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An Evaluative Study of Treatment Outcome of Psychiatric Disorder at a Saudi Psychiatric Clinic

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ABSTRACT

The treatment outcome iri 25I patierits was assessed after a niiriinium of six months, arid up to jive years follow-up. All patierits had received supportive therapy with pharnzacotherapy. The outcome was classified as: failure, unsatisfactory, satisfactory, or good. Results were compared with a similar study run in a Chicago Mental Health Center where almost identical results were concluded. A general satisfactory outcome was seen in 65% of patients. Satisfactory outconie is more likely to be associated with married patients, professional or clerical, self-referred arid patierits suffering from ajfective disorders.

The outconie was riot relevant to age or mode of presentation, it relates in different ways with the type of psychosocial stresses.

INTRODUCTION

In Saudi Arabia, and other developing countries, the practicing psychiatrist finds that he uses mainly one form of psychiatric treatment, that is, brief supportive psychotherapy plus medication with the emphasis on the latter, regardless of specific diagnosis or special circumstances *(Dubousky,* 1983). This is in conflict with his training and experience in a developed country, where a wide variety of treatments are practiced.

This situation in Saudi Arabia arises from the lack of well trained mental health specialists and an extreme shortage of psychiatrists. Even in Egypt, a Middle Eastern country which is considered as having a wealth of professional manpower, there is less than one

psychiatrist per 100,000 population, and most of these are not fully trained *(Sadek, 1985).*

Reports on the outcome of this single form of treatment in a mixed psychiatric population are scarce. There are reports on the outcome of treatment of specific disorders, such as mania *(Secunda et* al., *1985);* and of one treatment modality versus another on a group of disorders, for example the efficacy of psychotherapy versus pharmacotherapy for schizophrenia *(Kaplan and Sadock, 1981)* and of *a* specific treatment modality such as psychotherapy; and of social skill training outcome studies *(Morgan et* al., *1985)* and the outcome of treatment of mixed psychiatric population in **a** specific age group, such as children *(Fraiberg et al., 1981).* Some workers have studied the dynamic aspects of the outcome of psychiatric treatment *(Gruber and Wood, 1978)* and others have studied specially designed treatment programs *(Collins et* al., *1985). Denner arid Halprin (1974)* have developed an instrument to evaluate clinical services in a community mental health center as perceived by the patients' subjective sense of symptom relief. This study uses a modified version of the methodology used in that study. There were other similar unpublished reports by Miller and Sinclair *(Miller and Sinclair, 1972 arid Salsin and Baxter, 1972).* Because of the relevance of such a study to our clinical practice in Saudi Arabia, we report this pilot study assessing the efficacy of an indiscriminate single modality of treatment and identifying factors influencing outcome.

METHOD

The clinical outcome of treatment of **251** outpatients was analysed retrospectively by charts audit after a follow up period which ranged from 6 to 106 months.

A modified version of the Denner and Halprin method was used. Instead of sending a set of questions to ex-clients, the modification obtains responses on satisfaction of treatment from the patients' statements during their last visits. Classified as having unsatisfactory outcome are the ones who experienced no change in their presenting symptoms and reported no improvement of their condition. Patients lost to follow up were classified under this category on the assumption that the failure to keep their appointment showed dissatisfaction with the outcome of treatment, granting that this assumption does not reflect the full truth but pushes the odds of over

estimating the value of the treatment. Patients with satisfactory outcome include those who reported complete disappearance or **a** satisfactory relief of their presenting symptoms. The inbetween category was somewhere in the middle, with some improvement but not to the full satisfaction of the patient.

The breakdown of data includes demographic variables, source of referral, presenting symptoms, somatic manifestations, psychiatric diagnoses and related psychological stresses.

RESULTS

The age range was random. Of the **270** patients reviewed, the three categories of outcome are shown with sex denomination in Table (I); with marital status in Table (II); with occupation ("professional" includes specialized professions, businessmen and highly educated females whether working or not) in Table (III); with source of referral (directly from a general practice or screening clinic or after treatment in another medical or surgical speciality) in Table (IV); with presenting symptoms, (psychiatric and non-psychiatric including the system category of the latter indicating its relationship to the type of clinical outcome) in Table (V); with specific diagnosis in Table (VI) and with stresses related as reported subjectively by the patients, in Table (VII).

