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PSYCHIATRIC MORBIDITY AMONG PATIENTS ATTENDING MEDICAL OUTPATIENT DEPARTMENT

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SUMMARY

Patients attending the General Medical Out-patient department of a public hospital were selected randomly and screened by a physician and a psychiatrist independently. The data on 258 patients reveal an overall psychiatric morbidity of 36% consisting of 24% pure psychiatric illnesses and 12% with associated organic problems. Females are found to be suffering from psychiatric illnesses to a statistically significantly greater extent as compared to males. Symptoms related to the head and the central nervous system, psychological symptoms and sleep disturbances are significantly more in the psychiatrically ill group. Functional patients have on an average more presenting complaints as compared to the "organic" i.e. physically ill patient (2.73 against 1.96). Other relevant findings are discussed in comparison with other studies.

Introduction

Studies in Western countries have found psychiatric morbidity in general practice to range from 14% (Kessel 1960) to 44% (Goldberg 1972). Krishnamurthy et al (1981) reported 36% psychiatric morbidity in general practice in India. We found that 57% of non-acutely ill patients attending a general hospital out-patient department including all specialists, scored high on the general health questionnairs (Bagadia et al 1985), indicating likelihood of psychiatric morbidity. However the misclassification rate using this questionnaire was 30%, rather high, as found by random psychiatric examination of the same patient population.

The present study was undertaken to detect psychiatric morbidity in the General Medical Out-patient department of a large public hospital. The general medicine department was chosen because it closely resembles a general practice and draws a sizeable proportion of the total first attendance at the out-patient clinic and hence it is the department from which patients are subsequently referred to other specialities and super-specialities.

Material and Methods

The medical out-patient clinic is conducted once a week by the unit concerned. On these days every fifth case registered as a fresh patient was directed by the out-patient department staff to our team consisting of a physician (M.D. General Medicine) and a psychiatrist (M.D). Acutely ill cases in need of immediate medical aid were excluded from the study. The patient was seen by the physician who interviewed and examined him, asked for relevant investiga-

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tions and made an independent diagnosis. Then the patient was seen by a psychiatrist who also interviewed the patient, carried out a mental status examination, physical examination and arrived at a diagnosis. The order of examination by physician and psychiatrist was reversed if convenient. If a final decision could not be arrived at in one interview the patient was called again with his investigation reports and a diagnosis was established at follow-up. The interviews by both physician and psychiatrist were brief in keeping with the conducting of a fairly busy out-patient department.

For the purpose of this study the patients were classified as follows:

Group A: Labelled "ORGANIC" consisted of those patients in whom the presenting symptoms could be traced directly to a physical disease.

Group B: Labelled "FUNCTIONAL" consisted of those patients in whom the presenting symptoms could be traced to a purely emotional or psychological disorder.

Group C: Labelled "COMBINED" consisted of those patients who had illnesses with both a physical and a psychological basis and would benefit better by the attention of both a physician and a psychiatrist.

NB: In this study, well-known psychosomatic disorders like "peptic ulcer" or "hypertension" were classified in Group A because our endeavour was to detect pure psychiatric morbidity.

258 patients were thus screened by a physician and a psychiatrist independently and the data was pooled and subjected to statistical analysis.

Results and Discussion

The salient features of our observations during this study were as follows: (see Table 1.)

Discord in Diagnosis: In 19 out of 258 patients i.e. (7.36%) the physician and the psychiatrist had different opinions about the diagnosis and therefore these patients were excluded from further analysis.

"Other" refers to 5 patients who had sought medical examination for administrative purposes and were not ill either physically or psychologically and therefore were excluded from further analysis.

Sex differences in Organic/Functional grouping: A highly statistically significant finding was that more females were diagnosed as suffering from a functional illness as compared to males. In our study females have tended to show a greater tendency to somatization as seen in Table 4, Group B. This could probably be one of the reasons for more psychologically ill females attending the General Medical out-patient department. We feel that males may perhaps have a better knowledge of the working of a big general hospital and may get directed

Table 1

	Total patients seen	Group 'A' Organic	Group 'B' Functional	Group 'C' Combined	Discord in diagnosis	Others
Male	152	95	27	16	10	4
Female	106	45	36	15	9	1
Total	258	140	63	31	19	5

χ^2 test Male/Female, Organic/Functional $p<.001$ highly significant.

to the appropriate department, or may not be seeking consultation at general hospitals for milder and chronic physical complaints of psychological origin and hence their numbers may have been smaller in this study leading to the statistically significant finding.

