THE EUROPEAN SOCIETY OF MEDICINE
Medical Research Archives, Volume 14 Issue 3

PERSPECTIVE ARTICLE

Psychological Capacity Compression: Reframing Common Mental Disorders as Symptoms of Overload—A Theory of Change in Primary Care Settings

Abdullah Dukhail AlKhathami[1,2,3], MBBS, ABFM, FFCM(KFU), DTQM, MSc Medical Education (Cardiff University-UK), Diploma/MSc PMHC (Nova University Lisbon- Portugal), PC Leadership (York ST John University, UK-Sweden)

[1]Consultant Family and Community Medicine, Primary Mental Healthcare
[2]Chairman – Primary Mental Healthcare in EMRO region
[3]Vice-Chair Wonca-Working Party Group on Mental health

mabna@yahoo.com

OPEN ACCESS

PUBLISHED
31 March 2026

CITATION
AlKhathami, A.D., 2026. Psychological Capacity Compression: Reframing Common Mental Disorders as Symptoms of Overload—A Theory of Change in Primary Care Settings. Medical Research Archives, [online] 14(3).

COPYRIGHT
© 2026 European Society of Medicine. This is an open- access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

ISSN
2375-1924

ABSTRACT

Mental health issues are major contributors to global disability and are commonly encountered in primary care, often alongside chronic medical diseases. Despite their high prevalence, conditions such as depression and anxiety disorders are frequently under-recognised and treated as separate diagnostic entities, leading to fragmented care and suboptimal outcomes.

This paper proposes psychological capacity compression as a unifying, transdiagnostic mechanism underlying depression and anxiety in primary care. It conceptualises these conditions not as distinct diseases but as symptomatic expressions of a shared state of cumulative psychological overload, consistent with contemporary transdiagnostic models.

Psychological capacity compression reflects reduced well-being–related neurobiological activity (often described as happiness-related pathways) with an increase in stress hormones, such as cortisol and adrenaline, caused by chronic hypothalamic–pituitary–adrenal axis stimulation. This imbalance explains the heterogeneous psychological and somatic presentations observed in primary care and their improvement when neurobiological balance is restored.

This conceptual model provides a theoretical foundation for the AlKhathami Five-Step Patient Interview Approach. It reframes the traditional biopsychosocial perspective by replacing psychosocial components with a biologically informed five-step clinical framework (the Bio–Five-Step Approach). By targeting psychological capacity compression as the core process, the approach supports early identification, rational clinical decision-making, and effective integration of mental healthcare into routine primary care practice. Restoration of psychological capacity re-establishes adaptive regulation across psychological and physiological systems and is commonly experienced as well-being.

Introduction

Globally, mental health disorders account for a substantial proportion of years lived with disability, with depression and anxiety consistently ranking among the leading causes.[1] In primary care, these conditions frequently present indirectly through somatic complaints, sleep disturbances, fatigue, or poor control of chronic diseases such as diabetes and hypertension.[2,3]

Despite robust evidence supporting integrated mental healthcare, primary care systems often remain fragmented. Clinicians face diagnostic uncertainty, limited consultation time, and restricted access to specialist services, particularly in resource-constrained settings.[4] These challenges highlight the need for conceptually simple yet clinically powerful models that reflect real-world primary care practice and address the root drivers of psychological distress.

