

TITLE

PSYCHIATRIC MORBIDITY IN
A GYNAECOLOGY OUT-PATIENT CLINIC
AT KENYATTA NATIONAL HOSPITAL.
NAIROBI.

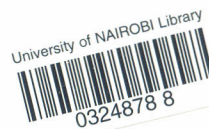
BY

JOYCE NANJALA NATO MB.Ch.B (NAIROBI)

A DISSERTATION SUBMITTED TO THE UNIVERSITY OF NAIROBI,
IN PART FULFILMENT OF THE DEGREE OF MASTER OF MEDICINE
(PSYCHIATRY) OF THE UNIVERSITY OF NAIROBI.

JULY 1992

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DECLARATION.

I JOYCE NANJALA NATO, DO DECLARE THAT THIS DISSERTATION IS MY ORIGINAL WORK. IT HAS NOT BEEN PRESENTED TO ANY OTHER INSTITUTION FOR THE PURPOSE OF OBTAINING A DEGREE.

CANDIDATE:

SIGNED *JN* DATE 14.8.92
(DR. JOYCE NANJALA NATO, MB.Ch.B.).

THIS DISSERTATION HAS BEEN SUBMITTED FOR THE DEGREE OF MASTER OF MEDICINE (Psychiatry) WITH MY APPROVAL.

SUPERVISOR:

SIGNED *Rachael N. Kang'ethe* DATE 17/8/92
(DR. RACHAEL N. KANG'ETHE MB.Ch.B; M.MED (PSYCH))

A C K N O W L E D G E M E N T S .

To Dr. Rachel Kang'ethe, Lecturer, for her unfailing support and encouragement. To Prof. D. Ndetei, Chairman, Department of Psychiatry for his concern and encouragement.

To Dr. F. Owiti for his guidance during the initial stages in preparation of this work. To Dr. Z. Mulindi for his contributions in the initial stages.

To Dr. S. Wanjala, Chairman, Department of Obstetrics and Gynaecology for his permission to have the study carried out in his department. To my colleagues both in the department of psychiatry and the department of obstetrics and gynaecology for their contributions and encouragement.

To Mr. Nyabola for his assistance with the statistical work. Special appreciation to Ms. Judith K. Fundi and Mrs. Esther Wamocho for secretarial services.

To my dear husband Mr. H.C. Nato and our children, Charles, Steven, Angeline and Aileen for their patience and understanding, without which this work could not have been completed. Last but not least to all those whom I cannot mention by name but in one way or another contributed to the success of this undertaking, I convey my sincere thanks and appreciation.

D E D I C A T I O N

I wish to dedicate this work to my mother Berita and my late father Erastus.

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SYNOPSIS

The main objective of this study is to survey and show the aetiology and presentation of psychiatric morbidity among female patients attending a gynaecology out-patient clinic at Kenyatta National Hospital (KNH).

There is evidence from literature review that research in this field is scanty in Kenya. From the literature review, women are likely to develop neurotic disorders such as depressive episodes, anxieties or somatization.

This prospective study covered 150 cases of female patients attending a gynaecology out-patient clinic. Using a two stage screening procedure (the self Rating Questionnaire and the standardized Psychiatric Interview) the subjects were interviewed by the author. The data collected were analysed statistically with the help of a statistician.

Psychiatric morbidity was 19.5% (29 cases of the total 150 cases interviewed). Those with Psycho-neuroses were 18% while only 1.5% had psychosis.

Patients who had a positive history of mental illness amongst family members showed a significantly higher psychiatric morbidity as compared to patients who had no history of mental illness amongst their family members.

The study also revealed that patients who had a positive history of alcohol ingestion had a significantly higher psychiatric morbidity than those with no history of alcohol ingestion. Other variables tested were not statistically significant.

Patient 0

The gynaecology out-patient clinic at KNH handles about 50 patients on a typical clinic day.

Discussion

The study revealed that many of the patients had a psychological component which was not attended to. A holistic approach that integrates psychological support into the total patient care is therefore formulated and recommended.

References

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2. Gyn

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7. Gyn

8. Gyn

INTRODUCTION.

There is scanty, if any, literature on psychiatric morbidity in a gynaecology out-patient clinic in Kenya. The trend in Kenya has been that of significant psychiatric morbidity in general out-patient departments in general hospitals (Dhadphale 1984; Ndetei and Muhangi 1979; Dhadphale and Ellison 1982).

Interest

Mutiso (1987) like many of the Western researchers, was only interested in psychiatric morbidity in infertile women attending a gynaecology out-patient clinic at Kenyatta National Hospital.

Featured

Few studies have assessed psychiatrically the whole range of patients attending a gynecology clinic. Worsely and Walter (1977) using the General Health Questionnaire (GHQ) reported high levels of psychiatric morbidity in an uncontroleed survey of women attending a gynaecology clinic (figures not given as quoted by Byrne 1984).

Modern investigation of psychosomatic aspects of Obstetrics and Gynaecology goes back to over 60 years ago. Lindenman in assessing women before and after hysterectomy, emphasized the psychic meaning of loss of the uterus (Nadelson 1983).

Concern about the frequency of psychological distress among women attending gynaecology clinics has been expressed by both gynecologists and psychiatrists (Smith 1979). There is high relationship between physical illness and neurosis and the presence of physical illness in the female is more likely to be associated with neurosis than in the case of males (Barquelo et al 1981). Interest among psychiatrists has focused on different gynaecological problems. In particular menopause (Munro 1972; Ballinger 1975, 1977) and the morbidity associated with hysterectomy (Barker 1968; Richards 1973; Gath et al 1982) have featured most. Laparoscopy has contributed to our understanding of chronic pelvic pain by making it possible to exclude organic pathology with greater certainty. However, since those patients without organic pathology often resist accepting this diagnosis, they have been particularly difficult to refer or treat. The presence of a psychiatric consultant in a gynaecology clinic may help minimize referral difficulties (Nadelson et al 1983).

Improved health status for women has fundamental implications for the development of society as a whole. Any programme of action to improve women's health must be comprehensive and dynamic and must be directed towards the improvement of womens' total social status, in keeping with the World Health Organization (WHO) all inclusive definition of health (WHO Magazine 1980).

CHAPTER I.

LITERATURE REVIEW.

For centuries medical observers have described an association between disturbances of mood and behaviour and changes in the reproductive system.

The observations have reflected beliefs about the existence of a special relationship between the Central Nervous System (CNS) and the reproductive endocrine system. Warnock in 1890 stated :

"The connection between the reproductive nerve centres and the higher physical centres in the brain is so intimate and the effects of menstruation on the vascular system is so marked, that a priori we should expect menstrual derangement to cause corresponding disturbances in the brain, both through the nervous and vascular system" . (Schmidt P.J and Rubinow D.R 1991).

Modern investigation of psychosomatic aspects of Obstetrics and Gynaecology goes back to about 60 years ago. Lindenman in assessing women before and after hysterectomy, emphasised the psychic meaning of loss of the uterus.

For a woman, the knowledge that she is able to bear children has always been considered critical to the development of her gender identity, sense of femininity, and self - esteem.

Recent societal patterns and cultural changes have diminished the emphasis on childbearing as the conversation of feminine identity and have resulted in the emergence of alternatives including the choice not to have children. Concepts of femininity have undergone many changes away from Freud's and Deutsch's descriptive trial of masochism, narcissism and passivity (Nadelson et al 1983).

According to Verbrugge (1976), women have higher rates of acute and chronic condition and disability due to acute conditions than men as revealed in a self report health interview survey, conducted by the Federal Government from 1957 - 1972, U.S.A. Neurosis was the primary diagnosis of women being treated in out-patient facilities. Most of the mentally ill patients treated by general physician were suffering from a psychosomatic disorder.

Mcgrovy (1980) gave the following as some of the reasons why women have high prevalence of mental illness as compared to man :

- a) Sex role stereotyping - from culture, women are praised for their domestic accomplishments, their timidity of soul, their gentle appearance and manners and at the same time fail to potray initiative, enterprise, physical prowess and genuine

intellect.

- b) Women in contrast to men, have one major source of societal gratification; family, men have two; work and family. Therefore women have no other source of gratification.
- c) Frequently women find housework and raising children frustrating; housewife role is unstructured and invisible.
- d) Working married women work more hours per day than their husbands.

A study group on mental health care in developing countries met in Geneva 1991 to discuss recent contributions made by mental health professionals to the provision of mental health services and to consider the role of WHO in facilitating future research. The evidence before the study group indicated that as many as 20% of all those attending general health care facilities in both developing and developed countries do so because of psychological symptoms.

These patients who often complain of multiple somatic symptoms, are subjected to needless and wasteful investigations and because their conditions go unrecognized and untreated, they attend the Health Care repeatedly and finally leave to try some form of alternative therapy. In order to avoid unnecessary intervention, all health workers must be able to recognize such patients and, because of their numbers, must learn how they can help them, at least by understanding them (WHO Tech.Rep. Ser. 698 : Geneva WHO 1984).

In their study on psychiatric illness in general practice, Goldberg and Blackwell (1970) noted that most of the psychiatrically ill patients were not "entirely psychiatric" and had physical complaints in association with their psychological disturbance. Many patients may feel that it is more socially acceptable to be physically ill than emotionally ill, and they fear the stigma of being thought of a "psychiatric cases".

Many doctors as well as patients consider that a stigma attaches to patients who are psychiatrically ill, and until this is no longer the case many patients are likely to continue to formulate their problems in somatic terms.

Physiological studies of depressed patients have provided objective evidence of autonomic imbalance and associated physical symptoms (somatic) such as fatigue, headache, palpitations and diarrhoea. In their study on physical symptoms of depression, Roy et al (1981) found that depressed patients had high incidence of physical symptoms e.g. impaired concentration accounted for 86.3% in depressed patients; weakness and fatigue (82.4%); day drowsiness and headache (76.5%) each; dizziness (64.71); flushing (45%); amenorrhoea (36%); lack of orgasm (34.3%); loss of libido (31.4%) polymenorrhoea (16.7%). In their paper, however, they did not show that physical problems were directly related to depth of depression.

Using the General Health Questionnaire (GHQ) Goldberg and Blackwell (1970) found that 20% of all those patients attending general out-patient clinics have psychiatric disorders.

A not inconsiderable number of women come for psychiatric help having had fairly recent gynaecological operations and at times suspicious that the operation was carried out because the patient was making a hypochondriacal complaint.

It is only afterwards when the complaint does not cease that this is recognized and the woman is sent to the psychiatrist.

It is a widely held belief that the possibility of any physical disorder should be eliminated first before a psychiatric diagnosis is made, but this is bad medicine.

A primary psychiatric diagnosis can and should be made and the appropriate treatment carried out the earliest possible moment, along side treatment of a somatic condition if need be. Ignoring the psychiatric element too often leads to unnecessary physical investigation and treatment and unsatisfactory outcome (Munro 1972).

A number of reasons could account for the discrepancy between reported psychiatric morbidity and referral rates to the psychiatrist. Referral may be prevented by the attitude of the non-psychiatric consultant or the unfavorable reaction actual or supposed of the patient (Mezey and Kellet 1971).

Lipowski et al (1969) reported that 20 out of 53 (38%) patients referred by general consultants failed to attend, suggesting reality basis for this belief i.e. attitude of the patient towards psychiatric review. Mezey and Kellet (1971) also showed that physicians have much higher referral rates than the surgeons and gynaecologists.

Few studies have assessed psychiatrically the whole range of patients attending a gynaecology out-patient clinic. In his study on psychiatric morbidity in a gynaecology clinic, Byrne, using standardized methods of case identification found that 46% women in the clinic scored as cases on General Health Questionnaire (GHQ) and the rate was 29% using Present State Examination (PSE) as compared to only 17% in the general population (Byrne 1984).

