IMPROVEMENT IN ALCOHOLICS MEASURED USING THE GENERAL HEALTH QUESTIONNAIRE

MELCHIOR J. A. J. M. HOES*, JOHAN H. B. ZEIJJPVELD and MAGGY RUIJGROK

Department of Psychiatry, Ziekenhuis Rivierenland, P.O. Box 6024, NL-4000HA Tiel, The Netherlands

(Received 15 December 1997; in revised form 16 February 1998; accepted 3 March 1998)

Abstract — Over a 1-year study period all patients admitted to the department of psychiatry in a general hospital were asked to complete the General Health Questionnaire at admission, discharge, and first polyclinic (outpatient) follow-up contact. Seventeen per cent of admissions were alcoholics. Alcoholics improved rapidly after admission to the psychiatric department. This improvement was comparable to that of all the (psychiatric) patients admitted and continued after discharge.

INTRODUCTION

The course of the general well-being of alcoholics hospitalized in a department of psychiatry of a general hospital (DPGH) is unknown (Franklin and Frances, 1992; Goodwin, 1992; Swift, 1993; Jaffe, 1995; Schuckit, 1995). General well-being is a reflection of mental, social, and physical well-being as formulated by the World Health Organization in 1948 (Testa and Simonson, 1996). In DSM-III-R and DSM-IV, the multi-axial system, the clinical practice of the bio-psycho-social model of disease (American Psychiatric Association, 1987) is used. This multi-axial system is the basis of the treatment programme in our department of psychiatry. All patients, including alcoholics admitted for detoxification, are offered a structured, multidisciplinary programme (Table 1) (Hoes, 1997). In this programme, the psychiatrist makes the multi-axial diagnosis. Axis-I is for clinical disorders, Axis-II for personality disorders, Axis-III for somatic disorders, Axis-IV for psychosocial disturbances, and on Axis-V the Global Assessment of Functioning is noted. After this diagnosis has been made, treatment is indicated by the psychologist/psychotherapist for focal Axis-II disorders or for Axis-V disturbances in the case of a structural coping deficit, by the social worker for Axis-IV factors, by medical specialists for Axis-III diseases, and Axis-I has the specialist attention of the psychiatrist and nursing staff. In tackling all existing problems promptly, the burdens on the patient's well-being are relieved as completely and as quickly as possible. This is expected to result in a shorter duration of admission.

We have therefore investigated whether this clinical approach yields positive results in alcoholics and whether these are comparable to those of the general psychiatric population of the department. Since the General Health Questionnaire (GHQ) is well suited for psychiatric case detection and follow-up of the general well-being of patients (Hodiamont, 1986; Goldberg et al., 1997), it was used for this research.

PATIENTS AND METHODS

All admitted patients over a 1-year study period were asked to complete the GHQ (30 items; Hodiamont, 1986) at admission, discharge, and first polyclinic (outpatient) visit. The 30-item GHQ is most appropriate for measuring at follow-up, because it is the most complete assessment.

Diagnoses were made according to DSM-III-R (American Psychiatric Association, 1987). Admission to a DPGH in The Netherlands is for Axis-I disorders, although the presence of co-morbid Axis-II disorders is also noted. For comprehensiveness, detailed diagnoses were classified into mood disorders, alcoholism, psychoses, and anxiety disorders. Although most alcoholics are hospitalized in the DPGH, some may be admitted to other departments due to lack of beds in the
Table 1. Outline of the structured personal multidisciplinary treatment protocol of the Department of Psychiatry of the General Hospital in Tiel

<table>
<thead>
<tr>
<th>Diagnostic category</th>
<th>Treatment (medication and case management)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Axis-I</td>
<td>Supportive care and psychopharmacological treatment; daily talk with one nurse on all relevant matters</td>
</tr>
<tr>
<td>Axis-II</td>
<td>Focal psychotherapy</td>
</tr>
<tr>
<td>Axis-III</td>
<td>Medical specialists</td>
</tr>
<tr>
<td>Axis-IV</td>
<td>Exploration by nurse, visiting follow-up by social worker</td>
</tr>
<tr>
<td>Axis-V</td>
<td>Exploration by nurse; psychotherapy by clinical psychologist on visiting basis</td>
</tr>
</tbody>
</table>

DPGH. Hospital personnel were used as the control population.