Psychological Capacity Compression: Conceptual Definition

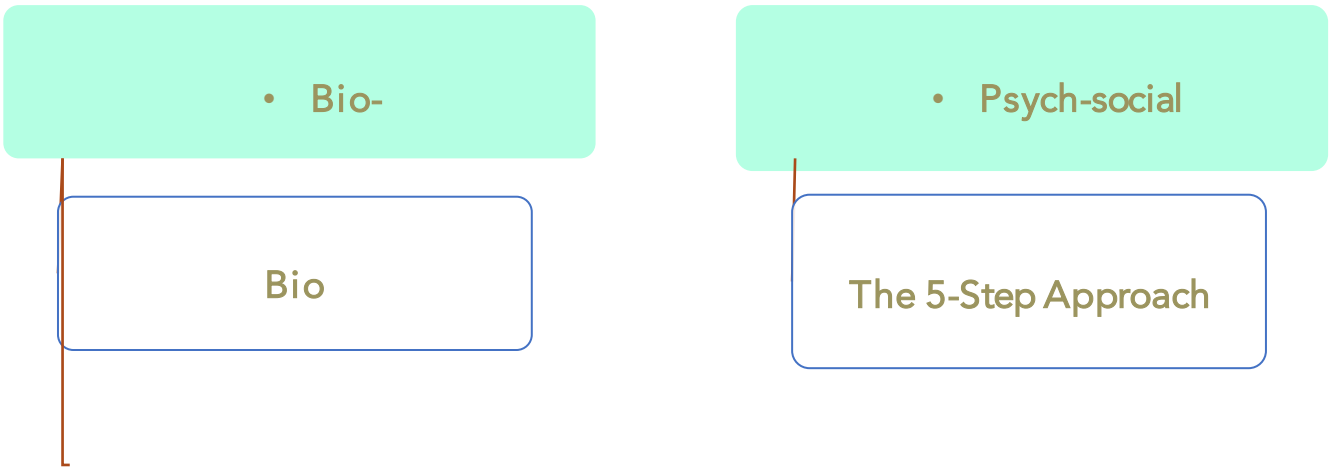
Psychological capacity refers to an individual's adaptive reserve—the ability to regulate emotions, tolerate uncertainty, process stressors, and maintain functional balance across emotional, cognitive, and physiological domains. When cumulative internal or external stressors lead to sustained reductions in well-being–related neurobiological pathways alongside increased activation of stress hormones, these demands may exceed the individual's adaptive reserve, resulting in psychological capacity compression.

Psychological capacity compression represents a characteristic and potentially reversible neurobiological imbalance arising from sustained psychological overload rather than a primary biological disease.[5,6] Prolonged exposure to psychosocial stressors or genetic vulnerability disrupts the balance between mood-regulating neurotransmitter systems and stress-response pathways.

This imbalance is characterised by reduced regulatory reserve, impaired emotional and cognitive control, and increased vulnerability to psychological and physical symptoms.[7,8] In this compressed state, chronic stress shifts neural functioning toward survival-oriented responses, constraining adaptive flexibility and resilience.[9]

Restoration of psychological capacity is associated with emotional stability, cognitive clarity, effective stress regulation, and preserved functional integration across psychological and physiological domains; experientially, this recovery is commonly perceived as peace of mind.[10,11] This dynamic and reversible continuum is consistent with contemporary transdiagnostic and primary-care models, including the Five-Step Patient Interview Approach.[12] This approach reframes the traditional biopsychosocial perspective by introducing a biologically informed five-step clinical framework (Bio–Five-Step Approach). Diagram 1)

Diagram 1. Step 5 Approach: Integrated Management Algorithm in Primary Care



© 2026 European Society of Medicine

Step 1: Recognising Psychological Capacity Compression

Psychological capacity compression provides the theoretical basis for Step 1 of the Five-Step Patient Interview Approach, consistent with the World Health Organization's Mental Health Gap Action Programme (mhGAP) and WONCA principles, emphasising early identification of mental health conditions in primary care.[13,14]

Within this framework, common psychological and somatic presentations are interpreted as indicators of cumulative stress exceeding adaptive capacity, prompting proactive assessment in patients presenting with:

a. unexplained or poorly controlled organic diseases or physical symptoms

b. frequent healthcare utilisation without satisfactory outcomes

c. sleep disturbances, including insomnia or fragmented sleep.[13,15]

Step 2: Neurobiological Mechanisms and Screening Framework

Psychological capacity compression produces a characteristic neurobiological imbalance marked by:

- Reduced serotonin and dopamine activity, impairing mood regulation, motivation, and emotional stability[6,16]
- Persistent activation of stress-response systems, including the hypothalamic–pituitary–adrenal axis and the sympathetic nervous system, leading to elevated cortisol and catecholamines[7]

Patients frequently present with low self-esteem, excessive self-blame, heightened emotional sensitivity, and a pessimistic worldview.

