

# Psychiatric Symptomatology in a Primary Health Setting in Malaysia

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## Summary

This study was conducted to find out the psychiatric symptomatology in the patients and their families attending a primary health care facility. The most frequent symptoms found were of depression (13.2%), followed by hypochondriacal symptoms (8.2%), anxiety symptoms (6.1%) and psychotic symptoms. A large proportion (21.5%) of children had psychiatric symptoms. The common symptoms include enuresis, hostility, tantrums, problems of conduct and destructiveness. Surprisingly, concern for these symptoms was lacking in both the patient and their family members.

**Key Words:** Psychiatric, Anxiety, Depression, Symptomatology

## Introduction

'Community', according to Le Bon<sup>1</sup>, is one of those words which are 'uttered with solemnity, and as soon as they are pronounced an expression is visible on every countenance and all heads are bowed'. Some have also felt that the concept has a moral imperative<sup>2</sup>, while yet others see it as a popular device to conceal various confusions and contradictions<sup>3</sup> or as a code word to embrace all good work. Community psychiatry of the 1960's generally neglected the chronically mentally ill and instead focussed on less sick patients, primary prevention and community activism in an effort to change the basic fabric of society.

Only a few studies have examined the prevalence of specific disorders in primary care. Before the 1970's the unreliability of psychiatric diagnosis and the absence of systematic assessment methods were formidable obstacles to obtaining such data in a meaningful fashion. With the development of psychiatric classification system with established reliability for individual disorders, such as the Research Diagnostic Criteria (RDC)<sup>4</sup>, DSM-III<sup>5</sup> and DSM-III-R<sup>6</sup>

accurate determination of the degree and type of specific disorders became possible. Prevalence rates for individual disorders were obtained ranging from 5.8% for major depression and phobic disorders to 1.6% for generalized anxiety disorder. The established prevalence for all RDC disorders was 26.7% for private practice attenders<sup>7</sup>. Other common disorders were alcohol abuse 8.2%; other substance abuse, 7.1%; and phobic disorders, 6.8%. Von Korff *et al*<sup>8</sup> reported the prevalence of specific disorders to be 8.5% for any anxiety or depressive disorder and 25.0% for any psychiatric disorder.

There is much evidence to show that only a small proportion of patients with significant psychiatric disorder who present themselves to their general practitioner are diagnosed to have such disorders, hence the 'hidden psychiatric morbidity'<sup>9</sup>. Goldberg and his colleagues<sup>10</sup> have shown that this misidentification, or misclassification, can be due to bias as well as inaccuracy. There is evidence to show bias is largely determined by factors such as the personality, attitudes and the experience of the general practitioner, whereas accuracy correlates well with the doctor's behaviour

during the consultation<sup>11</sup>. Regier<sup>12</sup> noted that about 20% of the estimated 32 million persons with mental disorders do not receive any care, while another 60% sought help from primary health care professionals.

It is said that it is not uncommon to find a person with mental illness untreated for several years in a Malay village<sup>13</sup>. It is observed that the majority of (90%) patients with mental illness brought to the hospital have previously visited a traditional healer. It is only when these efforts fail that the person is brought to the modern medical facility. This indicates that magico-religious beliefs about the causation are still pervasive in Malaysian society and directly influences health seeking behaviour. In Malaysia the delay of over six months in hospitalization after the onset of illness is significantly more frequent in those who had consulted traditional healers. It is often feared that consultation with traditional healers may delay treatment with modern medicine. Khare *et al*<sup>14</sup> reported a point prevalence of 0.8% for psychiatric illnesses in Malay population using the vignette method. They also reported that 50.48% of patients never sought modern medicine and 70% had never sought psychiatric help. This study shows that in Malaysia 34.9% of probable cases were not willing to attend the nearest clinic.

Salleh<sup>15</sup> in another study done in Malaysia has reported the prevalence of psychoemotional disturbance (neurotic disorder) to be 23% in the families of schizophrenics. He diagnosed neurotic depression in 45% of the cases. He also found the prevalence rate for all psychoses to be around 1% in general population.

