interface
comunicação, saúde, educação
https://www.interface.org.br
eISSN 1807-5762

Articles

Non pharmacological approaches for Common Mental Disorders: medical experiences in Primary Health Care

Repertório não farmacológico para o manejo do Transtorno Mental Comum: experiências médicas na Atenção Primária à Saúde (resumo: p. 19)

Repertorio no farmacológico para el manejo del Trastorno Mental Común: experiencias médicas en la Atención Primaria de la Salud (resumen: p. 19)

Victoria Petenati da Rovare[a]
<vp.rovare@unesp.br>

Eliana Goldfarb Cyrino[b]
<eliana.goldfarb@unesp.br>

Dulcian Medeiros Azevedo[c]
<dulcianmedeiros@uern.br>

Tiago Rocha Pinto[d]
<tiago.pinto@unesp.br>

[a, b, d] Departamento de Saúde Pública, Faculdade de Medicina de Botucatu, Universidade Estadual Paulista. Avenida Professor Mário Rubens Guimarães Montenegro, s/n., Distrito de Rubião Jr. Botucatu, SP, Brasil. CEP. 18618-970.
[c] Departamento de Enfermagem, Universidade do Estado do Rio Grande do Norte. Caicó, RN, Brasil.

Common Mental Disorders (CMD), frequent in Primary Health Care (PHC) consultations, are conditions related to mental suffering involving social, economic, familial, and individual determinants. They present as a range of mental and physical symptoms, impacting health and quality of life. This research aimed to analyze non pharmacological therapeutic repertoire used by PHC physicians when managing CMD. Qualitative, analytical, exploratory study was developed through semi-structured interviews with PHC physicians in a mid-sized municipality in São Paulo state, Brazil. Thematic analysis of data revealed that current medical approaches often lean towards medicalization of suffering and reflect insufficiency of health services. Factors such as limited time, inadequate training and disconnection from multidisciplinary teams contribute to excessive use of psychotropics, long waits for referral and perceived low care resolution. Continuous professional training is crucial to subsidize the practice of effective, accessible psychosocial interventions.

Keywords: Mental health. Integrality in health. Psychosocial intervention. Primary Health Care.

Rovare VP, Cyrino EG, Azevedo DM, Pinto TR. Non pharmacological approaches for Common Mental Disorders: medical experiences in Primary Health Care. Interface (Botucatu). 2026; 30: e260521
https://doi.org/10.1590/interface.260521

Introduction

One in every four individuals seeking Primary Health Care (PHC) presents some mental disorder according to the International Classification of Diseases (ICD-10)[1], and when those experiencing psychological distress below the diagnostic threshold are also included, the proportion reaches one person in distress for every two individuals[2]. Furthermore, demands related to mental health problems have increased even more following the COVID-19 pandemic[3,4], impacting services organization.

The manifestations of distress in PHC cannot always be easily categorized as diseases, and within the social context somatic pain is often a culturally accepted form of expressing and legitimizing suffering[2,5]. Presentations may include mental changes (nervousness, anxiety, sadness, compulsions, etc.), sleep disturbances, fatigue, and diffuse physical symptoms. Psychological distress may also precipitate or aggravate other conditions, such as pain syndromes, diabetes, hypertension, cardiovascular, gastrointestinal, dermatological, allergic, autoimmune diseases, among others[6].

There is no clear definition of what is pathological, and presentations are too diverse and complex to fit into a few diagnostic categories. They affect overall health, treatment adherence, self-care, performance of social and occupational functions, and are strongly associated with the social determinants of health. They may worsen over time and have an impact even when symptoms are insufficient to meet standardized diagnostic criteria[7].

Biomedical psychiatry categorizes manifestations of psychological suffering according to diagnostic manuals, seeking signs and symptoms isolated from their context rather than considering their correlations and meanings[8]. The dimensional classification model known as Common Mental Disorders[9], in contrast to the categorical model, was described with the aim of understanding the continuum of syndromes and the comorbidity between non psychotic psychiatric and clinical illnesses frequently observed in healthcare services, proposing three correlated axes corresponding to anxiety, depression, and somatization.

This article adopts the terminology Common Mental Disorders (CMD) due to the need to draw the attention of the medical community to a heterogeneous set of psychosocial illnesses. In Brazilian PHC services, individuals are frequently referred for medical consultations because of the common presence of somatic symptoms and because many professionals do not feel adequately trained to provide mental health care[7]. Nevertheless, it is understood that the word *Disorder* may contribute to excessive pathologization and medicalization of suffering, which is already prevalent[10]. In order to reduce this tendency, the present article addresses the repertoire of non pharmacological medical interventions for such conditions.