There are many gynaecological conditions in which psychological factors appear to play a significant part (Munro 1969). Munro showed that a minimum of 10% of an unselected sample of first attenders at a gynaecological clinic appear to be psychiatrically unwell and that about half of these disturbed women are around menopausal age. He also noted that the subjects often complained in vague terms and were especially likely to report excessive menstrual or post-menopausal bleeding.

Menopause , the last menstrual period - judged retrospectively usually 12 months without further menstrual periods is taken as a criterion (Katschnig 1990).

Her partner

Menopause is regarded as a significant life change for a woman, requiring effort to adopt to the new situation and carrying the possibility of difficulties in coping, which might result in psychological distress.

Symptoms

In Western Countries menopause usually occurs between the ages of 45 - 55 years. Somatic symptoms in menopausal syndrome includes hot flushes or flushes, sweating, chills, cold, moist and numb extremities, vertigo and headaches. Other symptoms attributed to the menopause are depression, irritability insomnia, and palpitations (Katschnig 1990; Nadelson 1983).

Ballinger (1975) in his study on psychiatric morbidity and the menopause in the general population, found that 29 of patients had minor psychiatric illness and also found that psychiatric morbidity was highest in the age group 45-49 years and in the menopausal women regardless of the age. In his subsequent study on psychiatric morbidity and the menopause in a gynaecology out patient clinic survey, he found that 52% of the women were identified as possible psychiatric cases (Ballinger 1977).

A number of typical life events such as children leaving home, death or severe disease of parents, separation on divorce, waning sexual interest in her relationship, increased risk of illness in her partner and in herself and diminishing job security; are also possible contributors to the menopausal syndrome, hence the climacteric syndrome is not just a consequence of the drop in oestrogen (Katschnig 1990).

Sainsbury (1960) in a survey of several out patient clinics found that women attending the gynaecology out-patient clinic obtained high scores for neuroticism and that menorrhagia was one of the conditions particularly associated with high neuroticism scores. Both Sainsbury (1960) and Munro (1969) commented on the association of complaints of abnormality of menstrual periods with psychiatric morbidity.

It may be that depressed women are unduly pessimistic about any minor variation in the pattern of their menstrual periods and therefore present at the gynaecology clinic; or it is possible that the endocrine changes which occur just before menopause are associated both with a change in uterine bleeding patterns and with excess psychiatric morbidity at this time (Ballinger 1977).

Premenstrual tension does show a marked correlation with psychiatric disorders. More than 150 different symptoms have been associated with the menstrual cycle, covering a vast array of

physical, psychological and behavioural symptoms. Most commonly cited among the psychological symptoms are depression, irritability, tension, mood lability, and let lehergy. Common physical symptoms are breast tenderness, headache and oedema (Gitlin and Pasnau 1989).

Longstanding personality factors are also important in many women since an excessively high proportion of these with premenstrual tension have a previous history of psychosomatic disorder (Munro 1972). Prevalence cannot be accurately assessed in the absence of reliable syndrome criteria.

However, one review (Longue and Moos 1986) concluded that forty percent (40%) of women experience some mild premenstrual symptoms not associated with change in functioning and that two- ten percent (2% - 10%) report severe symptoms with probable functioning impairment.

Conclusions about the relationships of premenstrual status with episodes of violence, symptomatic behaviour and subjective perceptions of changes have been based on correlational evidence alone. Figures for the prevalence of premenstrual syndrome vary widely (30% - 90%).

Some women continue to have pelvic pain after surgery, while others develop pain in new locations. They also tend to resist accepting the psychological aspects of their illness and may perceive such interpretations as demeaning. Psychotherapy has been useful for diminishing symptoms in some patients (Nadelson 1983).

Laparoscopy has contributed to our understanding of chronic pelvic pain by making it possible to exclude organic pathology with great certainty. However, since those patients without organic pathology often resist accepting this diagnosis, they have particularly been difficult to refer or treat. The presence of a psychiatric consultant in a gynaecology clinic may help minimize referral difficulties (Nadelson 1983).

A number of studies report a higher incidence of depression following hysterectomy as compared to other surgical procedures. Although methodological problems complicate these studies, they do suggest the vulnerability of some women to post-hysterectomy depression.

The most vulnerable women appear to be those without organ pathology in the uterus; those with dysfunctional uterine bleeding (DUB); persons under age 40 years, and those whose marital or societal supports have been disrupted.

Women with previous emotional disturbances also seem more likely to become depressed. The loss of an organ with important unconscious symbolic significance, especially if the preparation has been insufficient, can produce psychological symptoms particularly if there is anxiety about the underlying diagnosis. Adequate preparation before and after a procedure such as hysterectomy play an important role in the outcome (Nadelson 1983).

Richards (1973, 1974) noted that a part from the depressive syndrome, post-hysterectomy patients also exhibit a separate post-hysterectomy syndrome which is characterised by headaches, dizziness, insomnia, tiredness, hot flushes and urinary symptoms.

Based on the more recent studies, there is little evidence that hysterectomy is followed by a higher rate of post-operative psychopathology or depression. The subgroup at higher risk is composed of women with pre-operative psychopathology. This is consonant with the more general review that the best prediction of the future course for any psychiatric illness may be the past history (Gitlin and Pasnou 1989).

Married state in women often seems to act as an additional strain leading to the development of mental illness (Robertson 1974).

Compared with women in the general population, a higher proportion of women in the gynaecology clinic group were separated or divorced (Ballinger 1977).

Barker (1968) showed that a history of "marital disruption" was much commoner in women referred to a psychiatrist following hysterectomy than in those not so referred.

Holmes and Speight (1975) did a study on the problem of non-organic illness in Tanzanian urban medical practice. Of the 170 patients seen, 48% were categorized as having organic illness, 48% as non-organic while 4% were unsure. Only 20% of the organic group were thought to be psychiatrically abnormal while 78% in the non-organic group.

They concluded that patients with physical symptoms but without organic disease represent a considerable proportion of the work load in the medical out-patient departments and dispensaries in urban Africa, and many of these patients are apparently emotionally and socially crippled by their disease.

Geil, R. and Van Luijk, J.N. (1969) in their study on psychiatric morbidity in a general out-patient clinic, in a small Ethiopian town, Bonga, with 3, 200 inhabitants in Kefa Province, emphasised the common occurrence of psychoneurosis in Africa, particularly with physical symptomatology.

Five hundred consecutive patients attending a health centre for medical consultation were examined for psychiatric illness, 19% of the clinic population was primarily psychiatrically disabled.

In the majority of related studies in Kenya the setting has usually been on out-patient department in a general hospital or clinic. Depression is one of the commonest psychiatric illness all over the world. The majority of African patients suffering from depression present with somatic symptoms with pain in various parts of the body as leading complaints.

The other universally accepted symptoms of depression like those of appetite, disturbance of sleep and weakness were also complained of by many patients. Upto 25% of patients complain spontaneously of feeling depressed. Many of these patients had been to several medical clinics before being referred to the psychiatrist. Clinicians are helped not to waste time if they consider depression as a diagnosis in such cases (Cawthron and Acuda S.W. 1981).

The most extensive and comprehensive study has been that of Dhadphale, M. in his M.D. thesis (1984). In his study of the prevalence of psychiatric illness in primary health care facilities in rural districts (Kisumu, Kisii, Meru and Voi), a total of 881 patients were included.

Using a validated self-rating questionnaire (SRQ) and standardized Psychiatric interview (SPI), he found that overall psychiatric morbidity was 24.9%. 84% of the psychiatric morbidity cases did not have discernible organic illness but 15% of the psychiatric morbidity patients had an associated physical disorder. 58.2% psychiatric morbidity (or 14.5% of the total sample) had psychoneurosis. 15.4% of the psychiatric morbidity patients had affective psychosis (mainly manic type).

In another study on psychiatric morbidity among patients attending two general hospitals in Nyanza Province, Dhadphale and Ellison (1982), using General Health Questionnaire (GHQ) and SPI, found that 25.8% - 32% of the patients have conspicuous psychiatric morbidity.

Ndeti, D.M. and Muhangi, J. (1979) did a study on the prevalence and clinical presentation of psychiatric illness in a suburban area, Athi River, which is 28 km South East of Nairobi. They examined 140 patients in a walk-in-walk out clinic over a period of thirty days (30). 20% of the patients were found to be suffering primarily from a psychiatric disorder. These patients with psychiatric disorder were found to be suffering from anxiety and depressive states.

Mutiso, J. (1987) in his M.Med thesis focussed his attention to psychiatric aspects in infertile women seen at the gynaecology clinic at Kenyatta National Hospital. 52 women with primary and secondary infertility were included in the study. He had 35 controls matched for age, education, occupation and number of co-wives - selected from the family planning clinic at the same hospital. Using SRQ and SPI, he established that a high psychiatric morbidity (80.8%) exist among infertile women attending the clinic. The commonest symptoms were either anxiety or depressive states.

These were "Somatized" in nature and this he noted, was of great significance because the physician might find himself taking the wrong line in terms of management.

Because women are likely to develop neurotic disorders such as depressive episodes, anxieties or somatizations, and because anxiety, depressive states and psychosomatic disturbances are the most frequent types of mental disorder found in medical practice (Reichenheim 1991), the study is worth. The medical professional working in such clinics must know about and attend to the psychological components exhibited by the patients, and / or liaison amongst various departments should be increased.

CHAPTER TWO.

HYPOTHESIS

Various hypothesis were set.

- a) Psychiatric morbidity is significant among patients attending the gynaecology out-patient clinic.
- b) Psychiatric morbidity in gynaecological patients has multifactorial aetiology.
- c) These patient with psychiatric morbidity present with somatic symptoms more than psychological symptoms.

AIM OF STUDY:

To establish the magnitude of mental illness in a gynaecology out-patient clinic and the possible subsequent management of the problem.

OBJECTIVES OF THE STUDY.

- i) To determine the prevalence of psychiatric morbidity in female patients attending a gynaecology out-patient clinic.
- ii) To evaluate and determine the characteristics of this psychiatric morbidity with a view of formulating on effective approach to the holistic management of patients attending a gynaecology out-patient clinic.

iii) To collect any other relevant information on this subject thus making a tangible contribution to the advancement of scientific knowledge.

METHODOLOGY.

The study was done on female patients attending a gynaecology out-patient clinic at Kenyatta National Hospital (KNH), Nairobi, in the months of November, part of December (there was a break for Christmas holidays) 1991 and resumed in January and ended February 1992.

The author did a feasibility study at the said clinic prior to the study. She also sought ethical permission from the Ethical Research Committee which is based at KNH before starting the study. Permission was also sought from the Chairman of the department of Obstetrics and Gynaecology.

The population included all those female patients attending the gynaecology out patient clinic who were 18 years and above, as one is considered to be an adult from age 18 years and thence minimize any problem that may arise in terms of obtaining the consent. Also included in the study were those patients who were able to communicate in English and / or Kiswahili.

The systematic random sampling was used, whereby every fifth patient satisfying the inclusion criteria was included. Patients with known history of mental illness, obvious features of mental retardation, head injury, those with history of epilepsy or on anticonvulsants were excluded from the study.

The second

The interviews were carried out by the author after obtaining informed consents from the subjects. Questionnaires and patients' hospital files were used. All questionnaires were administered by the author. This was to ensure uniformity of questions which were put to all subjects in the study by the author. The study included 150 patients.

These

Every patient was interviewed for approximately 20 minutes, with the psychiatric morbidity cases taking approximately 25 - 30 minutes. An average of five patients were seen on each interview day. The patients were seen between 12.30 p.m. to 2.30p.m., as they waited to be seen by their gynaecology doctors.

