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A STUDY OF EMERGENCY PSYCHIATRIC REFERRALS IN A GOVERNMENT HOSPITAL

M.S. BHATIA[1*]
PRADEEP AGRAWAL[2]
UDAYAN KHASTBIR[3]
SHASHI RAI[4]
ANJALI BHATIA[5]
(MRS.) NEENA BOHRA[6]
S.C. MALIK[7]

SUMMARY

The socio-demographic and clinical characteristics of psychiatric referrals in emergency O.P.D. of a teaching general hospital were studied from January 1986 to December 1987. The referral rate was 1.5%. The source, reason and purpose of referrals were studied. Hysterical fits, altered sensorium and excitments together constituted three fourth of all emergency referrals. The diagnosis of neurosis was made in one third of the patients and about one fourth of all patients were labelled as suffering from hysterical neurosis (fits being the most common presentation).

Introduction

Acute psychiatric emergencies like excitment, violence, stupor, suicidal attempts etc., which previously were the domain of mental hospitals, are now handled by the general hospital psychiatric units (Schwartz et al 1972). But there is still a paucity of date concerning psychiatric emergency referrals in the Indian setting. Most of the available studies pertain to the routine inpatient referrals (Wig and Shah 1973, Chatterjee and Kutty 1977, Jindal and Hemrajani 1980) without considering the emergency aspect of the situation. Studies have been reported in the West (Whitley and Deniston 1963, Anstee 1972, Eastwood et al 1970) but in India, only few studies have been conducted on emergency psychiatric referrals (Trivedi & Gupta 1982, Kelkar et al 1982). Though psychiatric services are available in most of the general hospitals in India, the factors like reasons for referral, presenting complaints of the patient, the magnitude of the problem etc. have not been fully elaborated. The present study was conducted in this hospital means exclusively for females, with the aim to find out firstly the emergency situations on which the psychiatric services are required; secondly to know about the magnitude of the problem and thirdly to compare how these psychiatric emergencies in females differ from those in males. No such study has

1. Senior Resident
2. Research Scholar
3. Research Scholar
4. Research Scholar
5. House Surgeon
6. Associate Professor
7. Professor & Head

Department of Psychiatry, Lady Hardinge Medical College and associated Smt. Sucheta Kriplani Hospital, New Delhi — 110 001.

* D-1, Naraina Vihar, New Delhi — 110 028.

been conducted previously on psychiatric emergencies in females

Material and Methods

The present study was carried out by the Department of Psychiatry in the emergency outpatient department (OPD) of Smt. Sucheta Kriplani Hospital, a teaching general hospital attached to Lady Hardinge Medical College, New Delhi during a period from January 1986 to December 1987. This is a Government Hospital being attached to Kalawati Saran Children's Hospital (which provides the separate 24 hours services to children of 0-12 year age group). It has 783 beds, with all the specialist services available for 24 hours where only female patients (more than 12 years of age) can directly walk in and request for treatment. This hospital provides services to patient, coming mostly from Delhi and the surrounding semi-urban and rural areas. In emergency outpatient department, the patient is first briefly evaluated by lady casualty Medical officer and if in her assessment, a psychiatric consultation is required, then the services of the specialist are called for. If these patients had any psychiatric problem, they are either admitted or asked to attend regular psychiatric OPD (after management of acute emergency problems).

In the study, the following parameters were noted (a) total number of psychiatric emergency referrals compared with total attendance at casualty, (b) socio-demographic details of the psychiatric referrals (like age, marital status, income, occupation etc.), (c) reasons for referring the patients, (d) purpose of referral, (e) presenting complaints of the cases, (f) psychiatric diagnosis according to ICD-9 (WHO 1978). The accumulated data was analysed at the end of study period.

