



PREVALENCE OF PSYCHOLOGICAL SYMPTOMATOLOGY AND DISORDERS IN HOSPITAL SETTING

Dr. Sangram S Pundir	Assistant Professor of Psychiatry, Jaipur National University Institute of Medical Sciences and Research Centre (JNUIMSRC), Jaipur
Dr. Jaswant Goyal	Assistant Professor, Pharmacology, JNUIMSRC, Jaipur
Ms. Saloni Chandalia*	Clinical Psychologist, JNUIMSRC, Jaipur *Corresponding Author
Dr. Barkha Goyal	Tutor, Biochemistry, JNUIMSRC, Jaipur
Dr. Sumit Kumar Gakkhar	Senior Resident, Psychiatry, JNUIMSRC, Jaipur

ABSTRACT

Background

There is evidence that psychological and psychiatric disorders are common in general healthcare settings.

Objectives

- Study the incidence of psychological symptoms in general healthcare settings
- Study the prevalence of psychiatric disorders in patients presenting in general healthcare settings

Materials & Methods

200 patients presenting to General OPD in a large service hospital in Mumbai were administered the Symptom Checklist-90 Revised (SCL-90R). 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 psychological symptoms in patients presenting to general healthcare was 20.5% as per SCL 90 R. The prevalence of psychiatric disorders in general healthcare was 19% (Depressive disorders 10%, Anxiety disorders 6%, somatoform disorders 2% and alcohol dependence 1%).

Conclusion

A substantial proportion of patients presenting to general healthcare have significant psychological symptoms and well defined psychiatric disorders.

KEYWORDS : Anxiety disorders, Depressive disorders, General healthcare, Psychiatric disorders, Psychological symptoms.

Introduction

Mental and behavioural disorders are understood as clinically significant conditions characterized by alterations in thinking, mood (emotions) or behavior associated with personal distress and/or impaired functioning. Mental and behavioural disorders are common among patients attending general health care settings. 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. 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). The review of literature suggests that there is a high load of psychiatric morbidity, especially depressive and anxiety disorders, among patients attending both primary care and secondary care. The prevalence of psychiatric disorders varies with regions, sex, age, socio-demographic status. There is a particularly high incidence of psychiatric illness among frequent attenders of primary and secondary care and those with "medically-unexplained" symptoms. Importantly, only a small proportion of these patients were referred to a psychiatrist or treated by the general practitioner or physician. An integrated approach to the detection and treatment of psychiatric disorders in general medical care is required. (2,3,4,5,6,7,8,9,10,11,12,13).

Aims and objectives

1. To identify the incidence of psychological symptoms in patients reporting for general healthcare (General OPD).
2. To study the prevalence of psychiatric disorders in patients presenting for general healthcare.

Materials and methods

The study was a cross-sectional descriptive study conducted at a large

tertiary care service hospital located in Mumbai. The subject population consisted of service personnel, ex-servicemen and their families/dependents. 200 consecutive patients aged 18-70 years reporting to the General OPD were informed about the purpose of the study and confidentiality assured. They received an interview covering socio-demographic 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. The study group was administered the SCL-90R. Those found to have significant scores on these tests were subsequently examined by two independent psychiatrists to arrive at a diagnosis. Data was analysed to identify the incidence of psychological symptoms and the prevalence of psychiatric disorders in the subject population in accordance with the aims of the study.

The Symptom Check List-90-Revised (SCL-90-R) is a 90-item, multi-dimensional self-report inventory designed to screen for a broad range of psychological problems and symptoms of psychopathology. There are 9 primary symptom dimensions which are measured: somatization, obsessive compulsive, inter-personal sensitivity (feelings of inadequacy or inferiority), depression, anxiety, hostility, phobic anxiety, paranoid ideation, psychoticism. These are primary symptom dimensions and do not correspond directly with a diagnosis based on DSM-IV or ICD-10. However, elevated scores on any subscale is an indication that further investigation is warranted. The SCL-90-R provides 3 summary scores. The Global Severity Index is a composite score obtained by summing the scores on the nine symptom dimensions and dividing by the total number of responses (90 if there are no missing responses). GSI is the best single indicator of current level or severity of symptoms. The Positive Symptom Distress Index and Positive Symptom Total reflect the intensity and extensiveness of symptoms respectively. The scale has high internal reliability. In terms of validity, the SCL-90R performs better than most instruments in both assessment and in measuring change following treatment. It has been used with diverse populations and has been translated into numerous

languages.

