Psychiatric Outpatient Services in Matabeleland, Zimbabwe

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SUMMARY

A prospective survey was undertaken of 104 consecutive Black patients newly referred to a psychiatric outpatient clinic in a general hospital. Schizophrenia, acute brain syndromes and depression emerged as the major diagnostic categories, comprising almost two-thirds of the patients.

The differentiation between acute brain syndromes and schizophrenia proved to be particularly difficult, and the outpatient management of patients with significant thought disorders or clouding of consciousness is not recommended.

The diagnostic features of depression, on the other hand, are fairly reliable and depressives can usually be managed on an outpatient basis, which may save a large number of admissions to both medical and psychiatric beds.


In developing countries, patients with psychiatric illnesses frequently present with somatic complaints, which may lure the unwary doctor into an extended series of expensive but fruitless investigations before the true nature of the illness comes to light.

With this in mind, twice-weekly psychiatric clinics were introduced some years ago at Mpiho Hospital, which is a general hospital situated in Bulawayo but serving the whole of Matabeleland.

During the 4 years 1974 - 1977, an average of 1 510 patients (range 1 339 - 1 664), of whom 40 - 50% were new referrals, were seen each year. An average of 291 patients each year (range 278 - 316) were admitted to Ingutsheni Hospital from these clinics. These figures suggested that ready access to a psychiatrist not only facilitated admission to a psychiatric hospital when necessary, but also made it possible to avoid a number of admissions by enabling a substantial proportion of the newly referred patients to be dealt with as outpatients.

Notwithstanding the apparent success of this policy there are a number of pitfalls and uncertainties in psychiatric diagnosis, particularly when dealing with Black patients, so that a large proportion of the patients in mental hospitals in Africa fall into the category of 'not yet diagnosed.'

It was our impression that, because of these considerations and the short time which could be spent on each patient, outpatient diagnosis was often not very reliable and sometimes led to inappropriate management with consequent admission at a later date. In order to clarify these issues, it was decided to undertake a prospective survey of a small sample of newly referred patients.

PATIENTS AND METHODS

During the period 29 November 1977 - 2 February 1978, 20 clinics were held at which 104 newly referred patients were seen. For the purposes of the study, 'newly referred' was taken to mean patients who, as far as could be ascertained, had previously had neither inpatient nor outpatient psychiatric treatment. The nosological classification used was based on that recommended by the American Psychiatric Association (DSM II).

RESULTS

Diagnosis and Management

The patients were classified according to diagnosis and management patterns as set out in Table I. Inspection of this table reveals that almost two-thirds of the patients fell into the diagnostic categories 'schizophrenia', 'acute brain syndrome' and 'depression'. For the sake of simplicity, further discussion will be limited to these three categories.

Schizophrenia. There were 23 patients in this group, 15 men and 8 women. Apart from 1 woman aged 50 years, all were in the age range 18 - 40 years. Three patients manifested no overt symptoms by the time they reached the clinic; diagnosis in each case rested on the previous history, which was usually one of social incompetence or antisocial or aggressive behaviour. All 3 were treated as outpatients initially, but 1 deteriorated after 2 weeks and had to be admitted to hospital.

Twenty patients presented with disorders of form and/or content of thought in a setting of clear consciousness. Five of these also manifested disorders of affect, ranging from inappropriate elation to depression with suicidal ideas. Among the 15 patients with some disorder of thought content, persecutory delusions were present in 4, grandiose delusions in 1, and grandiose and persecutory delusions together in 1. Delusions secondary to auditory hallucinations were present in 2 patients, bizarre ideas were recorded in 2 patients, and feelings of passivity in 1. Many of the delusions showed a cultural influence. For example, one patient had been arrested by the police when he threatened to assassinate Sir Seretse Khama in the belief that the 'Botswana people' were the enemies of the 'Khumalo people' (i.e. the Matabele) and were continually using witchcraft against them. All the patients with thought disorders were admitted to Ingutsheni Hospital.

Acute brain syndrome. There were 21 patients in this group, 19 men and 2 women. Again 5 patients...
revealed no evidence of mental disorder by the time they reached the clinic; diagnosis in each case rested on a history of disturbed behaviour associated with heavy drinking. Two of the patients had been admitted to general medical wards for investigation, one with hypoglycaemia and the other with coma of unknown cause. Both had been discharged.

There were 3 patients with severe clouding of consciousness; 2 who did not respond to any external stimuli were admitted to general medical wards where 1 subsequently died from a middle cerebral artery thrombosis and pontine haemorrhage. The 3rd patient was admitted to Ingutsheni Hospital.

