IS THE LABELLING OF COMMON MENTAL DISORDERAS AS PSYCHIATRIC ILLNESS CLINICALLY USEFUL IN PRIMARY CARE?

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ABSTRACT

The present study has been carried out to examine the concepts of Common Mental Disorders held by primary health care providers in Goa. Ethnographic interviews and focus group discussions with primary health care (PHC) staff (n=33) and traditional healers (n=12) were done. Responses relating to the recognition and nature of case vignettes of depression, panic and agoraphobic disorder and multiple unexplained somatic symptoms and open-ended questions about mental illness were elicited. PHC staff recognised the somatic vignette frequently while the phobic vignette was rarely recognised. Both the somatic and the depression vignettes were related to non-somatic aetiologies frequently; Hindu spiritual healers used supernatural explanations while Catholic priests used psychological and cognitive models. Treatment was either religious/spiritual or psychological respectively. Implications for training and service included closer links between psychiatry and community medicine and avoiding the use of complex classification systems in primary care.

Key words: Common mental disorders, primary care, traditional healers, cross-cultural psychiatry

Common Mental Disorders (CMD) is a term which has gained increasing popularity to describe disorders previously categorized as "neuroses". It includes distress states manifesting with anxiety, depressive and unexplained somatic symptoms. CMD have been reported in studies in low-income countries, including India, to be very frequent in primary care settings and to be strongly associated with functional disability (Shamasundar et al., 1986; Ormel et al., 1994). However, the recognition and appropriate management by primary care workers is often disappointing. The most common reasons ascribed for this is that primary care staff are not adequately aware of CMD and that somatic symptoms may lead to misdiagnosis and inappropriate treatment. Research in developing countries such as Zimbabwe & India showed that both these explanations cannot explain the apparent low recognition rates; thus, somatic symptoms are often only the superficial reasons for consultation and even a brief inquiry often elicits psychological symptoms (Patel et al., 1977a; 1997b). Further, primary health workers are aware of the non-somatic aetiology of vague complaints presented by a substantial group of patients but are reluctant to use psychiatric labels for fear of
stigmatizing and alienating these patients (Patel, 1996). Thus, CMD are recognized as distress states of non-somatic aetiology; however, they are rarely viewed as mental disorders and this different conceptualisation could play a role in the low recognition and labelling of CMD in primary care.

The study described in this paper aimed to examine the views on CMD of a cross-section of primary health care workers and traditional healers in the state of Goa, India. The objective of the study was to explore whether CMD were recognized as distress states, whether they were considered as psychiatric disorders and the concepts of CMD such as a causal models and treatments.

**MATERIAL & METHOD**

Health care in Goa is provided by two main sources: biomedical services consisting of the government primary health clinics and central hospital and private medical practitioners: who include both general practitioners and specialists. Traditional medicine in Goa has a long history and a complex classification of practitioners. Traditional medical practitioners include ayurvedic practitioners, religious priests from the Catholic and Hindu faiths, and spiritual healers (ghaddis).

Two ethnographic data collection methods were used. Focus group discussions (FGD) were held with biomedical health care providers. The health care providers were recruited from a rural primary health clinic (PHC) and its four outreach sub-centres in Tiswadi taluka. These care providers included: physicians of two categories, viz., resident who were training in the specialty of preventive and social medicine and interns recently graduated from medical school. Other PHC staff were: nurses; social workers (SW), basic health care workers (BHW) and lady health visitors (LHV) who are relied upon to liaison with patients and their families in the community and auxiliary nurse midwives (ANM) who assist in antenatal and postnatal health care.

Unstructured interviews were used for data collection with traditional healers. Traditional healers were identified from key informants who included patients in psychiatric hospitals, health workers in PHCs, experts in the area of indigenous methods of healing and the general knowledge of well-recognized healers in Goa. For this study, we did not consider ayurvedic practitioners as being "traditional" due to their professional training akin to allopathy such as medical qualification. Traditional healers included in the study were: healing from either Hindu or Catholic religion and spiritual healers or ghaddis.

