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PHYSICAL ILLNESS IN PSYCHIATRIC PATIENTS*

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SUMMARY

Of the 85 psychiatric patients taken for the study 45 (52.9%) had physical illnesses. Results showed that 84.4% physically ill patients remained unrecognised at the time of psychiatric consultation. A significantly higher percentage of physically ill patients were drawn from larger families of lower socio-economic status. Significantly higher number of physically ill patients had psychiatric problems of longer duration. Severe type of physical illnesses were mainly found in schizophrenics. Respiratory system was most frequently involved.

The presence of physical illness in psychiatric patients not only creates problems in the diagnosis and treatment but often complicates the course of both psychiatric as well as physical illnesses. The presence of physical illnesses increases the mortality risks in psychiatric patients. Sims and Prior (1978) demonstrated an excess of deaths in neurotic patients due to diseases of central nervous, respiratory and circulatory systems.

Physical morbidity in psychiatric patients is reported to be much higher than the expected rate in general population. Estimates of incidence of physical illness that existed in psychiatric patients ranged from 33% to 66% (Johnson 1968). Marshal (1949) reported that no fewer than 44% of patients admitted in a psychiatric unit had some physical problems requiring attention. Similarly Mcguire and Granville-Grossman (1968) found 33.5% of 200 consecutive inpatients to have medical illnesses, 70% of which were severe and 49% had illnesses which were previously unknown to either the patient or his physician.

The study of the presence of physical illness in psychiatric patients may have more relevance in our socio-economic set up due to large scale poverty, malnutrition and unhygienic conditions prevailing in most parts of our country. The present investigation was undertaken to report the nature and frequency of various physical illnessess in psychiatric patients and to study their psychosocial variables.

Material and Methods

The sample consisted of eighty five randomly selected adult psychiatric patients above the age of 16 years who were attending Mental Health Clinic of G. S. V. M. Medical College Hospital, Kanpur. The patients without psychiatric problems were not included in the study. The patients thus selected were examined and psychiatric diagnosis was given based on I. C. D. 9 (1978).

The physical examination was conducted in detail and recorded on a proforma specially prepared for the purpose. Wherever considered necessary the opinion of the physician was also obtained for the

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diagnosis and treatment of physical illnesses. Besides routine investigations like urinanalysis, blood and stool examination which were done in every case, certain special investigations such as blood sugar, serum cholesterol, creatinine, W. R., VDRL, X-rays, ECG and thyroid functions were carried out whenever necessary.

Results

95 randomly selected patients were examined during a period of six months. Of these, five patients were found to have no psychiatric problem and were excluded from the study. Five patients did not turn up for the second interview and examination and thus were not included in the study.

Of the 85 psychiatric patients taken up for the study 45 (52.9%) had physical illnesses. These were divided into two groups of patients, Group I, patients with physical illnesses and Group II patients without physical disorders. It was interesting to observe that most of the physical illnesses (84.4%) remained unrecognised at the time of psychiatric consultation. Significantly higher percentage of physically ill psychiatric patients (Table 1) belonged

Table 1
Socio-economic status in the two groups

Patients		Socio-economic status (Based on Prasad's (1970) social classification)				
		Class I	Class II	Class III	Class IV	Class V
Group I N = 45	n	5	4	18	17	1
	%	11.1	8.9	40.0	37.2	2.2
Group II N = 40	n	3	14	20	3	–
	%	7.5	35.0	50.0	7.5	–
Total N = 85	n	8	18	38	20	1
	%	9.4	21.1	44.7	23.5	1.1

$P < 0.05$

to lower socio-economic status (class IV). Table 2 shows a significantly higher representation of larger families among physically ill psychiatric patients. The diagnostic distribution is given in table 3 and it is evident that the various diagnostic groups were more or less equally distributed among the two groups of patients. Significantly higher number of group I patients had psychiatric illness for more than three years (table 4). 68.8% psychiatric patients developed the physical illness after the onset of psychiatric disturbance.

Table 2
Family Size

Patients		Small	Large
Group I N = 45	n	17	28
	%	37.8	62.2
Group II N = 40	n	34	6
	%	85.0	15.0
Total N = 85	n	51	34
	%	60.0	40.0

Level of significance – $P < 0.05$

Table 3
Diagnostic distribution

Psychiatric diagnosis	Group I		Group II		Total	
	N	%	N	%	N	%
Schizophrenia	11	24.4	9	22.5	20	23.5
Reactive Psychosis	6	13.3	8	20.0	14	16.5
Affective Disorder	11	24.4	9	22.5	20	23.5
Neurosis	17	37.8	13	32.5	30	35.3
Miscellaneous	–	–	1	2.5	1	1.2

All the schizophrenics had severe degree of physical illness (table 5). More than 60% patients with reactive and affective psychoses also suffered from severe physical illnesses. The severe physical illnesses were defined as somatic conditions causing active symptoms and considerable disability to the patient, requiring immediate investigations and treatment. A physical illness was considered to be mild if it was judged to be of less important than the

Table 4
Duration of psychiatric illness

Duration of psychiatric illness	Group I		Group II	
	N	%	N	%
Less than one year	9	20.0	23	57.5
1 – 3 years	14	31.1	12	30.0
More than 3 years	22	48.9	5	12.5
Total	45	100.0	40	100.0

Level of significance – $p < 0.05$

Table 5
Severity of physical illness and psychiatric disorders

Psychiatric disorders in Group I N = 25	Physical illnesses			
	Severe		Mild	
	N	%	N	%
Schizophrenia	11	100.0	–	–
Reactive psychosis	6	66.7	2	33.3
Affective disorders	7	63.6	4	36.3
Neurotic disorders	9	52.9	8	47.1

psychiatric disorder and caused only a minor degree of disability, not necessarily requiring immediate investigations and treatment.