PHC must be able to efficiently address suffering in its various forms, prioritizing comprehensive care and health promotion. CMD are known to be not always identified, and are often minimized or neglected by healthcare professionals[11]. In many other instances, they fall under the highly medicalizing hegemonic rationale[10,12]. The implementation of the Psychiatric Reform incorporated biomedical psychiatry, and although it enabled the inclusion of non pharmacological therapies within

Psychosocial Care Networks, pharmacological treatment remains predominant and has increased[8], with studies describing psychotropic drug use prevalence in PHC of up to 53%[13].

Despite its prevalence, psychopharmacological therapy has increasingly proven insufficient and even deleterious. Regarding depressive symptoms, routinely prescribed medications have little effect in mild and moderate cases, performing better in severe conditions[14]. Moreover, withdrawal symptoms and chronic use may occur[15], often resulting in an unfavorable risk-benefit profile[14,15]. Evidence points toward reducing psychotropic drug use in several clinical situations, relativizing the hegemony of biomedical psychiatry through evidence of its tenuous relationship with pathophysiological bases and with the pharmaceutical industry. Researchers such as British psychiatrist Joanna Moncrieff, American journalist Robert Whitaker, and Brazilian psychiatrist Paulo Amarante have disseminated scientific evidence supporting the demedicalization of mental health care[16].

Aware of the importance of addressing CMD and of their direct relationship with the individual and social being, it is necessary to provide different resources that may benefit patients according to their singularities. In addition to common generalist training, PHC physicians are responsible for expanding their therapeutic repertoire in order to address the determinants of the health-disease process and make evidence-based therapeutic choices[17-19].

The approach to CMD should be regarded as a priority by PHC services, as a need to adapt to changes in the dynamics of modern life, and as a means of preventing mental disorders and disability while promoting comprehensive psychosocial health[2]. The guidelines of the Brazilian National Mental Health Policy prioritize the implementation of community-based mental health services and actions capable of providing effective care, operating within a humanized and comprehensive healthcare network[2]. The importance of expanding cost-effective and feasible strategies is reiterated, making use of light and light-hard technologies[6,12].

Treatments should be decided through shared decision-making, with the lowest possible likelihood of adverse effects and interactions and the greatest possible benefits, as part of an approach that seeks to understand the individual, promote empowerment, and foster autonomy[2]. Non pharmacological interventions (non allopathic, non psychotropic) are applicable and potentially beneficial, constituting viable alternatives to overmedicalization. Many are cited in guiding documents for mental health care at the primary care level, but are often absent from traditional medical education[14,18-22].

Given the context of medicalization of suffering, the high demand for psychosocial care, and the need to expand mental health care offerings in PHC, this study aimed to evaluate the current situation of medical mental health care in PHC, focusing on the analysis of the non pharmacological repertoire of PHC physicians in the management of CMD.

Methodology

This was an exploratory analytical qualitative study developed from the assessment of medical practices in the approach to CMD in PHC. Information was obtained through semi-structured interviews conducted with physicians in their workplace, namely primary care units. The municipality where the study was conducted presents a diversity of services and professionals that enables the exploration of non pharmacological approaches, as well as a PHC system with characteristics that can represent the Brazilian reality.

The sample was intentionally selected[23], including physicians working in the different PHC models of the municipality, namely the Family Health Strategy (FHS), Primary Health Care Teams (PHT), and Teaching Health Units (THU) located in different regions (central, peripheral, and rural areas). Invited professionals were indicated through dialogues with two PHC coordinators, one physician and one nurse, one linked to the Municipal Health Department and the other to the organization managing the FHS teams. Participant selection sought diversity regarding length of professional training and PHC experience, gender, age, and complementary qualifications.

For this purpose, prior individual contact was established with participants through messaging applications to verify interest in participating. Upon acceptance, the researcher's visit to the unit was scheduled for the interview. All interviews took place in the physicians' offices during working hours and began with an explanation of the research objectives and a request for signing the Informed Consent Form.

The interview script consisted of three parts. The first was a sociodemographic questionnaire containing closed-ended questions relevant to sample characterization. The second part consisted of presenting a definition of Common Mental Disorders, followed by open-ended questions regarding professional approaches to CMD. In the third part, the set of practices termed Psychosocial Interventions was defined, presenting a categorization developed based on the study by Mendes[19] with Family and Community Medicine residents, as well as interventions cited in widely disseminated reference texts[14,18,22], with the purpose of organizing the considered universe. Open-ended questions regarding these interventions were then conducted.

The interviews lasted approximately 30 minutes, were audio-recorded, and fully transcribed, constituting the material for qualitative analysis. Data collection was interrupted once the intended diversity, thematic depth, and scope had been achieved, and when completed interviews no longer provided new data[24,25], concluding with six participants.

Information was collected between September and December 2023 and analyzed through objective and systematic description and interpretation using thematic content analysis. Thus, after reading the transcripts, contents were organized into cores of meaning and significance, compared, organized, and classified into analytical categories in order to produce conceptual reflection and interpretative inferences, describing generalities and particularities articulated with perceptions of the studied reality and the adopted theoretical references[24,26].