Step 2 translates this survival-mode neurobiology into clinical screening through:

a. the Ideas, Concerns, Expectations (ICE) technique to explore explanatory models and detect disturbances in reality testing

b. functional stress-impact assessment focusing on sleep, performance, concentration, and social functioning.[12]

Step 3: Scoping of Services

Psychosis, impaired reality testing, bipolar disorder, suicidal ideation, postpartum depression, substance misuse, child psychiatric disorders, and dementia indicate greater complexity and warrant specialist referral.[13,17–19]

Step 4: Diagnosis

When compression predominantly affects mood regulation, depressive and anxiety symptoms emerge, which can be effectively managed in primary care using PHQ-2 for depression and GAD-2 for anxiety.[20,21] Anxiety phenotypes—including phobias, panic disorder, post-traumatic stress disorder (PTSD), and obsessive-compulsive disorder (OCD)—represent descriptive manifestations of stress-related dysregulation rather than fully independent diseases.[22]

Step 5: Management—Treating the Root Cause

Symptom-focused interventions alone often lead to partial or temporary improvement. Addressing psychological capacity compression targets the root process through three integrated domains:

1. Enhancing well-being neurotransmitters and reducing stress hormones
2. Providing nutritional and physiological substrates for neurobiological balance
3. Preventing excessive neurotransmitter breakdown through pharmacotherapy when indicated

This integrated approach restores psychological and physical function and resolves sustained symptoms.[23], as illustrated in Figure 2., and table 1.

