At the outset, I would like to express my deep gratitude to the distinguished membership of the Indian Psychiatric Society for giving me an opportunity to deliver Dr D L N Murthy Rao Oration. Dr Murthy Rao was one of the foremost psychiatrists in our country and as a Professor and Director of the National Institute of Mental Health and Neuro-Sciences, Bangalore, he not only trained many eminent psychiatrists, but was also instrumental in setting good traditions in academic psychiatry. I had the honour of meeting Prof. Murthy Rao and listening to him in 1962 when he visited the Central Institute of Psychiatry at Ranchi.

As a part of my tribute to Dr Murthy Rao, I have chosen the theme of psychosocial problems in primary health care for this Oration. I believe this area is emerging as one of the prominent fields in contemporary psychiatry, and which is going to have its impact on our understanding the etiology of mental illness, its phenomenology, and its management.

The concept of psychosocial problems in Primary Health Care is relatively a new one. It is based on the assumption that unlike physical and psychiatric illness, some illnesses originate due to various psychosocial stresses which an individual encounters in his day to day life. Right from the time of Virchow and Ehrlich the basic principle in traditional concept of disease is that a pathology lies in an organ or a system of an individual and consequently an attempt is made to treat the pathology. The nature of such pathology could be infective, metabolic, nutritional, degenerative or malignant in nature. The organs affected may be the heart, lungs, liver, brain, skin and may involve one or more systems. Based on similar concepts, in the field of psychiatry also, there are multitudes of conceptual frameworks regarding aetiopathogenesis of mental disorders. Depending on the theoretical school one adheres to, the psychopathology of various disorders may be attributed to be arising in the individual and in his mind. The resultant manifestations could be a product of conscious or unconscious forces or a part of a maladaptive learnt behaviour or it may be just an existential dilemma. It may also arise from faulty interplay of biological factors and psychosocial determinants.

The Primary Health Care can be described as essential health care based on practical, scientifically sound and socially acceptable methods made accessible to individuals and families in the community. It is related to the overall social and economic development. On the one hand it influences the socio-economic growth and on the other it is influenced by the socio-cultural milieu of the given society. (WHO 1978). As such, Primary Health care has a cultural component which varies

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strongly in different cultures. This function becomes more clear when people without an identifiable organic disease but with life problems, emotional problems and presenting with vague, ill defined functional complaints enter the medical system and create a dilemma to the physician. This dilemma of patients presenting with somatic symptoms with no detectable organic basis is not uncommon in a primary health care setting. These complaints are often confusing to the primary health care physician, which he/she wants to identify in early stages either as organic, psychiatric or other functional disorders, based on his perceptions, past experiences and level of understanding. In keeping with these he/she makes an attempt to treat these conditions. It is thus a boundary between the medical system and society.

Pathogenic psychosocial environment

In psychosocial problems an individual may present with physical and/or psychological complaints which may generally be vague, ill-defined and may not resemble any known physical diseases. Unlike the traditional organic or psychiatric disorders, the pathology in such cases is not in heart, liver or brain or any other system of the individual. On the contrary, it primarily lies outside the patient in his psychosocial environment. For example, a woman may go to the family physician with vague, ill-defined aches and pains associated with insomnia, irritability and fatigue. On enquiry, it may be revealed that her husband is an alcoholic, beats her and children, and does not support the family. When she is unable to cope with the problem and to find a solution, she develops some vague mental and somatic symptoms depending upon the vulnerability of an organ or a system, and the previous experience to express her distress. It is interesting to note that such somatic or mental symptoms may be present in depression, anxiety, and other psychosomatic diseases also. In each of these conditions the somatic symptoms may be often quite different from each other. During the initial stages of assessment, it may be difficult to differentiate between them. However, it may be possible to make some differentiation in such varied manifestations. Generally, the somatic symptoms in anxiety are related to autonomic hyperfunction, while in hysteria these may mimic a physical illness without its genuine associated features. In depression, somatic symptoms may be associated with sad moods, crying spells and poor sleep. In all these cases, the common feature is that the primary pathology lies within the individual’s body or mind and also in psychosocial environment.