The

The questionnaires were in three parts; the General socio-demographic data, the Self-Rating-Questionnaire (SRQ) and the standardized psychiatric interview questionnaire (SPI).

So

All patients were subjected to the socio-demographic information questionnaire which included information on age, level of education, occupation, religion, marital status, duration of

marriage, use of contraception, bad obstetric history, number of children, sex of children, any history of use of alcohol or any other substance use, any history of mental illness in the patient and / or in the patients family.

The "caseness"

The second part covered the mental state assessment. This is the self Rating Questionnaire (SRQ), which was designed by Harding et al (1980).

The SPI-15

This is a locally validated version (Dhadphale 1984). It consists of 25 items which require a "Yes" or "No" answer. The first 20 questions are designed to cover various neurotic symptoms. Of these 20 questions, four were on physical symptoms and 16 on psycho-emotional disturbances. The last part of the questionnaire has 5 questions of which four were for detecting psychotic illness and one question inquiring about seizures.

1.1.3) The

For analysis purposes, scores of 7 or under are defined as low and therefore no psychiatric morbidity. Those scoring 8 or over are defined as high.

Thus the predetermined cut off point for " caseness" was either 8 positive responses for the neurotic questions and / or one positive response to the psychotic questions.

In this study, the SRQ was therefore an instrument for detection of "cases". The "cases" are termed as psychiatric morbidity (PM) and the "non-cases" as No psychiatric morbidity (NPM).

The "cases" from the SRQ were subjected to the third part of the questionnaire, the standardized psychiatric interview (SPI), a modified version by Goldberg et al (1970).

The SPI is a confirmatory instrument, thus to confirm whether the case "cases" from the SRQ were "genuine cases" or not. It is a standardized semi-structured schedule for recording the subjects symptoms. It is divided into four parts:

- i) Sub-heading for recording the patients history of presenting illness.
- ii) Enquire more systematically about any psychiatric symptoms the patient may have experienced in the preceding week.
- iii) This part is unstructured for the recording of the family and personal histories.
- iv) This part enables the interviewer to observe and rate manifest abnormalities. These include behaviour, mood, perception and cognitive abnormalities. Each item was rated on a five-point scale:

- 0 - Not a case
- 1 - Subclinical degree of emotional disturbance.
- 2 - Mild.
- 3 - Moderate
- 4 - Severe psychiatric case (Dhadphale 1984).

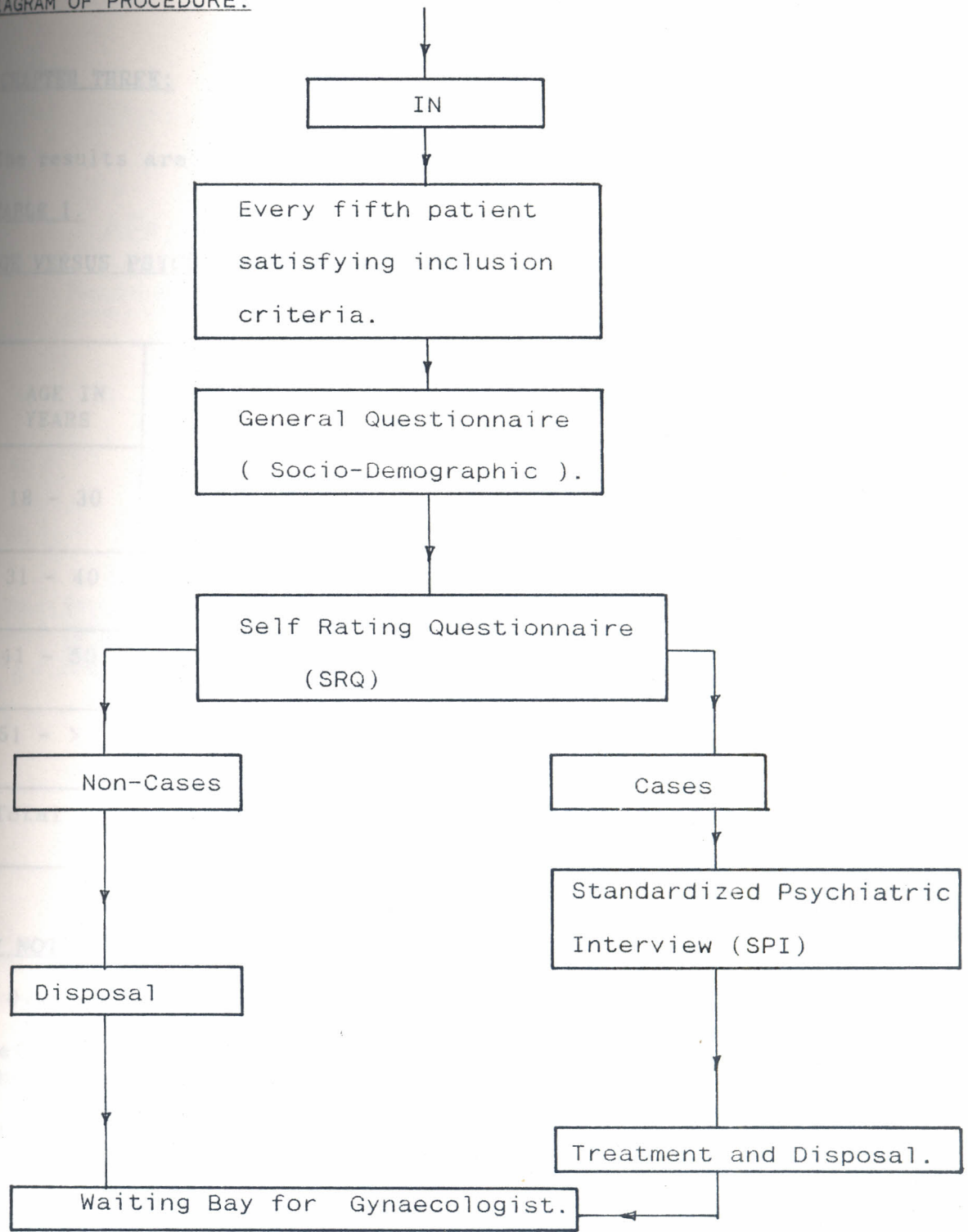
A psychiatric diagnosis of all the "genuine cases " was made using ICD 10 criteria (WHO, 1992). After the screening procedure the subjects were taken directly to the waiting - bay for the gynaecologist or to the gynaecologist right away.

The history of presenting illness and the gynaecologic diagnosis were also noted from the patients hospital files. Only "old" subjects were interviewed by the author as these had a gynaecological working diagnosis.

The data on the precoded questionnaires was analysed manually, with the help of a statistician.

The chi-squared test, χ^2 , was used for testing the significance. The results were significant if P value was less than 0.05. The results were also tabulated and in form of bar charts.

DIAGRAM OF PROCEDURE:



CHAPTER THREE:

The results are presented in form of tables, X^2 and Bar Charts.

TABLE 1.

AGE VERSUS PSYCHIATRIC MORBIDITY.

AGE IN YEARS	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
18 - 30	71(47.3%)	20(13.4%)	91(60.7%)	22%
31 - 40	34(22.6%)	7(4.7%)	41(27.3%)	17%
41 - 50	12(8%)	2(1.4%)	14(9.4%)	14%
51 - >	4(2.7%)	0(0%)	4(2.7%)	0%
Total	121(80.6%)	29(19.5%)	150(100%)	

FOOT NOTE:

$$X^2 = 0.44; p > 0.1$$

Therefore no significant relationship between age and morbidity. Of those with psychiatric morbidity 22% were between ages 18 - 30; 17% between ages 31 - 40; 14% between ages 41 - 50 while none in those 51 and over.

FIGURE 2.
LEVEL OF EDUCATION VERSUS PM.

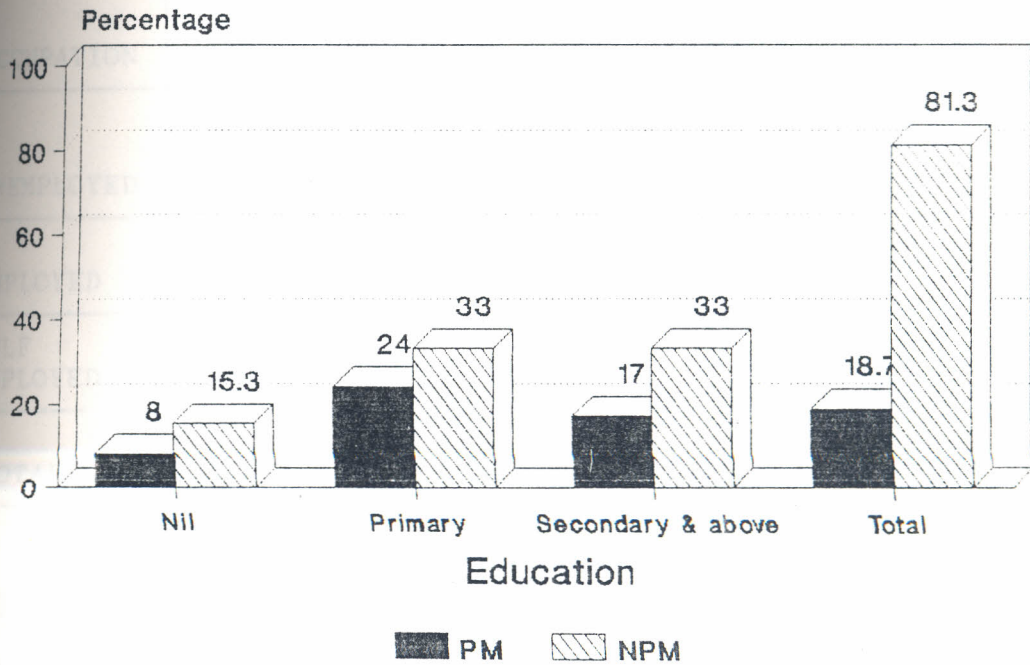


TABLE III.

OCCUPATION VERSUS PSYCHIATRIC MORBIDITY.

OCCUPATION	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
UNEMPLOYED	79(53%)	15(10%)	94(63%)	16%
EMPLOYED	29(19%)	7(5%)	36(24%)	19%
SELF EMPLOYED	14(9%)	6(4%)	20(13%)	30%
TOTAL	122(81%)	28(19%)	150(100%)	

FOOT NOTE:

$X^2 = 1.363; p > 0.1$

Therefore statistically not significant. Of the patients with psychiatric morbidity, 16% were unemployed, 30% self-employed while 19% were employed.

