Research Article

A study of psychiatric morbidity in patients presenting to secondary health care

Sangram Pundir[1], Jaswant Goyal[2], Saloni Chandalia[1], Barkha Goyal[3], Sumit Gakkhar[1]

[1]Department of Psychiatry, Jaipur National University Institute of Medical Sciences and Research Centre, Jaipur, Rajasthan, India, [2]Department of Pharmacology, Jaipur National University Institute of Medical Sciences and Research Centre, Jaipur, Rajasthan, India,[3]Department of Biochemistry, Jaipur National University Institute of Medical Sciences and Research Centre, Jaipur, Rajasthan, India

Correspondence to: Saloni Chandalia, E-mail: salonichandalia89@gmail.com

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ABSTRACT

Background: There is a reason to believe that psychiatric symptoms and psychiatric disorders are common in secondary care settings though few studies have been carried out. **Objectives:** The objectives of this study were to study the incidence of psychiatric symptoms in secondary care populations and to study the prevalence of psychiatric disorders in patients presenting to secondary care. **Materials and Methods:** A total of 200 patients presenting to secondary care (Medical Outpatient Department) in a large tertiary care Armed Forces Hospital in Mumbai were administered the general health questionnaire (GHQ 28). Those patients who had significant scores on the scale were assessed for psychiatric disorders as per ICD 10 criteria by two independent psychiatrists. **Results:** The incidence of significant psychiatric symptoms in patients presenting to secondary care was 38% as per GHQ 28. The prevalence of psychiatric disorders in secondary care was 26% (depressive disorders 14%, anxiety disorders 8%, somatoform disorders 2%, and alcohol dependence 2%). **Conclusions:** A substantial proportion of patients presenting to secondary care have significant psychiatric symptoms and well-defined psychiatric disorders.

KEY WORDS: Alcohol Dependence; Anxiety Disorders; Depressive Disorders; Secondary Care; Somatoform disorders

INTRODUCTION

Not all human distress is mental disorder. Individuals may be distressed because of personal or social circumstances; unless, all the essential criteria for a particular disorder are satisfied, such distress is not a mental disorder. Mental and behavioral disorders are common among patients attending primary health-care settings though few studies have been carried out in the secondary care setting. When the patient is seen in consultation, he or she may or may not have a psychiatric disorder. The presenting symptoms (anxiety, agitation, depression, hostility, uncooperativeness, or psychosis) may reflect a substance-induced syndrome, an adverse interaction between the patient's psychiatric disorder or personality style and the medical illness, or a manifestation of the medical illness. The subtle and complex interrelationships between psyche and soma require a thorough assessment to identify and clarify cause-and-effect relationships. An assessment of the extent and pattern of such disorders in these settings is useful because of the potential for identifying individuals with disorders and providing the needed care at that level.[1] Studies have shown that Indian populations have a tendency to somatize mental illness due either to stigma or ignorance.[2,3] Hence, it was postulated that among patients consulting a physician, there would be a significant group with psychiatric symptomatology and some with diagnosable psychiatric disorders.

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Objectives

The objectives of this study were as follows:

1. To identify the incidence of psychiatric symptoms in patients reporting at medical outpatient department (OPD) (secondary level).
2. To study the prevalence of psychiatric disorders in patients presenting for secondary care.

MATERIALS AND METHODS

The study design was a cross-sectional descriptive study conducted at a large tertiary care Armed Forces Hospital located in Mumbai. The subject population consisted of service personnel, exservicemen, and their families/dependents. Consecutive patients aged 18–70 years reporting to the medical OPD were informed about the purpose of the study and confidentiality assured. They received an interview covering sociodemographic information, previous medical and psychiatric history, recent symptoms, and general medical status. Those who had a prior psychiatric history, too ill physically or unwilling were excluded from the study. 200 patients were recruited into the study and consent obtained. The study group was administered the general health questionnaire (GHQ-28). Those found to have significant scores on the test were subsequently examined by two independent psychiatrists to arrive at a diagnosis. Data were analyzed to identify the incidence of psychiatric symptoms and the prevalence of psychiatric disorders in the subject population in accordance with the aims of the study.

