Common Mental Disorders in Primary Care

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Abstract- Psychiatric illness in the general health care setting pose a considerable burden not only to the individual and his or her family but also to the primary care services and economically to the wider society. Physician recognition of CMD is generally low in developing countries (patel et al 1998) because of high patient loads, poor undergraduate training in psychiatry, stigma associated with mental illnesses and somatic presentation of mental disorders. Neurotic illnesses in the primary care often become chronic and are associated with high use of services. This article presents an overview of the common mental disorders in a primary care.

Index Terms- Common , Mental, Disorder, Primary care

I. Introduction

Common Mental Disorders are depressive and anxiety disorders that are classified in ICD 10 (1) AS NEUROTIC, stress related, somatoform disorders and mood disorders. The Public significance of mental and behavioural disorders is demonstrated by the fact that they are among the most important cause of morbidity in the primary care setting (2). Primary care occupies apposition of utmost importance in the management of mental health problems this was recognized 45 years ago when Shepherd et al (1966) completed their seminal study Psychiatric illness in General Practice.

The World Health Organization , collaborative study, Psychological problems in General Health Care , screened nearly 26000 primary care patients for common mental disorders in 14 countries including India, 24% patients had a current mental disorders as defined by ICD 10.

Recognition of Psychiatric disorders of General Practitioners varies widely, between 30%-70% of patients with a psychiatric disorder, as determined by a standardised interview, are missed by G.Ps.Goldberg and Huxley (1980), proposed a" pathways to care model" to conceptualize psychiatric morbidity in the community. Their model have five levels, between each level there are filters which determine the passage of patients from one level to the next. Consultation skills that improve detection of mental health problems are:

. Open questions.
. Unhurried style of examination.
. Frequent eye contact.
. Picking up and following verbal cues.
. Picking up and following non-verbal cues.
. Ability to listen empathically.

Depressive disorder: Depressive disorder is the most common mental disorder in the primary health care. In the WHO collaborative study 10.4% primary care patient had depressive disorder as defined by ICD 10. 30-70% of depression is not recognized or treated , 50% of the treated patient stop medications within the first 3 months, medications are often not used at optimum dosage.

Depression can affect a person in many ways, patient suffering from depression have a continuous low mood, loose interest or pleasure in activities that one normally enjoys, feels hopeless, helpless or worthless, has difficulty in concentration, feels tired and lack of energy, has problems in sleep and appetite and in severe cases may harbour thoughts of death and suicide. These symptoms are present for weeks and lead to difficulty in carrying out routine activities, difficulty at work and withdrawal from social activities. Depression is significant impact on quality of life is greater than most chronic medical illness, increases morbidity / mortality from coexisting medical condition, causes economic loss and suicide.

Treatment**:** Depression is treated effectively by medicines and psychotherapy. The treating physician should rule out medical conditions like endocrine disorders, neurological illness like parkinsonism etc., chronic infectious diseases, chronic medical condition like diabetes, etc. that can cause depressive symptoms. Use of medications like beta blockers, antihypertensives,steroids, anti-tuberculardrugs can also cause depressive symptoms.

SSRIs (fluoxetine, sertraline, escitalopram etc.) are the commonly prescribed drugs for mild to mod. depression, are effective, safe and tolerable. Other medications like SNRIs (Venlafaxine, Milnacipranetc), Buproprion, Mirtazapine, Tricyclics (Imipramine, amitryptiline,etc) are also effective in treating depressive disorder.

Psychotherapy in form of Cognitive Behaviour Therapy, Interpersonal Therapy, Problem Solving Skills traning etc.is also effective in treatment of depression. The following tips also help patients.

.Exercise daily.
.Maintain good sleep habits.
.Seek out activities that brings pleasure.
.Talk to someone you trust about your feelings.
.Try to be around people who are caring and positive.

II. Anxiety Disorders

Anxiety is a normal reaction to stress. It helps one deal with a tense situation. In general, it helps one cope. But when anxiety becomes an excessive, irrational dread of everyday situations, it has become a disabling disorder.