Let us look at this aspect in the perspective of differential diagnosis in Somatoform disorders. Sometimes, such patients' somatic problems may represent one of the Somatoform disorders, which as defined in DSM III Manual, could include somatization disorder, hypochondriasis, psychogenic pain and conversion disorder (Table 1).

| Table 1 | Differential diagnosis in Somatoform disorders |
|---------|-----------------------------------------------|
|         | Age       | Sex          | Nature         | System       |
| Somatization disorder | Usually 30 years | Mostly females | Chronic/relapsing | Usually multisystem |
| Hypochondriasis | Middle age | Both sexes | Chronic, non-relapsing | May be one or more |
| Conversion disorder | Both ends of life | Mostly females | Acute | One system |
| Psychogenic pain disorder | More females | Acute | One system |

It is generally recognised that a somatization disorder is primarily a chronic psychiatric condition that begins before the age of 30 years. Patients with this
disorder report multiple somatic problems for which there is no adequate medical explanation. In such cases, the duration and type of the symptoms and the patient's age at the onset are mostly helpful in distinguishing among the somatoform disorders. But the question arises whether such disorders are common in our culture and also whether the manifestations of somatoform disorders are universally consistent? Let us compare it with hypochondriasis. It can occur at any age but it is most common in middle and old age. It occurs at equal frequency in men and women unlike somatization disorder which occurs almost exclusively in women and frequently begins in adolescence. Further, in patients with hypochondriasis the normal physiological sensations are often misinterpreted as indicators of disease. In these hypochondriacal cases, the patient is morbidly concerned with his/her health and believes that he/she has some specific disease. Contrarily, somatization disorder is a chronic relapsing disorder manifested by recurrent, excessive multisystem symptoms. How much such clearcut differences are seen in a health care setting is a matter of debate and needs both elaboration and confirmation, as there are no studies to support regarding the reliability and validity of occurrence in varied cultures. As far as conversion symptoms are concerned, the problem is not as difficult and complex. In conversion disorder, the symptoms are relatively persistent losses or alterations in sensory or voluntary motor functioning that cannot be explained by known physical disorders or pathophysiologic mechanisms. Conversion symptoms such as paralysis, blindness may occur as a part of a medical, neurologic or psychiatric disorder. When they occur by themselves, they are called conversion disorders. However, inspite of such limitations there is less controversy in diagnosing conversion disorders. It is also noteworthy that the incidence of such conversion disorders may vary from one culture to another. Let me conclude this argument by referring to psychogenic pain. In some patients, when unexplained pain is the predominant symptom and its nature is severe and prolonged the diagnosis of psychogenic pain is usually considered. But it is generally recognised that the subjective perception of pain and threshold of pain is influenced by personality factors; it varies not only from individual to individual but also from one culture to another.

Notwithstanding the above elaboration, the concept of psychosocial problem has not as yet clearly been delineated and it needs more understanding and elucidation, both about its nature and its myriad forms of manifestation.

**Salient characteristics of psychosocial problem**

The basic concept of a traditional illness is that the individual suffers from some pathology which may be in an organ or a body system which causes dysfunction, disability and pain to that individual. This basic premise is applicable both in the organic and psychiatric disorders. In psychosocial illness also, the individual suffers from a disability, distress or pain but unlike the traditional illness, the primary pathology is outside the individual, and due to this pathology, one or the other organ or a system may be affected by such pathology (Table 2).

Basically, the psychosocial problems have certain salient characteristics. The physical symptoms in these cases are vague, ill-defined and often fleeting. They are changeable and present in one form or another for a short or long time. There is always an associated stressful precipitant factor. The symptoms become more
Table 2
Concept of Psychosocial illness and Traditional illness

| CONCEPT OF ILLNESS |                      |
|-------------------|---------------------|
| Psychosocial illness | Traditional Illness |
| No primary pathology within | Primary pathology within |
| Individual distress | individual dysfunction |
| ↑                  | Organ (CNS)          |
| ↓                  | or system            |
| Pathology outside  | Biochemical          |
|                    | Degenerative         |
|                    | Malignancy           |
|                    | Trauma               |
|                    | Infections           |
|                    | Other physical causes|
|                    | Psychological        |

marked with rising stress and are linked with rising stress and are linked with continuation of stress. There is a clear time relationships between the initiation and continuation of the symptoms and the presence of psychosocial stress. The person suffering from these disorders may have an anxious, immature or a demanding personality. It is believed by most research workers in this field that such psychosocial problem behaviour can be differentiated from traditional illness behaviour. It is well known that all people with illness or illness feeling do not show illness behaviour. Illness behaviour relates to those occasions or situations, where someone assumes that he is suffering from illness, adopts the role of a patient and thus seeks help from a professional about situation which he/she is unable to understand the cope with.