The methodology and content of the FGD and unstructured interviews were similar to those of earlier studies conducted by VP in Zimbabwe (Patel et al., 1995). Two types of data were elicited. The first type of data was related to the opinions of the care providers on 3 case vignettes of typical presentation of CMD: a 40 year old woman with depression; a 34 year old man with agoraphobia and panic attacks and a 38 year old woman with unexplained multiple somatic complaints (see Appendix for case vignettes). The care providers were asked for their views on whether they encountered such patients in their daily clinical practice; the nature of the illness; the cause; and the appropriate treatment. The second set of data was related to the general concept of mental illness held by the care provider elicited by asking a series of open-ended questions such as: what are the type and causes of mental illness; what is the impact of mental illness on the sufferer and the family; and what types of health care are appropriate for treating mental illness.

Each of the interviews/FGD were facilitated by at least two of the authors; one author would conduct the interview/FGD itself while the other would either record the proceedings on tape or note key points on paper. Taped recordings were later transcribed. The traditional healers (TH) were interviewed individually at their place of practice or homes and the FGDs were conducted either at the main PHC or the
subcentres. The number of participant for the FGD ranged from 2 to 12. Participants were recruited based on whether they came from similar professional backgrounds e.g. doctors, nurses, etc. All data was collected in the preferred language of the participants i.e. English or Konkani; 2 out of 8 FGD (both for physicians) were in English, while 4 of the 12 TH preferred to be interviewed in English.

Analysis involved examining the data for themes and categories which were related to the various questions posed. Themes which recurred across interviews/FGD were of special interest due to their potential of being more representative. The overall method of analysing descriptive data followed standard techniques and included ordering the data in relation to the objective of the study; categorizing answers that had similar characteristics; and examining the data for possible associations between variables (Varkevisser et al., 1991). All terms in italics are Konkani terms.

RESULTS

There were 8 FGD held in the PHC and its subcentres. Two FGD were held with doctors: one FGD was with 11 interns (age range of 21-24 years) and the other with 5 resident doctors (age range 23-26 years). Six FGD were held with 17 other PHC staff, viz.: 5 nurses, 3 BHW, 4 ANM, 2 LHV, 2 SW and 1 pharmacist (age range 23-50 yrs). The experience on the non-medical participants in the FGDs ranged from 1-25 years (mean 3.3 yrs). Twenty-two of the participants were Hindus and 11 were Christians. Interviews were conducted with 12 TH (mean age 60 yrs, range 35-90 yrs). Only one TH was female. The mean length of experience was 23.3 years (range 8 mths-55 yrs). Seven TH were Catholics and the rest were Hindus. Three TH were university graduates (all Catholic priests), 2 had completed higher secondary education and one had completed schooling.

Case 1: A 40 years old female with depression (see appendix)

This case was recognised as occurring amongst patients who were known to both traditional and biomedical care providers. Many biomedical carers labelled the vignette as being an example of depression, some doctors felt that the subject had a "psychosomatic" illness. The possible causes for the illness cited by biomedical carers included: socioeconomic factors like poverty and financial distress; unemployment; medical illness; alcoholism; being single; and family factors like spouse abuse, death of spouse, parental abuse, overprotection, problems with inlaws, living in a large family and infidelity. The treatment recommended consisted of medicines, counselling and giving practical assistance such as helping the person find a job or a home. TH were not able to name the condition but felt that it may have been caused by psychological factors including depression; bottled up feelings, alcoholism; and inability to cope with circumstances; interpersonal factors like family problems and isolation; and financial problems. Spiritual healers also mentioned supernatural factors such as possession (varem laglam) or deeds that one's ancestors committed; and disregard for God, parents and ancestors. Christian healers felt that possession was due to the devil (evil spirit) or the souls of one's dead ancestors. Treatment followed two main guidelines: i.e. religious and psychological. The religious methods included prayer, asking for forgiveness of one's sins, performing rituals like giving masses, giving offerings to the deity like blood sacrifices of animals and praying for the person. Psychological treatments included listening to the person, and giving attentions, love and reassurance.