Major types of anxiety disorders are:• Generalized Anxiety Disorder
- Panic Disorder
- Post-Traumatic Stress Disorder (PTSD)

- Social Phobia (or Social Anxiety Disorder)
- Obsessive and Compulsive disorder

Generalized Anxiety Disorder: Generalized anxiety disorder (GAD) is a common chronic disorder characterized by long-lasting anxiety that is not focused on any one object or situation. Those suffering from generalized anxiety experience non-specific persistent fear and worry and become overly concerned with everyday matters. Generalized anxiety disorder is the most common anxiety disorder to affect older adults.[5]Anxiety can be a symptom of a medical or substance abuse problem, and medical professionals must be aware of this. A diagnosis of GAD is made when a person has been excessively worried about an everyday problem for six months or more.[6] A person may find they have problems making daily decisions and remembering commitments as a result of lack of concentration/preoccupation with worry.[7] Appearance looks strained, skin is pale with increased sweating from the hands, feet .Physical symptoms often accompany the anxiety include fatigue, headache, trembling, muscle tension, irritability, nausea, breathlessness, diarrhoea. These people mostly have trouble in falling asleep or staying asleep. Before a diagnosis of anxiety disorder is made physicians must rule out drug-induced anxiety and medical causes.[9]

Panic Disorder: In panic disorder, a person suffers from brief attacks of intense terror and apprehension, often marked by trembling, shaking, confusion, dizziness, nausea, difficulty breathing, weakness, faintness, numbness or tingling of hands of feet, chest pain or smothering sensations.. These panic attacks, defined as fear or discomfort that abruptly arises and peaks in less than ten minutes, can last for several hours and can be triggered by stress, fear, or even exercise; the specific cause is not always apparent.

In addition to recurrent unexpected panic attacks, a diagnosis of panic disorder requires that said attacks have chronic consequences: either worries over the attacks' potential implications, persistent fear of future attacks.

Phobic Disorders: The single largest category of anxiety disorders is that of phobic disorder, in which fear and anxiety is triggered by a specific stimulus or situation. Between 5% and 12% of the population worldwide suffer from phobic disorders.[6] Sufferers typically anticipate terrifying consequences from encountering the object of their fear, which can be anything from an animal to a location to a bodily fluid to a particular situation. Sufferers understand that their fear is not proportional to the actual potential danger but still are overwhelmed by the fear.[10] If the feared situation or feared object is easy to avoid, people with specific phobias may not seek help; but if avoidance interferes with their careers or their personal lives, it can become disabling and treatment is usually pursued.

Agoraphobia: Agoraphobia is the fear about being in a place or situation where escape is difficult or embarrassing or where help may be unavailable. [11] Agoraphobia is strongly linked with panic disorder and is often precipitated by the fear of having a panic attack. A common manifestation involves needing to be in constant view of a door or other escape route

Social Anxiety Disorders: Social phobia is an intense fear and avoidance of negative public scrutiny, public embarrassment, humiliation, or social interaction. This fear can be specific to particular social situations (such as public speaking) or, more typically, is experienced in most (or all) social interactions. Social anxiety often manifests specific physical symptoms, including blushing, sweating, and difficulty speaking. Those suffering from social anxiety often will attempt to avoid the source of their anxiety; in the case of social anxiety this is particularly problematic, and in severe cases can lead to complete social isolation.

Post-Traumatic Stress Disorder: Post-traumatic stress disorder (PTSD) is an anxiety disorder which results from a traumatic experience. Post-traumatic stress can result from an extreme situation, such as combat, natural disaster, rape, hostage situations, child abuse, or even a serious accident. It can also result from long term (chronic) exposure to a severe stressor, [13] for example soldiers who endure individual battles but cannot cope with continuous combat. Common symptoms include hyper vigilance, flashbacks, avoidant behaviours, anxiety, anger and depression. [12]People with PTSD may startle easily, become emotionally numb, have trouble feeling affectionate; they avoid situations that remind them of original incident.

Obsessive Compulsive Disorder: Obsessive–compulsive disorder (OCD) is a type of anxiety disorder primarily characterized by repetitive obsession (distressing, persistent, and intrusive thoughts or images) and compulsion (urges to perform specific acts or rituals). It affects roughly around 3% of the population worldwide.[6]The OCD thought pattern may be likened to superstitions insofar as it involves a belief in a causative relationship where, in reality, one does not exist. Often the process is entirely illogical. Commonly people are obsessed with germs or dirt; they develop compulsions to wash their hands over and over again. Other common rituals are need to repeatedly check things, touch things or count things. People with OCD may also be preoccupied with order and symmetry or have thoughts that are prohibited by religious beliefs.

In a slight minority of cases, sufferers of OCD may only experience obsessions, with no overt compulsions; a much smaller number of sufferers experience only compulsions.

Treatment of Anxiety Disorders: Anxiety disorders are treated with medication, specific types of psychotherapy, or both.[14] Treatment choices depend on the problem and the person's preference. Before treatment begins, a doctor must conduct a careful diagnostic evaluation to determine whether a person's symptoms are caused by an anxiety disorder or a physical problem.