Some of the more prominent criteria for recognition of psychosocial problems could be identified as given below:

i) The origin of symptoms is closely related to psychosocial factors.

ii) There is a direct relationship of complaints to psychosocial situations.

iii) There is a conspicuous absence of any identifiable physical or psychiatric illness.

iv) The routine diagnostic investigations are negative.

v) There is a clear time—relationship with stress in life.

The above mentioned guidelines may be of particular help to the physicians working in a primary health setting in identifying and diagnosing such cases. An understanding of the different dimensions of symptomatology in the primary health care setting can be helpful. These are given in Table 3.

Incidence of psychosocial problems

It is now recognised that the number of such patients having psychosocial problems and who come to a primary health care setting is vast (Barsky & Kleerman 1983; Kebbon et al. 1985). Yet, its prevalence in P.H.C. settings appears to be relatively less known because it has been
scantly investigated. According to authors like Martin et al. (1957), the prevalence was found to be as low as 4%, while Johnston and Goldberg (1976) found it as high as 32%. An average rate of 20–25% of such problems has been reported by other workers (Stewart et al. 1975; Wolfe and Badgley 1972; Lamberts 1975). This variation may partly be due to the reason that usually in psychosocial problems the individual presents with vague, ill-defined, single or multiple complaints without an identifiable organic or psychiatric illness. Sometimes these may present a predominantly somatic picture and at other times these may be manifested in the form of functional disorders. It is estimated that at least 20–25% of illness behaviour in P.H.C. setting cannot be explained on the basis of detectable and known physical or psychiatric illnesses. It has also recently been reported by some investigators from different countries in South East Asia that 12–24% of the patients visiting P.H.C. physicians were having somatic complaints without having any known or underlying organic disease and with history of having significant stressors in their life situations (WHO SEARO, 1986).

Though these figures do not represent hard epidemiological data, yet these give a fairly good idea of the extent of the problem and suggest the need for further research in this regard. Such problems are often undiagnosed or misdiagnosed and result in unnecessary investigations and wasteful prescriptions. Though the boundaries in psychosocial problems are not clear and not well delineated but the problem cannot be denied and its magnitude underestimated.

A schematic representation of the above mentioned facets of psychosocial problem is given below in Table 4:

**Empirical study – Ranchi data**

To understand this problem, an empirical study was undertaken at Central Institute of Psychiatry, Ranchi with a view to assessing the prevailing diagnostic and
Table 4
Facets of Psychosocial Problems

| Vast Magnitude          | Diagnostic Problems |
|-------------------------|---------------------|
|                         | (Undiagnosed/Misdiagnosed) |

Facets of Psychosocial Problems

| Unnecessary Investigation | Unwarranted Treatments |
|---------------------------|------------------------|
|                           | (Vitamins, Tonics Etc) |

therapeutic strategies used towards patients with basically psychosocial problems in a PHC setting. For the purpose of the study, a psychosocial disorder was defined as one in which stress in environment or in the immediate life situation of a patient could be contributing significantly towards causation and continuation of disorder. Cases were included in the study where a sensitised/trained primary health care physician and the investigator agreed on psychosocial caseness using a standardised flow-chart. The patients were seen by the PHC physician and the investigator together and the outcome as to the PS-caseness was then compared. All cases, where there was an agreement on PS-caseness, were included in the study.

25 consecutive cases identified as PS cases were included in Group ‘A’. These patients were kept as control group. No therapeutic intervention was made in these cases, and no influence was exerted on their utilisation of health facilities and the treatment they were receiving. However, these cases were evaluated at 3, 7 and 11 weeks interval from the time of first contact. Later, more patients identified as PS cases were randomly divided into B, C and D groups. The sequence of treatments of B, C and D groups was prearranged at random and both the PHC physician and investigator were blind to the treatment group to which the patient was going to be assigned. After the agreement on PS caseness the treatment was disclosed and the same treatment was prescribed to the patient. The same procedure continued till 25 patients in each group B, C and D were completed.

