Brit. J. Psychiat. (1966), **112**, 833–838

A Study of Long-Term Patients Attending a General Hospital Psychiatric Department*

By I. PILOWSKY and J. D. STIRLAND

During the past ten years much attention has been paid to the question of chronicity in mental hospital patients. At the same time there has been a trend towards establishing units (often attached to general hospitals) for short-stay in-patient and possibly day-patient care. In these units, where the emphasis is on out-patient treatment, it is soon apparent to the psychiatrists staffing them that they, too, have to cope with a population of chronic patients. They tend, however, to be out-patients rather than in-patients, and are probably better described as "long-term". Heasman (1962) gave a graphic description of this problem in the non-psychiatric out-patient department and compared it to that of the "institutional neurosis" as described by Barton (1959). The purpose of this paper is to describe the situation in a Teaching Hospital Department of Psychiatry attached to a general hospital.

Aims and Definition

In this paper we wish to describe the clinical characteristics of patients who can be designated "long-term" and to contrast them with control groups composed of new patients.

A long-term patient was defined as one who had been registered with us for more than two years at the time of sampling. Discontinuity of attendance did not disqualify from inclusion in the sample and is considered later.

The Setting

The department in which this study was carried out is part of the United Sheffield Hospitals. There is in-patient accommodation for 13 male and 25 female patients. There is also a day hospital for 20 to 25 patients. The average in-patient stay is five weeks. There are about 800 new referrals to the out-patient clinics each year and more than 10,000 out-patient visits are made each year—a fact which tends to undermine the "ivory tower image" of the psychiatric teaching department. No patients are admitted under compulsory orders.

The Patient Sample

The names and dates of first referral were obtained of all out-patients, day-patients and in-patients who received treatment in any form during two separate weeks in November and December 1962. From this sample we obtained the names of 79 patients who had been registered two or more years previously. All the case notes were traced and the required information obtained from these.

The Control Groups

Two control groups were used. Both were composed of randomly selected new patients; the first, consisting of 200 patients, was used for comparing variables such as sex, civil status, social class, number of children and history of previous treatment. This control group had been collected by Hall (1962) in this department.

The second control group, consisting of 169 female and 136 male consecutive new patients, was used to compare ages and diagnostic items. This group had been collected by one of us (I.P.) for another purpose. The two control groups did not differ significantly with regard to sex distribution and broad age groupings.

* Based on a paper presented to the Sheffield Regional Psychiatric Association on 4 April, 1964.

PATTERNS OF ATTENDANCE AND ADMISSION

Sixty-two of the 79 patients had originally been referred by their general practitioners and the remainder by other hospital departments. The average length of time since registration for the long-term group as a whole was 3 years 4 months. The patient attending longest had been registered over 6 years previously. Men averaged 3 years and women 3½ years. They attended the out-patient clinic on an average of once every 6½ weeks. The men came slightly more frequently than the women.

Table I shows the number of times patients in this group were admitted to the in-patient unit and the day hospital. The average stay was 4½ weeks. Fourteen patients had never been admitted to either.

TABLE I
Frequency of Admission to In-patient Unit and Day Hospital

Admissions	In-patient	Day Hospital
0	18	47
1	29	20
2	18	8
3	7	1
4	6	3
5	1	0
	79	79

SEX

Perhaps the most interesting finding is the preponderance of females in the long-term group. This is shown in Table II.

The average age on referral of long-term males was 44·6 years, S.D. = 11·5, while the male controls had an average age of 39·8 years, S.D. = 14·5. The long-term females had an average of 39·9 years, S.D. = 11·5 and the control females an average age of 37·5 years, S.D. = 15·0. There were no statistically significant differences between the long-term males and females, nor between each of these and the corresponding new patient control group. An examination of the distribution of ages shows a relative preponderance of females under 19 years among the new referrals (16 per cent. as opposed to 5 per cent. in the long-term female group).

TABLE II
Distribution of Sexes in the Long-Term and Control Groups

	Male	Female	Total
Long-Term ..	16 (20·3%)	63 (79·7%)	79
Control ..	83 (41·5%)	117 (58·5%)	200
Total ..	99	180	279

$\chi^2 = 10{\cdot}26$; df = 1 P<0·01

SOCIAL CLASS

The Hall Jones grading of occupations (1950) was used to determine the social class of patients. The classes were grouped as follows: 1–3 (Professional, high administrative, managerial, executive, inspectional, supervisory and other non-manual higher grade); 4–5 (Inspectional, supervisory and other non-manual lower grade, skilled manual and routine grades of non-manual); 6–7 (Semi-skilled and unskilled manual).

From Table III it can be seen that the long-term female group shows a significant under-representation of the upper social classes. In the male sample a similar trend is present but does not achieve statistical significance.