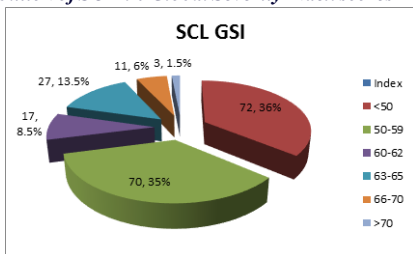
Results

200 patients were recruited into the study. All were service personnel, ex-servicemen and their families/dependents. There were 86 males (66 servicemen) and 114 females in the primary care group and 106 males (39 servicemen) and 94 females in the secondary care group. There was thus a preponderance of females in the sample group (57%). In terms of origin, the sample was drawn from all over India and it's distribution was similar to that of the uniformed services of India. The participants were all in the middle-income group. Almost all lived in Govt provided single/married accommodation or their own/hired accommodation. Health care facilities were readily available to the patients. As regards education, officers and families had done graduation and most of the rest had done at least 10 years of formal education. There was a fairly high level of awareness of health-related issues as expected in a group of service personnel and families. The mean age of the primary care group was 37.06 years.

Incidence of Psychological Symptoms

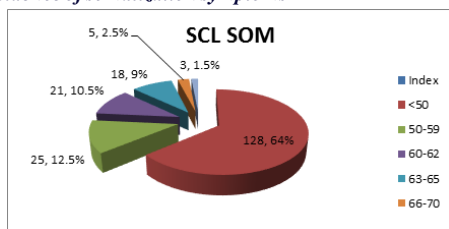
On the SCL-90-R, T-scores of more than 63, or a raw score of >0.57, on the Global Severity Index (GSI) or any of the subscales signifies a cut-off between a 'dysfunctional' and 'functional' population. It was observed that a number of patients who had significant scores of > 5 on the GHQ-28 scored between 60-63 on the SCL-90 GSI. Hence, for this study, this population was also considered. The average score on the GSI was 48.57. A total of 41 (20.5%) patients scored more than the cut-off T-score of 63. A further 17 patients (8.5%) scored between 60 to 62 on the GSI. The distribution of GSI scores on SCL-90 is shown in Fig 1.

Fig 1 Distribution of SCL-90 Global Severity Index scores



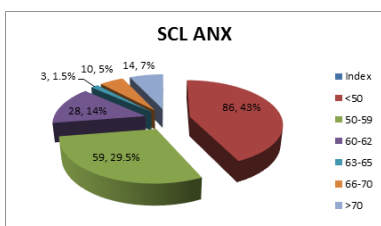
On the somatization sub-scale of the SCL-90, the average score was 47.25. As many as 26 patients scored over 63, the cut-off score for a 'dysfunctional' population. Another 21 patients (10.5%) scored between 60 to 62.

Fig 2. Incidence of somatization symptoms



On the anxiety sub-scale of SCL-90, the average score of the primary care population was 50.85. As many as 27 patients (13.5%) scored above the cut-off score of 63. A further 28 patients (14%) scored between 60 to 62. The incidence of anxiety symptoms on SCL-90 anxiety sub-scale is shown in Fig 3.

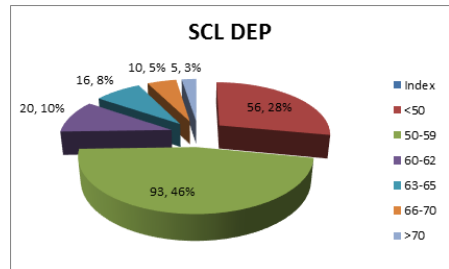
Fig 3. Incidence of anxiety symptoms on SCL-90 anxiety sub-scale



On the SCL-90 depression sub-scale, the average score was 50.75. A total of 31 patients (15.5%) scored more than the cut-off score of 63. A further 20 patients (10%) scored between 60 to 62. The distribution of

SCL-90 depression scale is shown in Fig 4.

Fig 4. Incidence of depressive symptoms on the SCL-90 depression sub-scale



Out of the 200 patients, who were screened for the presence of psychological symptoms 41 scored over 63, the cut-off score for a 'dysfunctional' population. Another 17 patients, had scores between 60 to 62 on GSI. These patients were also included for clinical examination to ascertain the presence of any psychiatric disorder by the psychiatrist.

38 patients (19%) were found to be suffering from a psychiatric disorder as per ICD-10 criteria. The remaining 20 patients had sub-syndromal problems.

Of these 19% patients, 10% (20) had depressive disorders, 6% (12) had anxiety disorders, 2% (4) had a somatoform disorder and 1% (2) had substance abuse disorder.