FIGURE 3.
OCCUPATION VERSUS PSYCHIATRIC MORBIDITY

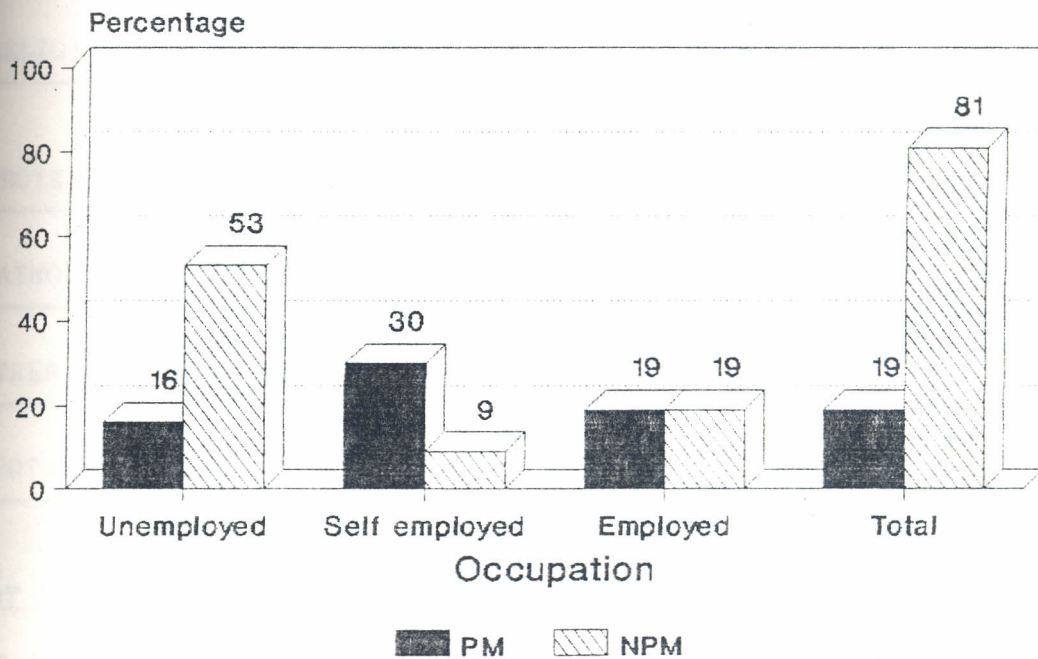


TABLE IV.

RELIGION VERSUS PSYCHIATRIC MORBIDITY.

RELIGION	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
PROTESTANT	76 (51%)	20 (13%)	96 (64%)	21%
CATHOLIC	37 (24%)	7 (5%)	44 (24%)	16%
OTHER	9 (6%)	1 (1%)	10 (7%)	10%
TOTAL	122 (81%)	28 (19%)	150 (100%)	

FOOT NOTE:

$X^2 = 0.305; p > 0.05$

Therefore statistically not significant. Of those with psychiatric morbidity, 21% were protestants, 16% were catholics while 10% belonged to other groups.

FIGURE 4.
RELIGION VERSUS PSYCHIATRIC MORBIDITY.

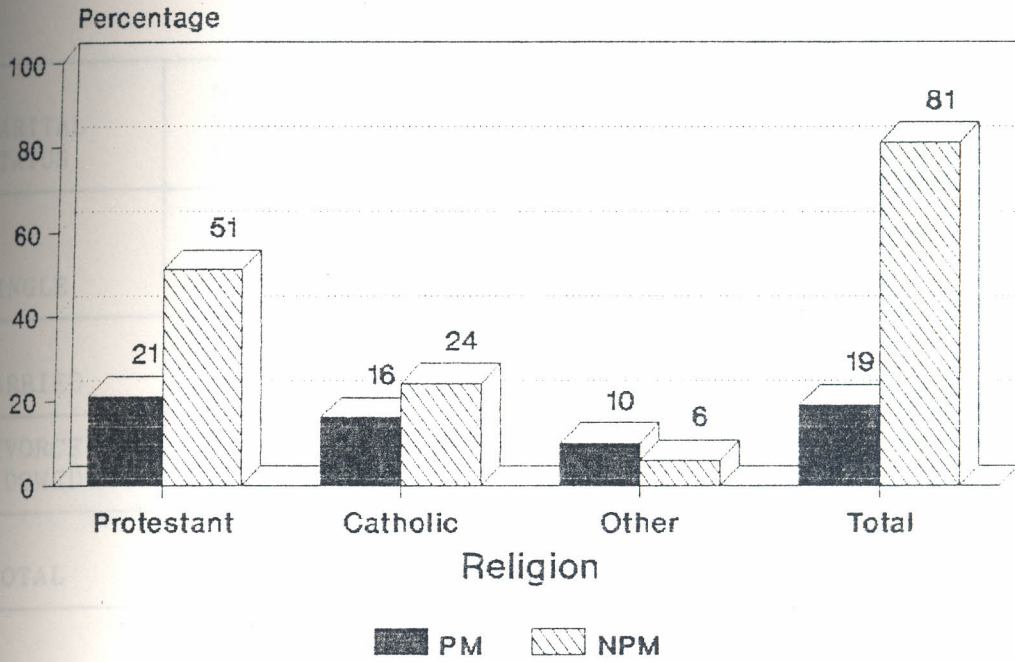


TABLE V.

MARITAL STATUS VERSUS PSYCHIATRIC MORBIDITY.

MARITAL STATUS	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
SINGLE	22 (15%)	3 (2%)	25 (17%)	12%
MARRIED	90 (60%)	19 (13%)	109 (73%)	17%
DIVORCED WIDOWED	11 (7%)	5 (3%)	16 (10%)	31%
TOTAL	123 (81%)	27 (19%)	150 (100%)	

FOOT NOTE:

$\chi^2 = 1.35; p > 0.1$

Therefore statistically not significant. Of the patients with psychiatric morbidity, 12% were single, 17% were married while 31% were divorced or widowed.

FIGURE 5. MARITAL STATUS
VERSUS PSYCHIATRIC MORBIDITY.

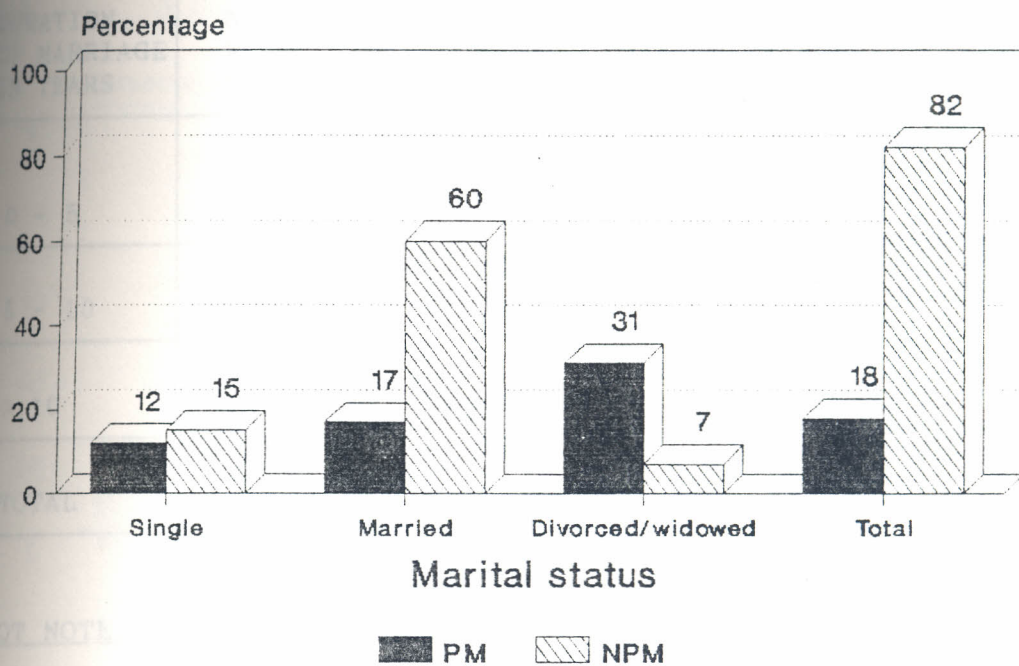


TABLE VI.

DURATION OF MARRIAGE VERSUS PSYCHIATRIC MORBIDITY.

FIGURE

DURATION OF MARRIAGE IN YEARS	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
0 - 5	27 (24%)	10 (9%)	37 (33%)	27%
5 - 10	22 (20%)	5 (5%)	27 (25%)	18.5%
> 10	39 (35%)	8 (7%)	47 (42%)	17%
TOTAL	88 (79%)	23 (21%)	111 (100%)	

FOOT NOTE:

$\chi^2 = 0.72; p > 0.1$

Therefore statistically not significant. Of those with psychiatric morbidity, 27% had been married for less than 2 years; 18.5% for 5 - 10 years while 17% for over 10 years.

FIGURE 6. DURATION OF MARRIAGE VERSUS PSYCHIATRIC MORBIDITY.

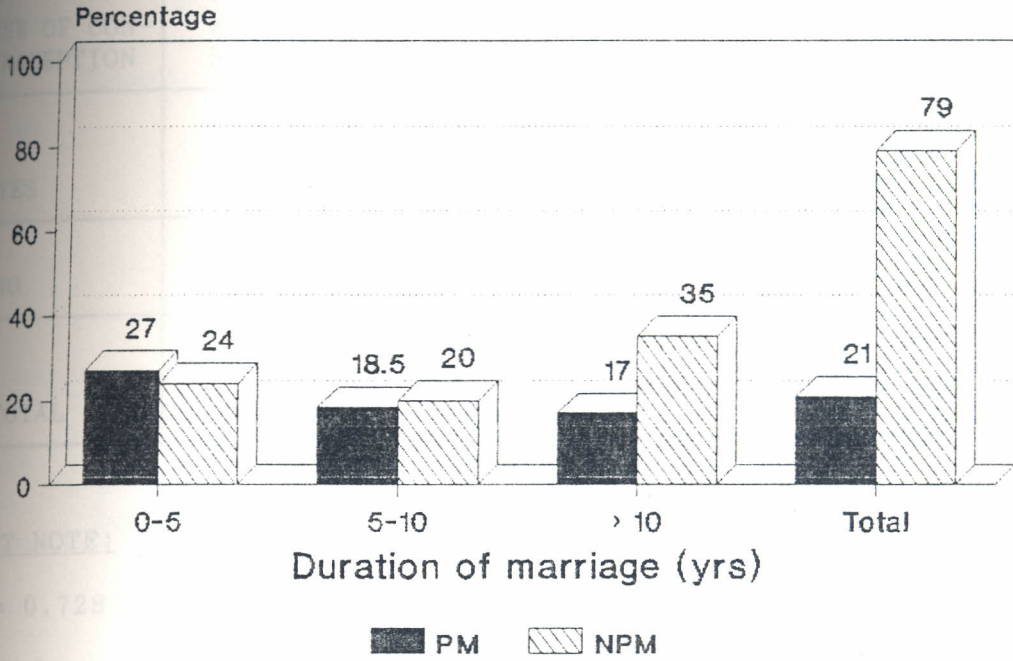


TABLE VII.

CONTRACEPTION USE VERSUS PSYCHIATRIC MORBIDITY.

USE OF CON- TRACEPTION	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
YES	38(25%)	12(8%)	50(33%)	24%
NO	84(56%)	16(11%)	100(67%)	16%
TOTAL	122(81%)	28(19%)	150(100%)	

FOOT NOTE:

$$X^2 = 0.728; \quad p > 0.05$$

Therefore statistically not significant. Of the patients with psychiatric morbidity, 24% used contraceptive methods while 16% did not.

FIGURE 7. CONTRACEPTION USE VERSUS PSYCHIATRIC MORBIDITY.