As the present situation of community psychiatry in Malaysia is far from satisfactory, this study was planned to find out the prevalence of psychiatric symptomatology in the patients and their families attending the primary health centres of two districts in Kelantan.

### Materials and Methods

This study was conducted in two districts in the State of Kelantan. Bachok and Tumpat districts were selected for the study as they are close to Universiti Sains

Malaysia. The study period was from October 1991 to July 1993. All patients with medical problems attending the primary health centres of these two districts were screened by the research team. One hundred consecutive patients visiting each primary health centre for medical problems were assessed. All the primary health centres were included in this project. The patients were screened using a mental health itemsheet<sup>16</sup>. The screening schedule has sixty questions on symptomatology designed to detect most psychiatric symptoms. The screening schedule was administered to the patient himself as well as a key family member to determine the presence of psychiatric symptomatology in the whole family. In certain cases patients were requested to attend the psychiatric unit of the University Hospital for a detailed assessment, diagnosis and further psychiatric management.

### Results

The district of Tumpat has one district hospital, one primary health centre and 4 smaller health centres. It also has 19 village clinics, 4 midwife clinics and 2 mobile dispensaries. These are all located within 35 kilometres of the University Hospital. Bachok, which is located around 20 kilometer from the University Hospital, has 2 primary health centres and 4 smaller health centres. It also has 11 village clinics, 10 midwife clinics and 2 mobile dispensaries. A total of 1,137 families were screened for psychiatric symptomatology. There were 6,342 family members or an average of about 5.6 members per family. Most (59.8%) of the subjects were females while the rest were males. Rubber tapping was the most common job (65.1%) followed by business, factory jobs and farming. The average age of the subjects was 33.4(±18) years. A total of 535 (8.44%) persons were found to have psychiatric symptomatology (Table I).

**Anxiety symptoms** – Many subjects (386, 6.1%) complained of generalized weakness, breathlessness and palpitation. They had feelings of heart sinking, perspiration and fear of becoming ill.

**Depressive symptoms** – Three hundred and sixty four persons (5.7%) showed lack of interest in their daily activities, such as decreased interest in self care, food or even carrying out daily chores. Many of these

subjects avoided mixing or meeting with people. Two hundred and ninety five (4.7%) had ideas of worthlessness and self deprecating thoughts. Ninety seven (1.5%) had ideas of committing suicide. Eighty subjects (1.3%) also complained of worrying all the time and even experienced sadness.

**Hypochondriacal symptoms** – Two hundred and sixty five (4.2%) subjects had vague somatic complaints which did not conform to any diagnosis, while another 174 (2.7%) had excessive concern about bodily symptoms. Ninety (1.4%) subjects would visit hospitals or doctors quite frequently on trivial complaints.

**Psychotic symptoms** – Five hundred and six (8.0%) subjects had some sort of psychotic symptoms. A large number of subjects, i.e. 265 (4.2%) were found to be emotionally unstable and having frequent mood swings. One hundred and two (1.6%) had referential thinking, i.e. they thought that people usually talked about them. One hundred and thirty nine (2.1%) subjects were very suspicious and thought that people were against them and wanted to harm them in many ways.

**Psychological problems of the children** – A large number of children 21.5% (1,361) had various psychological problems. There were problems of being handicapped – physically or mentally; neurotic, developmental and conduct problems. The individual symptoms were as follows: enuresis (4.7%), hostility (4.7%), decreased appetite (3.2%), temper tantrums (2.9%), destructiveness (1.9%), speech problems (1.0%), scholastic backwardness (0.8%), sleep walking (0.7%), truancy (0.5%), nail biting (0.4%), sleep disturbance (0.3%), unjustified fear (0.3%) and other abnormal behaviours (0.2%).

**Sleep problems** – Three hundred and twenty one persons (5.06%) were suffering from various forms of sleep disturbances. These persons did not take their sleep disturbance seriously nor did they seek any medical help. Of these, 150 (2.36%) persons had difficulty in going off to sleep. The rest had either intermittent sleep or early morning insomnia.

