Emotional disorders in a general practice in Singapore

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THE French philosopher Voltaire once said,"Doctors are men who prescribe medicines of which they know little to cure diseases of which they know less, in human beings of whom they know nothing." Of all the diseases today that doctors can be said to be relatively ignorant about, the field of mental illness must surely rank high on the list. Modern medicine today has seen progress in the field of medicine and surgery with the use of antibiotics and organ transplants, progress in psychiatric medicine has, however, been less spectacular. Only since the 1950s with the introduction of the newer drugs with specific action on the higher centres of the central nervous system has there been significant advance in this field. Even so Cassidy, Flanagan, Spellman and Cohen had occasion in 1957 to remark that in depressive illnesses "the cause of the illness is not clear, its diagnosis is inexact, the mechanism of symptoms is not known, and the treatment is still uncertain and a matter of debate."

Mental illness unlike the other diseases of organic origin responds but poorly to higher standards of living and hygiene. Whereas with improved public health care a decline in the incidence of physical ill-health is often seen and expected, this has unfortunately not been so with mental ill-health. On the contrary in advanced Western communities the trend of mental ill-health seems to be on the increase. In the East too Japan has a high morbidity rate and in developing countries like Singapore similar problems are found.

The management of the emotional disorders more often than not falls within the province of the general practitioner rather than that of the psychiatrist. This often arises because of the reluctance of those beset with emotional disorders to seek the help of the psychiatrist. The fear of the stigma attached to mental disorder is a real one with these patients. Aldrich observed that most practitioners have "their own patterns of care" in the management of these patients and the general practitioner who has not had the benefit of training in this field often finds himself at sea when confronted with patients presenting emotional disorders.

What is emotion?

It is difficult to define what 'emotion' really is. Hebb (1958) regards it as a layman's term, having an everyday 'common-sense' value, but not very useful in scientific investigation. The Oxford dictionary describes it as an "agitation of the mind, feeling, or excited mental state." Stafford Clark defines it as a "combination of subjective feeling and objective physiological change. It provides the drive underlying behaviour, as well as the subjective response and the accompaniment to experience."

It is obvious that in modern society it is often difficult if not altogether impossible for an individual always to be able to express his or her emotions without any form of restraint. The repression of emotions however seems to be less harmful than a conflict of the basic emotions. The tendency to build up patterns of behaviour during emotional development, and to be influenced by them repetitively without consciousness of their origin from that time on, is essentially a normal one. When these patterns happen to be

particularly morbid or unsuccessful they form the basis for all the wide and protean manifestations of what are called neurotic illness or neurotic patterns of activity.

In lower animals and even in human societies of low level of cultural standing, expression of the basic emotions is often unhindered. Davis in 1948 found that behaviour amongst the lower classes is less accompanied by anxiety because of the more frequent emotional outbursts and the untrammelled restrictions allowed by their society.

The study in a general practice in Singapore

Whereas many studies have been made of psychiatric morbidity in general practice in Western communities, such as work done by Watts *et al.* (1964), and Alexis Brook *et al.* (1966), little work of this nature has been carried out amongst people of Asian origin. It was felt that a small survey amongst the local populace in Singapore would be of interest to enable comparison between Eastern and Western patients with emotional disorders.

The study was conducted in a general practice in Singapore. The practice is in the outskirts of the city serving about 10,000 patients. The patients are a mixed lot, about 70 per cent follow rural-type occupations such as farming and husbandry, and 30 per cent are urban dwellers and take on occupations in the city. The racial distribution is also mixed. The Chinese are in the majority with 70 per cent, the next group are the Malays with 22 per cent, and the rest consisting of 8 per cent are made up of Indians, Eurasians and a few Europeans. Division of the patients into social groups presented some difficulty in that the most skilled were not always the best off financially and some who were completely unskilled enjoyed higher standards of living because of factors unrelated to their skills. A simple method of classifying the patients into three main social classes was therefore adopted.

Class I—all professional people.
Class II—skilled and semi-skilled workers.
Class III—unskilled workers.

Sixty-four per cent of the patients in the practice belong to class III, 28 per cent to class II, and 8 per cent to class I (*see* figure 1).

