International Journal of Emergency Mental Health and Human Resilience,Vol.25, No.2, pp 18-19 © 2022 OMICS International ISSN 1522-4821

Conventional mental health disorders and their socioeconomic factors

Amy Curtis*

Department of Health science, University of Greenwich, Park Row, UK

ABSTRACT:

The care and treatment of individuals with common mental health disorders, such as depression, generalised anxiety disorder (GAD), panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder, is the focus of this recommendation (PTSD). It offers suggestions for how to deliver efficient identification, assessment, and therapy referral in primary care. The recommendation will also apply to secondary care, and it is pertinent (but does not offer any specific advice) for the prison system, non-NHS services including social services, and the independent and volunteer sectors. This guideline's integration of existing NICE recommendations on the detection and evaluation of prevalent mental health problems, as well as its recommendations to promote the creation of local care pathways for these disorders, are some of its main objectives.

Keywords: Mental disorders, Antipsychiatry, DSM classification, Classification, Homosexuality.

INTRODUCTION

Excessive anxiety and worry (apprehensive expectancy), happening on more days than not for a period of at least six months, regarding a variety of events or activities, is the key component of GAD. The person with GAD has trouble controlling their anxiety and concern, which are frequently accompanied by restlessness, being easily tired, finding it difficult to concentrate, being irritable, and tension in their muscles, and having trouble sleeping. GAD does not only concentrate on symptoms of other disorders, such as having panic episodes (as in panic disorder) or feeling embarrassed in public (as in social anxiety disorder). Some people with GAD may have excessive worry about the results of daily activities, especially those connected to their health of or separation from loved ones (Hu 2004)

Obsessive-compulsive disorder (OCD) is marked by either obsessions or compulsions, but most frequently both. A thought, image, or urge that continuously bothers a person's mind is referred to as an obsession. Although upsetting, obsessions are recognised as coming from the individual's thoughts and not being forced by a third party. The person typically views them as being unreasonable or overbearing. The following are examples of common obsessions in OCD: contamination from dirt, germs, viruses, body fluids, etc.; fear of harm (for example, that door locks are not secure); excessive concern with order or symmetry; obsessions with the body or physical symptoms; religious, sacrilegious, or blasphemous thoughts; sexual thoughts (for example, of being a paedophile or a homosexual); and the urge to hoard useless or unimportant items (Wang et al, 2007)

POST-TRAUMATIC STRESS DISORDER (PTSD): PTSD frequently arises as a result of one or more traumatic events, such as wilful acts of interpersonal violence, serious accidents, disasters, or military engagement. Survivors of war and torture, natural disasters, violent crime (such as riots, bombings, and sexual abuse), refugees, women who have had traumatic childbirth, individuals with life-threatening illnesses, and members of the armed forces, police, and other emergency personnel are among those who are susceptible to developing post-traumatic stress disorder (PTSD) (Kohn et al, 2004).

SOCIAL ANXIETY DISORDER: A person with social anxiety disorder, also known as social phobia, experiences acute fear in social settings, which causes them great distress and affects their ability to carry out daily activities properly. The dread of being judged by others, as well as the fear of embarrassment or humiliation, is at the heart of the disease. This causes a number of social situations to be avoided, which frequently has a negative impact on academic and professional performance. The worries may start to surface in response to real or imagined examination from others (Jacob et al, 2007).

Socioeconomic factors: According to the 2007 ONS study, people in lower-income families had a higher likelihood of having a disorder than people in higher-income households. In the 2000 ONS survey, a number of socioeconomic factors had

Received: 26-Jan-2023, Manuscript No: ijemhhr-23-88633;

Editor assigned: 30-Jan-2023, Pre QC No. ijemhhr-23-88633 (PQ);

Reviewed: 13-Feb-2023, QC No. ijemhhr-23-88633;

Revised: 20-Feb-2023, Manuscript No. ijemhhr-23-88633 (R);

Published: 27-Feb-2023, DOI: 10.4172/1522-4821.1000572

*Correspondence regarding this article should be directed to: Amycurtis585@greenwich.ac.uk

a significant impact on prevalence rates. For example, people with depressive episodes were more likely than people without the disorder to be unemployed, to fall into social classes 4 and below, to lack formal education, to live in housing provided by the local government or housing association, to have moved three or more times in the previous two years, and to live in an urban area (Fekadu & Thornicroft, 2014).

A general practise survey indicated that 7.2% (range from 2.4 to 13.7%, depending on the practise) of consecutive attendees had a depressive condition, providing evidence of the social causes of depression. The difference in practises was explained by neighbourhood social hardship by 48.3%. Other factors were the percentage of people without a car or with only one automobile, as well as neighbourhood unemployment. The conclusion that gender and social and economic factors affect the prevalence of prevalent mental health disorders, whatever that term is defined, is therefore overwhelmingly supported by the research.

REFERENCES

Fekadu, A., & Thornicroft, G. (2014). Global mental health: perspectives from Ethiopia. *Glob Health Action*, 7(1), 25447.

Hu, T. W. (2004). The economic burden of depression and reimbursement policy in the Asia Pacific region. *Australas. Psychiatry*. 12, 11-5.

Jacob, K. S., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J. J., et al. (2007). Mental health systems in countries: where are we now?. *The Lancet*, 370(9592), 1061-1077.

Kohn, R., Saxena, S., Levav, I., & Saraceno, B. (2004). The treatment gap in mental health care. Bulletin of the WHO, 82(11), 858-866.

Wang, P. S., Aguilar-Gaxiola, S., Alonso, J., Angermeyer, M. C., Borges, G., Bromet, E. J., et al. (2007). Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. *The Lancet*, 370(9590), 841-850.