

## Psychological Diagnosis and Treatment of The Public (The Dark Side of the Spreading of Mental Disorders and Mental Diseases Terminology Among Non-Specialists)

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### Abstract

A call is being made for psychologists globally to "think beyond the box" . This paper emphasises that, especially in low- and middle-income countries, there is now a concrete data basis supporting the effectiveness of task sharing in mental health care provided by Non -Specialist Health Workers NSHWs. The actual implementation of such services in a sustained, sensible way that is balanced across provider cadres, collaborative, simple enough to be implemented yet with safety and quality ensured through sufficient training and supervision.

Therefore, non-specialist providers and health workers are well positioned to deliver interventions for mental disorders, and a variety of delivery approaches can support, facilitate, and sustain this innovation. These approaches should be used and evaluated to increase access to mental health services and prevent armchair psychology risks.

**Keywords:** Armchair Psychology - Non-Specialist Health Workers - Task Sharing .

التشخيص والعلاج النفسي للعامة  
(الجانب المظلم لإنتشار مصطلحات الإضطرابات والأمراض النفسية بين غير المتخصصين)  
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المستخلص

هناك دعوة لعلماء النفس على مستوى العالم "للتفكير خارج الصندوق". تؤكد هذه الورقة أنه - لا سيما في البلدان المنخفضة والمتوسطة الدخل - توجد بيانات ملموسة تدعم فعالية مشاركة المهام في رعاية الصحة النفسية التي يقدمها العاملون الصحيون غير المتخصصين. التنفيذ الفعلي لهذه الخدمات بطريقة عملية ومستدامة ومتوازنة عبر كوادر مقدمي الخدمات تعاونية، وسهلة التنفيذ، ولكن مع ضمان السلامة والجودة من خلال التدريب والإشراف المناسبين.

لذلك، فإن مقدمي الرعاية والعاملين الصحيين غير المتخصصين ملائمون لتقديم التدخلات الخاصة بالاضطرابات النفسية، ويمكن لمجموعة متنوعة من أساليب التقديم أن تدعم هذا الابتكار وتسهيله وتديمه، فإستخدام هذه الأساليب وتقييمها تزيد من إمكانية وصول خدمات الصحة النفسية ومنع مخاطر علم نفس الكرسي .

الكلمات المفتاحية: علم نفس الكرسي - العاملون الصحيون غير المتخصصين - تقاسم المهام.

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## introduction

It is clear that psychology has made a significant contribution to our lives and has discovered various treatments for various well-known mental illnesses and disorders thanks to its diverse fields, pioneers, and theories.

Events occur in a material world that is expanding and speeding up, day by day, even moment by moment. Psychological disorders have contributed to this disturbed life and its simplicity, necessitating prompt action to protect our psychological safety and health.

The need for improved access to mental health services in low and middle-income countries (LMICs) has been strongly argued and given political priority among public health researchers and practitioners (Prince, M., Patel, V., Saxena, Sh., Maj, M., Maseko, J., Phillips, M. R., & Rahman, A., 2007). This argument builds upon evidence that mental, neurological, and substance abuse disorders account for more than ten percent of the global burden of disease (Murray, Christopher J.L., Vos, Theo, Lozano, Rafael, Naghavi, Mohsen, Flaxman, Abraham D., Michaud, Catherine, 2012) and almost three-quarters of this burden affects people living in LMICs (Mathers and Loncar, 2006).

Yet, the gap between the availability and need for mental health services, known as the "treatment gap" exceeds 75 percent in most parts of the world (Kohn, R., Saxena, S., Levav, I., Saraceno, B., 2004) and in the lowest income countries, such as Ethiopia, the mental health treatment gap can be as high as 90 percent (Alem, A., Kebede, D., Fekadu, A., Shibre, T., Fekadu, D., Beyero, T., Kullgren, G., 2009).

As an attempt to raise awareness of mental health and mental disorders, however, it was one of the most important reasons for daring to use psychological terminology seriously by non-specialists, and here the term "armchair psychology" appears.

The term "armchair psychology" may be somewhat illustrated by giving this example , (An "armchair quarterback" is someone who is watching a football game at home, giving opinions about the team's decisions, even though they usually lack professional expertise !)

### But what about "ARMCHAIR PSYCHOLOGY"??

While an armchair quarterback is on the other side of the screen, the words of someone who practices armchair psychology may have a more significant impact. In addition, they can potentially have a destructive effect on the person on the receiving end.

