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# ASSESSMENT OF SOCIO- DEMOGRAPHIC DETERMINANTS IN PATIENTS WITH PSYCHOTIC DISORDERS

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**ABSTRACT**

**Background:** Psychotic disorders are a group of chronic debilitating psychiatric illness, characterized by loss in touch with reality and disorders of thought, behaviour, appearance and speech. The environmental factors have an important role in the onset of all psychoses. Our study was an effort these socio- demographic determinants in patients with psychotic disorders.

**Material and methods:** It was an unicentric, open labeled, prospective study which was included patients with psychotic disorders. The socio-demographic profile assessment was done in the study patients.

**Results:** Out of total 80 study patients, 41(51.3%) were males and 39(48.8%) were females. 29 (36.25%) study patients were in the age group 30-40 years closely followed by the age group 19-29 years, 27 patients(33.75%)., 50(62.5%) were of education status 'IX and above'. we observed that highest number of patients, 43(53.75%) were 'married'. Maximum patients belonged to class III (41.25%), followed by class V (22.5%) and class IV (20%). males were mostly unemployed 39.02% (16 patients).

**CONCLUSION:** Our study demonstrated equal gender distribution. Maximum number of patients were in the age group 30- 40 years, married, lower socio- economic status, had education 'IX and above' and were from rural areas. Females were mostly housewives and males were unemployed.

**KEYWORDS :** Psychotic disorders, Socio-demographic profile.

## INTRODUCTION:

Psychosis is defined as a loss of ego boundaries or a gross impairment of reality testing,in which a person's perception, thoughts, mood and behaviour are significantly altered.[1,2,3,4] Psychotic disorders can be broadly categorised into non-affective (schizophrenia and related psychoses), affective (major depressive disorder with psychotic symptoms; bipolar disorder with psychotic symptoms) and substance-induced disorders.[5] Psychotic symptoms are conventionally characterized to be the main features of schizophrenia and other non-affective psychotic disorders, while affective psychoses and secondary psychoses are often regarded as disorders where there are associated psychotic symptoms.[6] The symptoms of psychosis and schizophrenia are usually divided into 'positive symptoms', which include hallucinations (perception in the absence of any stimulus), delusions (fixed, firm and falsely held beliefs), disorganized behaviour;' negative symptoms' (such as emotional apathy, lack of drive, poverty of speech, social withdrawal and self-neglect).[4]

The average age of onset is in the mid to late twenties, with evidence of earlier onset for non-affective disorders in men and later for women. A study in Finland reported a life time prevalence of any psychotic disorder to be 3.48%, non-affective psychotic disorders 2.29%, schizophrenia 1.00%, and affective psychoses to be 0.62%. [5] In the Indian scenario, according to Mental Health survey 2015-16, the burden of schizophrenia and related psychotic disorders is about 0.4% in the surveyed population, with a relatively higher prevalence in the urban metros.[7]

As the onset of the disease is at the most critical period of educational, occupational and social development, their consequences often lead to lifelong disability.[6]

The environmental factors have an important role in the onset of all psychoses. Studies evidence the link of social environment and ethnic density[8-10] and individual social experiences over the life course with the onset of psychotic disorders.[10-12]

With this background and taking into account that not much effective research has been conducted in this direction in the Kumaon region, Uttarakhand, India, our study is an effort to assess the socio-demographic determinants in patients with psychotic disorders in our tertiary set –up hospital, Government medical college attached to Dr. Susheela Tiwari hospital, Haldwani, Uttarakhand, India.

## MATERIAL & METHODS:

The study was conducted in the department of Pharmacology and department of Psychiatry of Government Medical College and Dr. Susheela Tiwari Government hospital, Haldwani, Uttarakhand. This was an unicentric, open labeled, prospective study which included patients with psychotic disorders registered for treatment at psychiatry department, Dr. Susheela Tiwari Government Hospital, Haldwani, Uttarakhand.

## RESULTS:

In the course of the present study, we assessed 80 patients with psychotic disorders

### A. GENDER

The gender distribution of the study patients has been depicted . We found that out of total 80 study patients, 41(51.3%) were males and 39(48.8%) were females.

B. AGE: 29 (36.25%) study patients were in the age group 30-40 years closely followed by the age group 19-29 years, 27 patients(33.75%). 17 (21.25%) patients were in the age group 41-51 years and 7(8.75%) patients of age group 52-62 years.

