ASPECTS OF PSYCHIATRIC MORBIDITY IN THE OUT PATIENT POPULATION OF A GENERAL HOSPITAL IN SRI LANKA

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SUMMARY

A psychiatric morbidity study of a general hospital outpatient department population in Sri Lanka was done.

A two stage sampling method was used. Questions which differentiated the psychiatrically morbid group were identified. The disease pattern was compared and contrasted with that presenting at psychiatric facilities in the area.

Neurotic illness, the commonest being hypochondriasis was found to predominate in the general outpatient psychiatrically ill population in contrast to the population at in and outpatient psychiatric facilities where schizophrenia was the major diagnostic category.

Psychiatric services, as part of the Government Health structure have been present in some form since 1882 in Sri Lanka.

At present there are two large Mental Hospitals near Colombo and twelve psychiatric units attached to District General Hospitals in the country. Awareness of psychiatric illness is growing particularly with regard to psychotic illnesses. The psychotic patient is almost invariably recognised as such and taken for treatment to a medical practitioner (Allopathic system) whether Government or private, or to an Ayurvedic practitioner. Exorcism for possession state may also be done. Similar awareness for neurotic illness does not exist. A large number of neurotic ailments may well be treated for physical disorders by medical practitioners.

The institution in this study is the General Hospital, Colombo (the premier hospital in the Island). An average of 3000 patients per day present at the general out patient Department (O.P.D.) of this hospital to be seen by Medical Officers (M.O., O.P.D.) who may treat them, or refer them to specialised facilities.

Methodology

3000 patients were interviewed by Research Assistants by means of a questionnaire. Patients questioned were selected randomly over a period of two months from the new patients registered at the O.P.D. 35% of these patients who scored more than a predetermined cut off score were randomly selected and referred for psychiatric interview.

A standard psychiatric interview was conducted by one of the investigating psychiatrists. Diagnostic criteria and Classification used were according to the International Classification of Disease—9 (W.H.O.) The questionnaire was available in all three languages commonly used in the country, i.e. Sinhalese, Tamil and English. The questionnaire used was adapted from

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a questionnaire for neurotic symptoms which had been validated for a Sri Lankan population. The sensitivity and specificity of the questionnaire and cut off score was tested on a group of psychiatric patients and normal controls (N=300 for both groups), and in a pilot study done on a random sample of out patients (similar to the main study group). [50% of those scoring above and below the cut off score (Group 1 and 2 respectively) were given a psychiatric interview. 60% of Group 1 were, in the pilot study, found to be suffering from some degree of psychiatric disability, as opposed to 3% of Group 2.

The same psychiatrists (A.D.N., V.P., S.F.,) conducted the psychiatric interviews for the pilot and main study. Inter-rater reliability was found to be high.

A simple census including diagnosis of patients attending the University Psychiatric Clinic and the Psychiatric Ward, General Hospital Colombo during these two months was also done.]

RESULTS

38% (1145) of the 3000 patients interviewed scored above the cut off point on the screening questionnaire. 35% (405) of these 1145 patients were randomly selected and given a psychiatric interview.

TABLE 1—Results of psychiatric interview (N=405)

| Diagnosis                        | Total | Percentage |
|----------------------------------|-------|------------|
| Having a purely psychiatric Disorder (Gr. A) | 225   | 55.6       |
| Psychiatric and Physical (Gr. B)  | 55    | 13.6       |
| No Psychiatric Disorder (Gr. C)  | 125   | 30.8       |

Group B consisted of 55 patients with symptoms of anxiety or depression of some severity associated with physical disorders such as anaemia, malnutrition, Addisons disease, rheumatic fever and several with pyrexia of more than one week's duration.

27 patients in Group C had feelings of anxiety and depression related to recent environmental stress, not of a severity to include in Group A and apparently unrelated to their physical illness.

There were 43% male and 57% female in Group A subjects, whereas in the Group C subjects, there were 47% male and 53% female, 65% of the subjects were ever married in Group A and 35% were never married. On the other hand in Group C 50% subjects were ever married and 50% were never married. The mean age of Group A and C was found to be 34 years and 28 years, respectively.

Number employed, education and income levels were similar to that found in the main population, and there was no difference between Groups A and C.

Diagonsitic break up is given in Table-2.