© 2026 European Society of Medicine

Figure 2: Three components of the management approach

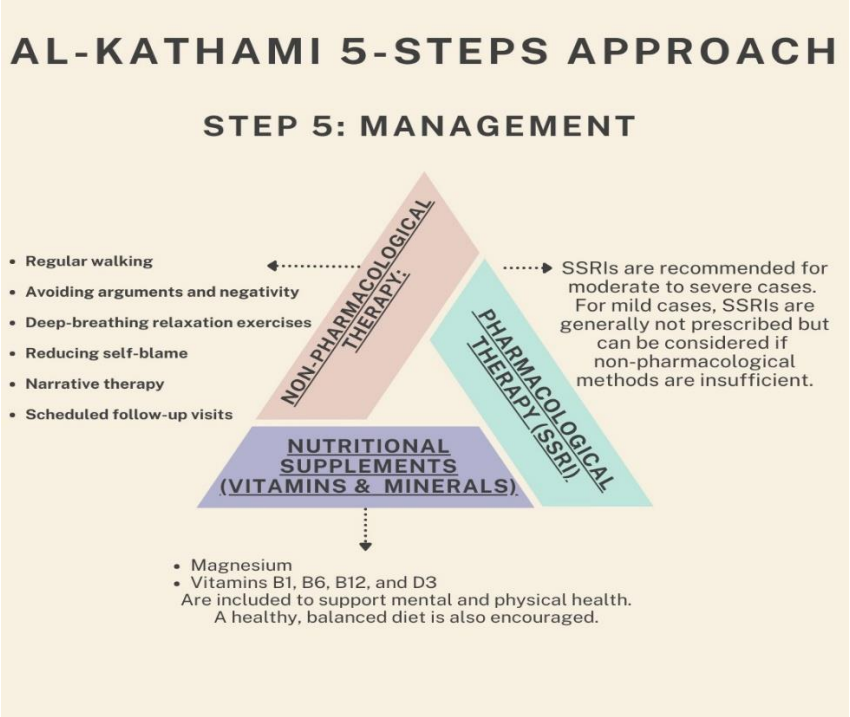


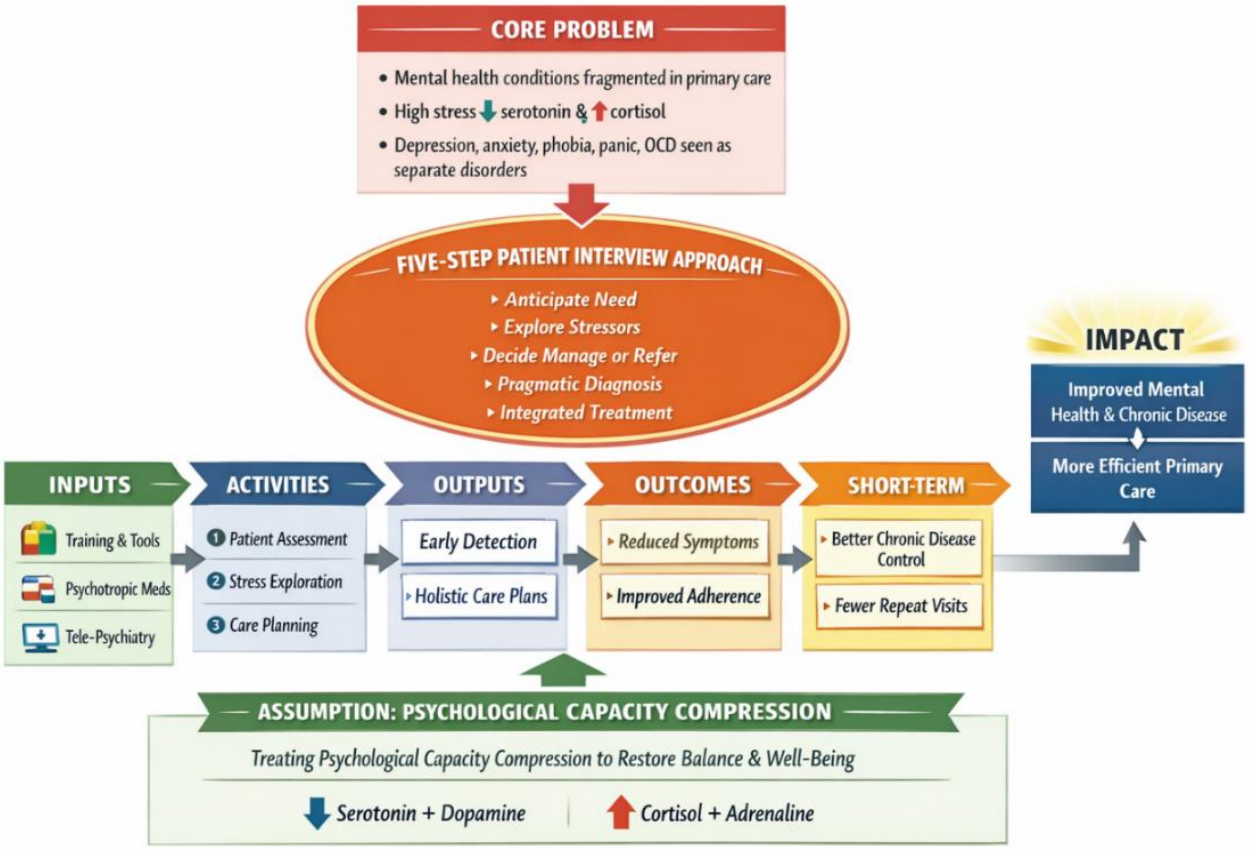
Table 1: Follow-up schedule for depression and anxiety management

Patient with Psychological Capacity Compression (Depression ± Anxiety)
Initial Clinical Encounter
Universal Interventions (All Patients) • Non-pharmacological care • Nutritional and vitamin support
Assess Severity
Mild Symptoms: • Continue non-pharmacological and nutritional care • Regular follow-ups Moderate to Severe Symptoms: • Add pharmacological treatment (SSRIs)
Second Visit: • Introduce modified narrative therapy
Structured Follow-up: • 2 weeks → 3 weeks → monthly
Remission Achieved
Maintenance and Tapering: • Follow-up every 2 months for 9 months • Gradual dose reduction (half monthly)

Impact on Chronic Disease and Health Systems

Addressing psychological capacity compression improves outcomes beyond mental health, including glycaemic control, blood pressure regulation, medication adherence, and quality of life, while reducing healthcare utilisation and costs.[23,24]

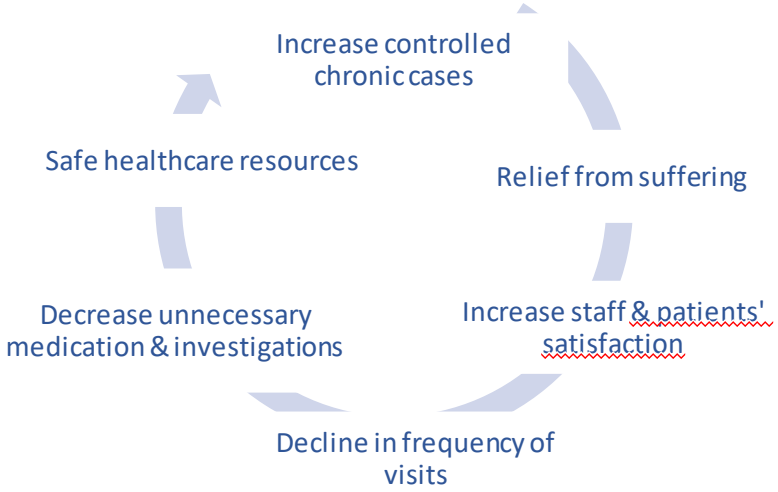
Figure 3. Bio–Five-Step Model for Integrating Mental Health into Primary Care Through Psychological Capacity Restoration



Global Health Relevance and Local Impact

This theory of change aligns with WHO mhGAP and global primary healthcare strategies, supporting scalable and culturally adaptable integration of mental health into primary care worldwide.[13,25], as illustrated in diagram 2.