Seven analytical categories were established from the interview content, with frequent repetitions of recording units. Sampling was concluded with approximately 10% of the total number of physicians, an estimated fluctuating value based on the aforementioned dialogues with PHC coordinators. Sample homogeneity regarding working conditions in primary care services was considered due to the study being conducted in a single municipality and the predominance of non specialist training.

The discussion of the identified themes provides an overview of the medical approach to CMD in PHC within the municipality. Thus, "content analysis attempts to understand the players or the environment of the game at a given moment, through the contribution of observable parts"[26] (p. 43), serving as a substrate for the development of reflections that enable real improvement in practice.

Participation in the research was voluntary, and confidentiality was preserved during data processing and result analysis, maintaining anonymity through the use of an alphanumeric identification system and excluding data that could identify participants. The study was approved by the Research Ethics Committee (6.500.245/2023), and resolutions 466/2012 and 510/2016 were followed.

Results and discussion

Among participants, the proportion of male to female physicians was 1:1. Interviewees included two PHT physicians, three FHS physicians, and one THU physician, one of whom was a covering physician. Regarding complementary qualifications, no specialists in Family and Community Medicine were interviewed, reflecting the Brazilian reality described by Anderson Savassi[27], in which the number of family and community physicians is far below what is required for PHC teams.

Participants' ages ranged from 29 to 64 years, and length of PHC experience ranged from two to 40 years. Considerable heterogeneity was also observed regarding length of employment at the health unit, varying from nine days to 24 years. Two interviewees had completed postgraduate training in Family Health through the federal deployment program for PHC physicians, and one was a Public Health physician.

The information obtained regarding medical practices in PHC when addressing CMD enabled the organization of three analytical categories: access and organization of care; relationship between physicians and multidisciplinary teams; and use of psychosocial approaches. The following discussion addresses practice, contrasting it with possible differences in other settings and confronting it with the adopted theoretical references.

Access and organization of care

The identified context is one of perceived high demand for medical consultations related to mental health issues, in agreement with trends described in Brazil and worldwide[2,4], within a majority of healthcare services where demand exceeds supply. Physicians describe that given the high patient flow in the units, there is time limitation

that hinders comprehensive care for individuals with CMD, and they agree on the need for longer consultations and follow-up visits.

The demand for multiple mental health professionals in PHC exceeds the teams' capacity, resulting in long waiting times. Since specialized care cannot be offered to a large proportion of these individuals, these patients remain in a mental healthcare gap, as reference teams also lack targeted actions.

> I would say that common mental disorders... it is very difficult for me to see a patient who does not have some form of it, right? Sometimes they may not exactly fit, they may not meet criteria for a depressive episode or an anxiety disorder. But I would say that almost all my patients have common mental disorders, somewhere on the spectrum, right? (E5)

> From the perspective that these patients demand more time, require a longer, more thoughtful, more qualified consultation, and considering the organizational issue of us unnecessarily attending an excessive number of same-day appointments, which undermines this possibility of providing proper attention. (E2)

In this scenario, most physicians report difficulties in their relationship with individuals with CMD due to time and resource limitations and because of the perception of low adherence to individually proposed interventions. Half of the interviewees reported dissatisfaction and a feeling of little or no effectiveness in the care provided to patients with CMD, whereas the other half felt satisfied with their practice.

> I think I do the best I can, but I think I cannot solve, nor even help, the vast majority. (E1)

> We are unable to offer patients many things that would be fundamental for addressing these common mental disorders. (E5)

Among professionals reporting greater satisfaction, greater personal preference for mental healthcare and a wider diversity of interventions employed were observed.

> I think so, I can manage many things here and I know how to recognize what I will not be able to manage, and then I know that what I cannot manage I will have to refer. But most cases I can manage relatively well. (E3)

Physicians, as the professionals responsible for the greatest volume of consultations involving CMD and generally responsible for referring patients throughout the healthcare network, play a relevant role in the use of available resources. According to territorial specificities, available services and local facilities, the presence and

structure of complementary teams, and depending on prior knowledge, preferences, and recognition of care flows, PHC physicians coordinate care through devices, professionals, and levels of care[18].

Participant physicians mainly reported the use of medications (psychotropic drugs) freely available in the units for CMD, but also mentioned the need for other psychotropic medications and the use of herbal medicines. As discussed by Faria and Guerrini[12] and Perrusi[8], PHC prioritizes pharmacological intervention over other approaches as it provides greater access to it, influenced by and reinforcing biomedical rationality.