TABLE 2—Diagnostic break up of group A

| Diagnosis                        | Total | Percentage |
|----------------------------------|-------|------------|
| Hypochondriacal Neurosis         | 81    | 36.0       |
| Anxiety Neurosis                 | 56    | 25.0       |
| Hysterical Neurosis              | 6     | 2.6        |
| Obsessive Compulsive Neurosis    | 5     | 2.2        |
| Sexual Dysfunction (Psychogenic) | 3     | 1.4        |
| Adjustment Reaction              | 8     | 3.5        |
| Reactive Depression              | 29    | 13.0       |
| Endogenous Depression            | 9     | 4.0        |
| Schizophrenia                    | 6     | 2.6        |
| Alcohol and Drug Dependence      | 12    | 5.3        |
| Other—Epilepsy, Mental Subnormality, Personality Disorder | 10 | 4.4 |

Total 225 100.0

70% of patients with hypochondriacal neurosis, 62% of patients with anxiety neurosis and 59% of patients with reactive depression were female. In contrast 55% of patients with endogenous depression were male. All patients with hysterical neurosis were female, and those with obsessive compulsive neurosis were male.
Alcohol and drug dependence were also observed only in the male patient population.

The percentages shown in Table 2 give the psychiatric morbidity profile for Group A i.e. the psychically ill population identified from 405 patients. These 405 patients were randomly selected from 1145 patients identified by the two stage sampling method used.

Thus, it can be estimated that perhaps 21% of the 3000 patients in the original sample were suffering from a psychiatric disorder.

Table 3 & 4 show the distribution of different demographic variables in various diagnoses.

### Table 3—Demographic variables in different diagnoses

| Diagnosis                  | Never Married | Married |
|----------------------------|---------------|---------|
|                            | M  | F  | M | F |
| Hypochond Neu. (N=81)      | 9  | 12 | 17 | 43 |
| Anxiety Neu. (N=56)        | 13 | 10 | 8  | 25 |
| Hysterical Neu. (N=67)     | --- | 2  | --- | 4 |
| Obs. Comp. Neu. (N=5)      | 2  | --- | 3  | --- |
| Sexual Dysfunction         | (N=3) | 1  | --- | 1  |
| Adjustment Reaction        | (N=8) | 5  | 1  | 1  |
| Reactive Depression        | (N=29) | 4  | 3  | 8  |
| Endogenous Dep.            | (N=9) | 2  | 1  | 3  |
| Schizophrenia              | (N=6) | 2  | 4  | --- |
| Alcohol and Drug           | --- | --- | 12 | --- |
| Dependence                 | (N=12) | --- | --- | --- |
| Other—Epilepsy, Mental Subn. | (N=10) | 4  | 6  | --- |
| Total                      | 42 | 39 | 53 | 91 |

### Table 4—Numbers in each diagnostic category

| Diagnosis                  | Age in yrs. |
|----------------------------|-------------|
|                            | 15-25 | 25-35 | 35-45 | 45-55 | 55 & over |
| Hypochondriacal Neurosis   | 11    | 35    | 19    | 12    | 4         |
| Anxiety Neurosis           | 23    | 23    | 6     | 3     | 1         |
| Hysterical Neurosis        | 5     | 1     | ---   | ---   | ---       |
| Obsessive Compulsive Neurosis | --- | 2     | 3     | ---   | ---       |
| Sexual Dysfunction         | 1     | 2     | ---   | ---   | ---       |
| Adjustment Reaction        | 6     | 2     | 8     | 2     | 3         |
| Reactive Depression        | 5     | 11    | 8     | 2     | 3         |
| Endogenous Depression      | ---   | ---   | 5     | 3     | 1         |
| Schizophrenia              | 2     | 3     | 1     | ---   | ---       |
| Alcohol and Drug Dependence | ---  | 1     | 5     | 6     | ---       |
| Other—Epilepsy, Mental Subn. | 4    | 5     | 1     | ---   | ---       |

### Table 5—Psychiatric morbidity profile in Group A, University Psychiatric Clinic and in the Psychiatric Ward, General Hospital, Colombo

| Diagnosis                  | Group A Clinic (N=225) | Psychiatric Ward (N=400) |
|----------------------------|------------------------|--------------------------|
|                            | %                      | %                        |
| Hypo. Neu.                 | 36.0                   | 3.6                      |
| Anxiety Neu.               | 25.0                   | 4.4                      |
| Hyst. Neu.                 | 6.6                    | 10.0                     |
| Obs. Comp. Neu.            | 2.2                    | 1.0                      |
| Sex. Dys.                  | 1.4                    | 1.0                      |
| Adj. Rea.                  | 3.5                    | 1.0                      |
| Reactive Dep.              | 13.0                   | 5.0                      |
| End. Dep.                  | 4.0                    | 7.5                      |
| M. D. P.                   | ---                    | 9.5                      |
| Schiz.                     | 2.6                    | 58.0                     |
| Alcohol and Drug Dependence| 5.3                    | 1.0                      |
| Other—Epilepsy, Mental Subn.| 4.4                   | 8.0                      |

| Diagnosis                  | Group A Clinic (N=225) | Psychiatric Ward (N=400) |
|----------------------------|------------------------|--------------------------|
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| Reactive Dep.              | 13.0                   | 5.0                      |
| End. Dep.                  | 4.0                    | 7.5                      |
| M. D. P.                   | ---                    | 9.5                      |
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DISCUSSION

Psychiatric morbidity studies in Sri Lanka have been few in number. The most comprehensive of these by Wijesinghe (1978) gives a prevalence of 25.2 per 1000 for neurotic illness and 3.8 per 1000 for schizophrenia.