Table 1: Outcome according to sex

		Un-satis-factory No./%	In-between No./%	Satis-factory No./%	Total No.
A.			KFSH Study		
	Male	23(21)	**25(26)**	**63(57)**	111
	Female	16(11)	**28(20)**	**96(68)**	**140**
		39(16)	**53(21)**	**159(63)**	**251**
			P = 0.82		
B.	Denner & Halprin Study	**15(17.5)**	**15(17.5)**	**56(65)**	**86**
	KFSH Study	**39(16)**	**53(21)**	**159(63)**	**251**
			P = 0.739		

Table II: Outcome according to marital status

	Un-satisfactory No./%	In-between No./%	Satisfactory No./%	Total No.
Married	14(10)	22(16)	100(74)	136
Single	19(22)	24(28)	43(50)	86
		P = 0.0015		
Divorced & widowed	6(21)	7(24)	16(55)	29
	39	53	159	251
		P = 0.0079		

Table III: Outcome according to occupation

	Un-satisfactory No./%	In-between No./%	Satisfactory No./%	Total No.
Unemployed	10(21)	16(34)	21(44)	47
Student	6(18)	7(21)	20(61)	33
Professional	3(9)	4(12)	27(79)	34
Clerical	9(20)	7(15)	30(65)	46
Manual worker	4(24)	5(29)	8(47)	17
	39	53	159	251
		P = 0.1124		

Table IV: Outcome according to source of referral

	Un-satisfactory No./%	In-between No./%	Satisfactory No./%	Total No.
Self-referred	18(12)	21(15)	97(71)	**136**
From other specialities	21(18)	32(28)	62(54)	115
	39	53	159	**251**
		P = 0.0141		

Table V: Outcome according to presenting symptoms

	Un-satisfactory No./%	In-between No./%	Satisfactory No./%	Total No.
Psychiatric	28(15)	39(21)	116(64)	183
Somatic	11(16)	14(21)	43(63)	68
Musculo-skeletal	11(19)	14(24)	34(57)	59
Gastroentero-logical	11(26)	**8(19)**	24(56)	43
Cardiovascular	**7(14)**	**8**(16)	34(70)	49
Neurological	9(12)	15(19)	54(69)	78
Sexual dysfunction	**2(25)**	**3(38)**	**3(37)**	**8**
	79	101	146	**488**

Table VI: Outcome according to specific diagnosis

	Un-satisfactory No./%	In-between No./%	Satisfactory No./%	Total No.
Schizophrenic	7(17)	13(31)	22(52)	42
Bipolar	1(5)	1(5)	16(89)	18
Unipolar	2(17)	2(17)	8(67)	12
Dysthymic	15(13)	23(19)	80(68)	118
Hysterical conversion	2(12)	5(31)	9(57)	16
Obsessive-compulsive	6(22)	3(11)	18(66)	27
Adjustment	9(0)	5(31)	11(44)	16
Somatisation	10(26)	7(18)	22(56)	39
Personality	3(23)	5(38)	5(39)	13
Other	7(33)	2(9)	12(57)	21
	53	66	203	322

Table VII: Outcome with relation to stress

	Un-satisfactory No./%	In-between No./%	Satisfactory No./%	Total No.
No stress	26(22)	22(18)	71(59)	119
Some stress	13(9)	31(23)	88(66)	132
Total	39	53	159	251
Marital stress	6(12)	13(26)	31(62)	50
Family stress	4(10)	15(39)	19(50)	38
Grief	1(4)	4(17)	18(78)	23
Illness	3(9)	7(22)	22(68)	32
Others including work & economic	1(5)	2(10)	16(84)	19
	54	94	265	413

DISCUSSION

The most interesting finding is the similarity in treatment outcome as perceived by the subjective experience of the patients between our study and the *Denner and Halprin* ***(1974)*** study in a Chicago mental health center (Table I) where ***65%*** of patients population reported a satisfactory outcome versus 63% in our patients population. 17.5% vs 21% reported an in-between response and 17.5% vs **16%** with unsatisfactory outcome. Considering the big difference in philosophy, means and facilities and manpower between American Center and ours, this result may support the value of supportive and pharmacotherapy as a universal means of psychiatric management since it might be the only method of psychiatric intervention that is used in many centers like ours.

Table (I) also points to another interesting finding. Although there are no significant differences between the two sexes as far as those who reported a satisfactary and in-between responses, males with unsatisfactory responses were twice as many as those of females. This could be explained on the! basis that females are better able to use psychiatric services, a statement supported by the fact that female and male ratio in outpatient psychiatric clinic in general is 2:1, which is not so in Saudi Arabia because of restrictions imposed on the mobility of the female and her entire dependency on the male to make use of any available service, which makes it unlikely for a female to use a psychiatric service unless she is in dire need of it which in turn reflects on her response to treatment.