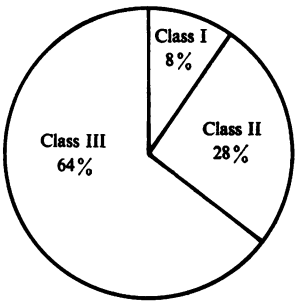

Figure 1
Distribution of patients by social class

Kessel (1960) studied the incidence of psychiatric morbidity in general practice and found that it varied between 5 per cent to 52 per cent of all cases seen, the higher figure being returned by practitioners with a keen interest in psychiatry and the lower figures by those not so keen. Ryle (1960) estimates that between 5 per cent to 36 per cent of all cases seen in general practice have a psychiatric background. Recent studies by Brook *et al.* (1966) estimate two thirds of all cases seen as having emotional complaints and only one third were free from such complaints.

Of the cases attending our clinic it was found that nearly 20 per cent of all cases seen had emotional involvement of some form. Of these 9 per cent presented chiefly with psychiatric complaints, 6 per cent had psychosomatic involvement, and 5 per cent had organic diseases which brought along some degree of emotional complication. The figure of 9 per cent for the mainly psychiatric cases was similar to the experience of Watts (1966) who thought that in rural practices the figure should be between 7 per cent to 10 per cent.

From this it can be seen that as far as psychiatric morbidity was concerned people of Eastern ethnic groups suffered as much as those of the West from emotional disorders. W. H. Lo (1967) in a study of obsessional neurotics in Hongkong Chinese found also

little difference between Eastern and Western races except for a higher proportion of male patients seen than in the West. The figures of Hewetson *et al.* (1963) make interesting comparison. They found that neuroses accounted for 11.4 per cent of all cases seen, patients with psychosomatic involvement 12.2 per cent, and those with organic illness complicated by emotional disorders formed 4.4 per cent (*see* figure 2).

Two hundred cases presenting chiefly with psychiatric complaints were selected at random for further study. From this it was found that those in the older age group (45 years and above) accounted only for 42 per cent of the cases whilst the majority (58 per cent) were amongst the younger age group. Of the younger group less than 2 per cent were children below 14 years. These figures differ somewhat from those recorded of Western patients. Watts (1966) and Logan and Cushion (1958) found that amongst their patients, the older people suffered more from psychiatric complaints. Crombie (1957), however, noted that in his practice psychogenic illness was more common amongst those between 30 and 44 years. The lower incidence of mental ill-health amongst the older Chinese has been remarked by Sainsbury (1961) who said that the suicide rates amongst old people were lowest amongst the Chinese. Wagner (1968) of Kuala Lumpur also noted that higher incidence of mental ill-health amongst the younger Chinese.

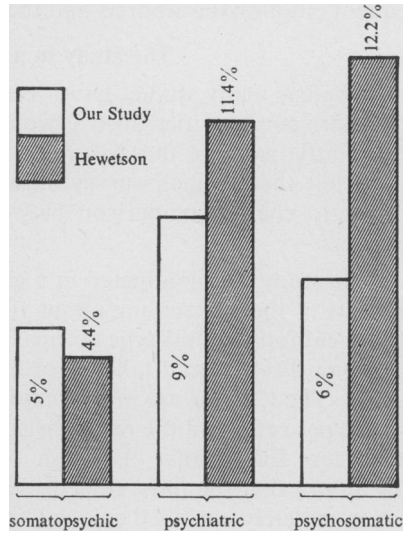

Figure 2
Incidence of psychiatric illness compared with Hewetson (1963)

The low incidence of emotional ill-health amongst the older Chinese as compared with the West can be ascribed to the influence of Chinese philosophy and culture. Filial piety is one of the main teachings of Confucius, and in Chinese families therefore the old are never neglected and there is much less feeling of insecurity amongst the elderly.

The higher incidence of mental ill-health amongst the younger Chinese may be due to several factors. Amongst these it is important to realize that in Singapore three quarters of the population are below 40 years of age. A further factor may be due to fear of parental displeasure and Wagner believes this to be of importance. He is also of the opinion that there are fewer outlets for relieving tensions amongst the young in the East.

A further breakdown of the figures in the younger age group shows a predominance of female to male patients, 34 per cent against 22 per cent. This may appear to be the reverse of Lo's findings amongst the Hongkong Chinese, but it is possible that since his figures deal only with obsessional neurotics, this does not reflect the true picture seen in general practice. The young married female was found to be the one that suffered most. This may be attributable to several factors.