RESULTS

Two hundred and fifty-seven patients were admitted to the department for an Axis-I disorder during the 1-year study period. Although mood disorders prevailed (62%), alcoholism was well represented (17%), being more prevalent than psychoses (15%) and anxiety disorders (6%). The hospital characteristics and time to the first polyclinic visit are comparable with those for the total population of the department (Table 2). Only evaluable questionnaires were counted; several alcoholics were admitted to other departments primarily for psychiatry, these have not been included. At admission, 213 questionnaires were evaluated. The controls (n = 273 out of 528) were younger than the total patient population (36 ± 10 vs 45 ± 15 years); women were more prevalent in the control group (M/F = 45/55) than the alcoholic-group (M/F = 74/26). The mean age of the alcoholics was 44.2 ± 12.9 years, and the sex ratio (F/M) was 1:2. Alcoholics possessed more co-morbid personality disorders than the other patients investigated (14/48 vs 90/213).

The alcoholics showed the same GHQ values as the total patient sample at all three measurement points (Table 3). The values for alcoholics were no different from those of the total population at any of the three measurements. At discharge, their previously elevated GHQ values had normalized (to <6), almost all of the female alcoholics who returned to the polyclinic had 'a problem'. When the total patient population was broken down into the four diagnostic categories, no differences were shown at admission or discharge; at discharge, all groups reached the cut-off value of less than 6. At the first polyclinic visit, a smaller number of patients (n_total = 74) completed the questionnaire, for the reasons given later.

When the results were evaluated with the paired t-test, the only group with three measurements large enough for proper statistical evaluation was the one with personality disorder as the index (n = 26). In this group measurement at entry and discharge, entry and polyclinic visit and discharge, and polyclinic visit showed significant differences (P < 0.05). The number of diagnoses per patient had no influence on the statistical result.

The admission duration of alcoholics was comparable to that of the total psychiatric population (28.2 days) and was much shorter for both than the average of a Dutch PDGH (42 days).

DISCUSSION

The smaller number of patient questionnaires at the first polyclinic visit deserves comment. Not all patients had an appointment, others did not attend. It should also be said that, in some cases, ques-
GENERAL HEALTH QUESTIONNAIRE AND ALCOHOLICS

Table 3. General Health Questionnaire scores for alcoholics and other psychiatric patients

<table>
<thead>
<tr>
<th>Time</th>
<th>Female</th>
<th>Male</th>
<th>Total alcoholics</th>
<th>Other psychiatric patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission</td>
<td>17.0 ± 9.0</td>
<td>17.0 ± 9.0</td>
<td>17.0 ± 9.0</td>
<td>18.9 ± 8.5</td>
</tr>
<tr>
<td>Discharge</td>
<td>4.6 ± 4.9</td>
<td>5.9 ± 6.7</td>
<td>5.4 ± 6.7</td>
<td>4.6 ± 6.7</td>
</tr>
<tr>
<td>Polyclinic (outpatient)</td>
<td>12.4 ± 9.6</td>
<td>4.6 ± 6.7</td>
<td>7.6 ± 8.7</td>
<td>5.8 ± 7.6</td>
</tr>
</tbody>
</table>

Values are means ± SD.

The differences for the three measurement points as established when personality disorders were taken as the index disorder were significant. Although the absolute values between the groups did not differ, this conclusion cannot be extended to all groups; in any case, the improvement in alcoholics lasted throughout the treatment period. It is therefore reasonable to assume that this study has shown that the general well-being of alcoholics, as measured by the GHQ, is no different from that of the general psychiatric DPGH population. The improvements were quantitatively similar and remained so in the long term. The GHQ is only one measure of the course of alcoholism. It was chosen for this study, because the general well-being of all patients was the end-point and the GHQ is a good measure of this; it seems to have been seldom used in alcoholics.

The short duration of hospitalization, compared to The Netherlands in general, deserves comment. A statistical comparison between the hospital data and the country mean is hampered by lack of data for the country as a whole. However, a very recent inventory of the 70 Dutch DPGHs revealed that the DPGH in Tiel is the only unit to use the structured, multidisciplinary approach already mentioned (Huyse, 1997). In this approach, the psychiatrist asks for, and coordinates, the support, diagnostic, and treatment efforts of Alcoholics Anonymous, the Consultation Bureau for Alcohol and Drug Abuse, internist and other co-workers. As the duration of hospitalization of alcoholics is no different to that of other cases and as the mean duration is considerably shorter than the mean for the country at large, it seems probable that the structured approach yields favourable results in all patient groups, including alcoholics.

Acknowledgements — Mr T. Houtriet and Mrs A. Niemantsverdriet-Loeffler are thanked for their enthusiastic and conscientious help with this study.

REFERENCES