Some people diagnose because of a disagreement. How many times have we heard a friend relay stories about his "bipolar" girlfriend after they have ended the relationship? Or what about a frustrated mother who is fed up with her son's "ADHD" when he refuses to do homework?

It is tempting to describe someone's action as a scientific flaw when they act in the opposite direction of what we want them to. After a disorder has been assigned to the problematic individual, all responsibility rests with them. We're free to go.

Compared to physical illnesses, psychological disorders are difficult to measure. An EKG examination can reveal a heart problem while a histrionic personality disorder is measured by a series of behavioral patterns. The reasons for behavior, however, are not always taken into consideration. If a patient is crying, talks about suicide often, and uses physical appearance to draw attention to herself, her behavior could be considered abnormal and labeled histrionic. Depending on the experience of the professional, this patient may or may not be labeled as having a personality disorder. To diagnose someone with a psychological condition, professionals in the field often use what is known as the Diagnostic and Statistical Manual. The DSM is owned, sold and licensed by the American Psychiatric Association.

Armchair psychology typically comes from the logic and introspection of an untrained person. Unlike professional psychologists and therapists, armchair psychologists are not certified, licensed, or trained to issue mental health advice. Instead, they might think about how things have worked for them, what they've read online, and what makes sense based on what they know.

While introspection can be a helpful tool, it can sometimes provide constrained or inaccurate perspectives. Moreover, armchair psychology can't replace professional help for those experiencing mental health issues.

## HOW THE ARMCHAIR PSYCHOLOGY BE USED ?

### 1. To Diagnose Themselves and Others.

When someone feels distressed by their behavior or that of another person, it's natural to want to label it. But without training, they're likely to choose labels they don't fully understand. As a result, even in the absence of symptoms, they might conclude that a person has a serious mental disorder. *Diagnosis is a complex process requiring the supervision of a licensed professional, so it's rare to arrive at the correct conclusion without training in psychology.*

Diagnoses made without formal training are usually incorrect. For example, if an armchair psychologist sees someone sleeping too much, he might decide that the person is depressed. And while depression may be at play, it's also possible that a physical condition is making this person tired. If the person accepts the diagnosis of depression, they might not seek medical help to find the physical source of their fatigue.

### 2. To Offer Advice

While their motivation can range from concern to control, most armchair psychologists love offering advice. They often think they know what's best and may use psychological words, phrases, and labels to back up their advice.

A mental health professional, on the other hand, won't usually tell someone what to do. Instead, they'll likely help the person examine their thoughts and feelings and use sound psychological methods

to help identify the source. Then, they may help the person come to conclusions and consider their options to make a healthy choices.

### **3. To Make Important Decisions**

Sometimes, people might use armchair psychology to solve personal problems or make critical decisions. However, since they're not a trained counselor, they may misuse psychological terms and concepts.

### **4. it ignores context and leads to stereotyping.**

Many mood and personality disorders are caused by situational factors such as abuse or neglect. Trained therapists and counselors work through these layers to understand the core person underneath. Attaching a label to the behaviors we observe only reinforces our assumptions of how people with mental conditions feel, think, and behave. Rather than seeing the person apart from the condition, armchair psychology tends to focus on the stereotypical case of the person with the mental illness.

### **5.Opportunities for real help are missed.**

Casually diagnosing somebody with a mental illness can go one of two ways. Ideally, they should see a professional to further validate these observations and get the help that they need. However, it is often the case with armchair diagnoses that people blindly accept labels for mental conditions without seeking help, which is more dangerous.

### **Diagnostic Risks of Armchair Psychology :**

Sharing information about mental health in this way could appear harmless. Some could argue that it is preferable to be hyper-aware of mental disorders than to be ignorant of them. Yet, armchair psychology can have a negative impact. Here are some possible outcomes of a poor diagnosis :-

#### **1. People begin to live up to labels.**

When someone is incorrectly labelled as borderline, obsessive compulsive, or any other pathological term, they could start acting in ways that corroborate that assessment. Projective identification describes this.

## 2. Decreased Self-Esteem And Self-Confidence

When someone hears an opinion about what he might be experiencing, they may believe it and begin feeling bad about himself. In addition, they might start seeing himself as inferior, weak, or different from other people, which could damage his self-esteem and confidence.

## 3. Increased Stigma

When an armchair psychologist labels someone and tells others about their opinion, that person may experience stigma and discrimination. As a result, people — even close friends and family — might begin to treat them differently.