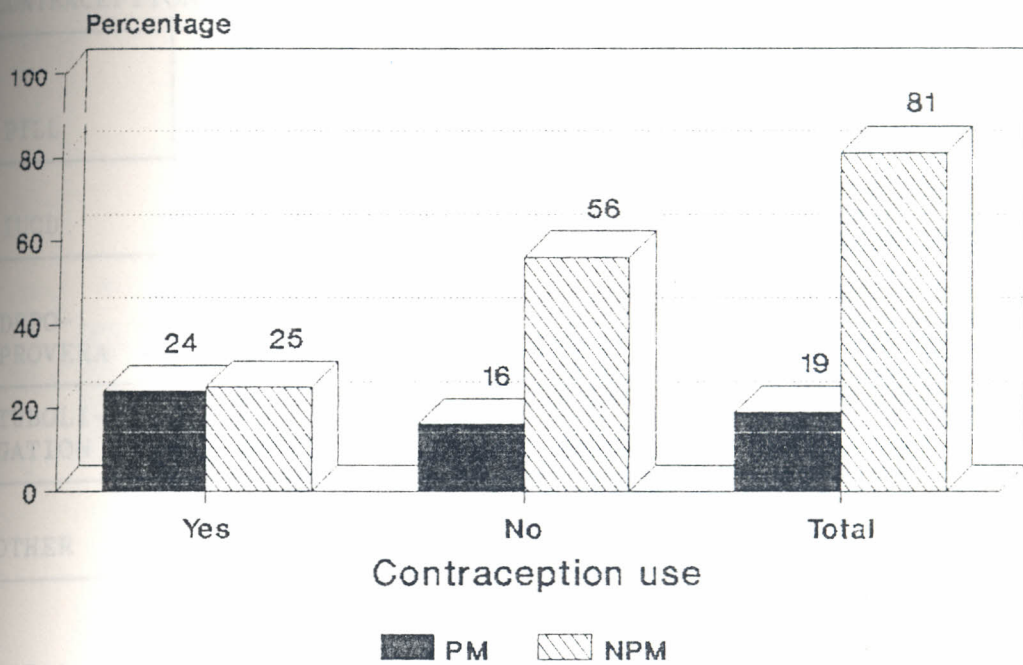


TABLE VIII.

TYPE OF CONTRACEPTION VERSUS PSYCHIATRIC MORBIDITY.

TYPES OF CONTRACEPTION	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
PILL	20 (29%)	10 (15%)	30 (44%)	33%
IUCD	17 (24.6%)	3 (4%)	20 (28.4%)	15%
DEPO-PROVERA	7 (10%)	1 (1.4%)	8 (11.4%)	13%
TUBOLI-GATION	5 (7%)	2 (3%)	7 (10%)	29%
OTHER	4 (6%)	0 (0%)	4 (6%)	0%
TOTAL	53 (76.6%)	16 (23.4%)	69 (100%)	

FOOT NOTE:

Of those with psychiatric morbidity, 33% used pills; 15% used intrauterine contraceptive devices; 13% used depoprovera; 29% had tuboligation while 0% for any other form of contraception.

TABLE IX.

BAD OBSTETRIC HISTORY (BOH) VERSUS PSYCHIATRIC MORBIDITY.

BOH	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
YES	53 (35%)	14 (9%)	67 (44%)	21%
NO	70 (47%)	13 (9%)	83 (56%)	16%
TOTAL	123 (82%)	27 (18%)	150 (100%)	

FOOT NOTE:

$$\chi^2 = 1.088; p > 0.05.$$

Therefore statistically not significant. Of the patients with psychiatric morbidity, 21% had BOH while 16% did not have.

TABLE X.

CHILD VERSUS PSYCHIATRIC MORBIDITY.

CHILD	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
YES	63 (45%)	14 (9%)	81 (54%)	17%
NO	56 (37%)	13 (9%)	69 (46%)	19%
TOTAL	123 (82%)	27 (18%)	150 (100%)	

FOOT NOTE:

$\chi^2 = 1.164^{03}$; $p > 0.05$.

Therefore statistically not significant. Of the patients with psychiatric morbidity, 19% had no children while 17% had children.

FIGURE 10. PRESENCE OF CHILD
VERSUS PSYCHIATRIC MORBIDITY.

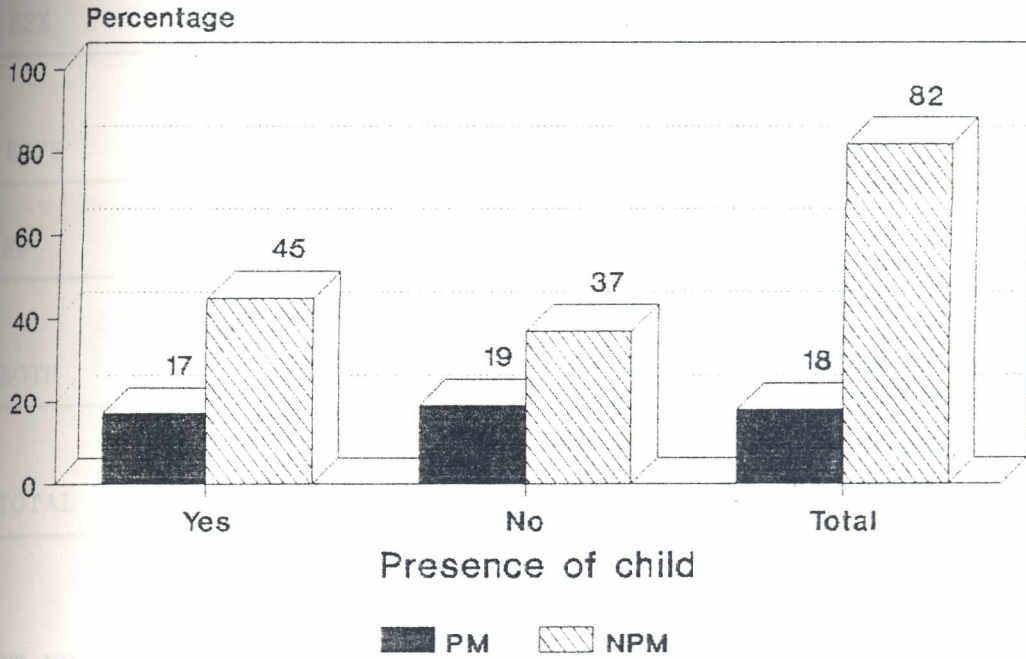


TABLE XI.

SEX OF CHILD VERSUS PSYCHIATRIC MORBIDITY.

SEX	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
BOYS	17(21%)	6(7.4%)	23(28.4%)	26%
NO	17(21%)	4(4.9%)	21(25.9%)	19%
BOTH	33(40.7%)	4(4.9%)	37(45.7%)	10.8%
TOTAL	67(82.7%)	14(17.3%)	81(100%)	

FOOT NOTE:

$\chi^2 = 1.8456; p > 0.05.$

Therefore statistically not significant. Of those with psychiatric morbidity 26% had only boys, 19% had only girls and 10.8% had both boys and girls.

FIGURE 11. SEX OF CHILD
VERSUS PSYCHIATRIC MORBIDITY.

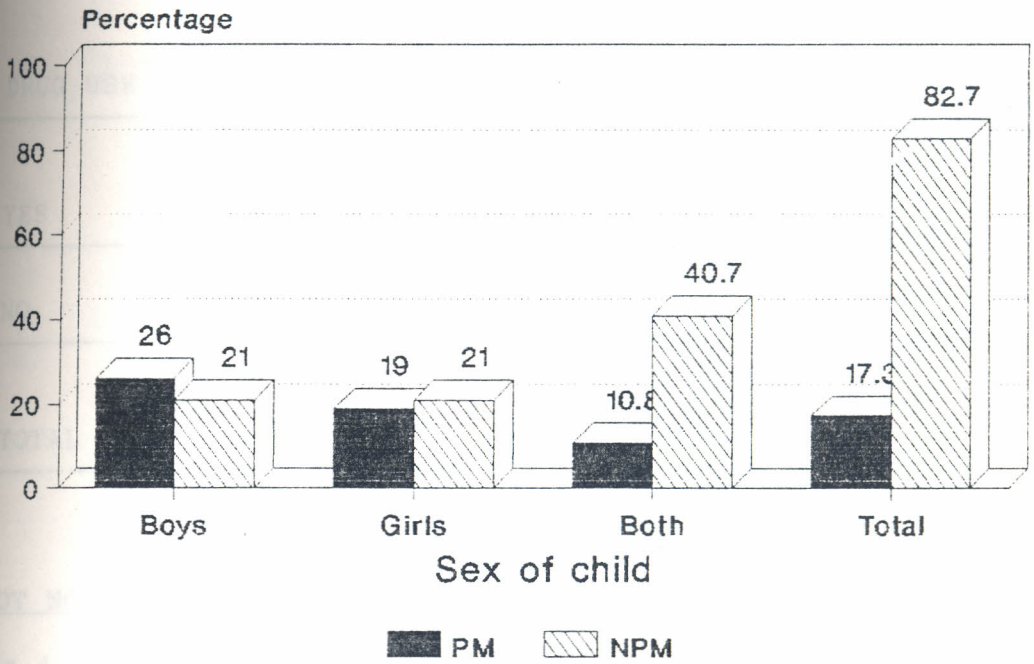


TABLE XII.

DRUG USED VERSUS PSYCHIATRIC MORBIDITY.

DRUG USE	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
YES	20 (13.4%)	11 (7.3%)	31 (20.7%)	35%
NO	102 (68%)	17 (11.3%)	119 (79.3%)	14%
TOTAL	122 (81.4%)	28 (18.6%)	150 (100%)	

FOOT NOTE:

$$X^2 = 4.6188; p < 0.05.$$

Therefore statistically significant. Of those with psychiatric morbidity, 35% had history of alcohol use while 14% had no history of alcohol use.

FIGURE 12.
DRUG USE VERSUS PSYCHIATRIC MORBIDITY.

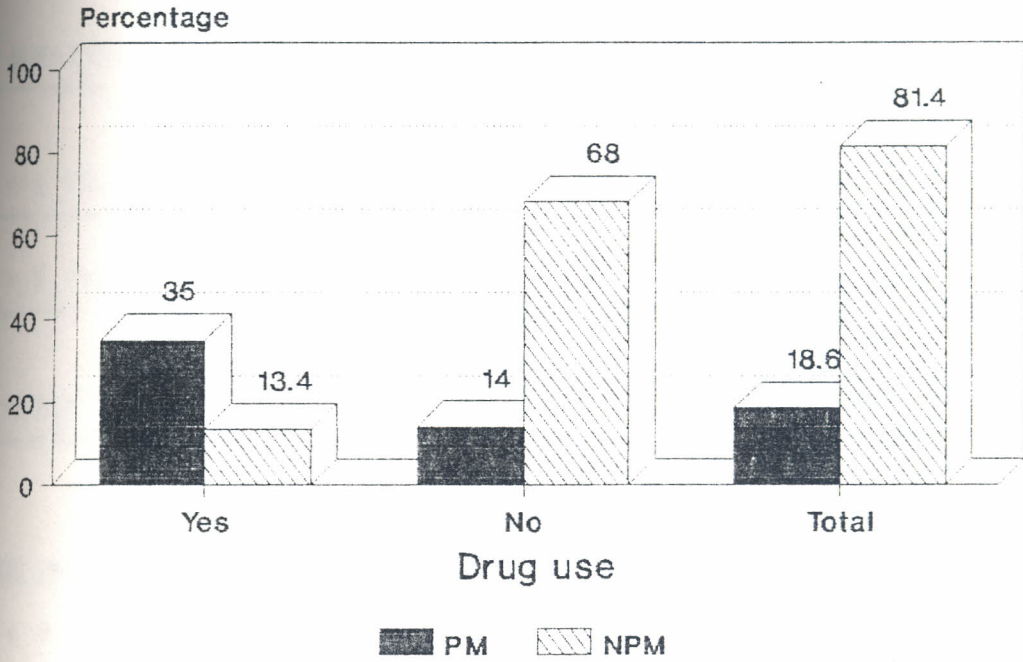


TABLE XIII.

DURATION OF DRUG USE VERSUS PSYCHIATRIC MORBIDITY.

