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PSYCHIATRIC MORBIDITY: PREVALENCE, ASSOCIATED FACTORS AND SIGNIFICANCE

Pages with reference to book, From 69 To 70

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ABSTRACT

A cross-sectional observational systematic study was carried out on ambulatory patients at a tertiary care hospital to determine the probable prevalence, associated factors and significance of psychiatric morbidity by using an Urdu translation of the hospital anxiety and depression (HAD) scale over a period of 6 days in a week. Results showed a prevalence of 38.4% which is slightly higher than what has been generally reported (30%). Two variables, i.e., female sex and being a housewife were significantly related with the outcome. An attempt has been made to identify the probable reasons for this and some suggestions laid down for further work (JPMA43: 69, 1993).

INTRODUCTION

“Mental disorder is part of life itself”, Arthur Kleinman. A study was conducted to estimate the prevalence of psychiatric morbidity and its associated risk factors in ambulatory patients of Aga Khan University Hospital. Goldberg¹ has reported a prevalence of psychiatric illness of 30% in general medical patients. Goldberg and Huxley² further said that out of 250 psychiatric patients per 1000 per year, 230 were accessible to primary care. Meagre data exists on psychiatric morbidity in Pakistan with Mumford and Tareen³ reporting an average prevalence of 30% in general hospital settings. Goldberg and Bridges⁴ have stated that anxiety and depression are the commonest psychiatric problems seen by general physicians when they found that of 590. patients presenting to their general practitioners with a new complaint, 31.6% were diagnosed to have anxiety or depression. Other DSM III diagnoses accounted for only 1.5% of cases. Accordingly it was decided to use anxiety and depression as indicators of psychiatric morbidity.

SUBJECTS AND METHODS

A descriptive cross sectional study was carried out at Community Health Centre a general walk in cum appointment clinic, at AKUH. Eligibility for inclusion in the study were patients 16 years and older. Over a period of one week a total of 180 patients were selected by systematic random sampling, of which 167 completed the interview. The reasons for dropping out were need for urgent medical care, language problem and refusal to participate after seeing the forms. The hospital anxiety and depression (HAD) scale⁵ was chosen as the instrument for data collection as it has been designed for use in outpatient departments of non-psychiatric hospitals. A validated Urdu translation of the I-LAD scale³ was used in this study and a score of 11 or above was kept as the cut off point. Informed consent was obtained and data was collected using the HAD scale. In addition, Socio demographic information (age, sex, marital status, occupation, family income) and family history of psychiatric illness was also recorded.

RESULTS

Analysis of data revealed that of the 167 people interviewed, 64 were screened positively for psychiatric morbidity, giving a point prevalence of 38.4%. The distribution being anxiety - 19.2%, depression - 4.2% and anxiety with depression - 15%. Psychiatric morbidity was found to be significantly associated with females and housewives. Only five people who were screened positive on HAD scale for depression had a positive family history of psychiatric morbidity. No significant association ($P=0.05$) was found between income and psychiatric morbidity but the data suggests that an association may exist (Table).

TABLE. Distribution of psychiatric morbidity by select socio- economic factors, Karachi, 1991.

Age	Yes	No	X^2	P value
Age				
≤ 35	31	54	0.25	0.62
>35	33	49		
Sex				
Male	27	62	5.14	0.02
Female	37	41		
Marital status				
Single	19	34	0.20	0.65
Married	45	69		
Occupation				
Housewife	34	27	12.33	<0.001
Employed	30	76		
Income				
≤ 2000	17	15	3.67	0.06
>2000	47	88		

DISCUSSION

A prevalence of 38.4% in a general clinic of tertiary care hospital (AKU) could probably be explained by the fact that anxiety and depression are masked by somatic symptoms often leading to unnecessary delays in diagnosis and management⁶ thus compelling patients to seek relief at tertiary care facilities. A high level of civilian stress⁷ that exists in Karachi could also explain the high prevalence found in this study. A large community based study is being planned to determine whether the reported prevalence is also true in a community Setting. Our study demonstrates that the female sex had higher psychiatric morbidity which is in consonance with medical literatures⁸. Studies in the West have shown that lack of paid employment increases the vulnerability of women to depression⁹. The relationship between household income and psychiatric illness has been documented⁷ and results from our study show that there is a strong possibility of this in the population studied. Only 5 of the cases admitted to a family history of psychiatric illness which can probably be explained by the taboos and stigmas associated with the problem. A prevalence of 38.4% in a general clinic, calls for a review of medical, nursing and public health education and practice in Pakistan, possibly on the lines of the USA medical school

curriculum¹⁰. In addition, mental health care needs to have an allocation in the National Health Policy which is proportionate to the prevalence of psychiatric problems⁶. Further attempts need to be made at developing highly focussed socio therapeutic and preventive interventions at the community level¹¹.

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