Experience in psychiatric clinics gives a definite impression that neurotic patients form a minority of patients seeking treatment, and that awareness and recognition of neurotic illness among medical personnel and the public was low. Increase of such awareness could mean that the psychiatric services would find difficulty in coping with the demands made by the treatment of such patients.

The questionnaire used, was adapted and modified by the investigators from a questionnaire validated for a Sri Lankan population. The technique for studying psychiatric morbidity described by Wing (1976) and the screening instruments currently being used in the W.H.O. Collaborative Study on Extending Mental Health Care were also studied and considered for this purpose.

A system of private medicine consisting of general practitioners and specialists exists in Sri Lanka. The population presenting at the O.P.D. for treatment would not therefore represent the socio-economic structure prevalent in the community, but would be specifically drawn from the lower income groups in and around Colombo.

On reviewing the results obtained we found that approximately 21% of the O.P.D. patients had a psychiatric disorder.

Hypochondriacal neurosis accounted for 36% and anxiety neurosis 25% of the psychiatric patients identified. These two disorders accounted for 50% of the morbid group in the Wijesinghe study although the relative preponderance was reversed, anxiety neurosis being the commonest disorder found—35%. Trends by age and sex were similar in both studies—a preponderance of married women in hypochondriacal and anxiety neurosis. Alcohol dependance was observed only in males in both studies probably due to socio-cultural practice in this country.

The differences in the number of married people in Group A compared to Group C should not lead one to infer that marriage is aetologically related to neurotic illness. It may be noted that the population in this study was not socio-economically favoured. It may be that marital responsibilities associated with socio-economic disadvantage is a relevant factor.

A study of Chowdhury (1979) in Bangladesh studying psychiatric morbidity in patients at a medical out-patients department gave a higher figure of 31.4% for psychiatric disorder classified as purely psychogenic as compared to 21% in this study. Of these 50% had neurotic illnesses, anxiety neurosis forming the largest group—56.9%. Hypochondriacal neurosis accounted for only 3% and sexual disorder 21.8%. It is difficult to explain this difference from the Sri Lankan figures as reasons could include cultural and diagnostic differences.

The morbidity profile of patients attending the University Psychiatric facilities shows a preponderance of schizophrenic patients (Table 5). In the Census Study of Mental Hospitals Angoda and Mulleriyawa (Nikapota, 1979) neurotic illness was not represented as a diagnostic category and schizophrenia accounted for 59% of recent admissions.

There needs to be more morbidity studies of hospital and community populations. Nevertheless on the basis of the figures in this study, it is reasonable to assume that a large number of neurotic patients do not reach a psychiatric facility even though they may present at a health facility with a psychiatric facility attached, for treatment. This is seen in the morbidity profile of the O.P.D. population studied, as compared to the patients at the Psychiatric
Clinic.

In the Wijesinghe study (1975) 95-98% of patients with anxiety neurosis and hypochondriacal neurosis had not received psychiatric treatment in contrast to schizophrenics of whom 80% had received psychiatric treatment. These figures serve to emphasise the difference in awareness and recognition of psychotic as opposed to neurotic illness prevalent in the country.

A possible reason for the non-recognition of neurotic illness could be identified when considering the presenting symptoms of the psychiatrically morbid group in this study, and the questions which differentiated them from the physically ill group. Symptoms relating to mood would be recognised as being psychiatric in origin but not the somatic symptoms. The results show that several somatic symptoms did significantly differentiate the psychiatric patient. These symptoms are known to be part of the clinical picture of anxiety state, hypochondriasis and depression. They are however not perceived to be psychiatric in origin by patients or the Medical Officers treating them. A lack of awareness of the physical manifestations of neurotic illness could contribute to the relatively small number of neurotic patients seen in specialised psychiatric facilities, and the small number referred by M.O., O.P.D.'s.

In conclusion, a majority of patients with neurotic illnesses were found among the psychiatrically ill population presenting at the O.P.D. of a General Hospital, but this is not reflected in specialist psychiatric facilities, perhaps because of non-recognition of the nature of the illness. Practical action to meet the needs of this patient group may include the development of a greater degree of psychiatric expertise by all medical personnel, and the reorganisation of the work load of existing psychiatric out-patient facilities, to include the treatment of a large number of patients with neurotic illness.

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