Case 2: a 34 year-old male with agoraphobia and panic disorder (see appendix)

Most biomedical workers did not recognize this vignette. Some doctors mentioned that the subject may have a bout of hysteria of anxiety neurosis; some paramedical staff
labelled the man as being a *awto* (out of his senses). This vignette was modified due to the low recognition by biomedical workers so that there was more stress given to the somatic symptoms of panic, in particular palpitations and dizziness. With this modification, most biomedical staff were able to recognize the disorder, though the majority diagnosed the condition as being somatic (mostly related to cardiac problems and anaemia). Some mentioned fear, sudden shock (e.g. due to the death of a husband) and family problems as possible causes. All felt that a medical checkup was necessary before treating the patient. Most of the TH recognised this case as one of possession which were described as being caused by evil spirits, dead souls and spiritual entities. Lack of confidence and getting scared were listed as additional reasons for possession. Most of the TH felt that fear was responsible for palpitation. They felt that religious modes of treatment like prayer, sacred ash and rituals were useful. Medical treatment and bed rest were also recommended for some subjects.

**Case 3: A 38 years-old male with somatization (see appendix)**

Biomedical careers felt that such symptoms were amongst the commonest presentation in primary care. One medical intern commented that "if such patients stopped attending the centre then the clinic would have to close down!". Some of them labelled the patients as being "psychic", suffering from "laziness" and having "nervachem". The age groups at which this illness occurred was over 40 years and students who were answering exams. Doctors felt that such symptoms also occurred in conditions such as bronchial asthma, hypertension, diabetes and respiratory tract infections. Causes for this condition were cited as post-hysterectomy complication, misinterpreting minor illnesses, attention seeking behaviour and disturbed interpersonal relationship. Some biomedical carers felt that these patients needed to be treated with placebos while other recommended counselling which included techniques like attention, listening, reassurance and suggestions. Most of the TH felt that the problems with the subject was a physical illness which could have been caused by other illnesses such as common cold, illness of the blood, rise in blood pressure or lack of calcium. The other causes which contributed to this problem were stress, tiredness, emotional deprivation, lack of affection, isolation, relationship problems and possession. The treatment recommended was counselling, confession or medical treatment.

**General concepts of mental illness**

For biomedical workers, mental illness was associated with behavioural disturbance; for e.g. some mentioned the condition "awto" as illustrated by a woman who had lost her child and was seen wandering from place to place, talking irrelevantly and neglecting her personal hygiene. As far as non-psychotic mental illness was concerned, the following types were mentioned: hysteria, hypochondriasis, forgetting by students during exam time, depression and anxiety. However, it was noted that they would rarely label the patients as being a "mental" or psychiatric case since it would alienate and stigmatize the patient. Thus, even though one of the PHC had a fortnightly psychiatric clinic, few of the patients described in the case vignettes were referred to this clinic. The causes of non-psychotic mental illness mentioned were - need for attention, stress especially financial, abandonment, alcoholism, marital strife, loneliness, unemployment, pressure to live up to high standards, sudden intense shock/fright and overstudying by students.

The views of TH was related to their backgrounds and tended to fall into two broad groups: those who belonged to mainstream churches and the spiritual healers or *ghaddi*. The former tended to have a higher education and used cognitive and psychosocial models of explaining mental illness.