TABLE III
Distribution by Social Class

Social Class	Females			Males		
	Long-term	Control	Total	Long-term	Control	Total
1–3 ..	3 (5%)	20 (17%)	23	1 (6%)	10 (12%)	11
4–5 ..	32 (51%)	46 (39%)	78	5 (31%)	44 (44%)	49
6·7 ..	28 (44%)	51 (44%)	79	10 (63%)	29 (35%)	39
Totals ..	63	117 (100%)	180	16	83 (100%)	99

$\chi^2 = 10{\cdot}07$ df = 2 P<0·01 $\chi^2 = 3{\cdot}19$ df = 1 n.s.

https://doi.org/10.1192/bjp.112.489.833 Published online by Cambridge University Press

Civil State

The long-term patients do not differ from new patients with regard to civil state. Of the long-term females 54 (85·7 per cent.) were married, and of the long-term males 14 (87·5 per cent.) were married. In the control group 80·3 per cent.) of the females and 77·1 per cent. of the males were married.

Number of Children

Table IV shows that the long-term female patients tend to have smaller families than the new female patients. The small numbers in the male sample do not allow for statistical comparison, but it is interesting to note that there are no men with more than two children in the long-term group.

Previous Treatment

The long-term patients did not differ significantly from the new patients with regard to a history of previous psychiatric treatment: Long-term females 17 (27 per cent.), controls 41 (35 per cent.); long-term males 8 (50 per cent.), controls 25 (30·1 per cent.).

Diagnosis

The diagnoses examined were those made when the patients were first seen. The comparison of diagnostic items for females is shown in Table V, and shows that three items occur more frequently in the long-term sample. They are Anxiety/Hysteria, Personality Disorder and Hypochondriasis. The term "Anxiety/Hysteria" includes patients diagnosed as anxiety neurosis, anxiety state, anxiety neurosis with hysterical features, and hysteria. "Hypochondriasis" is used in this context as a descriptive term occurring in a diagnostic formulation and not as a nosological entity. Reactive depression is more frequent in the new patients. Some patients were, of course, classified under more than one diagnostic category. "Personality Disorder" includes categories such as aggressive psychopath, hysterical personality and immature personality.

Table IV

Size of Family (excluding single patients)

Number of Children	Female		Male	
	Long-term	Control	Long-term	Control
0	6 (11·1%)	18 (19·1%)	5 (35·7%)	20 (31·3%)
1–2	39 (72·2%)	48 (51·1%)	9 (64·3%)	29 (45·3%)
3+	9 (16·7%)	28 (29·8%)	0 —	15 (23·4%)
Totals	54	94	14	64

$\chi^2 = 6·34$ df = 2 P<0·05

Table V

Comparison of Diagnostic Items in Long-term and Control Female Samples

	Long-Term (N=63)	Control (N=169)	
Reactive Depression	10 (16%)	54 (32%)	$\chi^2=4·12$ P<0·05
Anxiety/Hysteria	34 (54%)	42 (25%)	$\chi^2=19·74$ P<0·001
Personality Disorder	13 (21%)	9 (5%)	$\chi^2=10·81$ P<0·005
Hypochondriasis	32 (51%)	61 (36%)	$\chi^2=6·15$ P<0·025
Endogenous Depression	16 (25%)	43 (25%)	$\chi^2=0·017$ N.S.
Obsessional Neurosis	6 (10%)	3 (2%)	Numbers insufficient
Schizophrenia	3 (5%)	4 (2·4%)	Numbers insufficient

https://doi.org/10.1192/bjp.112.489.833 Published online by Cambridge University Press

TABLE VI

Comparison of Diagnostic Items in Long-term and Control Male Samples

	Long-Term (N=16)	Control (N=136)	
Reactive/Depression	1 (6·2%)	26 (19·1%)	Numbers insufficient
Anxiety/Hysteria	7 (43·8%)	27 (19·9%)	Numbers insufficient
Personality Disorder	2 (12·5%)	29 (21·3%)	Numbers insufficient
Hypochondriasis	11 (68·8%)	54 (39·7%)	$\chi^2=3·82$ n.s.
Endogenous Depression	5 (31·3%)	25 (18·4%)	Numbers insufficient
Obsessional Neurosis	0	0	Numbers insufficient
Schizophrenia	2 (12·5%)	7 (5·1%)	Numbers insufficient

There were too few patients in the long-term male sample to allow tests of significance to be carried out, except in the case of one diagnostic item "Hypochondriasis". For this item the chi-square value approached but did not reach the figure required for standard statistical significance. The distribution of diagnosis is shown in Table VI. On the whole the trends would seem to be similar to those found in the females.

CORRECTION FOR INTERRUPTION OF ATTENDANCE

A corrected attendance figure was calculated by subtracting from each patient's total attendance the longest continuous period during which he or she was not seen by a doctor on the staff of the unit. This yielded a sample of 39 females who had a total "corrected attendance" of over 2 years, and these were then compared to the new female controls. Significant differences were shown in only two diagnostic categories, viz. Anxiety/Hysteria ($\chi^2 = 20·6$ $p < 0·001$), which was more frequent in the long-term group, and Reactive Depression which was less frequent ($\chi^2 = 4·8$ $p < 0·05$).

