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UNSEEN BURDEN: THE OVERLOOKED PSYCHIATRIC MORBIDITY IN GENERAL MEDICAL OUTPATIENT DEPARTMENTS - A REVIEW

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ABSTRACT Psychiatric disorders are frequently underrecognized in general medical outpatient departments (OPDs), despite substantial evidence indicating high rates of comorbidity among patients presenting with physical symptoms. This review highlights the significant yet often overlooked burden of psychiatric morbidity—including depression, anxiety, and somatoform disorders—within general medical settings. Citing key studies from India and abroad, the paper underscores that up to 60% of OPD attendees may suffer from unaddressed psychiatric conditions. Factors contributing to this diagnostic gap include time constraints, inadequate psychiatric training among general physicians, diagnostic overshadowing, and societal stigma. The review also explores the bidirectional relationship between chronic medical and psychiatric disorders, emphasizing the compounded negative impact on patient outcomes. To address this hidden burden, the paper advocates for integrated care models, enhanced liaison psychiatry services, mental health training for non-psychiatric clinicians, and public awareness initiatives. A holistic, multidisciplinary approach is essential for improving both mental and physical health outcomes in general medical settings.

KEYWORDS :

INTRODUCTION

A significant number of patients visiting general medical outpatient departments (OPDs) suffer from underlying psychiatric disorders, many of which go unrecognized and untreated. This phenomenon has been consistently observed in various studies across the world, indicating a silent but considerable burden of psychiatric morbidity among patients who seek help for physical ailments. As a result, symptoms of anxiety, depression, somatoform disorders, and other psychiatric conditions are often overlooked or misattributed to physical illnesses.

Several research studies have highlighted this concerning trend. For instance, a study conducted in Kuwait found that 51% of patients visiting general medical OPDs had some form of psychiatric disorder. Similarly, research by Sri Ram et al. at KEM Hospital, Mumbai, revealed a nearly identical figure—about 51% of general OPD attendees were suffering from psychiatric illnesses. Another study at GMC Jammu by Thapa et al. found psychiatric disorders in 38.6% of patients, while Shoib et al. reported that approximately 60% of patients attending the endocrinology OPD at IMHANS Srinagar were suffering from depression, anxiety, or both. These studies reinforce the idea that psychiatric comorbidity is highly prevalent among patients seeking routine medical care.

Reasons

There are multiple reasons behind this high prevalence and underdiagnosis. Time constraints in busy outpatient settings leave physicians with little opportunity to explore psychological dimensions of illness. Moreover, many general physicians and specialists receive minimal training in psychiatry during their medical education, which limits their ability to recognize and appropriately manage psychiatric symptoms. Another contributing factor is the tendency to "club" physical symptoms under existing medical diagnoses, inadvertently neglecting the psychological distress driving or exacerbating them. Additionally, societal stigma attached to mental illness may discourage patients from disclosing their emotional struggles, leading to further diagnostic overshadowing.

It is also essential to consider the bidirectional relationship between physical and psychiatric disorders. Chronic medical illnesses such as diabetes, hypertension, cardiovascular disease, and thyroid disorders can often lead to the development of depression and anxiety. Conversely, untreated psychiatric conditions can worsen the course of these medical diseases. For example, depression may lead to poor self-care, nonadherence to medication, and lifestyle neglect, resulting in poorly controlled blood sugars or increased cardiovascular risk. This complex interplay further emphasizes the importance of recognizing psychiatric symptoms in medical settings.

Certain psychiatric presentations are particularly challenging to identify because they manifest primarily as physical symptoms. Patients with somatoform disorders, for instance, frequently present with vague or persistent physical complaints such as fatigue, headaches, or gastrointestinal issues, which may not have an identifiable medical cause. In such cases, unless the clinician is vigilant and trained to detect psychological contributors, the underlying psychiatric disorder remains hidden. Furthermore, stress-related disorders, panic attacks, and adjustment disorders can mimic serious medical conditions, leading to repeated medical investigations and a strain on healthcare resources.

Way Forward

The way forward requires a systemic change in how healthcare services are structured and delivered. There is a pressing need for better coordination between medical and

psychiatric departments to ensure a more integrated approach to patient care. Liaison psychiatry services, where mental health professionals are actively involved in medical settings, should be strengthened and made a routine part of hospital infrastructure. Awareness campaigns and continuing medical education programs can help equip general physicians and specialists with the skills to identify and manage common psychiatric disorders. Incorporating basic mental health screening tools into routine clinical practice could also help bridge the diagnostic gap.

Equally important is empowering patients with knowledge about the links between mental and physical health. Destigmatizing psychiatric disorders through education can encourage more open conversations between patients and doctors. Ultimately, a collaborative, multidisciplinary approach that treats the patient as a whole—body and mind—will lead to better health outcomes and more efficient use of healthcare resources.

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