**Miscellaneous symptoms** – Seventy one (1.12%) persons had abnormal, and/or aggressive behaviour, in the form of abusiveness, quarrelling, illogical speech,

tendency to wander and other abnormal behaviour. Fifty four (0.84%) were found to be talking or muttering to themselves. Some were found smiling to themselves without any obvious reasons. Thirteen (0.20%) people had history of talking excessively beyond what is socially accepted. Three hundred and fifteen (4.97%) persons complained of having problems in remembering things, names and said that overall their memory was impaired. Three (0.05%) persons were consuming drugs or alcohol regularly. Fifteen (0.24%) persons were excessively involved in religious activities which were out of the social norms that disrupted their normal daily activities. 1.2% persons were considered by their family members as lazy, slow, mentally subnormal or even involved in bizarre activities. Eighty nine (1.4%) persons at times believed that they were possessed or influenced by witches or some supernatural powers. They also claimed to have powers to make predictions about the future, under the influence of these supernatural powers.

**Table I**  
**Psychiatric symptomatology in patients and relatives attending primary health care**

Symptoms	Total	%
Depressive symptoms	836	13.2
Hypochondriacal symptoms	523	8.2
Anxiety symptoms	386	6.1
Sleep disturbance	321	5.1
Psychological problems of children	1361	21.5
Other symptoms	832	13.2

**Discussion**

Two districts of Kelantan were selected to find out the frequency of the psychiatric symptomatology in the general population. The screening was done by family history method in preference to the family study method which is time consuming and difficult to put into practice.

Depression was found to be the most common

symptom (13.2%) in the population studied. Mild states of depression were far more common than the more severe degrees. Ten per cent of all patients seeking medical advice from their family doctor suffer from mild to moderate depression. However, the doctor often fails to recognize this condition because the differences between the anxiety depression or obsessive states are often not clearcut. Furthermore, patients do not necessarily complain of feeling depressed; their presenting complaints may only be vegetative symptoms of which some are systemic (fatigue and sleep disturbance) and some are localized (pain in the back, chest pain, nausea, abdominal discomfort or shortness of breath). It is, therefore, understandable that many doctors prefer to make a medical rather than a psychiatric diagnosis in such situation. It is no help for the patients, however to be told that all the medical investigations have been negative. The symptoms of depression are as real to the patient as if he or she were suffering from a physical illness. If a mental disorder is considered next, the minor depressive state is often diagnosed as anxiety neurosis, partly because anxiety is often a component of depression and partly because many physicians find anxiety to be a socially more acceptable diagnosis than depression, justifying the use of benzodiazepines instead of the more potent antidepressants.

We agree with the report by Herrman<sup>17</sup> that the most common psychiatric disorders in the western world were depression and anxiety of mild to moderate intensity. In Herrman's study, up to 20% of the adult population experienced an identifiable psychiatric disorder in any year; most of these 20% visit their GP for one reason or another and in about half of them, a psychiatric disorder is diagnosed. Other common but often unrecognized disorders include alcohol and drug dependence incidence of which was found to be much less in our study. This may be due to religious and cultural reasons where alcohol is proscribed by religion.

That depressive disorders are indeed frequent in general practice was confirmed by Shepherd *et al*<sup>18</sup> who demonstrated that 20-25% of a GP's workload concerned psychiatric morbidity, the largest proportion of which involved depressive symptoms. A similar

report<sup>19</sup> stated that 23.5% of patients were diagnosed to have depression and 40% of these had presented with 'depression, nervousness or fatigue'.

Minor states of depression can be distinguished clinically from anxiety states if the physician recalls the essential triad of depression: the mood of depression, decreased motor activity and negative beliefs. In minor states this triad manifests itself by symptoms such as lack of interest, fatigue, work impairment, introversion and indecision. Recent studies<sup>20</sup> in primary health care have shown that social impairment is related much more to depression than to anxiety states. Finally, among the vegetative symptoms, decreased appetite is more related to depression than to anxiety.