Diagnosis in the Organic Group: 140 patients in Group 'A' suffered from a variety of diseases involving all bodily systems. This is in keeping with the pattern of diseases seen in a general hospital O.P.D. Acute Upper Respiratory Tract Infections (32 patients) was the single largest disease entity. If such acute infections are excluded then the proportion of the psychiatrically ill patients shows a marked rise. 32 different diagnosis were made in these 140 patients ranging from common conditions like Amoebic colities (15 cases) and Pulmonary Koch's (16 cases) to uncommon ones like renal calculus, spasmodic torticollis, intracranial tumour and carcinoma tongue (one case each).

Table 2
Diagnosis, Group 'B' Functional

	Male	Female	Total
Anxiety Neurosis	18	15	33
Depressions (Neurotic + Endogenous)	9	17	26
Hysterical Neurosis	0	3	3
Hypochondriacal Neurosis	0	1	1
Total	27	36	63

Diagnosis in the Functional Group 'B': As would be expected Neurotics constituted the functional illnesses. Neurotics with somatic complaints are likely to seek help for the same. Our findings are in keeping with those of Nikapota (1981), Kessel (1960) and Goldberg (1972) who too found anxiety neurosis and hypochondriasis to be the main diagnosis.

Diagnosis in Group 'C'—Combined Group: The organic diagnosis in this group of 31 patients were as follows:

Upper Respirator Tract Infections (5), Pulmonary Koch's (4), Amoebic colitis (11), Bronchial Asthma, Gastritis, Angular stomatitis, Bronchitis, Urinary Tract Infections, Amoebic Hepatitis, Cancer Cervix, Hypertension, Ischaemic Heart disease, Osteoarthritis and Epilepsy (1 each). The psychiatric diagnosis in this group were as follows: Anxiety Neurosis (8 males & 7 females), depression (Neurotic + Endogenous) – 7 males & 8 females and 1 male had Schizophrenia.

Presenting complaints: At the beginning of each interview the chief complaints or symptoms for which the patient was seeking relief were noted by the interviewers. It is on the basis of these presenting complaints that patients get directed to different departments in the hospital. An analysis of these presenting complaints would be of value in finding out why functional patients do not reach the psychiatry out-patient department.

Our total group of 234 patients (of 258 included) reported a sum of total of 545 presenting complaints, the arithmetical mean being 2.33 per patient. For ease in analysis and understanding, these complaints were classified into 8 groups – Fever, complaints referring to the chest (heart and lungs), pertaining to the G.I. tract, pertaining to the whole body i.e. general somatic, pertaining to the head, the central nervous system etc.

Functional Group 'B' patients reported more (average 2.73) chief complaints as compared to Organic Group 'A' (average 1.96) patients. The combined Group 'C' – stands between Group 'A' and Group 'B' in the average number of presenting complaints per patient.

Psychological presenting complaints (75) were ranked third behind chest

Table 3
Comparison of Presenting Symptoms

	Group 'A' Organic n = 140	Group 'B' Functional n = 63	Group 'C' Combined	Statistical significance Group A v's Group B	Statistical significance Group A v s Group C	Statistical significance Group B v s Group C	Total N = 234
1. Chest	81	37	14	n.s	n.s	n.s	132
2. Fever	59	0	4	Significant	$p < .001$	-	63
3. Gastrointestinal	24	9	15	n.s	$p < .001$	$p < .001$	48
4. General Somatic	48	31	18	n.s	$p < .05$	n.s	97
5. Head and C.N.S.	21	19	2	n.s	$p < .001$	n.s	42
6. Psychological	5	43	27	$p < .01$	$p < .001$	$p < .05$	75
7. Sleep Disturbances	14	33	17	$p < .001$	$p < .001$	n.s	64
8. Others	23	0	1	$p < .001$	-	-	24
Total	275	172	98				545

Average number of presenting symptoms per patient - 2.33
Average number of presenting symptoms - Group A - 1.96
Average number of presenting symptoms - Group B - 2.73
Average number of presenting symptoms - Group C - 2.18

complaints (132) and general somatic complaints (97) in the rank order of chief symptoms. This means that even in a busy outpatient department patients do mention their psychological symptoms like anxiety, apprehension, irritability and worry. If the physician is attentive he will be able to follow this clue in detail and thus pick up a large percentage of the functional group without subjecting them to unnecessary and avoidable investigations.