The sequence of treatment was as given below:

**Group B:** Tab. Diazepam 2 mg. in the morning plus 5 mg. at bedtime for 1 week and 2 mg. at bedtime for the further week. The effectiveness of this regime and the need of medicine over 2 weeks only was emphasised to the patient. Next appointment was given to the patient after 3 weeks and evaluated on that occasion. If the patient did not turn up for appointment, a home visit was made within 3 days and evaluation was made during the home visit. Similarly, the patient was followed up again at 7-weeks and 11-weeks interval from the first contact. In case, any patient had seen other physician or had taken other treatment for the same complaints during the study period, the case was considered as treatment failure and it was transferred to group C or D in a random fashion.

**Group C:** Brief session of counselling/reassurance were given to this group of patients and each session lasted for 4 to 5 minutes. Each patient was regularly reviewed and evaluated at 3, 7 and 11 weeks interval from the time of first contact. If the patient had seen other doctor/or taken other treatment for the same complaints during the study period, the case was considered as treatment failure and the patient was transferred to Group B or D in a random fashion.

**Group D:** The patients in this group were offered Relaxation Therapy. The mechanism of relaxation was explained to each patient and later a brief practical
demonstration of the technique was also given. The follow-up strategy as in the other groups was followed and in the event of consultation with another doctor, the case was considered as treatment failure and the case was transferred to Group B or C in random fashion.

The analysis of results revealed that:

i) The average number of stresses per patient were 1.36 on first contact and 1.31 on third evaluation. No significant change in the stress was found.

ii) The average somatic complaints per patient decreased significantly in each therapeutic group; in Group B the average somatic complaints decreased from 5.27 before intervention to 3.59 after intervention; in Group C the average complaints decreased from 5.09 before intervention to 3.68 after intervention; in Group D the average somatic complaints decreased from 5.35 to 3.88 after intervention. In group A, there was no significant change in the total and average number of somatic complaints which was 4.72 at the first contact and it remained as 4.00 at the end of 11 weeks. There was significant decrease in the number of complaints in each therapeutic group.

iii) Among the 75 patients who were originally selected for therapeutic groups, 60 patients continued till the end of 11 weeks period of follow up. Among these, 21 patients were satisfied with the treatment and 38 patients felt the treatment could be more effective. Only one patient was dissatisfied with the treatment.

iv) In respect of the improvement it was found that 23 patients reported that their condition had improved and 34 patients reported that they had "somewhat improved". 9 patients reported no change. None of the patients reported any worsening of the condition.

v) In the overall assessment it was found that out of 60 patients who continued till the end of 11 weeks, 44 patients were improved and there was no change in the condition of 16 patients. None of the patients became worse among the patients of therapeutic group.

vi) Regarding reduction in working capacity, there was 'nil' to moderate reduction as perceived by patients themselves, but on detailed assessment by the investigator there was no deterioration in working capacity.

vii) On the first evaluation, 3 patients in Group B, 3 patients in Group C, and 7 patients from Group D were identified as treatment failures. Out of 3 patients from Group B, 2 patients were transferred to Group C and 1 patient was transferred to Group D. Out of 3 patients from Group C, 2 patients were transferred to Group B and 1 patient was transferred to Group D. Out of 7 patients from Group D, 6 patients were transferred to Group B and 1 patient to Group C.

From these observations it was clear that all the therapeutic modalities, namely the tranquilisers, psychotherapy and relaxation therapy, yielded equal therapeutic benefits to these psychosocial cases though in the case of tranquiliser group the response to tranquiliser was better initially but after a lapse of 3 months the results were equal to psychotherapy and relaxation techniques. This highlights the simple but significant conclusion about the role of unnecessary medication in this group. It also indicates that cheaper modalities like brief psychotherapy and relaxation techniques are equally effective. In one of the studies conducted by Van Weel Chris
(1980), it was found that the patients reacted positively to group based care approach with consequent reduction in consultation rate, and also in the reduction of prescribing tranquillisers by the general practitioner.