### i) EDUCATION STATUS

Maximum number of patients, 50(62.5%) were of education status 'IX and above'. 21(26.25%) patients had education 'I to VIII' and 9 (11.25%) patients had 'no schooling'.

### ii) MARITAL STATUS

We observed that highest number of patients, 43(53.75%) were 'married', followed by 34 (42.50%), who were 'never married'. 3 (3.75%) patients were 'previously married'.

### iii) SOCIO- ECONOMIC STATUS

According to Revised Modified BG Prasad socioeconomic classific ation scale, 2016 : Class I-V [13] , we observed that highest number of patients belonged to class III (41.25%), followed by class V (22.5%) and class IV (20%).

### iv) OCCUPATION

Out of total 41 males, maximum number of male study patients 39.02% (16 patients) were unemployed. 12.2% (5 patients) were into service. 14.63% (6 patients) were skilled labourers and 12.2% (5 patients) were unskilled labourers. Agriculture as occupation

accounted to about 12.2%(5 patients). 3 patients (7.31%) were students. 1 patient (2.43%) was businessman .The female study patients were mostly housewives (61.5%, 24 patients ).

**v) FAMILY HISTORY OF PSYCHIATRIC ILLNESS**

17(21.2 %) of the study patients had positive family history of psychiatric illness.

**vi) SUBSTANCE ABUSE HISTORY**

Our study results demonstrated 25% (20 patients) with history of substance abuse out of the total 80 patients. Among the patients(n=20) with substance abuse history, cannabis was the most common substance of abuse (30%).

**vii) LOCALITY**

In our study we observed that higher percentage of our study patients 72.5%(58 patients) were from the rural areas.

**TABLE 1: Socio-demographic characteristics of the study patients.**

| SOCIO-DEMOGRAPHIC CHARACTERISTICS | NUMBER OF PATIENTS,n (%) |
|---|---|
| GENDER<br>MALES<br>FEMALES | 41(48.8)<br>39(51.2) |
| EDUCATION STATUS<br>'IX and above'<br>'I to VIII'<br>'No schooling'. | 50 (62.5)<br>21 (26.3)<br>9 (11.2) |
| MARITAL STATUS<br>NEVER MARRIED<br>MARRIED<br>PREVIOUSLY MARRIED | 34(42.5)<br>43( 53.7)<br>3(3.8) |
| SOCIO – ECONOMIC STATUS<br>I<br>II<br>III<br>IV<br>V | 4(5)<br>9(11.2)<br>33(41.3)<br>16(20)<br>18 (22.5) |
| LOCALITY<br>RURAL<br>URBAN | 58(72.5)<br>22(27.5) |

## DISCUSSION

In our study, a total number of 80 patients with psychotic disorders were assessed for socio- demographic profile. Out of total 80 study patients, 41 (51.2%) were males and 39 (48.8%) were females. Our study data of equal gender distribution is also similar to the conclusion as per the National Mental Health survey of India, 2015-16.[7] A metaanalysis by Aleman et al concluded higher incidence in males in schizophrenia.[14] A similar conclusion of higher incidence in males was reported by a multicentric study done in various parts of India.[15]

Our data suggested maximum number of study patients were in the age group 30-40 years (29 patients, 36.25%) closely followed by the age group 19 -29 years (27 patients, 33.75%). Our study result is approximately similar to the results of previous studies.[16],[17]

It is well established that psychotic disorders are common among lower socio- economic groups.[18-20] Studies have linked psychotic disorders with several social deprivation and low socio economic status: poor education, low income levels, unemployment, living alone, being unmarried, separated, widowed or divorced.[3,19,21]

While the above mentioned studies,[19,21] relate poor education to be associated with psychotic disorders, in our study we found that out of total 80 patients, maximum number of patients were of educational qualification “IX and above” (50 patients, 62.5%). This data is similar to the study done by Grover S et al.[16] which reported that more than half of the subjects were of education beyond matriculation. Another multicentric study[15] also reported higher percentage (46.9%) of patients upto or beyond high school. . In our study, out of total of 80 patients, 43 patients (53.75%) were married. This result is in line with the study done by Barua et al,[167] which reported that about 58.2% of study patients were married. Another multicentric trial done by Grover S et al [15] stated that most of the participants in their study to be married (71.8%)

In our study, maximum number of patients, 33 (41.25%) were of the socio- economic status class III (middle class) followed by Class V (18 patients, 22.5%) and class IV (16 patients, 20%). Our study data is in accordance with previous studies [18-20] which reported higher incidence in lower socio- economic status. In our study, out of 41 males, maximum number of patients, 16 (39.02%) were unemployed. This finding of our study is in line with various other studies, which reported higher number of unemployed patients.[15],[16],[22] Out of total 39 females, maximum number of females were housewives (24 patients, 61.5%). This finding is in accordance to a study done by Barua et al,[23] which reported most of the patients to be unemployed and housewives.