Table 1
Referral Rate

Total number of emergencies	46,172
Total number of psychiatric referral	672
Psychiatric referral rate	1.5%
Number of total emergencies per day	63.2
Number of psychiatric referrals per day	0.9

Results and Discussion

Referral rate (Table 1): During the two year period of study, there were 46,172 cases who attended the casualty of tis hospital. Out of these, 672 cases were referred to psychiatrist, the rate of psychiatric referral amounting to 1.5 per cent. This is in contrast of other Indian (Trivedi and Gupta 1982, Kelker et al 1982) and Western studies (Anstee 1972, Watson 1969, Whitley and Deniston 1963) which report the emergency psychiatric referral as 2.2 per cent to 5.6 per cent. This difference could be due to the fact that the other studies included both males and females whereas the present study was conducted only in female patients. The females, either due to low prevalence of psychiatric emergencies (Kelker et al 1982, Trivedi and Gupta 1982, Vyas et al 1986) or neglect, are being brought in lesser number to the hospital. No study has yet been conducted exclusively on female patients which can be used for comparing the present data.

Socio-demographic Characteristics: Table 2 shows the socio-demographic characteristics of the patients (all females). The majority of cases belonged to 25 to 34 years of age (37.5%) followed by 35 to 44 years (27.5%) and 15 to 24 years (23.9%). No patient was under 15 years of age. This distribution of age group is due to the fact the patients who utilize the services of this hospital belong to this age group (Bhatia Et al 1987, Agrawal et al 1987). This is different from what has been reported by Trivedi

Table 2
Socio Demographic Characteristics
(N=672 All Females)

Age (Years)	No. of Cases (%)
15-24	161 (23.9)
25-34	252 (37.5)
35-44	184 (27.5)
Above 44	75 (11.1)
Martial Status	
Unmarried	213 (32.4)
Married	368 (54.8)
Widowed	32 (4.7)
Divorced	54 (8.1)
Income (Rs. per month)	
Below 400	348 (51.8)
401-800	228 (33.9)
Above 800	96 (14.3)
Occupation	
Housewives	336 (50.0)
Unskilled workers	197 (29.3)
Clerical and Skilled Workers	69 (10.3)
Students	46 (6.8)
Others	24 (3.6)

and Gupta (1982) that the female patients who seen the emergency psychiatry services most often belong to 41-55 years of age (29.7%) followed by 26-40 years (25.6%).

Majority of cases, as reported by other Indian studies (Trivedi and Gupta 1982, Kelkar et al 1982, Vyas et al 1987 Bhatia et al 1986, Agrawal et al 1987) were married and housewives. This could be due to the fact that the married women are exposed more to the stressful environment, which may result in psychiatric problems (Sriram et al 1986, Shah and Dhavale 1986, Bhatia et al 1987). The women having monthly income less than Rs. 400/– formed a significant number (51.8%). This is comparable to what is reported by other Indian studies (Kelkar et al 1982, Agrawal et al 1987).

Source of Referral (Table 3): Majority of patients attended at their own or on the advice by family friends (57.9%) while rest of

Table 3
Source of Referal

Sources	No. of Cases (%)
1. Family friends or patients attended their own	389 (57.9)
2. Private practitioners (General physicians)	149 (22.2)
3. Government dispensaries	73 (10.8)
4. Other Hospitals	61 (9.1)
Total	672 (100.0)

the cases (42.1%) were referred either by private practioners (22.2%), other Government dispensaries (10.8%) or hospitals (9.1%). This is similar to the findings of the study by Kelkar et al (1982).

Table 4
Reasons for Referral

Reasons for Referral	No. of Cases (%)
1. Predominant Psychiatric symptoms	99 (14.7)
2. No physical illness detected	136 (20.2)
3. Mental symptoms coexisting with physical illness	108 (16.1)
4. Organic illness insufficient to explain symptoms	81 (12.0)
5. To rule out psychiatric illness	155 (23.1)
6. Old case of psychiatric service	65 (9.7)
7. Any other	28 (4.2)
Total	672 (100.0)

Reasons for referral: As shown in Table 4, majority of cases were referred for the exclusion of a psychiatric illness (23.1%) followed by those in whom either no physical illness could be detected (20.2%) or mental symptoms coexisted with definite physical illness (16.1%) or organic illness alone was insufficient to explain the symptoms (12.0%). This indicates increased awareness of other specialists about psychiatry and their desire to associate psychiatrists in the general management of patients in an emergency.