Six patients presented with minimal to slight clouding of consciousness. Five were admitted to Ingutsheni Hospital forthwith; the last was treated as an outpatient initially, but deteriorated and had to be admitted after 2 weeks.

Four patients presented with a clinical picture of excited and overactive behaviour. Two were found to have thought disorders as well and were admitted to Ingutsheni Hospital, while 2 were treated as outpatients. One of the outpatients improved after 2 weeks, but the other deteriorated and had to be admitted.

Three patients presented with psychomotor slowing as the principal clinical feature, with retarded and impoverished thinking. One who also had thought disorder was admitted to Ingutsheni Hospital; the other 2 were treated as outpatients, but neither attended for follow-through.

The putative causes of the acute brain syndromes included alcohol, dagga, or a combination of these, paint-thinners, skull fracture, hypoglycaemia, chlorpromazine overdose and cerebrovascular accidents.

Depression. There were 12 women and 9 men in this group. Most of the men were in the 40-50 year age group and most women in the 20-35 year group.

The traditional endogenous-reactive classification of depression has been found to be inadequate. Using the term 'endogenous' in a purely descriptive way to define a core syndrome, it was found that the clinical features of our outpatients fitted readily into a system of classification used in general practice in the UK, which comprises five categories: (a) severe psychotic syndromes — 1 man was admitted to a medical ward in a stuporous state associated with malnutrition and dehydration; (b) depression presenting as anxiety — 5 patients presented with anxiety symptoms such as shaking, weakness, dizziness or palpitations; (c) the depressive grafted — hormonal factors were implicated in 3 women; 1 became depressed after delivery, 1 after a miscarriage and the 3rd after prolonged use of an oral contraceptive; (d) behavioural disturbances — confused and irrational behaviour was the presenting symptom in 7 patients, all of whom were of apparently stable previous personality; and (e) depression presenting as organic disorder — pain was the presenting symptom in 5 patients, but was also reported by 10 others. The various sites of pain included the head, chest, abdomen, limbs and back.

Five patients were rated as severely depressed and all expressed suicidal ideas, but these ideas occurred only occasionally and none of the patients had made any plans for a suicide attempt.

Seven patients were rated as moderately depressed; 6 of them expressed a wish to be dead, but none had thought of killing themselves. Eight patients were rated as mildly depressed and 1 denied any subjective sadness.

The stuporous man and 1 woman with chest pain were admitted to general medical wards, but all the other patients were managed as outpatients. One man subsequently deteriorated and had to be admitted to Ingutsheni Hospital.

Outcome

Schizophrenia. Twenty-four patients in this group, including the 2 women with puerperal psychosis of the schizophrenic type, were sent to hospital for admission.
Two did not arrive, and, after observation and treatment, the diagnosis was changed in 7 patients. Other diagnoses included personality disorder, acute brain syndrome, chronic brain syndrome and depression. All but 2 of the remaining 18 patients were discharged from hospital within 4 months; the average length of stay was about 5 weeks.

**Acute brain syndrome.** Twelve patients in this group were sent for admission, but 2 did not arrive. Two patients were subsequently reclassified as schizophrenic and 1 as epileptic. One patient died from pulmonary oedema 11 days after admission, and of the remaining 8 patients in this category only 1 remained in hospital longer than 4 months; the average length of stay was about 2 weeks.

**Depression.** The stuporous man and the elderly woman with chest pain were treated as inpatients with large doses of amitriptyline. Both showed marked improvement after 2 weeks, and neither required ECT.

Of the 19 treated as outpatients, 9 were found to have improved at the 2-week follow-up, 1 was worse and had to be admitted to hospital, but was not given ECT, and 9 defaulted. In general, those with milder depression seemed to default more readily and may have been inadequately treated.

**DISCUSSION**

It has been argued that there are certain 'acute transient psychoses' peculiar to Black patients,\(^6,7,8\) which have been variously termed 'bouffée délirante' or 'hysterophrenia'. On the other hand, it has been pointed out that such conditions are not peculiar to Africa but are well described in the European literature of 50-80 years ago.\(^9\) Such transient psychoses seem to be characteristic of people living in poverty who are illiterate, malnourished and affected with physical diseases. Contemporary American authors describe 'borderline states'\(^9\) which are said to be related genetically to schizophrenia but clinically distinguishable from it by the brevity of the psychotic episodes; however, there is still considerable controversy over the diagnostic criteria. There is evidence that hysterical reactions are much more common in the populations of less developed countries,\(^10\) and it has been our custom to classify these 'acute transient psychoses' as frenzied states of hysterical origin, or, for the sake of simplicity, dissociated states.