Table 1. Prevalence of psychiatric disorders in primary care population

Name	Numbers	Percentage
Depressive disorders	20	10
Moderate depressive disorder	5	2.5
Mild depressive disorder	7	3.5
Dysthymia	3	1.5
Mixed anxiety depressive disorder	5	2.5
Anxiety disorders	12	6
Generalised anxiety disorder	6	3
Panic disorder	5	2.5
PTSD	1	0.5
Somatoform disorders	4	2
Somatisation disorder	2	1
Som autonomic dysfunction	2	1
Substance use disorders	2	1
Alcohol dependence	2	1

Discussion

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. As Middleton and Shaw pertinently put it, generalized distress and specific syndromes must be differentiated. (17). 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 (25). Knowing the high prevalence of mental disorders, their susceptibility to treatment and fact that most present to primary care doctors who will need to treat them, it is vital that primary care doctors as well non psychiatric specialist must recognized their presence. Instruments such as SCL-90R are useful screening tools in general care setting.

In this study, as per SCL 90, on the Global Severity Index, 20.5% of the patients qualified as "dysfunctional", having scored over 63 and another 8.5% scored over 60 and thus being close to "dysfunctional". The average score was 48.57.

These figures indicate that the burden of mental distress in the primary care population is considerable. On the SCL 90 somatisation subscale, 13% of the patient had T-scores more than 63, indicating "dysfunctional" status. A further 10.5% had scores near the cut off value (between 60 to 62) indicating considerable symptoms, but sub-threshold. These figures indicate that somatic symptoms are very

common in general healthcare 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 especially in India, partly owing to the stigma of mental illness, many patients complain of bodily symptoms rather than psychological ones. Somatisation of psychiatric complaints is also common in India. (19,20,21,22). This is also borne out by the findings on this study. On the SCL 90 anxiety subscale, in the primary care population 13.5% scored over 63 indicating "dysfunction", and 14% scored between 60-62. These figures indicate that there are significant levels of anxiety in patients in both primary and secondary care and a large number of patients have serious anxiety symptoms.

On the SCL 90 there also a depression subscale. Depressive symptoms are also covered under other subscales eg. Bio-drives are covered under "Additional Scales" which do not yield T-scores. Some symptoms are also covered under the inter personal sensitivity subscale. Hence these facts were kept in mind while analyzing this subscale.

15.5% of patients scored over 63 and further 10% scored between 60-62. This indicates that depressive symptoms are quite common in both primary and secondary care populations.

The prevalence of psychiatric disorders in the primary care population was found to be 19% in this study of these 3.5% were males and 15.5% were females. These figures are slightly lower than 24% found in the WHO multi-centric study overall and the 22.4% found by the WHO study in India. The other Indian study by Pothan revealed a much higher figure of 33.9%. A possible reason for these lower rates in the primary care population is that the study population consisted of service personnel, ex-servicemen and their families. Thus the majority of males in the study population from a defence background. It is possible this population is less prone to neurotic symptoms than a comparable general population.

In our study the prevalence of depressive disorders was 10%, anxiety disorders 6%, somatoform disorders 2% and that of alcohol dependence 1%. The prevalence rates of depressive disorders in our study is comparable to the WHO rates of 10.4% international and the Indian figures of 9.1%. The prevalence rates for anxiety disorders (6% in our study) are slightly less than WHO figures of 7.9% and Indian figures of 8.5%. The alcohol dependence rates were comparable. The WHO study did not give prevalence rates for somatoform disorders separately (13).

Lastly, it would at first glance, appear as if a third or more of patients require counseling and psychotropic medication (17). 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. But equally undermet needs, where those who require care do not receive it, must be avoided (18). As our study reveals most of psychiatric disorders are mild and treatable by general practitioners and non psychiatrist. A substantial proportion of patients have sub-threshold symptoms which need little more than counseling, explanation of their symptoms and most of all, a sympathetic ear. In India where psychiatrists are 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 Huysse et al say, the presence or absence of psychopathology most probably should 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 behavioural disorders. Such a system assigns the most intensive care (case management) to those in need and assigns protocols to those who are vulnerable (24). The World Health Organisation 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 (25).

Conclusions

A large proportion of the population had significant depressive, anxiety and somatic symptoms. In this study population, the incidence of depressive disorders was 10%, anxiety disorders 6%, somatoform disorders 2% and alcohol dependence 1%. Most patients suffered from mild psychiatric illness. International studies revealed that most

psychiatric illnesses present to general care and most of these present with physical symptoms. Internationally few of these patients are diagnosed as having a psychiatric illness and even fewer receive treatment. General practitioner and physicians need to be sensitized to recognize common medical disorders and such patients usually present to them.

However, it was found that the SCL-90R, though it is sensitive, is far too time-consuming to use routinely as a screening tool at a general OPD. It is felt that a simple brief questionnaire such as the 12 item GHQ 12 is best for screening for common psychiatric disorders this would only take 2-3 minutes and can be administered at the reception. This would be a useful input to the general practitioner/ physician. Most of these disorders are mild and amenable to treatment by non psychiatrist with medication and counseling. General practitioners and physicians particularly need to be sensitized in the diagnosis and treatment of common mental disorders.

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