> Initially, if the person has more anxiety and insomnia symptoms, I choose the nighttime medications that are provided free of charge. (E1)

> Of course, here at the clinic we experience the reality that patients often cannot afford to buy medications, so this is also an important issue for us to point out. So, let's say, many of my patients actually end up using fluoxetine, sertraline, or tricyclic antidepressants such as amitriptyline or nortriptyline, but in practice I do not use only these medications, right? Some patients also have the financial means to buy phytotherapy that I prescribe. (E5)

Since 2010, following Ministerial Ordinance GM/MS No. 886 establishing the *Farmácia Viva* program within the Brazilian National Health System (SUS)[28], several municipalities have offered herbal medicines, some of which are useful for CMD related situations. In the studied municipality, as in the country overall, there are isolated initiatives, but access is not universal. Regarding psychotropic drugs, given their importance in the treatment of several severe mental disorders and other comorbidities, they are widely and uniformly available in PHC pharmacies[29]. However, considering the importance of CMD and their low response to psychotropic drugs[14], it is necessary to expand initiatives that promote access to diversified, more effective, and potentially lower-cost resources.

Interviewees agreed with the use of Integrative and Complementary Practices (ICP) for CMD, with some degree of access to such practices. These resources remain unavailable in many regions of Brazil and represent an opportunity to improve the use of such practices. Within the health units, only one unit was identified as offering auriculotherapy groups through the individual initiative of a team professional.

> We have auriculotherapy groups here at the unit, which also helps a lot in these mental health cases. (E6)

> Even in the system we can register homeopathy, acupuncture, some issues related to phytotherapy, right? And I think this is actually little known, perhaps, among healthcare professionals in general. (E6)

CMD care should be included among PHC activities. High demand pressures services in ways that influence the organization of work processes, demonstrating the urgency of an institutional response capable of meeting the care needs of less severe cases[7]. For physicians, systematizing resources for CMD care allows it not to depend on individual aptitude, but rather on appropriate training and confidence in applying relevant interventions.

> This could improve overall if we managed to standardize, train, and provide training for professionals, not only physicians but everyone. So that we could make approaches more uniform, because some people have difficulties, and that is natural, because everyone has different skills, right? (E6)

The category "Access and Organization of Care" regarding CMD in PHC reveals a challenging scenario in which high demand exceeds service supply and limited consultation time compromises comprehensive care. The findings underscore the urgency of an institutional response to systematize resources and train professionals, ensuring that CMD management does not depend on individual aptitude but rather on a more effective and comprehensive care system.

Relationship between physicians and multidisciplinary teams

When discussing mental healthcare with physicians, complementary multidisciplinary teams are invariably mentioned (in the studied municipality these are named eMulti teams). Regarding CMD, interviewees describe that it is not possible to rely on eMulti in all cases because of the high number of patients, and that referrals and/or case discussions are carried out in more severe cases or in the presence of aggravating factors indicating the need for specialized approaches.

Worldwide, the prevalence of CMD exceeds the number of available professionals, generating a gap in care[20]. This situation is addressed through the role of PHC complementary teams and matrix support, which provide specialized support for cases requested by the reference team[2,30]. On the other hand, physicians understand mental healthcare provided by specialized professionals as appropriate for patients with CMD and express the desire for greater access to such care.

> Expand the mental health team and facilitate referrals [regarding how to achieve better outcomes in mental healthcare]. (E2)

The view of the role played by psychology within PHC was identified as limited, being restricted to psychotherapy or group activities. Psychiatrists were described as scarcely accessible within the units.

> I have never directly discussed cases with the psychiatrist, you know? With her we discuss through referrals documented in the medical record. (E2)

Social workers were rarely mentioned. This scenario is reinforced by service organization that fails to promote spaces for sharing among professionals.

> When I refer [to eMulti], it is usually because I realized that, despite not being a more severe case, there is some risk that I considered important or some warning sign. (E5)

> We refer them to eMulti, but there are no eMulti consultations every week, which is what is needed—the patient needs weekly psychological support, and that does not exist. [...] I do not know whether having therapy once a month helps at all. (E1)

In the routine of healthcare services, a distancing between physicians and eMulti professionals can be observed. There is limited space for discussion and little integration between physicians' activities and those of mental health professionals. Actions jointly carried out with eMulti mentioned by interviewees include case discussions (mentioned by all, with varying frequency), home visits (mentioned by two physicians), and shared consultations with psychiatrists (mentioned by one professional). No activities for team qualification were cited. The availability of groups varied, but all physicians denied participating in collective mental health activities.

> There is no time. When they are holding these groups, I am usually overwhelmed with patients. (E3)

The "discussion," when it occurs, often becomes in many contexts merely a way of presenting the case to the psychology professional in order to "refer" it, functioning as a means of regulating access, with little effective matrix support.

> With the support nucleus we also refer patients, despite the very long waiting list and the difficulty in discussing cases because of the demand. But we also have this tool. (E6)

> I also do home visits, even though this is a Basic Health Unit I still do visits, social and family-related aspects. They notify me when necessary, and I do visits together with them as well. (E4)

Fagundes et al.[31] describe qualification of care through matrix support practices, with reduction of unnecessary referrals and optimization of flows between reference teams and matrix support teams. Given the teams' limited time, opportunities for matrix support and learning become rare. Fragmentation prevents the progressive qualification that could result from these processes, and each new patient once again requires "referral" to mental health professionals.