## 4. Distressing Emotions

When an armchair psychologist offers opinions about someone's mental health, the person may feel angry, afraid, ashamed, self-conscious, or misunderstood.

Thus further, even if someone reads 100 articles online, they are still not considered an expert. They still haven't completed practicals, a licence exam, or five or six years of study.

**Here's the honest truth:** Even though the most of us share some traits from the Hare's Psychopathy Checklist (lying, lacking empathy, playing the victim, impulsive behaviour, and so on), this does not mean that we are all psychopaths !

Untreated mental disorders are highly prevalent in South Africa. The South African Stress and Health study (SASH), a nationally representative study, found that the 12-month prevalence of any mental disorder was 16.7% (Williams et al. 2008), with a life-time prevalence of 30.3% (Stein et al. 2008). Anxiety disorders had the highest lifetime prevalence (15.8%), followed by alcohol use disorders (11.4%) and mood disorders (9.8%) (Stein et al. 2008). Despite this high prevalence of common mental disorders (CMDs), only 25% of those meeting criteria for a 12-month mental disorder received treatment (Seedat et al. 2008). This large treatment gap is similar to that found in other low-and middle-income countries (LMICs) (Demyttenaere et al. 2004). Several factors contribute

to this treatment gap in South Africa. These include structural and financing barriers, low perceived need for treatment, low mental health literacy, stigma, and systemic barriers (Ameh et al. 2017; Mendenhall et al. 2014; Bruwer et al. 2011; Hugo et al. 2003). A key system constraint is the limited availability of mental healthcare providers. Nationally, the average number of psychiatrists working in the public sector is 0.31 per 100,000 people with 0.97 psychologists per 100,000 people (Docrat et al. 2019). Consequently, few mental health services are provided on the primary care platform; services that are available focus on medication provision for people with severe mental illness, with little provision of mental health counselling for individuals with CMDs (Docrat et al. 2019).

### So , How to Solve This Big Problem ?

Teaching psychology for non-psychologists influences psychology's public image and the basis of collaboration between psychologists and non-psychologists.

To bridge this problem, researchers and practitioners have proposed a rational redistribution of mental health services, known as **Task-Sharing** (also, task-shifting), from specialist mental health professionals, including psychiatrists, psychologists, and psychiatric nurses, to non-specialist health workers in primary care and community settings (Patel et al., 2007).

Given task-sharing mental health counselling to non-specialist providers is a recognised strategy to increase service capacity, ensuring that their training, supervision, and support needs are met is necessary to facilitate the sustainable delivery of a high-quality service. The World Health Organization's (WHO) recommendation of "task sharing" mental health counselling to non-specialist providers, including facility-based counsellors (FBCs) who work within primary healthcare (PHC) facilities (Department of Health Republic of South Africa 2013).

Several studies in LMICs, including South Africa, have investigated the acceptability, feasibility, and potential effectiveness of using dedicated FBCs to deliver mental health counselling at PHC facilities (Singla et al. 2017; Mendenhall et al. 2014; Padmanathan and De Silva 2013; Spedding 2014), including the Friendship Bench in Zimbabwe (Chibanda et al. 2016), the MANAS trial in India (Patel et al. 2010), and project STRIVE in South Africa (Sorsdahl et al. 2015). However, only a handful of studies from LMICs have explored the experiences of counsellors responsible for the delivery of these interventions (Shahmalak et al. 2019).

These studies suggest that counsellors are generally highly motivated, experience growth from training and supervision, and apply concepts from the intervention to address difficulties in their own lives (Shahmalak et al. 2019 ; Munodawafa et al. 2017). While these studies have conducted an in-depth exploration of the FBCs' experiences of training and supervision (Barnett et al. 2018), the potential differences in the experiences of designated or dedicated counsellors remains unknown. An understanding of FBCs' perceptions of the most beneficial aspects of training and supervision (e.g. content, intensity, duration) can guide the development of training and supervision models for the scale up of mental health counselling in these settings. Comparing the experiences of designated and dedicated counsellors is also relevant since they are likely to face different systemic challenges to delivering counselling. Implementation strategies required to support the scale up of dedicated versus designated approaches may therefore need to vary.