DURATION	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
< 1 YEAR	3 (10.7%)	4 (14.3%)	7 (25%)	57%
> 2 YEARS	14 (50%)	4 (25%)	21 (75%)	33%
TOTAL	17 (60.7%)	11 (39.3%)	28 (100%)	

FOOT NOTE:

$X^2 = 0.449; p > 0.05.$

Therefore statistically not significant. Of those with psychiatric morbidity, 57% had used drugs for less than one year while 33% had used for more than 2 years.

FIGURE 13. DURATION OF DRUG USE
VERSUS PSYCHIATRIC MORBIDITY.

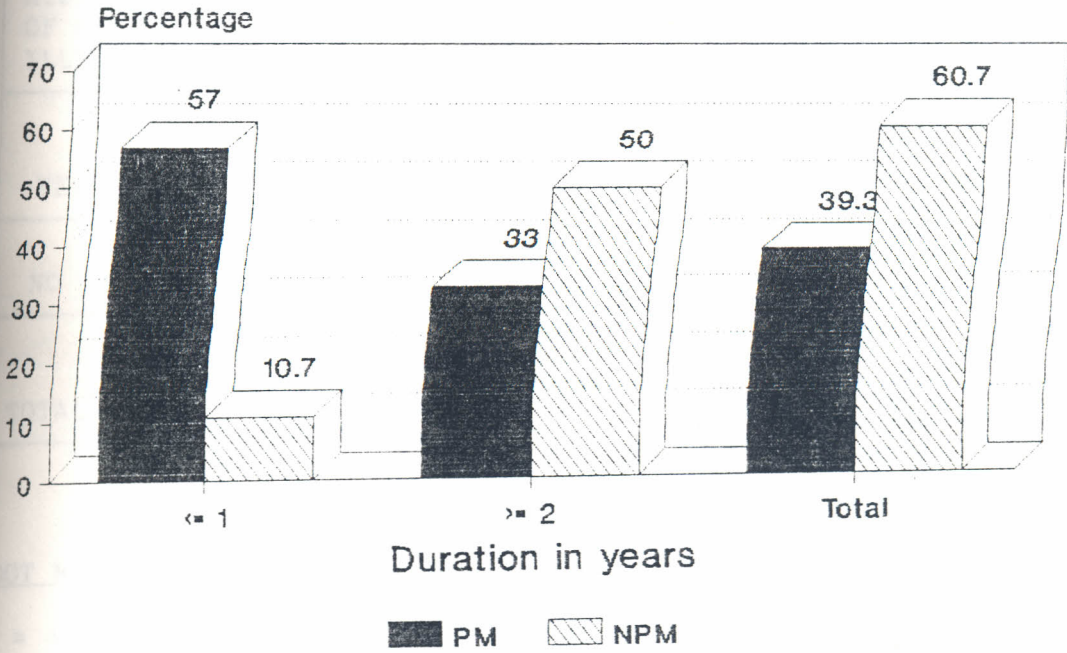


TABLE XIV.

MENTAL ILLNESS IN FAMILY VERSUS PSYCHIATRIC MORBIDITY.

HISTORY OF MENTAL ILLNESS	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
YES	9(6%)	6(4%)	15(10%)	40%
NO	115(76.7%)	20(13.3%)	35(90%)	14.8%
TOTAL	124(82.7%)	26(17.3%)	150(100%)	

FOOT NOTE:

$\chi^2 = 4.35; p < 0.05.$

Therefore statistically significant. Of those with psychiatric morbidity, 40% had positive history of mental illness in the family while 14.8% did not have a positive family history of mental illness.

FIGURE 14. MENTAL ILLNESS IN FAMILY VERSUS PSYCHIATRIC MORBIDITY.

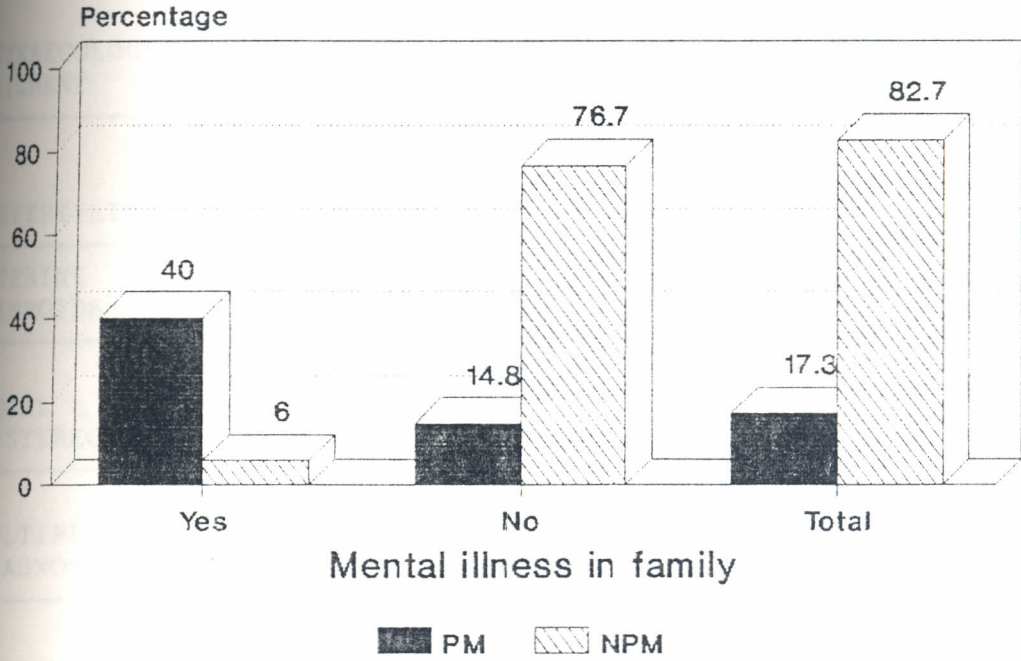


TABLE XV.

GYNAECOLOGICAL AILMENT VERSUS PSYCHIATRIC MORBIDITY.

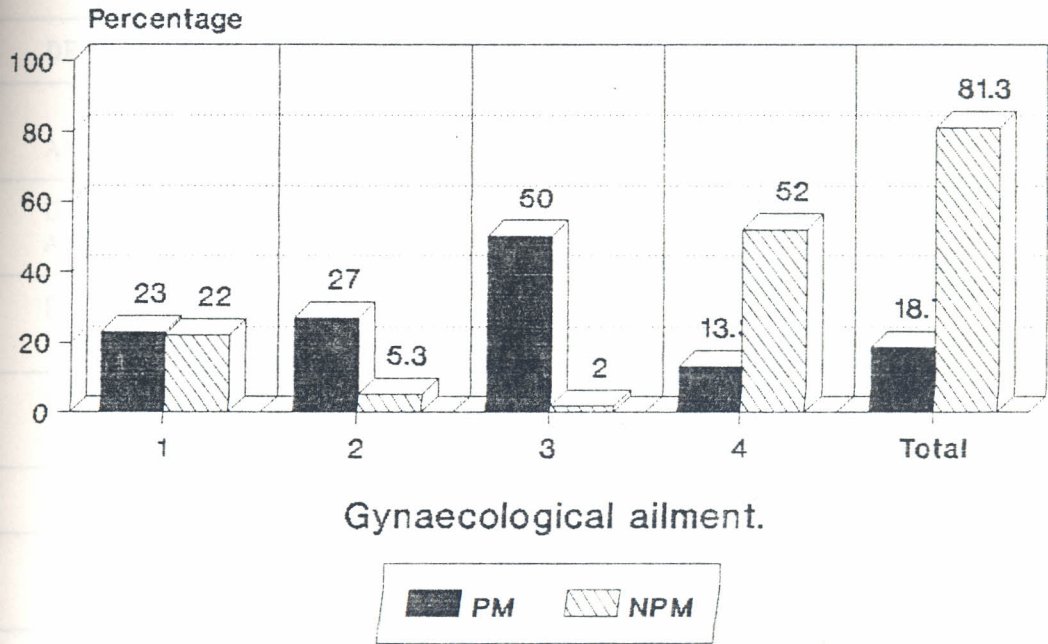
GYNAECOLOGY AILMENT	NUMBER WITH NPM	NUMBER WITH PM	WITH TOTAL	% OF THOSE WITH PM
INFERTILITY	33 (22%)	10 (6.7%)	43 (28.7%)	23%
UTERINE FIBROIDS	8 (5.3%)	3 (2%)	11 (7.3%)	27%
TOTAL HYSTERECTOMY	3 (2%)	3 (2%)	6 (4%)	50%
MULTIPLE DIAGNOSIS	78 (52%)	12 (8%)	90 (60%)	13.3%
TOTAL	122 (18.3%)	28 (18.7%)	150 (100%)	

FOOT NOTE:

$\chi^2 = 4.02; p > 0.05.$

There was no statistical significance between psychiatric morbidity and type of gynaecology ailment. Of the patients with psychiatric morbidity, 23% had infertility, 27% with uterine fibroids, 50% total hysterectomy and 13.3% had more than one gynaecology diagnosis.

**FIGURE 15. GYNAECOLOGY AILMENT
VERSUS PSYCHIATRIC MORBIDITY.**



1=infertility 2=Uterine fibroids
3=Total hysterectomy
4=Multiple diagnosis

TABLE XVI

DISTRIBUTION OF PSYCHIATRIC ILLNESS.

PSYCHONEUROSES	NO	%	% OF THOSE WITH PM
DEPRESSION	10	7%	34.5%
ANXIETY	4	3%	13.8%
DEPRESSION AND ANXIETY	13	9%	44.9%
PERSONALITY DISORDER	0	0%	0%
PSYCHOSIS SCHIZOPHRENIA	1	2.3%	3.4%
MD P	1	2.3%	3.4%
TOTAL	29	23.6%	

The distribution of psychiatric illness is shown in the table above. Of those with psychiatric morbidity, 34.5% had depression, 13.8% had anxiety 44.9% had both depression and anxiety, non had personality disorder while schizophrenia and Manic depressive pschosis both rated 3.4%

TABLE XVII

SRQ AND CONFIRMATION AS CASES ON SPI.

		NO	%
NPM	0-5	103	68.7%
	6-7	18	12%
PM CONFIRMED BY SPI	8-10	18	12%
	11-13	7	4.7%
	> 13	4	2.6%
	TOTAL	150	100%

The table above shows the distribution of the SRQ points, cut off point being 8 points.

CHAPTER FOUR.

DISCUSSION.

PREVALENCE OF PSYCHIATRIC MORBIDITY.

In the study, the point prevalence of psychiatric morbidity was 19.5% of the total population (29 cases of the total 150). Psychosis was found only in two cases. One had schizophrenia and the other had a bipolar affective disorder. The patient with schizophrenia had a positive history of auditory hallucinations and her elder brother and younger sister were patients of Mathare Mental Hospital. The patient was taking medication for psychosis from a private practitioner. The subject was encouraged by the author to continue with the medication but to be followed up at the psychiatric out-patient clinic, Kenyatta National Hospital.

The subject diagnosed as having a bipolar affective disorder had earlier on suffered two episodes of hypomania but had not been treated for the same. Currently the patient has psychosomatic symptoms suggestive of a depressive illness. Amitriptyline 50mg nocte for a three month's duration was prescribed and the patient booked for psychiatric follow up at the psychiatric out patient clinic, Kenyatta National Hospital.

No personality disorders were observed, probably because a single out-patient encounter does not expose sufficient assessment for a proper appraisal of personality.

Dhadphale (1984) in his study found that 20% to 24.9% of the total population had psychiatric morbidity.

The somatic presentation of psychiatric morbidity has never been adequately understood. Some people are selectively aware of bodily functions and this sensitivity may shape the pattern of their symptoms if they develop a psychiatric illness (Kendell, 1988). According to Kendell (1988) somatic symptoms occur in all psychiatric illness and in some, they dominate the clinical picture to such an extent that the patient believes herself to be physically ill. This perception determines the pattern of contact with medical services. The limited acceptance and greater stigma of psychiatric illness have been implicated in symptoms being described mainly in physical terms.