In municipalities where eMulti teams are absent and mental health professionals are organized within other services, relationships tend to be even more distant and fragmentation even greater. This increases overload and the general feeling of low effectiveness[31].

Given the magnitude of the demand for mental healthcare and the limited and specialized nature of multidisciplinary teams, resource management is understood as necessary in order to direct higher-risk situations to these professionals. In CMD cases with complicating factors, individualized therapeutic projects, shared or specialized care, and other escalated interventions are considered. Low-risk care, as in many other PHC conditions, should be the responsibility of the reference team. These professionals, however, generally lack theoretical and practical tools to provide interventions they consider adequate and therefore experience feelings of fear and helplessness regarding psychological suffering[31].

Limited understanding and low physician interest in interdisciplinary and collective mental health activities begins during medical training itself. All professionals reported insufficient content regarding psychosocial interventions during their training. The insufficient training leads them to fear certain therapeutic actions, refrain from applying them, and fail to recognize their effectiveness and rationale[30].

Thus, non pharmacological interventions are usually restricted to physicians who actively seek knowledge or who have personal experiences with certain practices. With a narrow repertoire of mental health interventions and without the possibility of transferring low-risk care, physicians often encounter individuals profoundly affected by such problems and must resort to the widely available pharmacological resources[10].

Use of psychosocial approaches

Considering that mental healthcare for non severe patients is primarily provided by the reference team, it is essential for PHC physicians to know different techniques for evidence-based and effective approaches. Adequate training promotes expansion of the scope of practice[15,19].

All interviewed physicians described psychotropic drugs as a possible resource to be considered in CMD, ranging from the only available resource to an option considered in situations of greater severity or failure of other interventions. More than half, however, described perceiving isolated pharmacological therapy as insufficient in these cases.

> With only sertraline and fluoxetine, basically our arsenal is very limited, right? (E4)

They cited problems associated with psychotropic use, such as side effects or dependence, but did not mention the possibility of lack of benefit in CMD.

> No medication will make the husband stop beating [his wife], nor pay off debts [...]. What medication can I prescribe for that? So the greatest difficulty is people's difficult lives. (E1)

> Anything we can do in terms of non-pharmacological measures to help patients is valid, because we know medications have side effects. Depending on the medication, there is also the issue of addiction, so whatever you can do to help the patient... as I say, medication is a crutch, it will not solve the problem. (E3)

The search for other resources varied among physicians. Due to diffuse knowledge and limited time, there is distancing from the application of psychosocial interventions and transfer of responsibility for such interventions to other professionals.

> Because, regarding the non pharmacological part, I think the eMulti manages to address it well, right? At least the psychologist—I have worked with her since I joined 10 years ago, and I like her work. (E4)

As there is no structured content regarding diverse approaches to CMD in regular medical training, physicians reported acquiring knowledge through practical experience within services and through personal interest. The individual use of non pharmacological approaches depends on profile and interest in complementary training.

> It was really more a matter of personal interest. There was a period when I needed acupuncture, and I became fascinated with it. [...] So I think my additional knowledge on this subject came more from personal interest and also from my own personal experience. (E5)

The interviews revealed heterogeneity regarding the value attributed to psychological approaches. There is limited knowledge about them, and their use generally involves referral to psychology professionals.

Almost all physicians emphasized the importance of welcoming attitudes, longitudinal care and listening in CMD cases, and one physician described how therapeutic listening is practiced. Only one professional mentioned psychoeducation as a possible approach. Self-care and autonomy were mentioned by the two physicians who reported using the largest number of interventions in their routine practice.

> Listening, in the sense of listening itself, but also therapeutic listening, which is that kind of listening where you return questions to the patient, try to discuss things, making your listening actually help them. It is not just something passive. (E2)

> I personally really enjoy working with mental health. I think we are an important gateway to this within the healthcare system as a whole. And I strongly believe that a good welcoming approach, care along these lines and in this aspect at the primary level, greatly improves quality of life and, ultimately, outcomes in these patients as well. (E6)

One physician mentioned encouraging leisure activities. Half of the interviewees reported seeking community or collective resources. Physical activity was encouraged through individual guidance, broader discussions, setting small goals, invitations to groups, and searching for available resources. Patients' acceptance of psychosocial approaches varied among professionals according to the skills and knowledge they reported.