Task sharing in mental health involves the training of Non-Specialist Health Workers NSHWs *-individuals with little or no prior formal training or background in mental health care -* to deliver mental health care, including brief, low-intensity psychological treatments . ( Singla DR,et al ,2017; Singla DR,et al ,2018) . NSHWs include a broad range of health supporters and providers without specialized training and have been known by a variety of names in various contexts, including the following: community health workers (CHWs); lay health workers; midwives; nurses; primary care



providers; village health workers; lady health workers; health promotores; auxiliary health staff; complementary alternative health providers; natural helpers; paraprofessionals; frontline health workers; teachers; religious and traditional healers; community members; and non-specialist providers.( Lehmann U, Sanders D,2018)

What is required for task-sharing mental health services in LMICs is presented in two significant articles. The first paper suggests three essential components: 1) contextually specific research to determine how and what task-sharing framework is suitable in light of local resource constraints and health care delivery systems; 2) training and a strong supportive supervisory framework for non-specialists; and 3) sufficient specialists who can provide the necessary referral support (Petersen et al., 2011). Second, a recent systematic review including 21 qualitative studies found task sharing mental health services in LMICs was largely considered acceptable and feasible by service users as well as health care providers (Padmanathan and DeSilva, 2013). However, important limiting factors emerged that require further investigation, including context-dependent variation in participants' satisfaction with having mental health needs met, the importance of the personal characteristics of non-specialist workers such as gender, age, training, and their role in the community; concern that lack of supervision for health personnel may result in psychological distress; logistical barriers such as transport, private spaces for meeting, restrictions on who can prescribe psychotropic medications, and funding for health worker training; and issues around compensation, support, and clearly delineated roles for health care providers. The major limitation of the review was that exploring the acceptability or feasibility of task-sharing was not the primary aim of the studies reviewed, and twelve of the 21 studies were of unknown quality. In addition, many of the studies had small sample sizes, and none took a multi-country approach using common methodology.

**Implementation Strategies for Task Sharing :-**

1- **Balanced Care** :-The balanced care model is a flexible approach to planning treatment and care for people living with mental disorders, describing mental health service components within a system. It can be adapted to account for human resource gaps that exist within countries, and it emphasizes the need for balance between different service delivery platforms and provider cadres (Thorncroft G, Tansella M. 2013 ; Patel V et al .2018 ).

Consistent with global health system strengthening efforts for scaling maternal and child health care, mental health interventions of various kinds are also developed and delivered at various system and societal levels, called “platforms.” Essential platforms include specialist referral centers, general hospitals, primary health care centers, and emerging community services, which should include self-care and informal health care (Thorncroft G, Tansella M, 2013) . For each delivery channel, interventions may be categorized as promotion and primary prevention; identification and case detection; and treatment, care, and rehabilitation. ( Petersen I, 2015).

The balanced care model also emphasizes the importance of evidence-based community and intersectoral interventions provided outside of the health care sector, such as employment opportunities, child protection services, measures to improve community level understanding of mental disorders and increase the availability of long-term social care, and suicide prevention measures. (Shidhaye R et al ,2015 ; Patel V et al , 2018)

**2- Sustaining Training and Supervision :-**

Maintaining Supervision and Training Our understanding of the best practises for training and supervising NSHWs in the delivery of mental health care, with an emphasis on core competencies, ( Murray LK, et al,2011 ; Cooper Z,2017 ; Fairburn CG, et al ,2017) is still being improved via ongoing work in global health and in higher-income settings. In 23 reviews, Kohrt et al.2018 investigated the duties, procedures, and methods of

NSHWs providing mental health treatment. A instrument, the ENACT scale, has also been piloted by Kohrt et al.2015 to evaluate therapist competency in international mental health settings. Any successful shared mental health task will require training, supervision, competency evaluation, and certification. A competency framework's significance has been The Increasing Access to Psychiatric Therapies model, one instance of a successful scaled task sharing model programme (IAPT) in the UK (Clark DM,2018).

### **3- Collaborative Care**

Integrated care is defined as health services that are managed and delivered such that people receive a continuum of health promotion, disease prevention, diagnosis, treatment, disease management, rehabilitation, and palliative care services, coordinated across the different levels and sites of care within and beyond the health sector and, according to their needs, throughout the life course.( Thornicroft G, Ahuja S et al,2018)

Research on stepped, collaborative care delivery models for treating depression has highlighted the significance of several key system elements across platforms, including population-based care for particular disorders that prioritises screening, treatment, and outcome tracking, self-care support, which includes family and patient education about illness and treatments, self-monitoring , and adherence support skills, care management, and measurement-based care using patient-reported outcomes. (Roenke K & Unutzer J, 2017)

### **4- Trans-diagnostic and Staged Interventions :-**

The success of a balanced, collaborative system with robust training and supervision will be dependent on interventions that are simple enough to be utilized, and that are designed to address problems early. An effective integrated, task shared model for the mobilization of NSHWs in mental health support and care delivery will need to make functional a continuum of innovation and standardization that is systems- and context-

specific, depending on the available work force and the tasks that are requested of NSHWs within the system.