These results also indicate that there is a need to evolve a system that should profitably involve other members of the health care team. These also suggest developing linkages with other social agencies to effectively meet such challenges in patients.

**Recognition of psychosocial problem**

In view of the magnitude of the problem, it is necessary that primary health care workers be made especially aware of the need to communicate with these patients meaningfully and without resorting to prescribing drugs. Recognition of psychosocial problems may increase their readiness to intervene on a social level rather than reinforce “medicalization” of social problems by wasteful prescriptions and unnecessary investigation. In order to recognise the psychosocial problems, the following points may be useful:

1. To identify patients whose somatic complaints are related to psychosocial problems.
2. To recognise the relationship of such complaints to immediate life events or conflictual or stressful situations and relate the meaning of the problem to the individual.
3. To execute minimal physical examination just necessary to exclude obvious organic conditions that could specifically cause the manifested complaints, e.g., visual problems or hypertension in headache, anaemia in weakness etc.
4. To educate such patients and their families on the uselessness of drugs usually given as tonics, vitamins etc.
5. To educate the patients and their families on uselessness of unnecessary laboratory investigations or casual referrals in such cases.
6. To identify the strengths of the individual, and to try to understand the past experiences of the individual in coping with similar situations.
7. To help the patients and their families to overcome the underlying problems by appropriate means through counselling, initiation into simple relaxation, recreation, opportunities for patients to talk about their problems to other professionals.
8. To seek help from other members of health team and develop linkages with social agencies.

It is to be recognised that the psychosocial problems may present as single or multiple complaints, may be of short or long duration, their onset may be sudden or gradual, however, there is a clear time relationship with stress. The identified stress may be related to work or school or its nature may be marital, sexual, financial. It may be related to confidential family situation or to alcohol and drug abuse and to manage them effectively, it is necessary to understand this phenomena by pursuing research in the area.

It has been stated above that due to lack of specificity of the disease, the patients suffering from psychosocial illnesses may make physicians uncomfortable. It may not only make proper diagnosis of the disease difficult but also may create problems in the management of such illnesses. It is obvious that when the problems are new, these cannot be solved with old solutions.

**Need for further exploration**

The attempt of this presentation has been to highlight psychosocial problems and to stimulate interest in the field. It is a
research area that needs to be explored further, both in depth as well as breadth. It can facilitate in finding appropriate intervention strategies to meet this near-challenge or our time.

References

BARSKY, A. J. & KLERMAN, G. L. (1983): Overview, hypochondriasis, bodily complaints and somatic styles. American Journal of Psychiatry, 140, 273-283.

JOHNSTONE, A. & GOLDBERG, D. (1976): Psychiatric screening in general practice. Lancet, 1, 605-608.

KEBBON, L., SWARTLING, P. G. & BJORN, B. (1985): Psychiatric symptoms and psychosocial problems in Primary Health Care as seen by doctors. Scandinavian Journal of Primary Health Care, 3, 23-30.

LAMBERTS, H. (1974, 1975): De Morbiditeit-sanalyse-1972 door de groups-praktijk om- moord: een nieuwe orderin van hickte-en probleengedrag voor de huisartsgeneeskunde.

LAMBERTS, H. (1979): Problem behaviour in primary health care. Journal of Royal College of General Practitioners, 29, 331-335.

MARTIN, F. M., BROTHERSTONE, S. P. W. & CHAVE, S. P. W. (1957): British Journal of Preventive & Social Medicine, 11, 196-200.

STEWART, M. A., McWHINNEY, J. R. & BUCK, C. W. (1975): How illness presents: a study of patient behaviour. Journal of Family Practice, 2, 411-414.

VAN WEEL CHRIS (1980): Group-based care: does it change problem behaviour. Journal of Royal College of General Practitioners, 30, 665-670.

WOLF, S. & BADGLEY, R. F. (1972): The family doctor. Milbank Mem. Fund Qly., 50, 1-201.

WHO (1978): Primary Health Care Report of the International Conf. on PHC. Alma Ata, USSR.

WHO (1986): Collaborative study on mental health in primary health care in six countries. SEARO, WHO, N. Delhi.