Respiratory and gastrointestinal systems were the most frequent areas of physical disturbance. 10 out of 15 patients with respiratory disorders had pulmonary tuberculosis.

Discussion

It is generally agreed that a high proportion of psychiatric patients either have or develop physical illnesses of varying severity before or after the onset of their psychiatric illnesses. The presence of physical illness in psychiatric patients not only creates difficulties in diagnosis and treatment but also complicates the course of psychiatric disorders and exposes them to disproportionately higher rates of morbidity and mortality.

The present study was undertaken so that one can become alert and careful in identifying and dealing with physical illnesses in psychiatric patients more effectively. The frequency of physical illness in psychiatric patients has been found to be 52.9% which is quite consistent to our expectations. The literature shows marked variation in the occurrence of physical morbidity among psychiatric patients. It is found to be varying from 9.1% (Hall et al. 1978) to 80% (Hall et al. 1980). But in most of the studies the incidence ranged between 30 to 60%. In an Indian study, Kuruvilla (1973) reported comparatively higher incidence of 75.9% which could be due to the fact that the study was conducted on long stay hospital patients who had undergone comprehensive physical evaluation

Table 6
Types of physical illnesses and physiological systems

Physiologic system	Physical illness (n)
Respiratory system	Pulmonary tuberculosis (10) Tropical pulmonary eosinophilia (1) Chronic bronchitis (2) Emphysema (1) Lobar pneumonia (1)
Gastrointestinal system	Worm infestations (6) Amoebic hepatitis (4) Amoebic colitis (2)
Cardiovascular system	Hypertension (5) Valvular heart disease (2) Congestive cardiac failure (4)
Genito urinary system	Urinary tract infection (3) Primary syphilis (1)
Haemopoietic system	Anaemia (3)
C. N. S.	Cerebral thrombosis (1) Parkinsonism (1)
Surgical illness	Piles (1) Hydrocoel (1)
E. N. T.	Chronic otitis media (2)
Skin	Herpes zoster (1) Systemaic lupus (1) erythematosus
Endocrinal/ metabolic	Thyrotoxicosis (1) Diabetes mellitus (1)
Musculo-skeletal	Cervical spondylitis (2)

over a period of time. Further, most of the patients in our as well as in the study of others (McGuire 1968 and Koranyi 1979) remained previously undetected for their physical illness. This places extra responsibility on psychiatrists to remain vigilant for detecting physical illnesses in their patients.

There could be several factors which can explain the presence of unrecognised physical illness in psychiatric patients. In some patients the physical illness was too mild to attract patients attention while others had symptoms but were ignorant about the nature and severity of the underlying physical disease. There was yet another group which had no symptoms at all of the underlying physical illness such as anaemia, worm infestations and colitis etc. and thus remained unknown to the patient. The treating doctor also may remain ignorant about existing physical illness when psychiatric symptoms or illness is predominant and when physical illness is not severe and disabling enough to attract doctor's attention. Extreme withdrawal and poor communication specially in chronic schizophrenics may also lead to the patients suffering in silence instead of complaining about physical symptoms.

Since poverty breeds illness, it was expected to find a significantly higher percentage of physical illness in patients with lower socio-economic status. Hall et al. (1980) also reported a much higher incidence (80%) of physical illnesses in lower socio-economic class. The significantly higher prevalence in larger families was expected because overcrowding and congestion are important contributory factors in the development of physical illnesses.

Although the nature of psychiatric illnesses did not influence the distribution of physical illness in psychiatric patients but the duration did. The physical morbidity was significantly higher in long standing psychiatric patients who had been ill for more than three years. The neglect of personal care and hygiene coupled with malnutrition due to prolonged and disturbed emotional states were responsible for an increased rate of physical illness in chronic psychiatric patients.

The finding of higher prevalence of respiratory disorders in our study is similar to that of general population. The unusually high prevalence of pulmonary tuberculosis (71.4%) among the patients with respiratory disorders is not unexpected because the city of Kanpur is known for the highest prevalence for pulmonary tuberculosis in the country. The poor nutritional status, overcrowding and physical inactivity produced by long standing psychiatric disturbances seem to have contributed to a high prevalence of pulmonary tuberculosis, amoebiasis and worm infestations in these patients. It is probably due to these reasons that all the schizophrenics in the group I had severe physical illness. The finding that in large number of patients, physical illness followed the development of psychiatric disorders further supports the view that psychiatric disorders give rise to poor nutritional status and physical inactivity thereby making these patients vulnerable to physical illness.

Thus from the observations made in the study it may be concluded that more than 50% psychiatric patients suffer from unrecognised physical morbidity of severe degree of which most of them belong to lower socio-economic groups. The patients with major psychiatric illnesses of longer duration are more likely to suffer from severe physical illness.

Further, it is our as well as others (McIntrye and Roman 1975) impression that most of the psychiatrists routinely fail to physically examine their patients either due to over work or they do not feel the need to do so. Many of them feel uncomfortable with their ability to conduct such an

examination. Hence there is a greater need for the psychiatrist to remain vigilant so that most of the undetected physically ill patients may not remain undetected in his clinic too.

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