17(21.3%) patients had family history of psychiatric illness. Our study is in line with the study done by Barua A et al[23] who reported 21.4% of patients with positive family history of psychiatric illness. A study done in Kuwait[24] reported 24 patients (26.7%) with positive family history of psychoses among 90 study patients. Our study results demonstrated 25% (20 patients) with history of substance abuse out of the total 80 patients. Out of all the substances, the most common substance of abuse was cannabis (30%). Many studies[25-27] have associated cannabis use with psychotic disorders. Studies[28,29] in many countries have clearly stated higher risk of schizophrenia in persons born or raised in urban areas as compared to rural areas. maximum number, 58 (72.5%) were from the rural areas, which clearly varies with the findings of above mentioned studies. This variation in data may be because Dr. Susheela Tiwari government hospital attached to Government medical college, Haldwani is the only nearby tertiary care level government institute, which covers the population of urban and the hilly rural areas of the Kumaon region.

## CONCLUSION:

Psychotic disorders are a group of chronic debilitating psychiatric illness, characterized by loss in touch with reality and disorders of thought, behaviour, appearance and speech. Our study demonstrated equal gender distribution with higher percentage of patients in the age group 30-40 years of age. Most of our patients were married, were of educational qualification 'IX and above', females were mostly housewives and males unemployed. A higher number of patients were residing in rural areas.

## REFERENCES


1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders. 5th edition. Arlington, VA: American Psychiatric publishing; 2013.
2. World Health Organisation. The ICD-10 Classification of Mental and Behavioural Disorders: Clinical descriptions and diagnostic guidelines; 2010. p.76-109. Available from : http://www.who.int/classifications/icd/en/bluebook. pdf[Accessed 16 July 2017].
3. Ivlena EI, Tamminga CA. Psychosis as a defining dimension in Schizophrenia. In: Sadock B, Sadock VA, Ruiz P. (eds.) Kaplan and Saddock’s Comprehensive book of Psychiatry. 9th edition. United Kingdom: Lippincott Williams & Wilkins; 2009. p.1594-1604.
4. National Institute for Clinical Excellence 2014. Psychosis and schizophrenia in adults: Prevention and management. Available from : https://www.nice.org.uk/ guidance/cg178 [Accessed30 Sept 2016].
5. Kirkbride JB, Errazuriz A, Croudace TJ, Morgan C, Jackson D, McCrone P, et al. Systematic Review of the Incidence and Prevalence of Schizophrenia and Other Psychoses in England. Available from: https://www.psychiatry.cam.ac.uk/files/2014/05/Final-report-v1.05-Jan-12.pdf. [Accessed 29 Sept 2016].
6. Perälä J. Epidemiology of psychotic disorders. National Institute for Health and Welfare; 2013.Availablefrom:https://helda.helsinki.fi/bitstream/handle/ 10138/38187/perala_dissertation.pdf?sequence=1. [Accessed 16 July 2017].
7. Gururaj G, Varghese M, Benegal V, Rao GN, Pathak K, Singh LK, et al. National Mental Health Survey of India, 2015-16: Summary. Bengaluru: National Institute of Mental Health and Neuro Sciences, NIMHANS Publication No. 128; 2016.
8. Allardyce J, Boydell J, Van Os J, et al. Comparison of the incidence of schizophrenia in rural Dumfries and Galloway and urban Camberwell. Br J Psychiatry. Oct 2001; 179: 335-339.
9. Allardyce J, Gilmour H, Atkinson J, Rapson T, Bishop J, McCreadie RG. Social fragmentation, deprivation and urbanicity: relation to first-admission rates for psychoses. British Journal of Psychiatry. November 1, 2005; 187(5): 401-406.
10. Veling W, Susser E, Van Os J, Mackenbach JP, Selten J-P, Hoek HW. Ethnic Density of Neighborhoods and Incidence of Psychotic Disorders among Immigrants. Am JPsychiatry. 2008; 165(1): 66-73.
11. Morgan C, Kirkbride JB, Leff J, et al. Parental separation, loss and psychosis in different ethnic groups: a case-control study. Psychological Medicine. 2007; 37(4): 495-503.
12. Moore THM, Zammit S, Lingford-Hughes A, et al. Cannabis use and risk of psychotic or affective mental health outcomes: a systematic review. The Lancet. 2007; 370(9584): 319-328
13. Shaikh Z, et al. Int J Community Med Public Health. 2017 Apr; 4(4): 997-999.
14. Aleman A, Kahn RS, Selten JP. “Sex differences in the risk of schizophrenia: Evidence from meta-analysis. Archives of General Psychiatry. 2003; 60(6): 565–571.
15. Grover S, Avasthi A, Sinha V, Lakdawala B, Bathla M, Sethi S, et al. Indian Psychiatric Society multicentric study: Prescription patterns of psychotropics in India. Indian J Psychiatry. 2014; 56: 253-64.
16. Grover S, Nebhinani N, Chakrabarti S, Avasthi A, Basu D, Kulhara P, et al. Evaluation of psychotropic prescription patterns at the time of discharge from inpatient unit of a tertiary care general hospital psychiatric unit. JMental Health Hum Behav. 2016; 21(1): 48-54.
17. Paul PK, Konwar M, Das S. To study the prescribing pattern of antipsychotic drugs in a