The cases who had either predominant psychiatric symptoms or were old cases of psychiatric service, constituted only 24.4%. This is in contrast to other studies (Trivedi and Gupta 1982, Kelkar et al 1982) which report that the presence of predominant psychiatric symptoms is the most common cause of emergency psychiatric referral. This difference is, again, due to the fact that the present study was conducted only on female patients.

Presenting complaints: Table 5 shows that the most common complaint due to which an emergency psychiatric consultation was sought was excitement and violence (25.2%) followed by hysterical fits (22.5%) and altered sensorium (20.4%).

Table 5
Presenting Complaints

Complaints	No. of Cases (%)
1. Excitement and violence	169 (25.2)
2. Altered sensorium	137 (20.4)
3. Hysterical fits	152 (22.5)
4. Somatic symptoms	83 (12.4)
5. Suicidal attempt	16 (2.5)
6. Acute Dystonic reactions	20 (2.9)
7. Acute Anxiety symptoms	67 (9.9)
8. Epileptic fits	28 (4.2)
Total	672 (100.0)

This is similar to what has been reported by Vyas et al (1986) whereas other Indian (Gautam 1978, Kelkar et al 1982) and Western Studies (Anstee 1972) report somatic symptoms as the most common cause of emergency psychiatric referral. The studies on indoor and outdoor psychiatric referrals (Ellenberg 1965), Chatterjee and Kutty 1977) also report somatic complaints as the most common presenting complaint. The findings of present study differ from those of other studies because this study included only female patients.

Table 6
Psychiatric Diagnosis (ICD-9)

Diagnosis	No. of Cases (%)
1. Organic Psychosis	94 (13.9)
2. Schizophrenia	71 (10.6)
3. MDP (Mania)	28 (4.2)
4. MDP (Depression)	63 (9.4)
5. Neuroses	209 (31.1)
6. Physical disorders (presumbly of psychogenic origin)	81 (12.1)
7. Psychosis associated with other physical illness	57 (8.4)
8. No Psychiatric disorder	69 (10.3)
Total	672 (100.0)

Psychiatric diagnosis (Table 6): In about one third of patients (31.1%), a diagnosis of neurosis was made. Some Indian Studies (Kelkar et al 1982) on emergency referrals have also reported neurosis as the most common psychiatric diagnosis. The studies conducted (on female patients) in medical outpatient department (Nikapota et al 1981, Bhatia et al 1987) and Gynaecology outpatient department (Worsley and Walters 1977, Wig et al 1982, Agrawal et al 1987) have also found neuroses as the most common psychiatric diagnosis whereas other studies on psychiatric emergencies report epilepsy and its related diagnosis (Trivedi and Gupta 1982) and acute schizophrenic and manic excitement (Vyas et al 1986) as the most common diagnosis. The difference of psychiatric diagnosis in the present study with those of above studies could be due to the fact that the present study included only female patients.

Organic psychosis was the second commonest psychiatric diagnosis whereas other studies on psychiatric referrals (Chatterjee and Kutty, 1977) and emergency psychiatric referrals (Kalkar et al 1982) report schizophrenia as the second commonest diagnosis in 27-29 per cent of

cases. Out of functional psychotics (N=162) in the present study, 33 cases (20.5%) came within 3 months of delivery. These include 19 cases of schizophrenia, 10 cases with MDP (depression) and 4 cases with MDP (mania).