The present study confirms the high prevalence and the significance of psychiatric morbidity in patients attending a gynaecology outpatient clinic. Most of those with psychiatric morbidity had psychosomatic complaints. This is of great concern to the psychiatrist.

PSYCHONEUROSES:

In this study, a significantly high rate of psychoneuroses was found. 27(18% of the total population) subjects were found to have psychoneuroses. This was 93% of those with psychiatric morbidity. Most of the subjects with psychoneuroses were within the age range of 18 - 30 years.

Most of them presented with multiple vague somatic symptoms. Of those with psychoneuroses, 10(7% of the total population and 34.5% of those with psychiatric morbidity) had depression; 4(3% of the total population and 13.8% of those with psychiatric morbidity) had anxiety ; while 13 (9% of the total population and 45% of those with psychiatric morbidity) had a mixed picture of depression and anxiety.

Dhadphale (1984) found that 14.5% of the total sample had psychoneuroses. The prevalence of psychoneuroses in this study is therefore comparable with other studies.

DEPRESSION.

In the study, 10 patients out of the 29 with psychiatric morbidity i.e 34.5% had depression, this was 7% of the total population. Symptoms complained of by these patients were mainly psychosomatic in nature.

They mainly complained of headaches which were mainly described as "burning sensations at the vault", at times the headaches were described as "cold sensations and tiredness in the head" particularly at the occiput and nape. They also complained of poor appetite which was mainly described as a persistent "fullness of the stomach" hence little need for eating. Patients also often complained of pain in other parts of the body particularly joint aches and low backache.

Most of them would say " I always suffer from 'malaria' which can't be cured, as I have taken many antimalarial drugs but with no good improvement " .

Other symptoms reported by the patients included poor sleep, constipation, feeling unhappy most of the time, forgetfulness, poor memory, feeling worthless, easy fatigability and anhedonia. A few of the subjects (four) reported suicidal ideation but none had actually attempted suicide and none had fixed plans on how to commit the suicide.

According to Cawthron and Acuda S.W (1981) depression is one of the commonest psychiatric illness all over the world and that the majority of African patients suffering from depression present with somatic symptoms with pain in various parts of the body as leading complaints.

They found that upto 25% of patients complained spontaneously of feeling depressed.

ANXIETY.

Anxiety per se was found in 4 subjects of the total 29 subjects thus 13.8% of those with psychiatric morbidity and 3% of the total population (see Table XVI). In this study, patients with anxiety reported mainly the following symptoms- fearful anticipation, nervousness, irritability, sensitivity to noise and feeling tense, worried and restless for no apparent reason.

Most of the patients with psychiatric morbidity had a mixed picture of depressive and anxiety states. Thus of the 29 patients with psychiatric morbidity, 13(45%) had both depressive and anxiety features (see Table XVI).

Dhadphale in his study (1984) found that 4.5% of those with psychoneuroses had anxiety. Mutiso (1987) in his study found that 9.6% of those with psychoneuroses had anxiety.

AGE:

The age distribution is shown in Table I and figure I. There was no statistical significance in age distribution between those patients with psychiatric morbidity and those without psychiatric morbidity.

However from Table I it can be seen that 20 subjects of the 29 subjects with psychiatric morbidity were between age groups 18 - 30 years. Thus 68.9% of the subjects with psychiatric morbidity and 13.4% of the total population were found in this age range.

7 subjects (4.7% of the total population and 17% of those with psychiatric morbidity) were in the age group 31-40 years, while 2 subjects (1.4% of the total population and 14% of those with psychiatric morbidity) were in the age group 41 - 50 years. Of the patients in the age group 51>, none had psychiatric morbidity.

Byrne (1984) also found that psychiatric morbidity was concentrated in the younger patients as compared to the elderly, thus he found high prevalence rates in those with ages 18 - 35 years.

LEVEL OF EDUCATION.

There was no statistically significant difference between the level of education and the prevalence of psychiatric morbidity. Of those with psychiatric morbidity 8% had no formal education (2 subjects - 1.3% of the total population). 16 subjects (24% of those with psychiatric morbidity and 10.7% of the total population had attained primary level education; 10 subjects (17% of those with psychiatric morbidity and 6.7% of the total population) had secondary level education.

None of the patients had University level education. Byrne (1984) using social classes, found no statistically significant difference between social class and psychiatric morbidity.

MARITAL STATUS.

Marital status bore no statistical significance to psychiatric morbidity in this study. From Table V however, psychiatric morbidity was higher in those who were married than any other marital status. 19 subjects (13% of the total population and 17% of those with psychiatric morbidity) were married.

3 subjects (2% of the total population and 12% of those with psychiatric morbidity) were single, while 5 subjects (3% of the total population and 31% of those with psychiatric morbidity) were divorced or widowed.

Duration of marriage did not also reach statistical significance.

Dhadhapple (1984) also found no statistically significant difference between marital status and psychiatric morbidity.

Robertson (1974) found that married state in women often seemed to act as an additional strain leading to the development of mental illness. Ballinger (1977) however, found that a higher proportion of women in the gynaecology clinic group were separated or divorced. Byrne (1984) also found that married women in the community tended to be protected against psychiatric disorders and had a case rate of 15% compared with the rate among subjects who were divorced, separated or widowed of 44%.

The small number in this study group however makes it difficult to make conclusive remarks.

USE OF CONTRACEPTION.

Use of contraception was not significantly associated with psychiatric morbidity (see Tables VII and VIII).

In the study it was found that 12 subjects (8% of the total population and 24% of those with psychiatric morbidity) had used contraceptive methods in one way or another. 16 subjects (11% of the total population and 16% of those with psychiatric morbidity) had not at any one time used contraceptive methods.

10 subjects (15% of the total number of those who have used contraception and 33% of those with psychiatric morbidity) had used pills, 3 subjects (4% of the total population and 15% of those with psychiatric morbidity) had used IUCD (Intrauterine Contraceptive Device); 1 subject (1.4% of the total population and 13% of those with psychiatric morbidity) had used Depo-provera;

2 subjects (3% of the total population and 29.1% of those with psychiatric morbidity) had been done tuboligation while none of those with psychiatric morbidity described any other form of contraceptive use, such as foam tablets, Barrier methods and condoms.

Because of the small number in this study, no conclusive remarks can be made from the study.

BAD OBSTETRIC HISTORY (BOH).

There was no statistically significant association between BOH and psychiatric morbidity. From the study (See Table IX), a total of 67 patients had BOH which included history of abortions,

stillbirths and ectopic pregnancy. Of the 67 subjects with BOH, 14 subjects (9% of the total population and 21.1% of those with psychiatric morbidity) had psychiatric morbidity. 83 subjects had no BOH; of these, 13(9% of the total population and 16% of those with psychiatric morbidity) had psychiatric morbidity.

Mutiso (1987) also found no statistically significant association between history of BOH and psychiatric morbidity.

INFERTILITY.

Surprisingly from this study, there was no statistical significance between infertility and psychiatric morbidity (see Table X). From the study, 14 subjects (9% of the total population and 17% of those with psychiatric morbidity) had children while 13 subjects (9% of the total population and 19% of those with psychiatric morbidity) did not have any child. 56 subjects (37% of the total population) had no children but did not have psychiatric morbidity.

For those who had children, the sex of the child did not have any statistical significance (see Table XI). Of those with psychiatric morbidity 26% had only boys, 19% had only girls and 10.8% had both boys and girls.

Mutiso (1987) in his study on infertile women attending a gynaecology out-patient clinic, established a significantly high psychiatric morbidity, 80.8% between those with infertility and those with no infertility.

DRUG USE

History of drug use bore statistical significance in relation to psychiatric morbidity (Table XII). In this study, patients were required to answer in an affirmative form whether they use alcohol or any other drug.

It was found that 11 subjects (7.3% of total population and 35% of those with psychiatric morbidity) had used alcohol while 17 subjects (11.3% of the total population and 14.1% of those with psychiatric morbidity) did not have a positive history of drug use. Of all the subjects with a positive history of drug use, only one had a history of tobacco sniffing but the rest (30 subjects) had ingested alcohol only. There was no statistically significant association between duration of drug use and psychiatric morbidity (see Table XIII). The small number that was included in the study population, however, makes it difficult to make conclusive remarks.

MENTAL ILLNESS IN THE FAMILY.

History of mental illness in the family was significantly associated with psychiatric morbidity (see Table XIV).

6 subjects (4% of the total population and 40% of those with psychiatric morbidity) had a positive history of mental illness in their family members. 20 subjects (13.3% of the total population and 14.8% of those with psychiatric morbidity) did not have a positive history of mental illness in the family members.

GYNAECOLOGY DIAGNOSIS.

There was no statistically significant association between the type of gynaecologic ailment and psychiatric morbidity. From Table XV however, 10 subjects (6.7% of total population and 23% of those with psychiatric morbidity) had infertility; 3 subjects (2% of the total population and 27% of those with psychiatric morbidity) had uterine fibroids; 3 subjects (2% of total population and 50% of those with psychiatric morbidity) had total abdominal hysterectomy while 12 subjects (8% of total population and 13.3% of those with psychiatric morbidity) had more than one gynaecologic diagnosis. In this last group (Multiple diagnoses), most of the patients had pelvic inflammatory disease and menstrual abnormalities in association with other diagnoses.

Byrne (1984) found that pelvic pain and swelling was associated with the highest case rate (74%) and that other symptoms did not have statistical significance.

CONCLUSIONS.

This research study, which was carried out at the Gynaecology out patient clinic, K.N.H., has revealed that psychiatric morbidity does exist among those patients attending the said clinic. The point prevalence found was 19.5%.

Most of these patients had psychoneuroses, in particular mood disorders (depressed state) which carried 34.5% of those with psychiatric morbidity; neurotic anxiety which had a case rate of 13.8% of those with psychiatric morbidity and the mixed state of depression and anxiety that had a case rate of 45% of those with psychiatric morbidity.

Most of the variables tested, though did not reach statistical significance, revealed high correlation with psychiatric morbidity. Age for instance revealed that most of those patients with psychiatric morbidity were in the younger age group, between ages 18 - 30 years.

Two variables however reached statistical significance. These are positive history of mental illness in the family members and a positive history of drug use by the patient.

It is however difficult to make conclusive remarks due to the small number of subjects included in the study.

One major thing that stands out clearly is that many of the patients' psychological needs were not attended to by their gynaecologic doctors. Most probably the gynaecologist pay little if any attention to the psychological component of the patients' illness.

From the literature review, most of the authors found the point prevalence of psychiatric morbidity in various out-patient health care facilities (general out-patient clinics or specific out-

patient clinics) to be a round 20%, in keeping with the current study (Dhadphale 1984; Ndetei and Muhangi 1979; Geil et al 1969; Byrne 1984).

LIMITATIONS.

During this study, several problems and constraints were encountered.

First, to get authority from the department of obstetrics and gynaecology took very long as it was not easy to get hold of the very busy chairman of the department to give consent. It was also very difficult to get the records clerks to fit the authors' schedule in theirs; particularly when the author was to interview the patients over the Lunch hour period.

During the initial stages, the author interviewed patients from 2.00p.m on the clinic day, thus coinciding with the gynaecologists. This method however, was not compatible with the gynaecology clinic routine. The fact that the gynaecologists first divided all the patients' files among themselves before they actually started seeing the patients, meant that those patients whose files were with the author were not divided among the gynaecologists, hence these patients were not seen by the gynaecologist. This necessitated the author to reschedule her time to 12.30p.m to 2.00p.m (Lunch hour period).