tertiary care hospital of Assam. Int J Pharm Pharm Sci. 2014; 6(4): 435-437.
18. Lehtinen V, Joukamaa M, Jyrkinen T, Lahtela K, Raitasalo R, Maatela J, Aromaa A. Mental Health and Mental Disorders in the Finnish Adult Population. Turku and Helsinki: Publications of the Social Insurance Institution; 1991.
19. Miettunen J, Lauronen E, Veijola J, Koponen H, Saarento O, Taanila A, Isohanni M. Sociodemographic and clinical predictors of occupational status in schizophrenic psychoses-follow-up within the Northern Finland 1966 Birth Cohort. Psychiatry Research. 2007; 150: 217-225.
20. Morgan VA, Waterreus A, Jablensky A, Mackinnon A, McGrath JJ, Carr V, et al. People living with psychotic illness in 2010: the second Australian national survey of psychosis. Australian and New Zealand Journal of Psychiatry. 2012; 46: 735-752.
21. Kendler KS, Gallagher TJ, Abelson JM, Kessler RC. Lifetime prevalence, demographic risk factors, and diagnostic validity of nonaffective psychosis as assessed in a US community sample. The national comorbidity survey. Archives of General Psychiatry. 1996; 53:1022-1031.
22. Lieberman JA, Stroup TS, Mc Evoy JP, et al, Clinical Antipsychotic trials of intervention Effectiveness( CATIE ) Investigators. Effectiveness of Antipsychotic drugs in patients with chronic Schizophrenia. N Eng J Med. 2005; 353: 1209-1223.
23. Barua A, Shankar H, Jain A, Bhat VK, Kiran NU, Jayarama S. Hospital Based Study on Psychoses in Mangalore. Indian Journal of Community Medicine. 2006; 31(1): 30-31.
24. Maha ElTayebani, Mamdoh ElGamal, Reda Roshdy, Sulaiman Al-Khadary. Gender difference in affective and non-affective psychosis. 2014; 35(1): 45-55.
25. Thornicroft G, Meadows G, Politi P. Is cannabis psychosis a distinct category?. European Psychiatry. 1992; 7:277-282.
26. McGuire P, Jones R, Harvey I, Williams M, McGuffin P, Murray R. Morbid risk of schizophrenia for relatives of patients with cannabis associated psychosis. Schizophrenia Research. 1995; 15: 277-281.
27. Basu D, Malhotra A, Bhagat A, Varma VK. Cannabis psychosis and acute schizophrenia: a case-control study from India. European Addiction Research. 1999; 5:71-73.
28. Pedersen CB, Mortensen PB. Evidence of a dose response. relationship between urbanicity during upbringing and schizophrenia risk. Archives of General Psychiatry. 2001; 58: 1039- 1046
29. Vassos E, Pedersen CB, Murray RM, Collier DA, Lewis CM. Meta-analysis of the association of urbanicity with schizophrenia. Schizophrenia Bulletin. 2012; 38: 1118-1123.