Among the organic psychosis (N=94), delirium was the most common diagnosis (72.3%) followed by epileptic psychosis (13.8%), dementia 9.6%) and others (4.3%). This finding is comparable to what has been reported by Nikapota et al (1981) and Bhatia et al (1987).

The psychosis associated with other physical illness (N=57, 8.4%) had physical symptoms related commonly to chest (73.7%), like pain, cough, breathlessness, palpitations followed by genital system (28.7%) with symptoms related to puerperal sepsis, hysterectomy, leucorrhoea, ovarian malignancies. This was followed by gastrointestinal symptoms (24.6%) like pain, indigestion, nausea, vomiting, constipation, diarrhoea etc. and lastly, symptoms related head and central nervous system (15.8%) like headache, tingling and numbness, blurring of vision, photophobia etc. These findings are comparable to those reported by Bagadia et al (1986). In 10.3% of cases, no psychiatric illness was discernible. This a higher figure than that of Western studies (Ungerleider 1960, Eastwood et al 1970) but is comparable to inpatient referrals studies (Shukla et al 1980, Chatterjee and Kutty 1977, Wig and Shah 1973) and outpatient psychiatric morbidity studies in females (Bhatia et al 1987) which report absence of psychiatric illness in 6 to 11 per cent of cases respectively.

Type of Neurosis (Table 7): In the present study, hysteria constituted the most common neurotic illness presenting as psychiatric emergency (77.0%). Out of

Table 7
Type of Neuroses (ICD-9) (N=209)

Neurosis	No. of Cases (%)
Anxiety Neurosis	30 (14.3)
Phobic Neurosis	1 (0.5)
Obsessive Compulsive Neurosis	2 (1.0)
Hysterical Neurosis	161 (77.0)
Neurotic Depression	15 (7.2)
Total	209 (100.0)

161 cases of hysterical neurosis, 152 (94.3%) presented with fits. The other presentations were hemiparesis (3 cases), paraplegia (2 cases), hyperventillation (2 cases), hiccough (1 case), aphonia (1 case). Among the anxiety neurotics (N = 30), palpitations (22 cases), giddiness (12 cases), sweating (20 cases), breathlessness (6 cases), feeling of impending doom (18 cases) etc. were the common presenting symptoms. The cases with neurotic depression (N = 15), insomnia was the most common presenting symptom (11 cases) associated with sad mood, suicidal ideation or attempt (7 cases) or somatic symptom (10 cases) like bodyache, lethargy, loss of appetite or weight etc.

These findings are different from other Indian studies conduced on female patients in medical Outpatient Department (Bhatia et al 1987) and Gynaecology Outpatient Department (Wig et al 1982, Agrawal et al 1987) which report neurotic depression as the most common neurosis followed by hysteria and anxiety neurosis. This could be because hysteria (Commonly fits), most frequently present as psychiatric emergency followed by anxiety neurosis and depression (Kelkar et al 1982, Wig 1979).

References

AGRAWAL, P., MALIK, S.C. & PADUBIDRI, V. (1987). A study of Psychiatric morbidity in

Gynaecology outpatient department, M.D. Thesis submitted to Delhi University, Delhi, India.

ANSTEE, B.H. (1972), Psychiatry in the casuality Department, *British Journal of Psychiatry*, 120, 625-628.

BAGADIA, V.N. AYYAR, K.S., LAKDAWALA, P.D., SHETH, S.M., ACHARYA, V.N. & PRADHAN, P.V. (1986), Psychiatric morbidity among patients attending medical outpatient department, *Indian Journal of Psychiatry*, 28, 139-144.

BHATIA, M.S., BALKRISHNA, DHAR, N.K., BOHRA, N., GUPTA, H.L. & MALIK, S.C. (1987), Psychiatric morbidity in patients attending medical OPD, *Indian Journal of Psychiatry*, 29, 243-246.

CHATTERJEE, S.B. & KUTTY, P.R. (1977), A study of psychiatric referrals in military practice in India, *Indian Journal of Psychiatry*, 19, 32-38.

