SUMMARY

Emotional disorder or minor psychiatric morbidity, has been shown to account for 10-30% of consultations in general practice. It is well established that in the community and in primary care attenders, emotional disorders are detected twice as often in females as in males. I had also observed in my own practice, that minor psychological problems accounted for the third commonest reason for consultation among women.

Women in the reproductive period of life, being the mothers of the future generations of our country should remain in good physical and mental health in order to carry out their role. An investigation into aspects of emotional disorder in women, was thought to be a worthwhile project as such a study has never been carried out in Sri Lanka. Therefore, a study on emotional disorders in women patients was carried out in my family practice, from May 1987 to September 1988.

The objectives were, to estimate the conspicuous psychiatric morbidity among women between 15-49 years consulting in my practice, and to identify socio-demographic, physical or medical and psychological

factors associated with the development of such disorders, by means of a case control study. Other objectives were, to demonstrate the mode of presentation of all women in the study population and to categorise those with emotional disorders according to Section V. in the ICHPPC.

The study population consisted of women between 15-49 years, consulting on account of their own illness or on behalf of a child's illness. Patients who were too ill or new to the practice were excluded.

Those who were selected and consented to participate, completed the translated and validated 30 item GHQ, at the end of the consultation. A structured questionnaire, with regard to personal data was next completed by an interviewer. An independent clinical assessment of the degree of psychiatric disturbance on a severity rating scale from 0-4 and the mode of presentation and the diagnosis according to the ICHPPC classification was recorded by me, on the doctors data collection form.

One Hundred and fifty women completed the 2 questionnaires, whereas the doctors data collection form was completed for the total 375 women consulting during

the period of study.

The GHQ was scored by computer according to the conventional scoring method, with those scoring positively to 5 or less than 5 items being considered non cases and those scoring 6 or more being considered cases. By clinical assessment on severity rating 0 & 1 were non cases and 2, 3,& 4 were cases.

For the case control study, those in whom there was agreement between the 2 assessments as to caseness were taken as cases, and where agreement was present as to normality, were taken as controls. In this manner 112 women were taken in to the case control study, three were rejected from analysis, and the 35 disagreements were analysed separately.

In determining the extent of emotional disorder in women between 15-49 years, only clinical assessment was used, so that all 375 patients were included in the estimate. The mode of presentation and ICHPPC classification was also made on the total study population.

A pilot study of the first 20 patients, showed that the degree of association between the GHQ assessment

and the clinical assessment was significant at the 5% level. That, in the main study the correlation coefficient was highly significant, confirmed the accuracy of my assessment of emotional disorder. This also showed that a combination of the 2 assessments was a valid method of case identification. Taking the GHQ as the sole criterion of a case, the sensitivity and specificity of the clinical assessment was 64.3% and 80.9% respectively.

The estimate obtained for conspicuous psychiatric morbidity in women was 23.4%.

The case control study revealed that factors significantly associated with Emotional Disorders in women were, low educational status, being separated and divorced, living in a household of 7 or more, one or more life events in the preceding 2 years and occurence of one or more specific physical symptoms, namely chest pain, backache, headache and gastric or bowel symptoms. With regard to never married women, it was found that women who were factory workers and lived away from home, suffered from emotional disorders to a significantly greater extent, than those in other occupations and who lived with their parents.

With regard to mothers of sick children, 15.7% were found to be over anxious about the child.

With regard to the mode of presentation of all women consulting during the study period, 29.6% were found to have had a psychiatric component to the consultation. However, only 1.6% had presented with entirely psychiatric complaints while 12.3% had presented with entirely somatic symptoms.

Classification according to the ICHPPC, showed that the Psychoses were rare, while half the cases of emotional disorder, belonged to the Neuroses. About two thirds of the remainder,suffered from pain of psychogenic origin and most others from transient situational disturbances.

Limitations of the study were small sample size and the fact that the sample was not a random one. Bias caused by having many exclusions was minimal, because in terms of basic demographic data, the included and excluded groups were broadly similar. Non sampling errors were reduced by having one interviewer and getting the patient to complete the GHQ on her own in the surgery itself.

In conclusion, this study has identified certain factors, which could act as positive stereotypes, to alert the family physician to the presence of emotional disorder in women patients. The commonest mode of presentation of these women was with somatic complaints. Neuroses accounted for the bulk of emotional disorders seen in general practice.

The GHQ was acceptable to female general practice attenders and useful as part of a 2 stage design in case identification. The clinical assessment had a reasonable sensitivity, specificity and a highly significant association with GHQ assessment. Therefore, the protocol for diagnosis in the form of a flow chart and severity rating scale used for clinical assessment in this study, could be recommended as a useful and valid method for general practitioners to use in psychiatric research. Used in day to day practice, such a protocol for diagnosis could also be helpful in early and easy detection of cases. This would hopefully result in institution of appropriate management resulting in secondary and tertiary prevention of emotional disorders.