Diagram 2 : Proposed Outcomes of the 5-Seps Approach application in Primary-care centres



Conclusion

Psychological capacity compression reframes common mental health problems as manifestations of adaptive overload rather than discrete diseases. By addressing this root cause, the Five-Step Patient Interview Approach enables effective, integrated mental healthcare within routine primary care, improving outcomes for patients, clinicians, and health systems.

Conflict of Interest Statement:

None.

Funding Statement:

None.

Acknowledgements:

None.

References:

1. GBD 2019 Mental Disorders Collaborators. Global prevalence and burden of depressive and anxiety disorders in 2019. *Lancet Psychiatry*. 2022;9(2):137-150.

2. Katon W, Lin EH, Kroenke K. The association of depression and anxiety with medical symptom burden in primary care. *Psychosom Med*. 2007;69(2):147-155.

3. Moussavi S, et al. Depression, chronic diseases, and decrements in health. *Lancet*. 2007;370:851-858.

4. WHO & WONCA. *Integrating Mental Health into Primary Care: A Global Perspective*. Geneva: WHO; 2008.

5. McEwen BS. Protective and damaging effects of stress mediators. *N Engl J Med*. 1998;338:171-179.

6. Nestler EJ, Barrot M, DiLeone RJ, et al. Neurobiology of depression. *Neuron*. 2002;34:13-25.

7. Herman JP, McKlveen JM, Ghosal S, et al. Regulation of the HPA stress axis. *Nat Rev Neurosci*. 2016;17:33-47.

8. Arnsten AFT. Stress signalling pathways impair prefrontal cortex function. *Nat Rev Neurosci*. 2009;10:410-422.

9. McEwen BS, Wingfield JC. Allostasis and allostatic load. *Horm Behav*. 2003;43:2-15.

10. Fredrickson BL. The broaden-and-build theory of positive emotions. *Philos Trans R Soc B*. 2004;359:1367-1377.

11. Ryff CD, Singer B. The role of positive health. *Psychol Inq*. 1998;9:1-28.

12. AlKhathami AD. An innovative 5-Step Patient Interview approach for integrating mental healthcare into primary care centre services: a validation study. *Gen Psychiatry*. 2022;35:e100693.

13. World Health Organization. *mhGAP Intervention Guide Version 2.0*. Geneva: WHO; 2016.

14. WONCA Working Party on Mental Health. Integrating mental health in family practice. WONCA; 2017.

15. Buysse DJ. Insomnia. *JAMA*. 2013;309(7):706-716.

16. Cowen PJ, Browning M. What has serotonin to do with depression? *World Psychiatry*. 2015; 14:158-160.

17. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*. 5th ed. Washington, DC; 2013.

18. Patel V, et al. Addressing the burden of mental disorders. *Lancet*. 2018;392:1553-1598.

19. Prince M, et al. No health without mental health. *Lancet*. 2007;370:859-877.

20. Kroenke K, Spitzer RL, Williams JB. The PHQ-2. *Med Care*. 2003;41:1284-1292.

21. Kroenke K, Spitzer RL, Williams JB, Löwe B. The GAD-2. *Med Care*. 2007;45:109-113.

22. Harvey AG, Watkins E, Mansell W, Shafran R. *Cognitive Behavioural Processes Across Psychological Disorders*. Oxford: OUP; 2004.

23. Katon WJ, et al. Collaborative care for patients with depression and chronic illness. *N Engl J Med*. 2010;363:2611-2620.

24. Egede LE, Ellis C. Diabetes and depression. *Lancet*. 2010;375:219-229.

25. World Health Organization. *Comprehensive Mental Health Action Plan 2013–2030*. Geneva: WHO; 2021.

© 2026 European Society of Medicine