-group.
Møller et al. (2018)[17] also notes a hindrance and frustration on the part of GPs owing to the way renumeration for talking therapy in general practice is structured in Denmark, *"since Danish GPs receive reimbursement for conversational therapy only if the patient receives at least two consultations. If a patient does not return for a second conversational therapy consultation, the GP is not entitled to reimbursement for the time spent on the first consultation; this can have a negative impact on the motivation of some GPs"*. Davidsen et al. (2010)[16] makes similar observations concerning some general practitioners' reluctance in using talking therapy, due to the time consumption it incurs relative to its value and the unspecific nature of the indication for talking therapy. And a rule of the primary sector renumeration, which features in Davidsen et al. (2011)[27] is the fact that general practitioners can only charge for seven sessions of talking therapy per patient a year, disincentivizing longer stretches of this treatment in the practice.

Discussion:

In this investigatory study, the literature search was very wide as regards to mental illness as an attempt to include borderline cases and reflect the difficulty of overlapping symptomologies present in this patient population. However, a more specific and restrictive search on psycho-social stress, affective disorder and adjustment disorder, with more strict definitions of mental illness, might have yielded different findings.

Nevertheless, the scope of the study was in other aspects quite narrow with a focus on the Danish health care system, specifically the primary sector, and how patients are characterized, experienced and managed here by general physician. Valuable knowledge and characteristics of this patient group and their symptoms from studies in other countries is likely to be missing. However, diagnosis, referral and treatments are in large part based on structural issues such on national guidelines, referral possibilities and the financing of these, as well as renumeration set-ups for the general practitioner. Therefore, this narrow focus was chosen. It would, however, likely be rewarding to do a wider international search focused on the differences and similarities, both with countries with nominally similar health care systems and population composition as well as countries where this is not the case.

Arguably, the patient group included in the present has been too narrow since co-morbidity has excluded several patient groups and the studies of them. For example, patients suffering from cancer or one or more strokes are not included since the somatic is seen as the primary issue needing treatment, whereas it might very reasonably be seen as a significant stress factor resulting in mental health complications, which is indeed a well-known sequalae, especially as regards depression.[28] Whether this patient population receive a different understanding and treatment in their general practice due to their underlying somatic morbus might be worth investigating.

For this literature study the primary focus has been to assess how GPs describes their challenges with this group. To this aim the choice was made to focus on qualitive studies centered on GP experiences. To this end formal assessments of the included qualitative studies using CASP and VAKS were performed. Different choices of assessment could possibly have influenced what studies were deemed eligible for inclusion. Also, regarding the majority of the studies found in the search, were only

reviewed and evaluated by title or abstract, possibly resulting in bias regarding which studies were included and classified. This could have led to the overlooking of certain relevant and valuable data. Likewise as noted by Dixon-Woods (2005)[14] thematic analysis can either be data driven – as attempted here – or theory driven, and the distinction can be lacking or unclearly defined, and the reviewer can find it difficult to disregard the influences of any theories used in the reviewed qualitative articles.

Over the last 20 years there have been a few Danish qualitive studies that dealt with this patient population and their GP-consultations, but hardly in sizable numbers, which hampers the strength of observations, recommendations and conclusions possible to draw from this literary study. Perhaps most prominently Davidsen have done several qualitative studies dealing with the experiences of GP's handling and treating patients with mental illness, and in the present search a large part of the qualitative studies included were spearheaded by Davidsen, sometimes drafting from the same sample of general physicians. The total number of qualitative studies and the number of researchers investigating this part of the field must presently be considered somewhat sparse, and one should be careful in drawing any firm conclusions. There could be hope for a more extensive, wider and broader use of qualitative studies in the field of mental illness in general practice in the future, focused on the diagnostic and treatment challenges these patient pose in the Danish health system.

Certain tendencies do, however, appear across the studies, where general practitioners note challenges due to the significant increase in time spent on group of patient, both as pertains to diagnosis, treatment in both the general practice and through referrals. It is noted repeatedly that general practitioners can be less inclined to perform prolonged sessions, talking therapy with the patients due to renumeration, resources and time concerns during stressful period in the practice, especially in cases where the general physician does not feel adequately trained or comfortable with formalized talking therapy. A recurring theme of the studies is likewise that general practitioners are interested in increased collaboration and referral opportunities with regional and private psychiatric and psychological specialists.

Conclusion:

Several recurrent characterizations of issues handling patients psychological stress, anxious and/or affective disorders in general emerged. Several studies note that increased education and training in handling these patients, as well as more effective and timelier referral and collaboration opportunities with mental healthcare specialists, are desirable, since they would make general practitioners more secure in treating these patients. It is expressed that many general practitioners are comfortable and capable of delineating between mental illness and natural reactions to life circumstances, though these definitions are an area of debate. Nevertheless, a strengthened understanding of the interplay between stressors, social network, life circumstances and mental illness is required, and this must be considered an area fertile for more studies, examining how best to treat these this diverse set of patients and whether general practices are always the best place for this. Forthcoming international diagnostic guidelines in ICD-11 and as well as its implementation in Denmark and DSAM own guidelines are set to address this to some extent.

However, due to the sparseness of the findings in the search of the available literature and the centrality of few scientific voices in the present literature study, caution should be taken regarding any possible conclusion.

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