Medications: SSRIs are generally recommended as first line agents. SNRIs such as venlafaxine are also effective. Benzodiazepines are also indicated for short-term use. They should be used judiciously as they can cause cognitive impairment and due to their risk of causing dependence.[48] There is evidence that certain newer medications including the GABA analogue Pregabalin and the novel antidepressant like mirtazapine are effective treatments for anxiety disorders.[17][19] Tricyclic drugs such as imipramine, clomipramine, as well as atypical antipsychotics such as quetiapine, are also useful in some anxiety disorders.[14]

Psychotherapy: Education about the illness, reassurance, life style changes, and relaxation techniques should be included in the treatment. Psychotherapy such as Cognitive behaviour

therapy, Social skills training, Exposure and response prevention are helpful in treating anxiety disorders.

People with anxiety disorders benefit from joining a self-help or support group and sharing their problems and achievements with others. Talking with a trusted friend or member of the clergy can also provide support.

Stress management techniques and can help people with anxiety disorders calm themselves and may enhance the effects of therapy. There is preliminary evidence that aerobic exercise may have a calming effect. Since caffeine, certain illicit drugs, and even some over-the-counter cold medications can aggravate the symptoms of anxiety disorders, they should be avoided.

Somatoform Disorders

Another group that comes under the rubric of common mental disorders is Somatoform Disorders. This include broad group of illnesses that have bodily signs and symptoms as a major component without any physical illness explaining them completely. The complaints are not imaginary.

This includes Somatization disorder, hypochondriacal disorder, persistent somatoform pain disorder and other related disorders.

Somatization Disorder: It is an illness of multiple somatic complaints in multiple organ systems that occur over a period of several years and results in significant impairment or treatment seeking, or both. The disorder is chronic and is associated with significant psychological distress, impaired social and occupational functioning, and excessive medical-help-seeking behavior. Most patients have a long and complicated history of contact with both primary and specialist medical services, during which many negative investigations or fruitless operations, may have been carried out. The lifetime prevalence of somatization disorder in the general population is estimated to be 0.2 percent to 2 percent in women and 0.2 percent in men, with a 5-to-1 female-to-male ratio. Among patients in the offices of general practitioners and family practitioners, 5 to 10 percent may meet the diagnostic criteria for somatization disorder. Somatization disorder is defined as beginning before age 30; it usually begins during a person's teenage years. Symptoms may be referred to any part or system of the body, but gastrointestinal sensations (pain, belching, regurgitation, vomiting, nausea, etc.), and abnormal skin sensations (itching, burning, tingling, numbness, soreness, etc.) and blotchiness are among the commonest. Sexual and menstrual complaints are also common. The three features that most suggest a diagnosis of somatization disorder instead of another medical disorder are the involvement of multiple organ systems, early onset and chronic course without development of physical signs or structural abnormalities, and absence of laboratory abnormalities that are characteristic of the suggested medical condition. About two thirds of all patients with somatization disorder have identifiable psychiatric symptoms, and up to half have other mental disorders. Marked depression and anxiety are frequently present and may justify specific treatment. The course of the disorder is chronic and fluctuating, and is often associated with long-standing disruption of social, interpersonal, and family behaviour. Dependence upon or abuse of medication (usually sedatives and analgesics) often results from the frequent courses of medication. Medical Disorders presenting with vague symptoms like thyroid disease, hyperparathyroidism, intermittent porphyria, multiple sclerosis (MS), and systemic lupus erythematosus should be ruled out before diagnosing this entity. Treatment strategy includes single identified physician as primary caretaker, regularly scheduled visits, avoidance of additional laboratory and diagnostic procedures, listen to the somatic complaints empathically, increase the patient's awareness of the possibility that psychological factors involved in the symptoms, referral to a mental health specialist after explaining the nature of illness. Giving psychotropic medications whenever somatization disorder coexists with a mood or anxiety disorder is always a risk, but psychopharmacological treatment, as well as psychotherapeutic treatment, of the coexisting disorder is indicated.

Hypochondriasis: The essential feature is general and nondelusional preoccupation with fears of having, or the idea that one has, a serious disease based on the person's misinterpretation of bodily symptoms. Patients with hypochondriasis believe that they have a serious disease that has not yet been detected, and they cannot be persuaded to the contrary. Their convictions persist despite negative laboratory results, the benign course of the alleged disease over time, and appropriate reassurances from physicians. This preoccupation causes significant distress and impairment in one's life; it is not accounted for by another psychiatric or medical disorder. Hypochondriasis is often accompanied by symptoms of depression and anxiety. 6-month prevalence may be as high as 15 percent. Men and women are equally affected by hypochondriasis. The belief must last at least 6 months, despite the absence of pathological findings on medical and neurological examinations. Hypochondriasis must be differentiated from nonpsychiatric medical conditions, especially disorders that show symptoms that are not necessarily easily diagnosed. Course is usually episodic; the episodes last from months to years and are separated by equally long quiescent periods. Treatment strategy includes frequent, regularly scheduled physical examinations help to reassure patients that their physicians are not abandoning them and that their complaints are being taken seriously. Invasive diagnostic and therapeutic procedures should only be undertaken, however, when objective evidence calls for them. Pharmacotherapy is indicated for underlying primary disorder or co-morbid anxiety or depressive disorder.