There is good evidence that the characteristics of schizophrenia are much the same in different cultures,\(^11\) and there is a surprising amount of agreement on the cardinal symptoms,\(^12\) many of which are strongly reminiscent of Schneiderian first-rank symptoms. In our own practice, first-rank symptoms such as thought insertion and thought withdrawal are not easy to elicit from Black patients, either because of culturally determined differences in presentation\(^13\) or an inadequate conceptual framework in the vernacular language, but the reliability of our diagnosis of schizophrenia would seem to bear comparison with that found elsewhere.\(^14\)

Nevertheless, there is scant room for complacency. Other illnesses which present with a clinical picture indistinguishable from that of the idiopathic disease are important sources of error — for example, the schizophrenia-like psychoses of epilepsy have been well documented\(^15\) and in our own practice accounted for 5 misdiagnoses among 40 patients routinely examined by electro-encephalography after an initial diagnosis of schizophrenia.\(^16\) In the present study, unless clouding of consciousness was present the differentiation between schizophrenia and acute brain syndrome was obviously difficult, and mistakes were made in either direction. These findings serve to emphasize the inadequacy of any diagnosis of schizophrenia based on a single initial assessment.

A factor-analytical study of depression in African and European cultures\(^17\) suggested that in African cultures the illness is characterized by depressed mood, somatic symptoms and motor retardation. Consequently, the diagnosis of depression in our practice rests primarily on the detection of subjective and/or objective evidence of depressed mood.

In some cultures there may be difficulty in the subjective recognition of depressed mood because the vernacular language does not distinguish between anger and sadness;\(^18\) this is not so as regards Sindbele, in which there are separate verbs for being angry (\textit{ukuzondola}) and being sad (\textit{ukudana}), although it is understood that rage may lead to sadness.

In the objective recognition of depressed mood, considerable reliance is placed on non-verbal cues; there is good evidence that facial displays of emotion are recognizable across cultures.\(^19\) In the present study it was possible that, in a comparatively inaccessible patient, depressed mood and emotional blunting were not always distinguished, with some consequent confusion in diagnosis.

As might have been anticipated\(^20,21.22\) feelings of uselessness, worthlessness or self-blame were comparatively rare in this study, but an unusual feature was the frequent appearance of a dissociative defence instead of the more common projective defence found elsewhere,\(^23,24\) which may have given rise to diagnostic difficulty.

**CONCLUSIONS**

The sample was small and was taken during the rainy season, but there was considerable variation within it and it was our impression that it was fairly representative of the practice as a whole. Despite the limitations of the survey it seemed justifiable to draw a number of tentative conclusions:

1. Schizophrenia is likely to be difficult to diagnose in an outpatient setting, the differentiation of acute brain syndromes (including epilepsy) being particularly troublesome. It is therefore recommended that all newly referred patients with a significant degree of thought disorder should be admitted to a psychiatric hospital. These considerations do not apply, of course, to the patient already diagnosed as schizophrenic, who can often be managed as an outpatient quite successfully.

2. Patients with severe clouding of consciousness present little diagnostic difficulty, but it is recommended that
patients with minor degrees of clouding should be admitted for investigation of the underlying lesion. This may seem a little over-cautious but a missed diagnosis of underlying organic illness may easily have fatal consequences. 3.

3. Provided due account is taken of somatic and behavioural manifestations, the diagnosis of depression would seem to be fairly straightforward. Most patients can be managed on an outpatient basis, and only the severely retarded or actively suicidal require admission.

4. In general, very few patients require admission after outpatient treatment.

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Haemophilus influenzae Lobar Pneumonia with Underlying Multiple Myeloma

A Case Report

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Haemophilus influenzae is a well-known cause of meningitis and respiratory tract infections in childhood. Fifteen years ago it was virtually unknown as a pathogen associated with lobar pneumonia, but it has been recognized as an increasingly important cause of this disease in recent years. Until January 1978 only 167 cases had been reported in the world literature, but the true incidence may be greater than these figures suggest. The apparent rise in the incidence of this condition over the past decade can probably be attributed to increased awareness, improved diagnostic procedures and increased life-expectancy of susceptible hosts. To our knowledge, this report is the first of its kind in South Africa.

CASE REPORT

A 75-year-old White woman was admitted with recurrent pneumonia. Despite smoking 30 cigarettes per day for 45 years, she had been completely well with no respiratory