Firstly the 'matriarch syndrome'. In Chinese families the female has an important say in running the family, and the mother-in-law has the most say of all. A newly-wed girl has to fit herself into the pattern of family life. She begins at the lowest rung of the ladder. She ascends the ladder only after she produces an offspring, and reaches somewhere near the top only when she acquires a daughter-in-law of her own.

The second important factor is the lack of financial security. In the East where the task of providing adequately for the family is often difficult, this is a real problem. Here one should note also that poverty *per se* need not always cause an emotional breakdown. A person who has been born into social class III and has been accustomed to living

conditions of that class is not usually emotionally upset by its conditions. He or she may wish for better living conditions but there is usually no conflict within to precipitate a neurosis. On the other hand, persons born into class I, who by misfortune find themselves having to bear living conditions of class II, often resent the change. Emotional conflict becomes inevitable.

The ever present fear of pregnancy is the third important factor for neurosis amongst the young, married Eastern woman. Torn between this and the desire to submit to the wants of their menfolk, the young Eastern woman often finds herself at cross purposes. The fear of pregnancy is of course related to the economic considerations of feeding yet another mouth in an already overburdened family.

In our present study it was found that emotional disorders were more common in social class II than in the other social groups. Figures show that although only 28 per cent of all cases seen belonged to this class, they accounted for 45 per cent of the cases with emotional disorders. This is not altogether surprising as Dollard and Miller (1950) had hitherto observed that the average neurotic was often "stupid about certain aspects of life." Most people in this social group are ones who though intelligent enough to be anxious over changes in their environment, are often not intelligent enough to surmount the situation. The conflict caused by stress then precipitates the neurosis.

Racial and cultural factors

Our studies show that although the Chinese constituted only 70 per cent of all patients attending the clinic, they accounted for 95 per cent of the 200 cases studied. The Malays who formed 22 per cent of the practice came up with only one per cent of the cases with emotional disorders seen (*see* figures 3a and 3b).

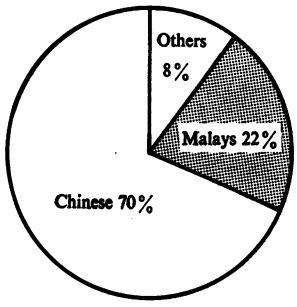

Figure 3a
Distribution of patients attending clinic

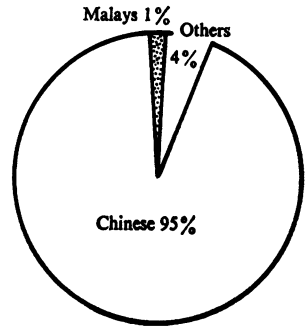

Figure 3b
Distribution of patients with emotional disorder

The Chinese, therefore, are much more prone to emotional disorders than the Malays. This can be explained by the differences in philosophical outlook between the two races. The Chinese as a rule are hard-working, ambitious and tend not to show their emotion. Emotional conflicts are not 'externalized' but tend to be somatized instead. The Malays on the other hand are a much easier-going race, less ambitious, and often willing to accept a lower standard of living.

A study of the emotional problems amongst the Chinese must also take into account the cultural background of the people together with traditional concepts of medicine. The Chinese concept of health and disease is based on a balance between the opposing principles of Yang the bright or male element and Yin the dark or female element. This concept was first elaborated in the Chin-Yuan period over 700 years ago (Lee *et al.* 1962) and is still subscribed to by most Chinese even today. According to this theory disease results when there is an ascendancy of the Yin or dark element. A concept such as this

makes the average Chinese worried about the balance of the opposing forces within him and therefore more prone to emotional conflict.

In October 1967 this concept of Yang and Yin caused mass hysteria amongst many Chinese in Singapore. Rumour went round that by eating pork from pigs which had been afflicted by swine fever, and which had found their way into the market through unscrupulous pork-dealers, people became victims of the disorder known as 'Koro'. The victim of Koro was supposed to suffer from a shrinking of the male genitals 'into' the abdominal cavity and die. The belief was that the male organ which was classified as a member of Yang should not withdraw into the abdomen which was a region of Yin. No less than 80 cases were seen in the hospital on a single day! Yap (1965) describes Koro as a culture-bound de-personalization syndrome whereas Gwee (1963) believes it to be an acute hysterical panic reaction.

