

PSYCHIATRIC MORBIDITY IN THE MEDICAL OUTPATIENTS OF A GENERAL HOSPITAL

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SUMMARY

Psychiatric morbidity in the patients attending the medical outpatient clinic of a large general hospital was studied using a short 5 - item version of the General Health Questionnaire (GHQ). The overall percentage of high scorers, (score 2 and above) was found to be 51 % (45 % for Males and 59 % for Females). Morbidity was higher in women who were married and those who were widowed or separated. There was no relationship with other sociodemographic variables, the duration of the medical illness and the medical diagnosis. 11 % of the patients had a psychiatric disorder without any concurrent medical illness. Among the patients with both medical and psychiatric illness, the medical illness preceded psychiatric illness in 28 % of the cases, both occurred simultaneously in 31 % of the cases, while in 41 % of the cases, the medical illness followed psychiatric illness.

Introduction

With the increasing emphasis on decentralization of psychiatric services (National Mental Health Programme for India), mental health care is becoming an integral part of General Health Care, both at the general hospital and at the primary care level. Many patients presenting at the general practice and at general hospitals mainly have somatic symptoms with little or no organic basis (Shepherd 1966, Mayou 1976). Lipowsky (1967) has reviewed the studies of psychiatric morbidity in patients consulting different non psychiatric services and has concluded that 50-80% of these patients suffer from significant psychiatric disturbances.

The method of screening for psychiatric morbidity in most of these studies has been by clinical interview, which is fairly time consuming, particularly so in the busy outpatient clinics of general hospitals. In this study a very short screening tool was used to assess the extent of psychiatric morbidity in medical outpatients.

Material and Methods

The screening tool used in this study (Appendix I) was a shortened 5-item version of the General Health Questionnaire (GHQ) (Goldberg 1972). The 5 questions were extracted as a potential screening tool from the 12-item version of the GHQ during a survey of psychiatric morbidity in general practice (Shamasunder, Unpublished data). The 5-item version has been validated by Shamasunder *et al* (submitted for publication) in a sample of attendants of psychiatric patients, with a structured Interview Schedule, the Indian Psychiatric Interview Schedule developed and standardized for the Indian population by Kapur *et al* (1974). This 5-item version was found to have a sensitivity of 86 %, a specificity of 89 %, and an overall misclassification rate of 13 % with a cut-off point of 1/2, i.e. a score of two or more indicate probable psychiatric morbidity.

The present study was conducted in a large general hospital in Bangalore City. About 200-300 outpatients attend the me-

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dical outpatient services every day. There are separate sections for male and female patients. About 8-10 doctors sit in the outpatient clinic each day at different tables. The patients go to the different tables depending upon the doctor at any given table being free. Thus there is an automatic randomization of patient population in respect of any given doctor or table.

The outpatient attenders were administered the 5-item version of the GHQ as a part of the routine clinical enquiry. As the GHQ questions are basically questions about psychiatric symptomatology, whenever a patient answered positively, its duration was also recorded as indicative of the duration of psychiatric symptoms. Similarly the diagnosis and duration of medical illness was also recorded.

Along with the patient's responses to the 5-item GHQ, minimal sociodemographic data were collected. As the male and female patients are seen in separate sections of the outpatient services, the data was collected and analysed separately for two sexes. A total of 300 patients were thus studied (Male = 170, Female = 130).

Results

Out of 300 patients, 154 (51.3%) scored 2 and above on the 5 item GHQ. Using the indices of validity of the GHQ-5, and applying the formula as suggested by Goldberg (1972) for the above figures, the more accurate estimate of morbidity was 53.7% (Male 45.7% and female 64.2%).

The morbidity was higher in the 26-35 age group and in those above 55 years of age in both sexes. Among the females, the morbidity was higher in the married as well as in those who were widowed or separated. There was no relationship between psychiatric morbidity and education, occupation, the urban/rural background of the patients, the duration of medical illness or the

medical diagnosis.