Lastly, the author thought initially that she would be sponsored by the University of Nairobi, Postgraduate Programme Unit or by any other organization to carry out her study, but to her surprise, this was not so. This meant that the author had to sponsor herself to do the study, it was therefore very difficult for the author to hire any assistants. The author therefore had to see every patient and ask all the questions.

RECOMMENDATIONS.

Health education programmes to the community through mass media, schools, churches and chiefs' "Barazas" should be encouraged. In these programmes, emphasis must be put on mental health, to educate the community that mental illness is just like any other illness and that having a psychiatric disorder is not equal to being "mad".

All clinicians must be aware that about 20% of the patients they are seeing at any one given time have psychological disturbance and hence must always remember to ask their patients questions that will reveal this, questions on appetite for food and sex, sleep pattern; pain in several parts of the body or duration of symptoms and medication in the past will guide the clinician to whether the patient has psychological disturbance or not.

A gynaecologist with psychiatric training should be based at the Gynaecology out-patient clinic so that any patient suspected to be having psychological disturbance should be referred to him immediately. Alternatively psychiatrist should be attached to gynaecology out-patient clinic, so that he can be able to review those patients thought to have a psychiatric disorder.

A gynaecologist should be able to diagnose and treat mild to moderate psychiatric disorders and refer those patients thought to have severe psychiatric disorders.

Psychopharmacological refresher courses should be established as the author noted that of those patients already started on medication, were started on far too small doses such as tables chlorpromazine 25mg once daily for treatment of psychosis.

CHAPTER FIVE.

APPENDIX I- CASE VIGNETTS.

CASE NO.1

This was a young lady 28 years of age, married with no child, and working as a subordinate staff with the University of Nairobi. She has been attending the Gynaecology out-patient clinic for the last six months in hope of getting a baby.

Six months ago, she was admitted to the gynaecology in-patient wards as an emergency case to rule out ruptured ectopic pregnancy. At laparotomy, there was no uterus nor fallopian tubes. Patient was however, not told of the findings at laparotomy, and yet continues with the out-patient clinic in hope of getting a baby. Gynaecology doctors did not know how to disclose the laparotomy findings to the patient.

On interview with the patient, she had only three question on the SRQ answered "Yes" therefore did not qualify as a "case". During the interview however, the patient broke down in tears but could not disclose the reason of her crying. The author booked the patient to be followed up in the Psychiatric out patient clinic but she did not show up. The author however, discussed the issue with the gynaecology doctors and advised that the patient should know the truth, as this will make the patient grieve over it and hopefully reover from the "shock".

CASE NO.II

This was a 38 year old mother of one, widowed now for five years, living at Kariandudu. She has been attending the gynaecology outpatient clinic due to lower abdominal pains, a mass per abdomen and now associated with PV bleeding for the last three weeks. Patient is being treated as a case of uterine fibroids with pelvic inflammatory disease (PID).

Interview with the patient revealed that she uses alcohol as much as is available (over 6 bottles of beer) now for over five years. SRQ rated ten for "Yes" and on SPI, she was rated as a case of moderate depression.

Her elder brother is being followed up at Mathare mental hospital due to mental illness (the nature of the illness is not known).

The author advised the patient to stop alcohol immediately as this will "aggravate" her illness and was given a prescription for an antidepressant (tabs amitriptyline 50mg nocte) for three months.

CASE NO.III.

This was a 68 year old mother of three living children and three dead (two during infancy and one was a still birth). She has been a widow for several years. She lives in Muguga with her sons. There is no history of mental illness in the family.

She has been attending the Gynaecology outpatient clinic since 1985 due to lower abdominal pains that radiate to the back for over ten years. Total abdominal hysterectomy was done five years ago, however patient still has the same complaints. She also complains of poor sleep (both initial and terminal insomnia), trouble in thinking clearly, easily tires, poor appetite for food, apprehensive, and feels unhappy most of the time. She also complained of having "Malaria" everyday.

A diagnosis of mixed picture of depression and anxiety was made. Patient was put on an anxiolytic low dose for two weeks (diazepam 2.5mg nocte) and an antidepressant (Tabs amitriptylic 50mg nocte) for three months. She was booked in the psychiatric out patient clinic for follow up.

APPENDIX II

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APPENDIX III

PSYCHIATRIC MORBIDITY IN PATIENTS ATTENDING A GYNAECOLOGY-OUT-PATIENT CLINIC AT KENYATTA NATIONAL HOSPITAL, NAIROBI, KENYA.

I Miss/Mrs----- hereby freely consent to participate in the above mentioned study.

The study has been explained to me by the researcher and that all the information obtained will be confidential and my name should not appear in any future publication.

DOCTOR'S SIGNATURE-----

PATIENTS' SIGNATURE -----

DATE -----

MANDATORY COLLECTION ON SPI - SYMPTOMS

1. SOMATIC SYMPTOM.

(i) Have you noticed anything else wrong with your health apart from the things you have already told us?

(ii) In the past week, have you been troubled with headaches or indigestion ? Anything else ?

2. FATIGUE

(i) Have you noticed that you get tired easily ?

(ii) Or that you seem to be lacking in energy ?

3. SLEEP DISTURBANCE

(i) How is your sleep ?

(ii) Have you lost sleep in the last week ?

(iii) Do you have difficulty in starting to sleep ?

(iv) Are you restless at night.

(v) Do you wake up early ?

4. IRRITABILITY

(i) Do you find that you are easily upset or irritable with those around you ?

(ii) Do you lose your temper or get angry easily ?

5. LACK OF CONCENTRATION.
- (i) Do you find it difficult to concentrate ?
 - (ii) Do you get nuddled or forgetful ?.
6. DEPRESSION / UNHAPPINESS
- (i) How have you been feeling in your spirits in the past weeks ?
 - (ii) Have you at times felt sad, unhappy or miserable ?
7. WORRY/ANXIETY.
- (i) Do you find that you get anxious or frightened for no obvious reasons ?
 - (ii) Do you worry alot on trivial matters ?
8. PROBIAS
- (i) Are you scared or frightened of certain things or situations for no good reason ?
 - (ii) When ?
 - (iii) Where
9. DISORDERED LIBIDO
- (i) Do you find any change in your sexual performance, desire or frequency ?.
 - (ii) Have you lost interest in marital relationship ?
10. BEWITCHMENT.
- (i) Do you think that bewitchment, spirits or witchcraft are responsible for your present condition or sickness.
 - (ii) How ?

RESEARCH PROJECT
DR. JOYCE N. NATO
DEPARTMENT OF PSYCHIATRY
UNIVERSITY OF NAIROBI.

PSYCHIATRIC MORBIDITY IN A GYNAECOLOGY CLINIC AT KENYATTA NATIONAL HOSPITAL.

SOCIO-DEMOGRAPHIC INFORMATION

1. HOSPITAL NO.....STUDY.....
2. AGE.....
3. EDUCATION: NIL PRIMARY SECONDARY POST-SECONDARY TRAINING UNIVERSITY
4. OCCUPATION: unemployed SELF-EMPLOYED EMPLOYED
5. RELIGION: PROTESTANT CATHOLIC MUSLIM OTHER
6. MARITAL STATUS: SINGLE COHABITING MARRIED SEPARATED DIRVOCED WIDOWED
7. DURATION OF MARRIAGE: 0-2 YEARS 2-5 YEARS 5-10 YEARS OVER 10 YEARS
8. HAVE YOU EVER PRACTICED CONTRACEPTION: YES NO
9. METHOD USED: PILL IUCD BARRIERS DEPOPROVERA TUBOLIGATION OTHER NOT APPLICABLE
10. HAVE YOU EVER HAD: AN ABORTION STILL BIRTH ECTOPIC PREGNANCY NONE

11. NUMBER OF CHILDREN
12. NUMBER OF BOYS GIRLS
13. DO YOU USE ALCOHOL MIRAA BHANGI OTHER
14. HOW MUCH
15. HOW LONG :
- 6 MONTHS 1 YEAR 2-5 YEARS OVER 5 YEARS
16. PAST HISTORY OF MENTAL ILLNESS FROM PATIENT 7 NOTES
- YES NO

SCREENING QUESTION.

- | (A) S.R.Q. | YES | NO |
|--|-----|----|
| 1. Do you often have headaches ? | | |
| 2. Is your appetite poor ? | | |
| 3. Do you sleep badly ? | | |
| 4. Are you easily frightened ? | | |
| 5. Do your hands shake ? | | |
| 6. Do you feel nervous, tense or worried ? | | |
| 7. Is your digestion poor ? | | |
| 8. Do you have trouble thinking clearly ? | | |
| 9. Do you feel unhappy ? | | |
| 10. Do you cry more than usual ? | | |
| 11. Do you find it difficult to enjoy your daily activities? | | |
| 12. Do you find it difficult to make decisions ? | | |
| 13. Is your daily work suffering ? | | |
| 14. Are you unable to play a useful part in life ? | | |
| 15. Have you lost interest in things ? | | |
| 16. Do you feel that you are a worthless person ? | | |
| 17. Has the thought of ending your life been in your mind ? | | |
| 18. Do you feel tired all the time ? | | |
| 19. Do you have uncomfortable feelings in your stomach ? | | |
| 20. Are you easily tired ? | | |

(B) PSYCHOTIC SCREENING QUESTIONS.

YES NO

- 1 Do you feel that somebody has been trying to harm you in some way ?
2. Are you a much more important person than most people you think?
3. Have you noticed any interference or anything else unusual with your thinking?
4. Do you ever hear voices without knowing where they come from, or which other people cannot hear ?
5. Have you ever had fits, convulsions or falls to the ground, with movements of arms and legs, biting of tongue on loss of consciousness ?

1. SYMPTOMS

SYMPTOM	CIRCLE THE RATING	REASON FOR MORBID
i) Somatic symptoms	0 1 2 3	
ii) Fatigue	0 1 2 3	
iii) Sleep disturbance	0 1 2 3	
iv) Irritability	0 1 2 3	
v) Lack of concentration	0 1 2 3	
vi) Depression/unhappiness	0 1 2 3	
viii) Worry / anxiety	0 1 2 3	
viii) Phobia	0 1 2 3	
ix) Disordered	0 1 2 3	
x) Bewitched	0 1 2 3	

2. ABNORMALITIES OF BEHAVIOUR

ITEMS	CIRCLE THE RATING	STATE FOR MORBID	REASON RATING
i) slow lacking spontaneity	0 1 2 3		
ii) Suspicious defensive	0 1 2 3		
iii) Histrionic	0 1 2 3		
Sub-Total			

3. ABNORMALITIES OF MOOD

i) Depressed	0 1 2 3		
ii) Anxious, agitated tense	0 1 2 3		
iii) Elated euphoric	0 1 2 3		
iv) Flattened incongruous	0 1 2 3		
Sub-Total			

4. PERCEPTION AND COGNITIVE ABNORMALITIES.

ITEMS	CIRCLE THE RATING	STATE FOR MORBID	REASON RATING
i) Excessive concern with bodily function	0 1 2 3		
ii) Depressive though content	0 1 2 3		
iii) Delusion, thought disorder misinterpretations	0 1 2 3		
iv) Hallucinations	0 1 2 3		
v) Intellectual impairment	0 1 2 3		
Sub-Total			

5. FAMILY PSYCHIATRIC HISTORY.

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10. ASSESSMENT OF THE RELIABILITY OF INFORMATION.

- i) Good ii) Fair iii) Poor

11. ICD DIAGNOSIS

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12. OVERALL SEVERITY RATING 0 1 2 3

REMARKS.

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