EASTWOOD, M.R., MINDBAN, R.H.S. & TENNET, T.G. (1970), The physical status of psychiatric emergencies, *British Journal of Psychiatry*, 116, 545-548.

ELLENBERG, M.D. (1965), Survey of inpatient referral to an American psychiatric department, *British Journal of Psychiatry*, 111, 1211-1215.

GAUTAM, S.K.S. (1978), A comprehensive study of patients presenting with somatic symptoms. Dissertion submitted to Bangalore University, Bangalore, India.

JINDAL, R.C. & HEMRAJANI, D.K. (1980), A study of psychiatric referrals in a General Hospital, *Indian Journal of Psychiatry*, 22, 108-112.

KELKER, D.K., CHATURVEDI, S.K. & MALHOTRA, S. (1982), A study of emergency psychiatric referrals in a teaching general hospital, *Indian Journal of Psychiatry*, 24, 366-369.

NIKAPOTA, A.D., PATRICK, V. & FERNANDO, L.H.S. (1981), Aspects of psychiatric morbidity in the outpatient population of general hospital in Sri Lanka, *Indian Journal of Psychiatry*, 23, 219-223.

SCHWARTZ, D.A., WEISS, A.T. & MINER, J.M. (1972), Community psychiatry and Emergency, *American Journal of Psychiatry*, 129, 710-713.

SHAH, M. &DHAVALE, H.S. (1986), Psychiatric morbidity in the first year of marriage, Paper presented at 38th Annual conference of Indian Psychiatric Society, Jaipur.

SHUKLA, G.D., MISHRA, D.N. & NIGAM, P. (1980), Utility of psychiatric unit in teaching general hospital: A study of inpatient psychiatric referrals, *Journal of Association of Physicians of India*, 28, 229-234.

SRIRAM, T.G., SHAMA SUNDER, C., MOHAN, K.S. & SHANMUGHAM, V. (1986), Psychiatric morbidity in medical outpatients of a general hospital, *Indian Journal of Psychiatry*, 28, 325-328.

TRIVEDI, J.K. &GUPTA, A.K. (1982), A study of patients attending emergency outpatient services of a large teaching hospital, *Indian Journal of Psychiatry*, 24, 360-365.

UNGERLEIDER, J.T. (1960), The psychiatric emergency analysis of six months, experience of a university hospital's consultation service, *Archives of General Psychiatry*, 3, 593-597.

VYAS, J.N., SINGH, D., GUPTA, O.P. & GUPTA, I.D. (1986), Psychiatric emergency services - an analysis, paper presented at 38th Annual Conference of Indian Psychiatric Society, Jaipur.

WATSON, J.P. (1969), Psychiatric problem in accident departments, Lancet, i, 877-880

WHITLEY, J.S. & DENISTON, D.M. (1963), The psychiatric casuality, *British Journal of Psychiatry*, 109, 488-491.

W.H.O. (1978), The International classification of Diseases, 9th revision (ICD-9), Geneva: W.H.O.

WIG, N.N. (1979), Review of depressive illnesses among patients attending P.G.I. Chandigarh, Paper presented at National Seminar on Depressive illness, Madurai, India.

WIG, N.N. & SHAH, D.K. (1973), Psychiatric unit in a general hospital in India: Patterns of inpatient referrals, *Journal of the Indian Medical Association*, 60, 83-85.

WIG, N.N. & RUSTOGI, P.K. (1982), Psychiatric and Psychosomatic problems in obstetrics and gynaecology. In 'Post graduate Obstetrics and Gynaecology' ed. Menon M.K., Devi, P.K. & Bhasker Rao, K. New Delhi: Orient Longman.

WORSLEY, A. & WALTERS, W.A.W. (1977), Screening for psychological disturbances amongst gynaecology patients, *Australia and New Zealand Journal of Obstetrics and Gynaecology*, 17, 214-217.