The GHQ-28 is a self-administered screening test, which is sensitive to the presence of psychiatric disorders in individuals presenting in primary care settings and non-psychiatric clinical settings. The GHQ is not designed to detect symptoms that occur with specific psychiatric disorders but rather provides a measure of overall psychological health or wellness. To assess this, the GHQ focuses on two major classes of phenomena: (i) Inability to continue to carry out normal "healthy" functions and (ii) symptoms of a distressing nature. There are several versions of the GHQ. The GHQ-28 provides four specific subscales: Somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. These subscales do not necessarily correspond to psychiatric diagnoses and nor are they independent of each other. The GHQ is a widely used measure of psychological health, have been translated into 38 languages and used in diverse cultural groups. It has both content validity and construct validity.[4,5]

RESULTS

A total of 200 patients medical OPD (secondary care population) were recruited into the study. All were service personnel, exservicemen, and their families/dependents. There were 106 males (39 servicemen) and 94 females in the secondary care group. There was thus a slight preponderance of males (53%) in the sample. In terms of origin, the sample was drawn from all over India and its distribution was similar to that of the Armed Forces of India. There was a fairly high level of awareness of health-related issues as expected in a group of service personnel and families. Mean age of the group was 46.79 years.

Incidence of Psychiatric Symptoms in Secondary Care Population

There was a high incidence of psychiatric symptoms in the secondary population. On the GHQ-28, a total score of 5 or more is considered significant. The average total score on the GHQ was 6.01. As many as 76 patients (38%) scored more than the cutoff limit of 5 or more on this scale. The incidence of psychiatric symptoms on the GHQ is shown in Figure 1.

Incidence of Somatic Symptoms in Secondary Care Population

The average score on the GHQ somatic symptom subscale was 2.10. A total of 72 patients (36%) scored 3 or more on this subscale and a further 28 had two symptoms on this subscale. The incidence of somatic symptoms in the secondary care population is shown in Figure 2.

Incidence of Anxiety Symptoms in Secondary Care

A high incidence of anxiety symptoms was found in the target population. On GHQ anxiety subscale, the average score was 1.81. A total of 63 patients (31.5%) scored 3 or more and further 26 had two symptoms each. The incidence of anxiety symptoms on GHQ is shown in Figure 3.

Incidence of Depressive Symptoms in Secondary Care

On the severe depression subscale of the GHQ, the average score was 0.58. 14 patients (7%) scored 3 or more on this scale and another 15 (7.5%) scored 2. The incidence of severe depressive symptoms is shown in Figure 4.

Incidence of Social Dysfunction in the Secondary Care Population

On the social dysfunction scale of GHQ, the average score was 1.51 and 52 patients (27%) had a score of 3 or more. The incidence of social dysfunction is shown in Figure 5.

Prevalence of Psychiatric Disorders in Secondary Care Population

Of the 200 patients screened in the secondary care population, 76 patients (38%) had significant scores of 5 or more on

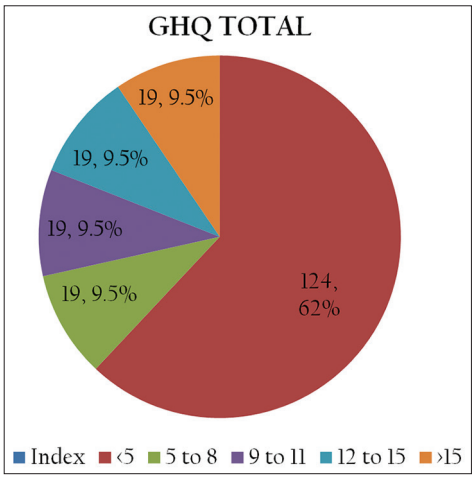

Figure 1: Incidence of psychiatric symptoms in secondary care population

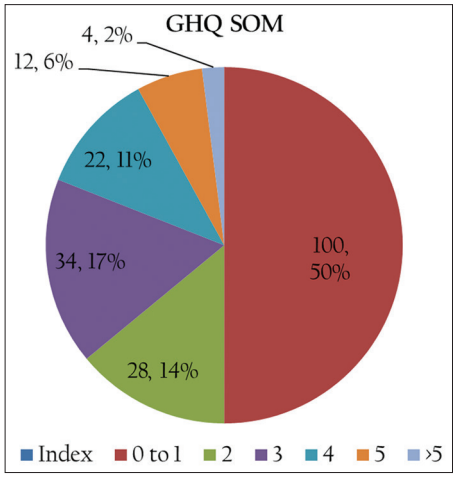

Figure 2: Incidence of somatic symptoms as per general health questionnaire somatic symptom subscale in the secondary care population

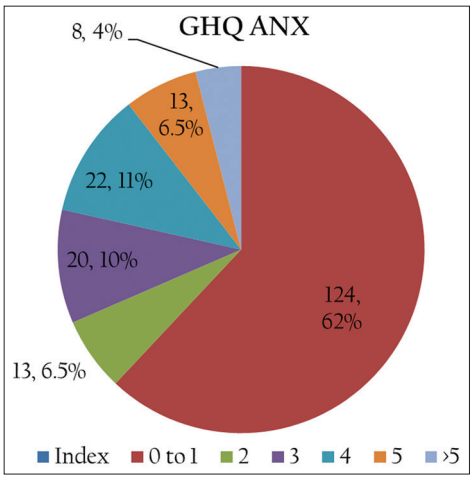

Figure 3: Incidence of anxiety symptoms on general health questionnaire in secondary care

GHQ. Among these, 63 also scores of 63 or more on SCL-90 GSI. These 76 patients were then clinically examined for the presence of a psychiatric disorder as per ICD-10 criteria.