Amongst the psychological and somatic
causes/types of mental illness were: forgetfulness by students during examinations, alcoholism, mental depression, schizophrenia, anxiety problems and hallucinations. Isolation, anger, selfishness, narrow-mindedness, lack of sleep, lack of proper food, frustrations, family problems, worries, bereavement, fright, problems in upbringing, insecurity, loneliness, hurt, failure in relationships, thinking too much, lack of attention, guilt, conflict and inferiority complex were all cited as potential causes of illness. Mental illness was classified by ghaddi in two ways, viz., based on the behaviour of the patients and on aetiological theories of causation. The classification based on behaviour bore resemblance of psychiatric categories of mental illness. For example, "pixiachem" was used to described a disturbed individual who was talking irrelevantly, shouting abusive language and having neglect of personal hygiene and "nervachem" was used to describe an individual who complained of feeling stressed, lacking in motivation to work, having disturbed sleep or suicidal ideas. The aetiological model of classification was based on the two broad groups of supernatural/spiritual and psychological/somatic causes. The commonest supernatural cause was possession by spirits (vareachem doenca) which resulted from failure to fulfill the wishes of the spirits, evil eye (nodor), witchcraft (korun ghatlam), the killing of a cobra and astrological factors (kundalee). Witchcraft was effected by another person on his victim by making offerings of blood, animals or alcohol to the deity, while "evil eye" was caused by a person with evil energy in his eyes who, when jealous of somebody's prosperity, could effect harm on that person by looking at him or just by wishing it. A range of symptoms were described by both groups (table).

The impact of mental illness was most likely to be on the family. The social stigma attached to the illness caused difficulty for individual family members by diminishing the prospects of marriage for family members and hence, they did not seek help for the patient's illness. Indeed, the risk of poor marriage prospects was cited as a reason why CMD were not labelled as psychiatric illnesses by health workers. The family was burdened by the expenses involved in buying medicines as patients usually needed to take it for a long time and as the patient were usually unemployed the responsibility of providing treatment fell on the family. Time that could be spent on other work was spent on looking after the patient, occasionally work was given preference leading to neglect of the patient by the family.

The biomedical carers felt that nurses and social workers were ideally suited to deal with mentally ill patients as they tended to have more contact with the patient and the family. Mental illness needed to be treated by giving medical care, counselling and changing one's lifestyle. Change in lifestyle included diet, rest entertainment, work and avoiding stress. Counselling was need for both patients and family members. The ingredients in counselling required were: attention, listening, inquiry, advice, reassurance, love, affection and support. The TH felt that patients could be treated in four ways i.e. religious, traditional, psychological and medical. The first three required their expertise, and the last requiring

| TABLE | SYMPTOMS OF MENTAL ILLNESS ELICITED FROM PHC STAFF AND TRADITIONAL HEALERS |
|-------|-------------------------------------------------------------------------|
| **Behavioral** | Aggressive: verbal and physical |
|       | Disinhibited: not wearing clothes, laughing inappropriately. Loss of appetite. |
|       | Sleep disturbance: increased or decreased. |
| **Impaired self care** | Wearing torn dirty clothes |
| **Mood** | Fluctuates from high to low |
|       | Sadness |
| **Speech** | Talks irrelevantly; Weird sounds; |
|       | Talks continuously. |
| **Cognitive** | Cannot concentrate. Cannot reason logically. Cannot study. Suicidal thoughts. Forgetfulness. |
referral to the doctor when necessary. The religious treatments consisted of prayer, penance, fasting, holy water, holy oil, confession, repentance and faith in God which were mostly recommended by the Catholic priests whilst the spiritual healers mentioned offerings to their deity. The traditional methods included blood sacrifices (manri) of animals to exorcise the evil spirit, salt for the removal of evil eye which is rotated in clockwise and anticlockwise direction around the person, drinking water in copper container, applying sacred ash and herbal medicines. Psychological methods recommended were counselling which included talking to patients, giving advice, reassurance, love and attention.