The nature of presenting complaints are different in group A and group B. Fever is a characteristic and distinguishing 'organic' complaint. Symptoms related to the chest like pain, cough, breathlessness, palpitations, etc. gastrointestinal symptoms like gaseous distension, indigestion, belching, passing flatus, pain in abdomen, diarrhoea, nausea, vomiting and general somatic complaints including tiredness, bodyache and fatigue cannot distinguish between group A and group B. Symptoms related to the head and central nervous system like headache, tingling and numbness, throbbing in the head, psychological symptoms like worry, anxiety, apprehension, irritability and sleep disturbances are characteristic of the functional group to a statistically significant degree.

As seen in Table 3, group C differed markedly from the organic group A in their presenting complaints. Group B and group C resemble each other except that gastrointestinal upsets are more in combined group C than in either group A or group B and frank psychological complaints as presenting symptoms are more in the functional group to a statistically significant degree. From the symptom profile it is possible to hypothesize that the combined group C consists of patients with longstanding untreated psychiatric illness with an organic illness of acute onset for which they have sought treatment at the time of examination. In group C the role of psychological stress affecting the immune response and increasing vulnerability to physical illness appears to be of importance.

Sex Differences in presenting comlaints

In group A there were no intra-group

Table 4
Sex Differences in Presenting Complaints

	Male	Female	Total	Statical significance
Group 'A'	n = 95	n = 45	n = 140	n.s. in all symptom groups.
Group 'B'	n = 27	n = 36	n = 63	
General Somatic	9	22	31	$p < .05$ n.s in the rest of the symptom groups.
Group 'C'	n = 16	n = 15	n = 31	
Chest	11	3	14	$p < .01$
Gastrointestinal	1	10	15	$p < .05$ n.s in the rest of the symptom groups.

sex differences of any significant degree with reference to presenting complaints. In the functional group B women reported more general somatic complaints like bodyache, lassitude and fatigue to a statistically significant degree. In the rest of the symptom groups the sexes were more or less alike. In the combined group C men reported more chest complaints and women more gastrointestinal complaints to a statistically significant degree.

Overall Psychiatric Morbidity: We found 24.4% of 258 patients to be suffering from a purely psychiatric problem and an additional 12% to have an associated psychiatric disorder bringing the overall morbidity to 36%. Krishnamurthy et al (1981) estimated the morbidity to be 36% in a general practice.

Kessel (1960) found the psychiatric morbidity in a London general practice to be 14%. Shepherd et al (1966) using the Cornell Medical Index to detect functional illness found 35% of patients in general practitioner's clinic to be psychiatrically ill. Nikapota et al (1981) report a psychiatric morbidity of 21% from an out-patient population of a general hospital in Sri Lanka which is comparable to our 24.4% pure psychiatric morbidity. Goldberg (1972) using the General Health Questionnaire estimated the morbidity to be 44%. Compared to the questionnaire technique used by many workers and by ourselves in the past, the present methodology of double physical and mental status examination by a physician and a psychiatrist independently is much more sound and reliable. Diagnostic discordance was seen in 19 (7.3%) of 258 cases, which is very small because rigorous follow-up and investigations were carried out in all cases to establish the diagnosis. That a significant number of general medical out-patients actually need psychiatric treatment should be brought to the notice of medical administrators, specialists in other fields and medical teachers, because directing these patients to the proper department will save an immense amount of time and money spent on fruitless investigations and non-specific treatments.

Improvement on this methodology could be effected by adding psychometric investigations for detailed psychological assessment and by having a four-week follow-up on all cases.

Somatic complaints in 'functional' patients: In the functional group B, 96 out of 172 presenting complaints were somatic in nature. On an average the functional patient had 2.73 chief complaints of which 1 or 2 are found to be somatic in nature. Unnecessary and avoidable investigations are usually carried out to establish the functional nature of these complaints though no corresponding clinical signs can be elicited. Viewing these somatic complaints against a psychological background and a gentle exploration of the patient's life can prevent

the physician from being led astray by these somatic symptoms.

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