> I recommend some community resources as therapeutic spaces as well. [...] I help evaluate with the patient whether they have a support group, a social network, some things that may help. (E2)

> Depending on what the patient brings to me, I always try to assess the patient's socioeconomic situation as well, thinking about the type of living conditions they have. Whether they would have the possibility of investing in their health, for example by joining a gym or taking dance classes [...] which is very important, especially for extremely anxious patients. We notice they improve significantly simply by engaging in physical activity. [...] Looking into the possibility of being included in the sports center, there are some classes and activities there, including activities open to the community. (E5)

Regarding ICP, knowledge varied greatly, ranging from insufficient theoretical basis for application to specific training. Only one participant described frequent personal use of homeopathy.

> Personally, regarding medications, I always prefer to start with homeopathy first, depending on the case, these common ones, right, mild to moderate. (E6)

A considerable proportion cited the value of phytotherapy in mild conditions and reported using them in practice whenever possible. Professionals with basic knowledge were able to identify potential benefits and referred patients to outpatient homeopathy and acupuncture services within the healthcare network, while also reporting barriers to access due to the absence of such resources within their own units. Other ICP modalities were not mentioned as known or used.

> And yes, I do sometimes use some medications, but I still use herbal medicines a lot, you know? I still treat anxiety, if insomnia is present, with valerian and passionflower. (E2)

> There are some patients we refer for acupuncture. Especially those who, in addition to mental symptoms, also have a lot of associated pain. So we do refer these patients for acupuncture as well. (E3)

It is therefore understood that the lack of organization of CMD care and the absence of specific training in this regard contribute to the current situation of insufficient and unsatisfactory approaches. In agreement with the observations of Molk et al.[10], meeting current healthcare demands related to the CMD phenomenon requires innovative practices and the use of light and light-hard technologies for comprehensive care in order to transform hegemonic rationality. According to Fonseca[7] and Mendes[19], this can be achieved through professional training at the PHC level while simultaneously ensuring sufficient space and time for such care to actually take place.

Corroborating the observations of this study, a recent study by Santos et al.[32] on mental health in Brazilian PHC highlights that despite the advances of the Psychiatric Reform, the care model still faces significant challenges, with a concerning regression toward medicalization and a fragmented care network. The study reveals the urgent need for investment in continuing education for PHC professionals, aiming to overcome barriers and foster territorial actions based on the psychosocial care model. It reiterates that effective integration between mental health and PHC requires not only mastery of techniques but also transformation of the hegemonic biomedical rationality, ensuring that psychosocial interventions, such as ICP and matrix support, become accessible and effectively incorporated into routine care.

As from this study a didactic support material was developed in the form of a digital guide, presenting psychosocial interventions for physicians working in PHC. The practices were selected according to relevance, evidence base, and applicability, aiming to provide professionals with access to compiled information. The guide was made available in open-access digital librarie[33].

Final considerations

This study allowed to discuss how PHC physicians deal with CMD in daily practice, including the use of pharmacological and non pharmacological interventions, interaction with complementary support teams, and issues around the organization of such care. The identified overview is consistent with the reality of the medicalization of suffering and with the insufficiency of services to meet the growing demand for mental healthcare.

The results describe, based on the experiences of physicians directly involved in the care of individuals with CMD, a situation of limited care offerings. Limited available time, insufficient training in mental healthcare, distant relationships with complementary teams, limited effective matrix support, restricted outpatient services, and access to medication as the primary resource generate excessive psychotropic drug use and a sense of low effectiveness.

A limitation observed during the development of the study was the relative representativeness of the sample, since Brazilian PHC settings are highly diverse, both regarding available resources and physician qualifications. The represented scenario is the one most frequently found regarding specific qualification in Family and Community Medicine and training in psychosocial interventions; however, there are more qualified centers and more limited settings. Regarding resources available to PHC, the findings may not represent the reality of small municipalities distant from major urban centers, an issue considered in the discussion of the results.

Diverse mental health interventions, whether related to lifestyle, psychological, social, or integrative approaches, that address issues relevant to each individual's illness are technologies that should be known and considered in order to cope with the pressure of mental health demands in PHC. Their use by physicians favors comprehensive care for users within the territory, reduces professional overload and excessive medication use, and improves effectiveness. In order for these interventions to be properly indicated and applied, continuous professional qualification is necessary through matrix support practices as well as institutional encouragement and provision, thereby expanding knowledge and practices in CMD care.

Data Availability

Research data is only available upon request.