DISCUSSION

The main aim of this study was to examine whether CMD were recognized by health care providers and whether they were considered to be psychiatric disorders. We used two methods of data collection due to the unfeasibility of organizing focus group discussions with TH due to the cultural distance between them. The biomedical case vignettes allowed us to examine the first aim of the study, i.e. whether CMD were recognized by health care providers. Most of the biomedical carers recognised the depression and somatization vignettes, and specifically mentioned the latter as being one of the commonest clinical presentations in primary health clinics. However, the phobia vignette was recognised only when it was modified by placing emphasis on the somatic symptoms such as palpitation and dizziness and removing the emphasis from the fearful avoidance of the phobic stimulus, a finding which is consistent with other studies carried out in developing countries (Patel et al., 1995). The TH recognised all three vignettes as being common presentations; the depression and the phobic vignettes were seen as being particularly frequent. The somatization vignette though recognized, was often ascribed to a physical illness. From these findings it is possible to hypothesize that patients tend to present specific types of symptoms to specific groups of health care providers. For instance, patients having somatic symptoms were more likely to consult biomedical carers and phobic patients with prominent cognitive symptoms presented to the TH. This, in turn, could be related to the patient's causal model for the illness experience. For instance, somatic symptoms were perceived as being somatically caused and thus more amenable to biomedical treatments whereas sudden fear was linked to psychological or supernatural causes and thus brought to TH. Despite the findings that the vignettes were recognised, majority of both types of care providers were not prepared or unwilling to label them as being mental or psychiatric illnesses. The most common reason cited was that mental illness was typically associated with psychotic behavioural disturbances, hospitalization in mental hospitals and the associated stigma affected the family's position in society and the marriage and economic prospects of the patient. Lumping CMD with mental illness would stigmatize and alienate the patient. Most carers preferred to focus on the causes of the problems. Biomedical carers gave psychological and social models of causation such as poverty while the TH views were influenced by their professional background with church priests using cognitive and social model and spiritual healers using supernatural models such as spirit possession.

Both groups of carer's general concepts of mental illness confirmed that this term was mostly used to describe states characterised by behavioural disturbance which resembled those of psychoses. Some of the TH described possession as a type as well as a cause of mental illness. Interestingly, a common psychological disorder mentioned was that related to the stress of examination for adolescent. This disorder and its symptoms bear close similarity to the Brain Fog Syndrome which has been described from several parts of Africa since the 1960s (Prince, 1989). We speculate that this is a CMD, specifically associated with exams stress and
may be particularly common in developing countries due to the uniquely competitive nature of education and the lack of adequate educational counselling services in these countries. Treatment for CMD recommended by the biomedical carers was counselling and helping the patient financially. Nurses and social workers were ideally suited to counsel such patients as doctors tended to be busy in the clinic and were less familiar with the patients family and social background. The TH felt that such patients needed exorcism of the spirit by praying, offering sacrifices; psychological treatment was recommended only by the Catholic priests. TH saw their role as increasingly important in the treatment of mental illness especially when the causes tended to be supernatural.

Thus, contrary to popular psychiatric thought, CMD are well recognised by both biomedical PHC staff and TH but their conceptual models are different. Biomedical workers utilize psychosocial (as opposed to psychiatric) perspectives whereas TH use psychosocial and supernatural perspectives. Both types of care providers were reluctant to label the patient as being mentally ill for fear of stigmatizing the patient and the family. These findings have implications for training of primary health care workers and research. Thus, the subject of CMD needs to be integrated with general and community medicine which is the setting in which most patients with CMD are encountered. Instead of using diagnostic labels which lack clinical validity in primary care where most patients have symptoms which straddle the narrow boundaries of multiple psychiatric categories, a problem-oriented clinical approach offers a more pragmatic and acceptable model to primary carers to label and manage patients with CMD. Finally, psychiatric research in primary care must closely involve primary health care staff and academic departments of community medicine to ensure that the findings are meaningful to those involved directly in the care of patients with CMD.

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APPENDIX : CASE VIGNETTES

Case 1: Depression

A 40 year old lady has been looking sad, miserable, unable to look after her home and children, slow in speech and movements. She says that life is not worth living. Nothing seems capable of cheering her up. She does not eat or sleep well and lies on a bed for days without doing anything. Once she even tried to take her own life.

Case 2: Agoraphobia & Panic Disorder

A 34 year old man has been unable to use public transport since a month because he feels unwell and frightened to do so. He used to go shopping with his wife but now feels uncomfortable in markets. Crowds made him break out in sweat and he feels tense and panicky. When this happens he feels that something terrible is going to happen and now he spends most of his time indoors.

Case 3: Somatization

A 38 years old mother has been complaining of body aches and pains, especially headache, crawling sensation in her skin, chest discomfort, tiredness and backache. Physical tests and examination do not show any sign of a physical disease.