PSYCHIATRIC DISORDERS IN GENERAL PRACTICE

Pages with reference to book, From 2 To 4

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Abstract

An attempt is made to document the prevalence of psychiatric disorder among the adult population of three general practices in Karachi. After a brief course in psychiatry we tried to identify broad diagnostic categories like psychosis, neurosis, anxiety-depression syndrome, psychosomatic and somatopsychic disturbances. Being aware of our limitations we can with confidence state that the prevalence of psychiatric disorder among the adult patients attending our practice is much higher than 12% which this study reports
(JPMA 37 2, 1987).

INTRODUCTION

The developing countries are depending heavily on the concepts and natural history of psychiatric disorders derived from the investigation of Western societies. No attempt has been made to generate our own data for the incidence and prevalence of various disorders. It is important for reasons of planning and developing mental health services based on objective realities.
WHO Expert Committee on Mental Health[1] (1975) reported that in developing countries mental disorder cause severe disablement and incapacity in 10% of every population at some period in their lives. They include such disorders as schizophrenia, affective psychosis and organic brain syndromes. Much higher rates are found if other conditions are included such as neurosis, epilepsy, mental retardation and drug dependence. In another study 10,000 physicians practising in Austria, Germany, France, Italy, Switzerland concluded that 10% of all patients consulting these doctors were depressed and among half of them the depression was masked.[2] From the private practice of 74 doctors in Switzerland (excluding psychiatrists and paediatricians) 18% of the patient sample of 1,260 were found to be depressed.[3]

MATERIAL AND METHODS

In the absence of any data on incidence or prevalence of psychiatric morbidity in Pakistan this is a humble effort in this direction. After an intensive four weeks course in psychiatry for family physicians at the department of Neuropsychiatry, Jinnah Postgraduate Medical Centre, Karachi an offer was made to enlist all the participants to conduct a survey on the prevalence of psychiatric illness in their area of practice. Out of eighteen, eleven agreed to participate but only three could carry out the data collection as agreed.
The material was collected from three practices located in different, parts of the city (A-PECHS, B-Shershah, C-Frere Road). Henceforth referred as practice (A, B & C). The time and period of data collection by the three practices was also different (Table - 1).
The broad categories of disorders to be identified were Anxiety depressions syndrome, psychosis (Schizophrenia, hypomania and acute psychotic reactions were combined), Hysteria and related neurotic conditions, and psychosomatic and somato-psychic disorders which were lumped together. In a separate category of other's included were Qatra (white discharge before or after micturation), impotence and drug dependence.

Infanes and children under 14 were excluded from the study.

RESULTS AND DISCUSSION

Average age of patients in all the practices is 35.5 years, males predominate in A and B but itis reverse in practice C. This is explained on the basis of location of the clinics. Practice A was situated in industrial area and B in a shopping centre. They cater for the workers from social security and families residing in hutments and small flats. Practice C is in middle class residential cum business locality (Table 1).

TABLE – I

Demographic characteristics of Patients and Period of Data collection.

	Aver-age Age	Male	Female	Marital Status % M	S	Others
Practice A Nov 83–Nov 84 N : 2552	32.7	1666	886	64.1	30.3	5.6
Practice B Aug – Sept 84 N : 1800	34.9	1115	685	85.5	13.5	1
Practice C Sept 84 N : 815	39.1	183	632	82.0	16.9	1.1

TABLE – II
Diagnostic Categories indentified as Percent of Total Adult Patients.

	Anxiety depression syndrome	Hysteria neurotic disorder	Psychosis	Psychosomatic and somatopsychic	Others	Per total
Practice A N : 2552	4.8	.1	.5	4.1	1.4	10.9
Practice B N : 1800	7.2	.1	.2	6.2	2.4	16.1
Practice C N : 815	4.3	.1	.4	2.3	2.2	9.3
Total 5167	5.4	0.1	0.4	4.2	20	12.1

The breakup of various broad categories of illness given in table II shows anxiety/depression syndrome to be highest and closely followed by psychosomatic/somatopsychic disorders. Hysteria and neurosis is surprisingly low in all the practices. Psychotic patients are generally considered to be possessed and resort to spiritual means of treatment, rather than brought to a family physician[4]. Psychosexual disorders like Qatra also known as Jiryan and impotence predominate understandably in practice A and B though occasional drug addicts do turn up. It is not surprising because opium eating among old is not considered worthy of treatment, the charas abuse among working class is a pattern of relaxation in this subculture[5].

The heroin is attracting a lot of youths. It is only parents who turn to family physicians for advice and rarely for treatment (which is impossible on outpatient basis anyway).

Diagnostic Categories indentified as Percent of Total Adult Patients.

It can be stated that 12% of patients three general practices suffer from attending the one or the other psychiatric disorder. In our opinion this is grossly on the lower side. This could be because most of the patients come to us for their physical symptoms and we have limited experience in psychiatry. In fact the senior family physicians had no formal training in recognition and treatment of mental disorder. We must have missed a sizeable number of neurosis, obsession and masked

depression. Retrospectively, we concede that a large number of undiagnosed cases like backache, headache, giddiness, feeling faint and general debility were not included. But most important of all the children are excluded from this study because we were not equipped to diagnose them. They constitute 45% of our population and a large proportion of our practice. It means all the mentally retarded, those with behaviour disorder, bed wetting and adolescent problems including epilepsy are not included in this study.

In conclusion we would like to accept that this study has not been able to fulfil the strict epidemiological methodology. Being aware of our limitations we can with confidence state that the prevalence of psychiatric disorder among the adult patients attending our practice is much higher than this paper reports. Needless to emphasise that teaching and training in psychiatry both at undergraduate level and of a continuing education in this field cannot be disputed any more?

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