Authors' contribution

Victoria Petenati da Rovare participated in the conception and design of the study, data collection, analysis and interpretation, manuscript drafting and revision. Eliana Goldfarb Cyrino participated in the conception and design of the study and critical revision of the manuscript. Dulcian Medeiros de Azevedo participated in data interpretation and critical revision of the manuscript. Tiago Rocha Pinto participated in the conception and design of the study, data analysis, and manuscript revision. All authors approved of the final version of manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

Copyright

Editor
Erotildes Maria Leal
Associated editor
Robert Filipe dos Passos

Translator
Victoria Petenati da Rovare

Submitted on
08/30/25
Approved on
05/03/26

References

1. Wells RHC, Bay-Nielsen H, Braun R, Israel RA, Laurenti R, Maguin P, et al. CID-10: classificação estatística internacional de doenças e problemas relacionados à saúde. São Paulo: EDUSP; 2011.
2. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Saúde Mental. Brasília, DF: Ministério da Saúde; 2013. (Cadernos de Atenção Básica; n. 34).
3. Miranda TS, Soares GFG, Araujo BE, Fagundes GHA, Amaral HLP, Soares HC, et al. Incidência dos casos de transtornos mentais durante a pandemia da Covid-19. Rev Eletron Acervo Cient. 2020; 17:e4873. doi: 10.25248/reac.e4873.2020.
4. World Health Organization. World mental health report: transforming mental health for all. Geneva: WHO; 2022.
5. Senicato C, Azevedo RCS, Barros MBA. Transtorno mental comum em mulheres adultas: identificando os segmentos mais vulneráveis. Cienc Saude Colet. 2018; 23(8):2543-54. doi: 10.1590/1413-81232018238.13652016.
6. World Health Organization, World Organization of Family Doctors. Integrating mental health into primary care: a global perspective. Geneva, Brussels: WHO, WONCA; 2008.
7. Fonseca MLG. Sofrimento difuso, transtornos mentais comuns e problema de nervos: uma revisão bibliográfica a respeito das expressões de mal-estar nas classes populares [dissertação]. Rio de Janeiro: Escola Nacional de Saúde Pública Sergio Arouca, Fundação Oswaldo Cruz; 2007.
8. Perrusi A. Sofrimento psíquico, individualismo e uso de psicotrópicos: Saúde mental e individualidade contemporânea. Tempo Soc. 2015; 27(1):139-59. doi: 10.1590/0103-20702015017.
9. Goldberg D, Huxley P. Common mental disorders: a bio-social model. London: Routledge; 1992.
10. Molck BV, Barbosa GC, Domingos TS. Psicotrópicos e Atenção Primária à Saúde: a subordinação da produção de cuidado à medicalização no contexto da Saúde da Família. Interface (Botucatu). 2021; 25:e200129. doi: 10.1590/interface.200129.
11. Figueirêdo AAF. "O problema é como você olha": de um conjunto amorfo de sintomas não-psicóticos ao nascimento de diagnósticos clínico-psiquiátricos. Rio de Janeiro: Autografia; 2021.
12. Faria MLVC, Guerrini IA. Limitações do paradigma científico hegemônico no acolhimento ao sofrimento psíquico na atenção básica. Interface (Botucatu). 2012; 16(42):779-92. doi: 10.1590/S1414-32832012000300015.
13. Alves EO, Vieira PDA, Oliveira RAS, Rodrigues RF, Silva SC, Martins TP, et al. Prevalência do uso de psicotrópicos na Atenção Primária à Saúde em um município do interior de Minas Gerais. Rev Med Minas Gerais. 2020; 30 Suppl 4:S61-8. doi: 10.5935/2238-3182.v30supl.4.09.
14. World Organization of Family Doctors. Working party for mental health guidance paper: family doctors' role in providing non-drug interventions (NDIs) for common mental health disorders in primary care. Brussels: Wonca; 2017.
15. Pereira MTCG, Souza FAM, Cardoso FM. Tratamento medicamentoso para depressão e prevenção quaternária. Rev Bras Med Fam Comunidade. 2021; 16(43):2568. doi: 10.5712/rbmfc16(43)2568.

16. Amarante P, Whitaker R. Desmedicar: A luta global contra a medicalização da vida. São Paulo: Zagodoni; 2024.

17. Lermen-Junior N. Currículo Baseado em Competências para Medicina de Família e Comunidade. Rio de Janeiro: Sociedade Brasileira de Medicina de Família e Comunidade; 2015.

18. Gusso G, Lopes JMC. Tratado de Medicina de Família e Comunidade: princípios, formação e prática. Porto Alegre: Artmed; 2018.

19. Mendes FDM. Intervenções psicossociais para transtornos mentais comuns: percepções e demandas formativas na Medicina de Família e Comunidade [dissertação]. Juiz de Fora (MG): Universidade Federal de Juiz de Fora; 2021.

20. Menezes ALA. Intervenções psicossociais para Transtornos Mentais Comuns na Atenção Primária à Saúde [dissertação]. Rio de Janeiro: Universidade do Estado do Rio de Janeiro; 2012.

21. Brasil. Ministério da Educação. Conselho Nacional de Educação. Câmara de Educação Superior. Resolução CNE/CES nº 3/2014. Diretrizes Curriculares Nacionais do Curso de Graduação de Medicina. Diário Oficial da União. 23 Jun. 2014; Sec. 1, p. 8-11.