In the total population of 300, 32 patients (10.6%) had primary psychiatric illness, without any identifiable physical illness. The diagnosis of these patients was made using the ICD-9. Of the 32 patients, 29 were identified by the 5-item GHQ as probable cases and 3 patients were not so identified. The diagnostic breakup of the patients was: Depressive neurosis 13, Anxiety neurosis 14, Alcoholism 2, Neurosthenic neurosis 1, Psychalgia 1 and Drug dependence 1.

Among the patients who had both medical and psychiatric illness, the medical illness antedated the psychiatric illness in 28% of the cases, both occurred simultaneously in 31% of the cases, while in 41% of the cases, the medical illness followed the psychiatric illness.

Discussion

The 5-item version of the GHQ was found to be very capable of easy integration with the routine clinical enquiries made in the busy outpatient clinic.

The psychiatric morbidity in this sample of 300 medical outpatients using the 5-item version of the GHQ was 54%. Robert and Norton (1952) examined 50 medical outpatients of a general hospital by clinical interview and found a morbidity of 72%. Srinivasa Murthy *et al* (1976) in their study of 110 medical outpatients obtained a figure of 33.4% (27% pure psychiatric disorder plus 6.4% combined organic and psychiatric disorder). Glass & Allan (1978) studied 82 medical outpatients and found a high figure of 83%. As Lipowsky (1967) has pointed out, the psychiatric morbidity figures in medical patients vary depending upon the setting, the sample, the measuring tool, the definition of psychiatric distress and the presence or absence of psychiatric unit.

The higher morbidity among females is a well reported phenomenon. The increased rate among married females is probably related to increased role responsibility, while that among the widowed and separated is understandable and is similar to the finding of Kiran Rao (1980) in her study of patients in a rural health clinic.

It is interesting to note that 10.6% of the total outpatient sample consulting at the medical outpatient, did so primarily for a psychiatric problem, despite the fact that specialist psychiatric services were available already in the same outpatient building of the hospital. This probably reflects the public fear and reluctance to use mental health facilities.

There are three possible associations seen in this study between medical and psychiatric illnesses.

a) The psychiatric illness being a part of the medical illness e.g. feeling strained and sleepless during an acute febrile illness.

b) The psychiatric illness preceding medical illness, increasing the susceptibility of subjects to medical illness.

c) The psychiatric illness occurring as an understandable consequence of the often incapacitating medical illness.

All medical patients with associated psychiatric symptoms may not need specific psychiatric intervention. The mere treatment of the medical illness will, most probably alleviate the psychiatric symptoms in those cases where the psychiatric symptoms appear with or after medical symptoms. Yet a sizeable proportion of medical patients have psychiatric problems, recognition and treatment of which would reduce much suffering to the patients.

Conclusions

A sizeable percentage of patients who attend medical clinics have significant psy-

chological disturbance. Among these a proportion of patients consult at the medical clinic solely for a psychological problem. The 5 questions of the GHQ are capable of being used by the physician to quickly screen his patients for psychiatric morbidity. The magnitude of the problem outlines the need for psychiatric orientation of physicians.

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Appendix 1

The five questions of the GHQ (Serial number in the 60-item version indicated on the left)

4. Have you recently lost much sleep over worry?	0 Not at all	0 No more than usual	1 Rather more than usual	1 Much more than usual
39. Have you recently felt constantly under strain?	0 Not at all	0 No more than usual	1 Rather more than usual	1 much more than usual
42. Have you recently been able to enjoy your normal day to day activities?	0 More so than normal	0 Same as usual	1 Less so than usual	1 Much less than usual
49. Have you recently been feeling unhappy and depressed?	0 Not at all	0 No more than usual	1 Rather more than usual	1 Much more than usual
54. Have you recently been feeling reasonably happy, all things considered?	0 More so than usual	0 About the same as usual	1 Less so than usual	1 Much less than usual

Appendix 2

- $$P = \frac{\% HS - \% fp}{s - fp}$$

$$\% HS = \text{Percentage with high scores}$$

$$P = \text{Prevalence}$$

$$fp = \text{False positive rate } (= 100 - \text{Specificity}/100)$$

$$s = \text{Sensitivity rate } (= \text{sensitivity}/100)$$