It is clear, as stated by Goldberg<sup>21</sup>, that the detection of a disorder is most important when it can be shown that an available intervention will favourably influence its further course. The more severe the depression, the more easily it can be shown that detection will shorten its course. While the treatment of minor depression with anti-depressants is a relatively simple matter today, its diagnosis is sometimes extremely difficult. Minor depression is, however, a clinical syndrome that can be detected by an interview directed towards the symptoms of depressed mood, anxiety, sleep disturbance, fatigue and social impairment as evidenced by introversion, indecision and general work impairment.

In our study the next common group after depression was of subjects exhibiting hypochondriacal symptoms (8.2%). Persons with vague somatic complaints or worrying excessively about their bodily symptoms keep on frequenting the general practitioners or hospitals. They tend to insist on investigations for their symptoms. These patients also resort to 'doctor shopping' as their symptoms are neither relieved nor are they convinced that they are healthy. Rarely do they come in contact with the psychiatrist at an early stage of the illness. If they are identified and referred to psychiatrist early, a lot of unnecessary, and often costly investigations may be avoided.

Anxiety was found in 6.1% of the population. Whether anxiety, depression and related conditions are

mild or severe, they may often be longstanding and are a source of misery to the patient and the family. They may often present as unrecognized components of somatic complaints. Special investigations and treatments for physical disorders in these patients consume a significant proportion of the health budget and result in additional distress.

It was quite surprising to find that children had a lot of psychological problems in our study. Emotional problems in children are usually difficult for the family members to detect because of individual variations in children and their development. However, if the community is well informed about the significance of these minor symptoms, the quality of development of the child may be improved. It is not uncommon to find children with hyperkinesia or conduct disorder being considered by their parents as only overactive or naughty and seeking psychological help is not even considered.

Sleep disturbances were found in 5.1% of the subjects in our study. About half of them had early night insomnia while the others had either intermittent sleep or early morning insomnia. Moreover, they had been neglecting this problem. Kissane<sup>22</sup> reports that 10-20% of general population classify disturbances of sleep as their problem. He reports that women of all ages have more sleep complaints than men, as do the more socio-economically disadvantaged. Sleep complaints are a key to the diagnosis of many psychiatric disorders.

Ford and Kamerow<sup>23</sup> in a study of 7,954 respondents reported that 40.4% of those with insomnia had a psychiatric disorder as compared to 16.4% of those with no sleep disorders. These data suggest the possibility that disturbances of sleep may be critical in the pathogenesis of sleep disorders, particularly depression and anxiety, and that early recognition and treatment of sleep disturbance may prevent future psychiatric disorders. Transient disturbance of sleep are a part of everyday life and do not warrant a diagnosis. However, most people with chronic insomnia are preoccupied with their sleep disturbance while denying any emotional or medical problem. Careful assessment is, therefore necessary before ruling out psychopathology. A common mistake made in the approach to a complaint of insomnia is to have only

a brief consultation followed by quick prescription of a hypnotic.

Psychotic symptoms were found in 3.7% of our subjects. In Malaysia the currently available psychiatric facilities are almost exclusively used for the treatment of psychotic disorders. Psychotic disorders constituted 93.3% of all admissions in the study of Yeoh<sup>24</sup> and 64% in that by Simmons<sup>25</sup>. A study conducted by Upadhyaya *et al*<sup>26</sup> in a similar population reported a prevalence of 3.5% for psychotic illness and a total prevalence of 8.0% for all psychiatric illnesses. These psychotic symptoms may later on progress to become full-fledged psychotic illness which could have been prevented if it had been detected early. Khare *et al*<sup>14</sup> reported that in Malaysia, 34.9% of the probable psychiatric cases were not willing to come for psychiatric help.

### Conclusion

It is, thus seen that the psychological problems are not uncommon in general population but they often go unnoticed. Therefore, specialized mental health workers should devote only a part of their working hours to the clinical care of patients, spending the greater part of their time in training and supervising the non-specialized health worker who would provide basic mental health care in the community. This is true for Malaysia where the number of psychiatrists is very low. Thus we emphasize the assumption underlying the need for public health prevention programme targetted at primary care providers. A training programme for general practitioners must be directed at improving recognition and diagnosis and at enhancing the availability and quality of mental health interventions. The effectiveness of these programmes then should be tested in randomized trials.

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