

MORBIDITY PATTERNS OF PATIENTS ATTENDING PSYCHIATRY OPD IN TERTIARY CARE HOSPITAL IN AHMEDABAD

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ABSTRACT

Objective: To find out the common psychiatric disorders among patients attending psychiatry OPD and also to study the role of factors like age, sex, education and occupation, marital status and various precipitating factors on mental health status of the patients.

Study Design: Cross Sectional Study.

Methods: A total of 200 patients were studied in a period of two months (April-July '08). Patients attending psychiatry OPD were examined with the help of a trained psychiatrist. Information regarding the patients was taken using pre-designed structured proforma. Diagnosis was made by trained psychiatrist based on ICD-10 classification in regard to DSM IV criteria.

Results: Majority of psychiatric patients (27.8 %) belonged to age group 20-29 years and above 49 years in 25.5 % cases, most of them were males (59.9 %). Occupational analysis showed that more number of psychiatric patients (32%) belonged to labourer group followed by unemployed (26%). 39% of patients belonged to class IV, Modified Prasad's Classification and in 12.5 % cases psychiatric problems were precipitated by poor financial condition. Psychiatric problems were more in illiterates (28%) and majority of the patients (65.5%) were married. In 46% cases patients were suffering from various health related problems and 12 % of patients consumes alcohol. The morbidity pattern showed that majority were affected by depression (29%), schizophrenia (18%) and substance abuse psychiatric disorder (11%).

Key words: psychiatric disorder, OPD, diagnosis

INTRODUCTION

WHO data on global burden of disease says that mental illnesses accounts for over 15 percent of the total burden of disease.¹ Disability caused by major depression ranked second only to ischemic heart disease in magnitude of disease burden. National all-India prevalence rates for 'all mental disorders' National Prevalence Rate is 70.5 (rural) , 73 (urban) and 73 (rural +urban) per 1000². Prevalence of schizophrenia is 2.5 /1000 and this seems to be the only disorder whose prevalence is consistent across cultures and over time.² INDIA - Urban morbidity is 3.5 % higher than the rural area. Surveys in developed as well as developing countries reported more than 25% of individuals with one or more mental or behavioral disorders, during their life.³

Gujarat: It is estimated that there are 2.8 million adults with common and severe mental disorders at any given

point in time. Every year, around 11,000 new cases of schizophrenia are added to the mental disorder burden. (GOI, 2002)

India has a high rate of suicides – 89,000 persons committed suicide in 1995, increasing to 96,000 in 1997 and 104,000 in 1998, which is a 25% increase over the previous year (WHO 2001b).

OBJECTIVES

To know the common psychiatric disorders among patients attending psychiatry OPD.

To find the role of key factors like Age, Education, Occupation, and various Precipitating factors on mental health status of the patients.

MATERIALS AND METHODS

Sample: Patients who came to the Psychiatric OPD, Kesar SAL Medical college hospital located in outskirts of Ahmedabad city which operates six days a week and around 6 hours a day.

Sample size: A total of 200 new patients aged more than 12 years were purposely selected for the study in a period of one year (05-06). First 2-3 new patients attending psychiatric OPD were selected daily for the study.

Children <12 years of age are excluded from this study. Patients suffering from mental retardation are also excluded.

Analysis was done using Epi info 6.04 d statistical software package wherever applicable.

Proforma: Information regarding patients was taken using pre-designed structured proforma.

Diagnosis: With the help of trained psychiatrist based on American classification of DSM IV criteria.⁴ Those with a diagnosis of – mental retardation and epilepsy were excluded from the study.

RESULTS AND DISCUSSION

Most common psychiatric disorders were Depressive illness (29 %), Schizophrenia (18 %), Manic type mood disorder (12 %), Substance abuse disorder (11 %) and other Psychotic disorder (14 %). Major

psychiatric disorders found in males were depression (24%), bipolar disorder (16%), and Schizophrenia (15%) while major cases in female were minor depression (22%), Brief psychotic disorder (11%), and schizophrenia (9%). It has been observed from the results of our study that in our population group causes of psychiatric distress were poor financial condition (13%), marital breakdown/disturbed marriage life (12%), death of nearer relative (12%), family quarrel (12%) and loss of importance/ poor social backup (9%). Many studies have also shown that men have greater rates of substance related disorders and personality disorders ^{6,7,8}. Higher percentage of male patients (58% vs 43%) were married than females and higher percentage (67%vs 33) of males patients were single than females. It can be inferred from these findings that married men are likely to suffer from psychiatric problems as compared to single women. The possible reasons for these finding can be related to disturbed marriage life and family quarrel. No cases were found with eating disorders, this finding is somewhat consistent with literature review which showed comparatively less prevalence of eating disorders in subcontinent regions than other parts of the world ⁹.