To support people in distress, specific interventions can include the following: psychoeducation, social support, addressing social determinants, screening for symptoms, and basic psychological strategies; basic support, brief and evidence-based psychological treatments, case management, follow-up, and referral for people living with illness; and psychological treatments, medication, and community outreach activities. To ensure quality and sustainability, resources should be devoted to the supervision and professional development of NSHWs at all dimensional levels of the continuum.

A more detailed understanding of the most often used psychosocial and psychological components in existing services is being gained as a result of ongoing study. A taxonomy of common elements utilised across 27 trials in low- and middle-income countries was created by Singla et al. after evaluating the particular and non-specific elements used to treat common mental diseases ( Singla DR,et al ,2017) . It is also becoming clearer how to create psychosocial and psychological therapies from treatments with scientific backing using transdiagnostic approaches (composed of "core dysfunction," "common elements," and "principle-guided approaches") (Marchette LK & Weisz JR,2017). The efficacy and value of "common elements treatment approaches" (CETA), which are crucial to comprehending the possible sustained, "real-world" practise of NSHWs providing psychological therapies, are now being clarified by ongoing research in high- and low-resource contexts. (Bernstein A, Chorpita BF et al, 2015 ; Murray LK, Haroz EE, Doty SB et al ,2018)

Taken together, trans-diagnostic psychosocial and psychological interventions utilized within a balanced system, screening, and other tools and practices used in the collaborative care model, and sufficient NSHW training and supervision, could lead to a significant growth in access to care and services.

## 5- Digital Innovations :-

The use of digital technologies (i.e., mobile devices, smartphone applications, web platforms) can be applied to the following: screening, diagnosis, treatment, and care by NSHWs; training and supervision of NSHWs; health care and system-level improvement efforts including data management and enhanced care coordination across provider cadres; online therapies and self-directed care; peer support; social media and intervention; and reduction of stigma (Patel V et al , 2018).

An increasing amount of studies on NSHWs shows how digital technology may efficiently assist data collecting, outcome tracking, health worker training, referral coordination, and enhancing patient-health worker contact .Digital technologies have the potential to improve NSHWs' access to training and skill-building opportunities, support clinical care and decision-making, and enable direct outreach and contact with patients, as well as facilitate data collection and monitoring for quality assurance. They can also empower NSHWs by enhancing their access to training and skill-building opportunities.

Recent years have seen the emergence of projects that support NSHWs in treating and preventing common mental disorders in primary care or community-based settings, responding to perinatal depression, and supporting care for people with schizophrenia (Gureje O & Oladeji BD, 2015;Shields-Zeeman.Let al2017;). These projects use digital interventions like text messaging, voice calls, web applications, and smartphones.In these instances, digital technologies were primarily used to strengthen the role of NSHWs by facilitating patient support, facilitating access to training and continuing education opportunities, supporting data collection and care coordination, and facilitating connections with more specialised providers for supervision and clinical support .

The use of digital technologies in these research holds promise for assisting NSHWs in their duties and enhancing the provision of current evidence-based mental healthcare services.

**Conclusions:-**

Hence, the researcher came up with several proposals that would improve mental health services and make them more widely available in our society :-

- 1- Paying attention to television programs and awareness bulletins about mental health, with easy and simplified information about common disorders.
- 2- Strict adherence to institutions that provide content in psychology until ensure the efficiency of trainers.
- 3- Preventing content makers, bloggers, and influencers from using psychological terminology without proving their scientific validity (licence) .
- 4- Psychology curricula for non-psychologists in all faculties should be need-oriented.
- 5- Psychology curricula for non-psychologists should be internally consistent and systematic enough to enable understanding of the relevant psychological phenomena.
- 6- A HOTLINE for reporting emergency and serious psychological cases, self-harm, or harm to others to take appropriate action.
- 7- Conducting an extensive longitudinal study on society every decade to monitor its problems, mental disorders, and mental illnesses that occur on it.
- 8- Eradicating psychological illiteracy by graduate students studying psychology, mental health and mental illness.. and making it a graduation requirement.

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