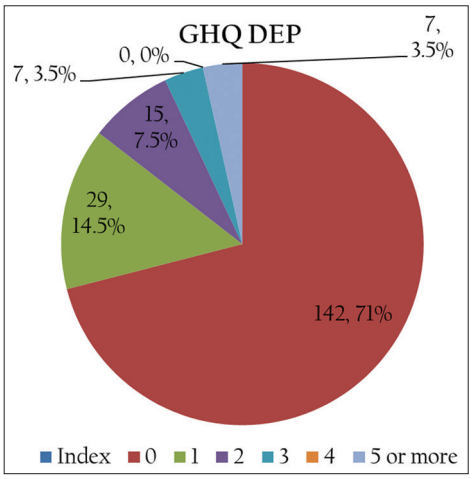

Figure 4: Incidence of severe depressive symptoms on general health questionnaire in secondary care

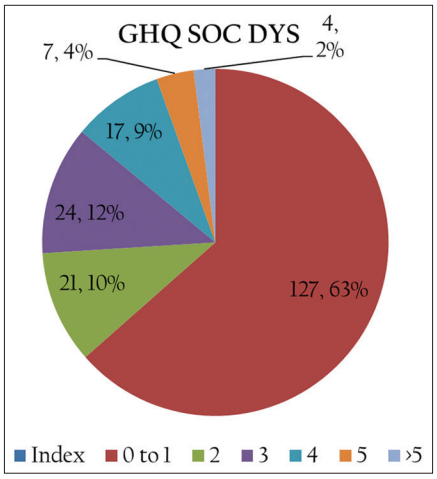

Figure 5: Incidence of social dysfunction in the sample

A total of 52 patients (26%) were found to be suffering from some form of psychiatric disorder. The remaining 24 patients had significant but subsyndromal psychiatric problems. The prevalence of psychiatric disorders in secondary care population is shown in Table 1.

DISCUSSION

The current study was aimed at studying the prevalence of psychiatric disorders in patients presenting for secondary care. In the study, it was found that the psychiatric symptoms were common. The average total score on the GHQ was 6.01, higher than the significant cutoff. 38% of the patients scored more than 5. These figures indicate that the burden of psychiatric symptoms is quite high in the secondary care population. As expected, there was a high incidence of somatic symptoms on the GHQ. 36% of the patients scored 3 or more. These figures indicate that somatic symptoms are very common in secondary care populations. While it may be argued that this is not surprising, considering that physically ill patients are being studied, it is also important to note that

Table 1: Prevalence of psychiatric disorders in secondary care population

Psychiatric disorders	*n* (%)
Depressive disorders	28 (14)
Moderate depressive disorder	7 (3.5)
Mild depressive disorder	13 (6.5)
Dysthymia	3 (1.5)
Mixed anxiety depressive disorder	5 (2.5)
Anxiety disorders	16 (8)
Generalized anxiety disorder	9 (4.5)
Panic disorder	6 (3)
PTSD	1 (0.5)
Somatoform disorders	4 (2)
Somatization disorder	2 (1)
Som autonomic dysfunction	2 (1)
Substance use disorders	4 (2)
Alcohol dependence	4 (2)

PTSD: Post-traumatic stress disorder

especially in India, partly due to the stigma of mental illness, many patients complaint of bodily symptoms rather than psychological ones. Somatization of psychiatric complaints is also common in India.[2,3] On the GHQ anxiety subscale, the average scores were 1.81% and 31.5% of patients scored more than 3 on the subscale. These figures indicate that anxiety symptoms are frequent among secondary care patients. GHQ also has a "severe depression" subscale which deals mostly with suicidal ideation. On this subscale, 7% of patients in the 3 or more. This reflects the fact that only a few patients had moderate depression in the group. In the social dysfunction subscale, 27% had a score of 3 or more. This indicates that significant levels of social dysfunction occurred. The study population had high prevalence rates of psychiatric disorders, 26% of the patients were found to have a psychiatric disorder. The prevalence rates of depressive disorders were 14%, for anxiety disorders 8%, for somatoform disorders 2%, and for alcohol dependence 2%.