Table **(11)** indicates that married patients have the best prognosis. **A** well-expected finding considering accepted observation that psychiatric morbidity occurs far more frequently in singles (Gregory and *Smeltzer, 1983).* It also points to the value of social and family support in getting over an emotional disorder.

Good prognosis was also associated with a higher socio-economic and educational background as shown by the higher rate of satisfactory outcome in professionals and students (Table III).

A big proportion of our patients presented with somatic rather than psychiatric symptoms and consequently more likely to be seen by another speciality first and then referred to a psychiatrist, an

observation that is probably more linked to Saudi culture (Racy, *1980).* This was partially explained on the basis of a lack of psychiatric insight, hence it was assumed that patients who were self-referred to our services were more psychologically inclined and expected to have a better outcome. Surprisingly this was not the case (Table IV).

Furthermore, the type of presenting symptom as classified according to the system involved was again not a factor in determining response to treatment (Table V).

Different diagnostic categories were not associated with a particular outcome except for some diseases with inherently good prognosis, such as affective disorders (Table VI).

The way in which the presence or absence of a specific psychosocial stress affects outcome is intriguing in that the absence of identifiable stress was associated with significantly more treatment failure (x^2 = **14.533,** D.F. **3.** P. = 0.0023). This is not related to any specific stressor except possibly grief, which is associated with the least number of failures. Again this is not easy to explain but it might be that the fortuitous removal of the stress in the development of psychiatric disorders in Saudi culture has been discussed in an earlier work by the same author (Chaleby. **K** in press) where females are more prone to be affected by stress, especially marital ones, and dependency and lack of sense of control were strong factors in the development of those stresses.

In conclusion, it seems that the restricted psychiatric treatment modality which is imposed on us because *of* the shortage of manpower and facilities, namely an indiscriminate pharmacotherapy with brief supportive therapy, gives satisfactory results in general and that the outcome is affected by factors other than psychiatric insight, mode of presentation and specific diagnosis.

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WNE ETUDE EVALUATIVE DU RÉSULTAT DU TRAITEMENT DES DESORDHES. PSYCHIATRIQUES DANS UNE CLINIQUE PSYCHIATRIQUE EN ARABIE SÉOVDITE

ABSTRAIT

Le resultat du traitement de 251 patients a ete evalue apres une periode de poursuite médicale de 6 mois jusqu'à 5 ans. Tous les patients etaient sous pharmacotherapie. Le resultat a ete classifié comme: echec, peu satisfaisant, satisfaisant, ou bon. Les resultats de cette etude ont ete comparés avec une etude similaire entreprise au centre d'hygienne mental de Chicago, ou des resultats presque identiques on ete obtenus. Un resultat generalement satisfaisant etait obtenu chez 65% des patients. Les resultats satisfaisants etaient plutôt associes avec les patients mariés, etudiants ou professionnels, presentant par eux-même, et les patients souffrant de desordres affectifs.

Le resultat n'avait pas rapport a l'àge ni le mode de presentation, il etait plutôt relié au type de tension psychosocial.

الموجـــــز
تقييم النتاج العلاجى للأمراض النفسية بالسعوديه

تم تقييم النتاج العلاجى لـ ٢٥١ مريضا بعد ٦ أشهر على الاقل وبحد أقصى ٥ سنوات من المتابعه.

وكان جميع المرضى يحصلون على علاج تدعيمى بالاضافة الى العلاج الدوائى. ولقد تم تقسيم النتاج الى: الفشل، غير مرضى، مرضى، أو جيد. وتمت مقارنه النتائج بدراسة مماثله أجريت فى مركز الصحة النفسية بشيكاجو حيث استنتجت نتائج مشابهه. ولقد ظهر ناتج عام مرضى فى ٦٥٪ من المرضى، وكان النتائج المرضى مرتبطاً بالمرضى المتزوجين، المهنين أو الطلبه، الاعمال الكتابيه، المرضى المحولين بأنفسهم أو الذين يعانون من الاضطرابات الوجدانيه.

ولقد كان النتاج غير مرتبط بالسن أو طريقة الظهور، وكان مرتبط بطرق مختلفة مع نوع الضغوط الاجتماعيه النفسيه.