A similar procedure was carried out on the male group. This produced 9 cases who had attended more than two years. Of these 5 had been considered hypochondriacal, 4 fell in the Anxiety/Hysteria category, and one in the Personality Disorders. Four were endogenously depressed, one schizophrenic and one reactively depressed.

FREQUENCY OF ANXIETY/HYSTERIA IN MALE AND FEMALE NEW PATIENTS

Table VII compares the frequency of Anxiety/Hysteria in male and female new patients. The difference is not significant ($\chi^2 = 0·827$ df $= 1$). Thus the possible hypothesis that long-term illness in females is related to a preponderance of this diagnosis in new female patients is not supported.

TABLE VII

Frequency of Anxiety/Hysteria in Male and Female New Patients

	New Patients		Total
	Male	Female	
Anxiety/Hysteria	27	42	69
Other	109	127	236
Total	136	169	315

DISCUSSION

We have shown that in this department the long-term patients are mainly females of the middle and lower classes, who have small families and fall into the diagnostic category of Anxiety/Hysteria. Cases of endogenous and reactive depression are less likely to become long-term. This is more marked if we exclude cases of recurrent rather than long-term illness. Such cases of schizophrenia and obsessional neurosis as are selected for referral to the Clinic may also tend to become long-term attenders, but the numbers in our sample are too small to generalize.

If discontinuity of attendance is not taken into account, then females given diagnostic labels such as "hypochondriasis" and "personality disorder" are also over-represented in the long-term sample.

A study of this sort cannot hope to explain why female neurotics are more likely to become long-term. They may derive a form of support which the male neurotic can obtain from social interactions during his hours of work. Together with this must be considered the fact that, given similar amounts of discomfort due to neurotic symptomatology, the housewife (particularly with a smaller family) is likely to have more time for attending clinics held during normal working hours. It is also noteworthy that of the small group of sixteen long-term males, only five were working at the time of the survey.

Considering the out-patient commitments mentioned, it can be safely assumed that no efforts are spared to help the patient towards independence or at least to refer them to their own G.P. for the support they may still require. Certainly no patients were attending for research or teaching purposes. Referral back to the G.P. is not easily achieved. Frequently an attempt to do so results in early referral back to the department (Sheldon, 1964). It may be that these patients are not tolerated well by G.P.'s, and the rate at which they change their practitioner would tend to support this. Twenty of the sample of 79 patients changed their G.P.'s at least once since referral to our Clinic. We were able to obtain the figure for the number of changes in the Sheffield region during 1963; there were 19,274 changes in a population of 495,290. This figure was treated as referring to the number of individuals changing in one year, thus producing an overestimate. For the long-term group the numbers of changes per patient were disregarded, thus producing an underestimate. On the basis of the Sheffield figures we calculated the expected number of changes of G.P. for each patient for the time since referral, and these were summed. The difference between the expected number of changes (4·78) and the observed number (20) was highly significant ($\chi^2 = 11{\cdot}02$ $p < 0{\cdot}001$, 1 df. corrected for continuity).

Although this is a striking finding, it must be borne in mind that of the long-term sample, 10 had moved house, leaving only 10 who had changed their G.P. without a move of house. The figures for movement within Sheffield by the general population are not known, and our finding must therefore be interpreted with caution.

A point often made is that these women would not constitute a psychiatric problem if the presence of clinics such as ours did not act as an encouragement to G.P.'s to refer them for treatment.

There is no clear-cut answer to this question, but one possibility is that in the absence of psychiatric clinics many of these patients would be referred to other hospital departments where their lives become a prolonged round of special investigations and non-specific therapies; evoking from physicians and surgeons such heart cries as that of Gehring (1932) who wrote: "One may indulge in the luxury of terminology and call these persons neurasthenics, or psychasthenics, examples of anxiety neurosis or just plain variants. In any case, they are the bane of the average physician's existence, for they tax his medical skill, his tact, his patience and his endurance . . ."

With psychiatric services becoming available to ever greater sections of the population, it may be that patients such as those constituting our long-term sample represent an expanding mental health problem.

Summary

A sample of 79 psychiatric patients registered with a general hospital psychiatric department for more than two years has been compared with control groups of new patients referred to the same department. The following findings emerged:

1. Females were over-represented in the long-term group.
2. The long-term females had fewer children than the controls and higher social classes were under-represented.
3. More long-term females were labelled "Anxiety/Hysteria", "Personality Disorder"

and "Hypochondriacal"; less frequently as "Reactive Depressions".

4. The 16 male patients were described separately. Unemployment and hypochondriasis were prominent features.
5. The whole sample changed their general practitioner significantly more often than the population of Sheffield.

ACKNOWLEDGMENTS

We wish to thank Professor E. Stengel for the help and dvice he has given us in the preparation of this article.

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I. Pilowsky, *Lecturer in Psychiatry, University of Sheffield, Whiteley Wood Clinic, Sheffield 10*

J. D. Stirland, *Consultant Psychiatrist, Chesterfield Group of Hospitals*

(*Received 19 May, 1965*)