III. Adjustment Disorders

The adjustment disorders are a diagnostic category characterized by an emotional response to a stressful event. The prevalence of the disorder is estimated to be from 2 to 8 percent of the general population. Women are diagnosed with the disorder twice as often as men, and single women are generally overly represented as most at risk. 10 to 30 percent of mental health outpatients and up to 12 percent of general hospital inpatients referred for mental health consultations have been diagnosed with adjustment disorders. Up to 3 months may elapse between a stressor and the development of symptoms. Symptoms do not always subside as soon as the stressor ceases; if the stressor continues, the disorder may be chronic. The disorder can occur at any age, and its symptoms vary considerably, with depressive, anxious, and mixed features most common in adults.

Physical symptoms, which are most common in children and the elderly, can occur in any age group. Manifestations may also include assaultive behaviour and reckless driving, excessive drinking, defaulting on legal responsibilities, withdrawal, vegetative signs, insomnia, and suicidal behaviour. Psychotherapy remains the treatment of choice for adjustment disorders. Psychotherapy can help persons adapt to stressors that are not reversible or time limited and can serve as a preventive intervention if the stressor does remit. Patients can find therapists' attention, empathy, and understanding, which are necessary for success, rewarding in their own right, and therapists may thereby reinforce patients' symptoms. Psychiatrists should not attempt to rescue such patients from the consequences of their actions. The judicious use of medications can help patients with adjustment disorders, but they should be prescribed for brief periods.

IV. Alcohol Use Disorders

Alcohol use disorders form a major public health problem in India. 25.6-74.2% of Indian population has ever used alcohol among which 19-82.5% used within last one year. It is a CNS depressant. Its effect is variable depending on blood alcohol levels. At a level of 0.05 percent alcohol in the blood, thought, judgment, and restraint are loosened and sometimes disrupted. At a concentration of 0.1 percent, voluntary motor actions usually become perceptibly clumsy. At 0.2 percent, the function of the entire motor area of the brain is measurably depressed, and the parts of the brain that control emotional behavior are also affected. At 0.3 percent, a person is commonly confused or may become stuporous; at 0.4 to 0.5 percent, the person falls into a coma. At higher levels, the primitive centres of the brain that control breathing and heart rate are affected, and death ensues secondary to direct respiratory depression or the aspiration of vomitus. It also adversely affects the functioning of Liver causing alcoholic liver disease; gastrointestinal system causing esophagitis, gastritis, pancreatitis; increased blood pressure, dysregulation of lipoprotein and triglyceride metabolism, and increased risk for myocardial infarctions and cerebrovascular diseases. Alcohol use disorders include intoxication, withdrawal, harmful use and dependence. Symptoms of alcohol intoxication include slurred speech, incoordination, unsteady gait, nystagmus, impairment in attention or memory, stupor or coma while symptoms of withdrawal includes autonomic hyperactivity, increased hand tremor, insomnia, nausea or vomiting, psychomotor agitation, anxiety, grand mal seizures, transient visual, tactile, or auditory hallucinations or illusions. Harmful use is characterized by a pattern of alcohol use that is causing damage to health includes physical or mental health. Alcohol dependence is a brain disease characterized by compulsive use of the alcohol regardless of the consequences. It is often accompanied by physical dependence which results in withdrawal symptoms when not taking alcohol. Treatment of intoxication is mainly supportive and abstinence from alcohol. Withdrawal syndrome however requires alcohol substitute in the form of benzodiazepines including chlordiazepoxide or lorazepam dose of which is decided by amount of regular alcohol intake and current severity of withdrawal. For treatment of Alcohol dependence apart from the detoxification, motivational enhancement therapy is also done to prolong the duration of abstinence and to reduce rates of relapse. Its characteristic course is relapsing and remitting.

V. Conclusion

Most of the common mental disorders can be treated in the general care settings. However the interface between primary care and psychiatric services is of great importance in the delivery of mental health services.

Referral to a psychiatrist or to a treatment centre should be considered in the following circumstances:

- If the patient is expressing a suicidal intent or there was a recent suicidal attempt.
- If the presenting symptoms of the disorders are severe e.g. severe weight loss, severe withdrawal symptoms or severe psychomotor retardation etc.
- If there is change in symptomatology (e.g. manic switch)
- If patient fails to respond to a treatment.
- If the diagnosis is not clear.

Owing to shortage of mental health professionals in our country, general physicians plays an important role in the delivery of mental health services to the society.

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