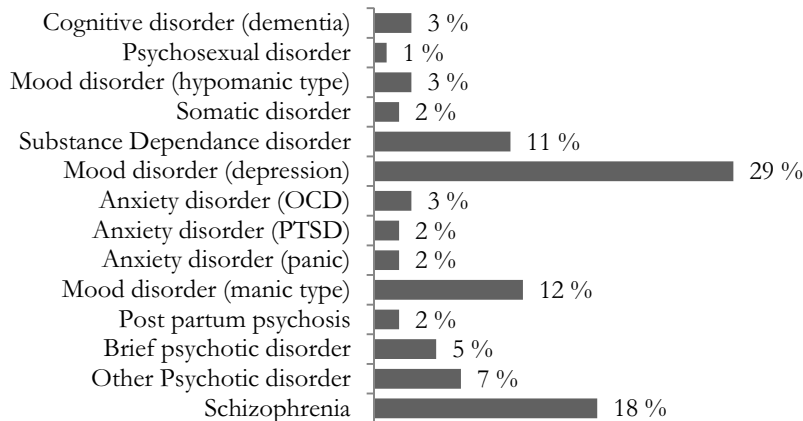


Fig 1: Common Psychiatric Disorders

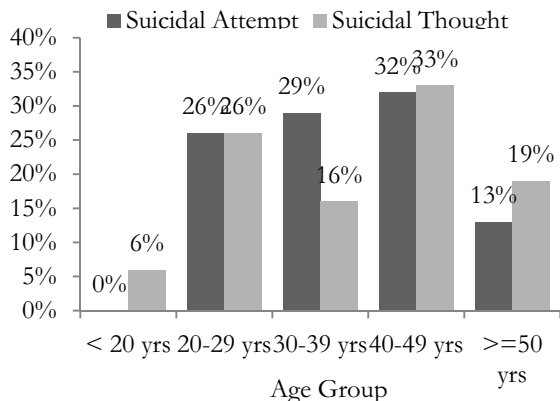


Fig 2: Suicidal Attempt & Thought in Relation to Age Group (P <0.05)

Fig 2 shows the relation of between suicidal attempt & Suicidal thought and age group of the psychiatric patients – represents as the age advances there is an increase in tendency towards suicidal thought and suicidal attempt, and after the age of 50, it may be possible that many of our patient get died due to suicidal attempt. This is highly significant.

RECOMMENDATION

Awareness: Major concern is to be given to increase awareness in the general population regarding psychiatric ailments. Utilization of the media should be done properly. Street plays should be encouraged as a source of knowledge regarding psychiatric disorders.

Table 1: Profile of study population

Characteristics	Frequency	%
Precipitating factors		
Death of nearer relative	23	11.5
Disturbed marriage life / Marital breakdown	24	12.0
Family quarrel / Quarrel with neighbor	23	11.5
Financial problem / Poor condition	25	12.5
Stress responsibility (at work, home, sexual harassment at work, not being able to work)	13	6.5
Medical condition	15	7.5
Competition stress / Failed in exam	9	4.5
Job dissatisfaction / Problem with boss	7	3.5
Extra marital affaire	2	1.0
Fear of something	7	3.5
Loss in business	4	2.0
Non compliant with drugs	8	4.0
Property problems	5	2.5
Loss of importance / Poor social backup	17	8.5
Not known	18	9.0
Sex		
Male	119	59.5
Female	81	40.5
Occupation		
Government servant	20	10.0
Self employed	47	23.5
Private employed	17	8.5
Labourer	64	32.0
Un employed	52	26.0
h/o Suicidal Thought		
Yes	125	62.5
No	75	37.5
h/o Suicidal Attempt		
Yes	38	19.0
No	162	81.0
Family History Positive		
Yes	69	34.5
No	131	65.5
Age Group Distribution		
<20 yrs.	11	5.5
20-29 yrs.	55	27.5
30-39 yrs.	34	17.0
40-49 yrs.	49	24.5
>50 yrs.	51	25.5
Marital Status		
Single	40	20.0
Married	131	65.6
Widowed (loss of spouse)	10	5.0
Divorced	11	5.5
Separated	8	4.0
Medical Condition +		
Yes	92	46
No	108	54.0
Habit		

No habit	84	42.0
Tobacco chewing	63	31.5
Smoking	18	9.0
Alcohol	24	12.0
Opioid (morphine-heroin – brown sugar)	8	4.0
Cannabis (bhang-charus-ganja)	3	1.5
Per Capita Income Group (Modified Prasad's Classification) AICPI-530		
I (>2612)	8	4.0
II (1306-2612)	31	15.5
III (783-1305)	62	31.0
IV (391-782)	78	39.0
V (<391)	21	10.5

Provision of mental health care to Community and Primary level : Mental health disorders account for nearly a sixth of all health-related disorders. Yet we have just 0.4 psychiatrists and 0.02 psychologists per 100,000 people, and 0.25 mental health beds per 10,000 populations. If access to mental healthcare is to be improved, mental healthcare must be provided at the community and primary level.

Rehabilitation should be given emphasis. There should be strict ban on the faith healers. Vigilance should be strong over the media, so that wrong messages are not conveyed to a lay person and also the health budget should be properly utilized for mental health programme.

There is also need to develop primary and secondary prevention policies: the primary care prevention should be aimed at reducing the prevalence of mental health problems, and there is relentless need of much greater co-operation and collaboration between mental health and primary care health workers.

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