The Chinese are not the only Eastern race whose culture and traditions are woven around sex. The Indians venerate the phallic symbol or 'lingam' and preoccupation with masculine virility is often the cause of emotional disturbance amongst Indian men. A chronic anxiety state often seen is centred around the fear of the loss of semen, or 'jiryan' (Courtenay 1966). This is akin to effort syndrome and the patient complains of exhaustion and wasting of body tissues following excessive loss of seminal fluid.

TABLE

FREQUENCY OF SYMPTOMS COMPLAINED IN PERCENTAGES

Symptoms	*Our study*	*Paulett (1956)*	*Wood (1941)*
1. Pain in the chest	*64*	?	?
1. Pain in left chest	—	*34*	*56*
2. Dizzy spells	*60*	*70*	*78*
3. Headache	*48*	*80*	*72*
4. Palpitations	*36*	*53*	*89*
5. Dyspepsia	*24*	*36*	—
6. Breathlessness	*20*	*61*	*93*
7. Lassitude	*13*	*44*	*88*
8. Trembling	*4*	*50*	*65*
9. Sweating	*2*	*62*	*80*

Management

Of the 200 cases studied the major group was formed by those with anxiety neurosis (72 per cent). Depression accounted for 24 per cent. Of the anxiety neurotics 58 per cent were chronic anxiety, and 14 per cent acute cases. Amongst the depressives 16 per cent were of the endogenous type and 8 per cent of the reactive type (*see* table). For comparison Watts (1966) recorded that the cases of depression accounted for about a quarter of all the psychiatric cases he saw.

The main complaints amongst the cases seen are set out in figure 4. The chief complaint is a sense of discomfort in the chest occurring especially amongst young females. The next most frequent complaint is the feeling of giddiness amongst the older women. Headache is third on the list and shared equally by both men and women. Coming in fourth is the complaint of palpitation, here again occurring chiefly amongst the younger women.

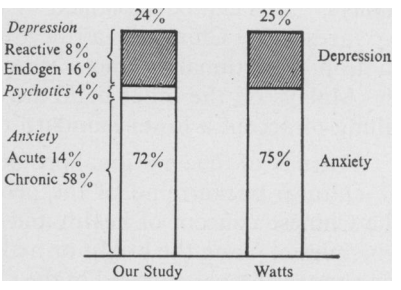

Figure 4

In such a limited survey it is unfair perhaps to comment categorically on the proper lines of management, nonetheless it is possible to make a few observations. A. U. MacKinnon (1966) found that 70 per cent of his cases of depression improved with treatment. In our study we found that 68 per cent of all cases showed improvement (of these 54 per cent were suffering from anxiety neurosis), of the rest 18 per cent showed slow progress and 14 per cent no improvement at all.

The place of psychotherapy in the management of emotional disorders in general practice is a little controversial. In the first instance the ordinary general practitioner is usually not adept at this and unless he has had special training in this he is not likely to get far with his patient. Eysenck (1962) holds the view that with or without psychotherapy there was little difference in the recovery rates. Against this view Kessel held that psychotherapy was just as effective as the use of drugs.

In our study, patients were treated both with drugs and psychotherapy. It was found that cases of acute anxiety usually responded well to the tranquillizers, and the ones we found useful were chlordiazepoxide and trifluoperazine. The chronic cases of anxiety were more disappointing but some were helped a little by the drugs. The chief drawback in these cases was the relapse which frequently occurred following the withdrawal of the drugs.

The acute reactive depressives reacted well to psychotherapy and the antidepressive drugs imipramine or isocarboxazid (Marplan). Both these drugs however took time to act and this bears out the observation of R. E. Hemphill (1961) that no drug can be relied upon to terminate depression in less than ten days. Psychotherapy is of little use in cases of endogenous depression and we found the antidepressant drugs disappointing.

Summary

In this study of 200 cases of emotional disorders seen in a general practice in Singapore, we find the morbidity rates for the East are very similar to those in the West.

There was a difference in the age-groups affected and in the East more of the younger age group suffered from emotional disorders than the older age group.

The racial and cultural factors behind the emotional disorders were discussed. It was noted also that those in social class II were more prone to emotional disorders. These were the people who were intelligent enough to be aware of the difficulties in their environment but not sufficiently intelligent to surmount their obstacles. The Chinese were found to be more prone than the Malays to emotional disorders.

In the management of the cases seen, 68 per cent of all cases showed improvement and the acute cases of anxiety and depression often responded well to psychotherapy and drug management. Treatment of the chronic cases of anxiety and depression was disappointing.

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