



PATIENTS AS PARTNERS

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Tel: +27 11 783 1474 Fax: +27 11 884 7074 E-mail: anxiety@iafrica.com website: www.anxiety.org.za

Depression, Anxiety and the Primary Healthcare Professional

Winnie De Roover

Clinical and Research Psychologist, Mental Health Information Centre, Department Psychiatry, University of Stellenbosch

Although there is an increasing awareness of psychiatric disorders in primary care, many of these conditions remain under-diagnosed and under-treated. Depression in particular, remains significantly unidentified in primary practice. This article aims to stipulate the crucial role the primary healthcare professional plays in the diagnosis and treatment of depression and anxiety in South Africa.

The anxiety disorders: panic disorder and social anxiety disorder (social phobia) are among the most common of psychiatric disorders.¹ Each is characterised by panic attacks or hyper-arousal, and in primary care settings may be missed or may be treated as physical illnesses. In addition, each may be associated with significant morbidity and functional impairment. In reality it has been estimated that anxiety disorders account for one third of the costs of all mental illnesses. Mental disorders often go undiagnosed and, as a result, less than 33% of those who need treatment actually receive it.² Only a small minority of the 450 million people suffering from mental or behavioural disorders are receiving treatment.³ An international survey by the World Federation of Mental Health (May 2005) found that on average, people with major depressive disorder waited more than 11 months to see a doctor and were only diagnosed with depression after 5 visits to the doctor.⁴

Estimates indicate that in the US, 58% of people with depression are not identified or adequately treated in health care settings. Between 66% and 75% of people with a mental health disorder do not report receiving treatment.²

Too little attention and funding is being directed to promoting positive mental and physical health and wellness as a long term strategy to reduce the burden of disease. Most countries continue to spend less than 1% of their total budgets on diagnosis, treatment and prevention of mental and behavioural disorders.³

The WHO estimates that in general practice surgery every third or fourth patient has some form of mental disorder.⁵ Levels of disability among primary care patients with such disorders are high – greater on average than disability among primary care patients with chronic diseases such as hypertension, diabetes, arthritis and back pain. This is in clear contrast with the fact that simple, effective treatment is available for many mental disorders and some can be treated more effectively than hypertension or coronary heart disease.⁵

Mental illnesses are often misdiagnosed as physical illnesses because of the commonly masked presentation (i.e. a person suffering from a mental malady often presents primarily physical symptoms). Common symptoms include fatigue, change in sleeping habits, vague aches and pains, headaches, back pain, digestive problems and dizziness. Emotional problems also complicate physical problems; therefore it is crucial that they are treated at an early stage.

The New Mental Health Care Act (2002) promotes the management and treatment of mental disorders in primary care – therefore general health personnel need to be trained in the essential skills of mental health care. The primary care setting is ideal for accurate identification and diagnoses, since the majority of people actively seek mental health care in these settings. The flip side of the coin is that mental illness often goes undetected and is therefore improperly treated.

It needs to be emphasised that good mental health is a collaborative effort, which incorporates the primary team (nurses, counsellors, psychologists, GP's, etc) and the community mental health team (nurses, occupational therapists, clinical psychologists, social workers, support workers and psychiatrists).⁵

Specialist mental health care teams should ideally include medical and non-medical professionals, such as psychiatrists, clinical psychologists, psychiatric nurses, psychiatric social workers and occupational therapists, who can work together towards the total care and integration of patients in the community.⁵

A psychologist is trained in the assessment and treatment of mental health problems, for example psychotherapy. A social worker is trained to provide practical help to people such as assisting with paperwork, budgets and counselling on various life-skills issues.

The services of a psychologist are recommended when an individual wants to be treated for depression or anxiety. The aid of a social worker is warranted when the depressive mood or anxiety is caused by family problems, financial worries and if the anxiety or mood disorder disables the individual to the degree that liaison with an employer, financial institution, medical aid

etc is necessitated on their behalf.

It is important to note that the combination of medication and psychotherapy, which incorporates components of cognitive behavioural therapy such as exposure techniques, has been proven effective in many cases. Exactly the same brain changes occur after implementing cognitive behavioural therapy, which involves exposure, and after medical treatment has been administered.¹ Therefore, both interventions lead to a decrease in the basal ganglia false alarm so as a key learning, every form of therapy should include a psycho-educational component for both patient(s) and family.¹

The role of psychotherapy in the treatment of anxiety (panic disorder and social anxiety disorder) and mood disorders, including major depression, must be emphasised. Cognitive behavioural psychotherapy, which aims to break the vicious cycles of depressive or anxiety provoking thoughts, can augment the anxiolytic and mood-enhancing effects of medication and is thus essential in reducing avoidance behaviour, such as the avoidance of social situations, and may be important in ultimately enabling the discontinuation of medication. Cognitive-behavioural therapy is also important prior to the commencement of medication and during medication withdrawal, in order to maintain the positive change experienced.

Although medication will at time have side effects, these are typically transient. It is important to understand that a therapeutic response is relatively slow in its onset. The effect of the medication will have a slow but steady onset and maintenance at optimal dose and gradual decrease are necessary. For best results, it is important to ensure optimal dose for adequate duration.

Primary care patients sometimes have less than optimal response to therapy because they often receive lower doses of medication, no adequate follow-up, less than adequate monitoring of symptoms and the premature discontinuation of therapy. When the patient has a good response to medication, it is important to reinforce the necessity for continuing the medication at the therapeutic dose despite this improvement.¹

Guidelines for maintenance therapy of anxiety disorders have become increasingly conservative, favouring longer courses of medication, in view of the safety of modern antidepressant agents and the likelihood of relapse in patients with an untreated chronic illness. In panic disorder, depression, social anxiety disorder and PTSD, it is not unreasonable to continue medication for at least a year before gradual tapering is undertaken.¹

Mental disorders can be very isolating, which has a negative impact on the prognosis. Stigma, discrimination and inadequate services still exist, resulting in people not receiving the treatment they need and deserve.

Psycho-education of both patient and physician is an important part of facilitating better understanding of mental disorders. Such education includes CPD activities, consulting professional literature regularly, getting training in counselling skills, and educating and counselling patients and families about their mental disorder.

If all role players work together and understand the complexities of mental illness, there will be a significant improvement in the quality of life of people living with mental illness in South Africa.

References

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