Physical illness and mental suffering are inextricably interwoven. Where one exists, so does the other, differing only in degree. They influence each other both in causation and consequence. To illustrate this link, let us take of coronary artery disease. Depression/anxiety increases the chances of developing computer-aided design (CAD). Developing CAD leads to an increased incidence of anxiety and depressive disorders. Moreover, finally having depressive/anxiety symptoms worsen the outcome of CAD.[6] Thus, it seems that there is a reciprocal relationship between the "Psyche" and the "Soma." Hence, as we analyze the occurrence of psychiatric symptoms in patients reporting for secondary medical care, we must keep in mind the while some symptoms are almost inevitable in those who are ill for any reason, there is point beyond which these symptoms become significant in themselves and require treatment. As Middleton and Shaw pertinently put it, generalized distress and specific syndromes must be differentiated.[7] The World Health Organization Programme Guidelines on Mental Disorder in Primary Care (1998) states that 24% of the patients who present themselves to primary care suffer from a well-defined mental disorder. The majority of these patients (69%) across the world usually present to physician with physical symptoms and majority of these disorders remain undetected.[8] Knowing the high prevalence of mental disorders, their susceptibility to treatment and fact that most present to primary care doctors and physicians who will need to treat them, it is vital that primary care doctors as well physicians must recognize their presence. Instruments such as GHQ are useful screening tools in this setting. These figures could not be compared to other studies directly. A Japanese study by Sato *et al*. in a secondary care population found high lifetime prevalence rates for psychiatric disorders.[9] Hence, these figures could not be compared to our study which dealt with point prevalence rates. The few other studies found which were conducted on psychiatric disorders in a secondary care population have focused mostly on other areas such as the relation of the presence of present psychiatric disorder to whether the physical illness was diagnosed satisfactorily and whether the symptoms were "medically explained." It is interesting to note in these studies that the prevalence of psychiatric disorders was much higher in those patients who had "unexplained" or "illexplained" symptoms.[10] This may have also being a factor which causes a higher prevalence of psychiatric disorders in the secondary care population in our study as patients which such ill-defined physical symptoms may have been referred to the physician for evaluation. Another reason for the higher rates in secondary care is that many of these patients have chronic medical conditions which have also been shown to lead to a higher prevalence of psychiatric disorders, 25.8% in those with chronic medical disorders versus 16.7% in those without.[11] Finally, it would at first glance appear as if a third or more of patients require counseling and psychotropic medication[7] that is not the contention. As Bijl *et al*. put it that would be a case of overmet needs, where patients with mild disorders are treated by psychiatrist. However, equally undermet needs, where those who require care do not receive it, must be avoided.[12] As our study reveals most of psychiatric disorders are mild and treatable by physicians. A substantial proportion of patients have subthreshold symptoms which need little more than counseling, explanation of their symptoms and most of all, a sympathetic ear. In service setting, especially where psychiatrist is few, the task of recognizing and treating patients with mild or moderate psychiatric disorders will fall inevitably to the general practitioner and the physician. As Huyse *et al*. said, the presence or absence of psychopathology most probably not be the primary focus of detection as it is not in the best interests of the health-care providers. They will refer troublesome patients. The assessment of integral health service needs in patients who are likely to require more complex care seems more important. This will result

in a protocol-based approach, consult, or case management strategies, depending on the severity of psychiatric symptoms or resulting behavioral disorders. Such a system assigns the most intensive care (case management) to those in need and assigns protocols to those who are vulnerable.[1] The World Health Organization has published a set of guidelines to the diagnosis and management of common medical disorders in primary care that serves as a useful input to the general practitioner or the non-psychiatrist.[8]

The detection of psychiatric symptoms and psychiatric disorders can serve as a medium to develop approaches and management strategies for these patients. This would imply more intensive care. Due to time constraint, the patient population size was kept limited and this population could not be compared across cities and states.

CONCLUSIONS

The incidence of significant psychiatric symptoms in the secondary care population is 38% as per GHQ 28. A large proportion of the study population had significant social dysfunction, depressive, anxiety, and somatic symptoms. The prevalence rate for psychiatric disorders in the sample was 26%. The prevalence rate for depressive disorders was 14%, for anxiety disorders 8%, for somatoform disorders 2%, and for alcohol dependence 2%. No cases of psychotic disorders were found. Most patients suffered from mild psychiatric illness. International studies reveal that most psychiatric illnesses present to general care and physicians and most of these present with physical symptoms. Few of these patients are diagnosed as having a psychiatric illness and even fewer receive treatment.

General physicians need to be sensitized to recognize common medical disorders and such patients usually present to them. A simple brief questionnaire such as the 12-item GHQ 12 is best for the screening for common psychiatric disorders this would only take 2–3 min and can be administered at the reception. This would be a useful input to the general practitioner/physician. Most of these orders are mild and amenable to treatment by non-psychiatrist with medication and counseling. Therefore, general practitioners and physicians particularly need to be sensitized in the diagnosis and treatment of common mental disorders.[4,5]

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