22. Organização Pan-Americana da Saúde. MI-mhGAP Manual de intervenções para transtornos mentais, neurológicos e por uso de álcool e outras drogas na rede de atenção básica à saúde. (Versão 2.0.). Brasília, DF: OPAS; 2018.

23. Ritchie J, Lewis J. Qualitative research practice: a guide for social science students and researchers. London: SAGE Publications; 2003.

24. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 10a ed. São Paulo: Hucitec; 2007.

25. Fontanella BJB, Ricas J, Turato ER. Amostragem por saturação em pesquisas qualitativas em saúde: contribuições teóricas. Cad Saude Publica. 2008; 24(1):17-27. doi: 10.1590/S0102-311X2008000100003.

26. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 1988.

27. Anderson MIP, Savassi LCM. Formação, Ensino e Pesquisa na Medicina de Família e Comunidade e na Atenção Primária à Saúde no Brasil: situação atual, desafios e perspectivas. Rev Bras Med Fam Comunidade. 2021; 16 Suppl 1:18-27. doi: 10.5712/rbmfc16(1)3249.

28. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Práticas integrativas e complementares: plantas medicinais e fitoterapia na Atenção Básica. Brasília, DF: Ministério da Saúde; 2012. (Cadernos de Atenção Básica; n. 31).

29. Brasil. Ministério da Saúde. Relação Nacional de Medicamentos Essenciais Rename 2022. Brasília, DF: Ministério da Saúde; 2022.

30. Chiaverini DH, Gonçalves DA, Ballester D, Tófoli LF, Chazan LF, Almeida N, et al. Guia prático de matriciamento em saúde mental. Brasília, DF: Ministério da Saúde, Centro de Estudo e Pesquisa em Saúde Coletiva; 2011.

31. Fagundes GS, Campos MR, Fortes SLCL. Matriciamento em Saúde Mental: análise do cuidado às pessoas em sofrimento psíquico na Atenção Básica. Cienc Saude Colet. 2021; 26(6):2311-22. doi: 10.1590/1413-81232021266.20032019.

32. Santos JCG, Cavalcante DS, Vieira CAL, Quinderé PHD. Medicalização do sofrimento psíquico na Atenção Primária à Saúde em um município do interior do Ceará. Physis. 2023; 33:e33010. doi: 10.1590/S0103-7331202333010.

33. Rovare VP, Pinto TR. Guia de intervenções psicossociais para transtornos mentais comuns: para médicos da Atenção Primária à Saúde. Botucatu: Faculdade de Medicina de Botucatu, Universidade Estadual Paulista (Unesp); 2024 [citado 28 Maio 2026]. Disponível em: https://hdl.handle.net/11449/324539.

Transtornos Mentais Comuns (TMC) são prevalentes na Atenção Primária à Saúde (APS), resultado de sofrimento psíquico e determinantes sociais, econômicos, familiares e individuais. Manifestam-se com sintomas mentais e físicos, impactando a saúde e a qualidade de vida. Esta pesquisa buscou analisar o repertório não farmacológico de médicos da APS no manejo do TMC. Trata-se de estudo qualitativo, analítico e exploratório que utilizou entrevistas semiestruturadas com médicos da APS de um município do interior de São Paulo. Análise temática dos dados revelou que a abordagem médica tende à medicalização do sofrimento e à insuficiência dos serviços. A falta de tempo e de capacitação e a distância com equipes complementares contribuem para o uso excessivo de psicotrópicos, filas para encaminhamentos e baixa resolutividade. É crucial a capacitação contínua, por meio de apoios matricial e institucional, para fomentar o uso de intervenções psicossociais eficazes e acessíveis.

Palavras-chave: Saúde Mental. Integralidade em saúde. Intervenção psicossocial. Atenção Primária à Saúde.

Los Trastornos Mentales Comunes (TMC) son prevalentes en la Atención Primaria de la Salud (APS), como resultado de sufrimiento psíquico y de factores determinantes sociales, económicos, familiares e individuales. Se manifiestan por medio de síntomas mentales y físicos, impactando la salud y la calidad de vida. El objetivo de esta investigación fue analizar el repertorio no farmacológico de médicos de la APS en el manejo del TMC. Se trata de un estudio cualitativo, analítico y exploratorio que utilizó entrevistas semiestructuradas con médicos de la APS de un municipio del interior del Estado de São Paulo. El análisis temático de los datos reveló que el abordaje médico tiende a la medicalización del sufrimiento y a la insuficiencia de los servicios. La falta de tiempo, de capacitación y la distancia con equipos complementarios contribuyen al uso excesivo de psicotrópicos, filas para derivación y baja capacidad de resolución. Es crucial la capacitación continua, por medio de apoyo matricial e institucional, para fomentar el uso de intervenciones psicosociales eficaces y accesibles.

Palabras clave: Salud Mental. Integralidad en salud. Intervención psicosocial. Atención Primaria de la Salud.