

Psychiatric morbidity and perceptions on psychiatric illness among patients presenting to Family Physicians, in April 2001 at a teaching hospital in Karachi, Pakistan

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Abstract

Objective: To assess psychiatric morbidity and the perceptions about psychiatric illness, among patients presenting to family physicians, at a teaching hospital in Karachi, Pakistan.

Methods: A questionnaire based survey was developed to collect demographic data, information on psychiatric morbidity and perceptions on psychiatric illness. It was administered to 400 patients, against a sample size of 347. The study objective was explained, written consent was taken and confidentiality was assured.

Results: There were more women than men in the study, with a mean age of 37 years. The majority was married, better educated and socioeconomically placed than the rest of the population. A total of 175 (43.75%) subjects reported psychiatric illness in the family. A psychiatrist or a family physician diagnosed the illness in 110 (62.85%) and 37 (21.14%) of the cases, respectively. A total of 68 (38.85%) subjects reported reluctance in accepting a diagnosis of psychiatric illness. A total of 296 (74%) of the respondents thought that psychiatric illness is stigmatized and therefore treatment is not sought for it. Alternate treatment for psychiatric illness were quoted as seeking treatment from a Hakim (49 subjects, 12.3%), spiritual healers (49 subjects, 12.3%) and family support (10 subjects, 2.5%). A total of 121 (30%) subjects thought that psychiatric illness is caused by supernatural powers and spirits. A total of 109 (27.3%) subjects felt a need to seek psychiatric help, but did not visit a psychiatrist because of reluctance.

Conclusion: Considerable psychiatric morbidity exists among our patient population and is stigmatized. We recommend improvement in psychiatric services, as well as patient education programs.

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Key words: psychiatric illness, psychiatric morbidity, stigma.

Psychiatric services in Pakistan have undergone considerable changes over the past 50 years.¹ However, according to the Pakistan Association for Mental Health, there are still only 200 psychiatrists in Pakistan.² Different figures for the prevalence of psy-

chiatric illnesses are quoted in published reports. In a survey conducted in urban Pakistan, 25% of women and 10% of men, were found to have anxiety and depression.³ In another survey of patients attending a faith healer's clinic in rural Pakistan, 61% had a mental disorder according to the Diagnostic and Statistical Manual III (revised) classification.⁴ There is clearly a need to study psychiatric morbidity, in order to create awareness among the concerned authorities and also for the need to improve psychiatric services in this country.

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The diagnostic label of mental illness may render a person vulnerable to stigmatization.⁵ We are aware about the possible stigma attached to psychiatric illness in Pakistan, but data is lacking on this important issue. In the UK, evidence of community stigma associated with mental illness has been documented among Pakistani men.⁶

It has been documented that the tendency to perceive and report distress in psychological or somatic terms is influenced by the degree of stigma associated with particular symptoms.⁷

A previous study demonstrated that social stigma in patients with psychiatric illness is variable, with less prevalence in Islamic societies in comparison to those in India and China.⁸

In India, a study was conducted concerning stigma with regards to patients with schizophrenia. Marriage, fear of rejection by neighbors, the need to hide the fact from others and the female patient were all identified as stigmatizing aspects.⁹ Medical students in India are known not to study psychiatry as a career due to the stigma attached to it.¹⁰ This study aimed to assess psychiatric morbidity and the perceptions about psychiatric illness, among patients presenting to family physicians at a teaching hospital in Karachi, Pakistan.

Results of this study will be useful in facilitating debate and further studies on the issue. Hopefully, this can increase awareness of medical professions about the issue.

Methods

Study design

This was a descriptive study using a pretested questionnaire. Data were collected through interview for maintaining uniformity, the interviewer met and it was agreed how to administer the questions and ask for clarifications.

Sample

A sample size of 347 was estimated.¹¹ The study was conducted at the Family Practice Center of the Aga Khan University Hospital in Karachi, Pakistan, in the month of April 2001. There are between eight and 10 family physicians, who each see 15–20 patients daily, Monday to Saturday.

A questionnaire was developed to collect demographic data, information on psychiatric morbidity and perceptions on psychiatric illness.

The questionnaire was pilot tested in order to ensure its reliability and validity.

A total of 413 patients were approached, but 13 declined. The reason of non-responders for refusal to participate was not questioned. Therefore, 400 agreed to participate after the study objective was explained.

Written consent was taken and confidentiality was assured for the participating patients. The questionnaire was self-administered, but opportunity for any clarification was available.

Results

The questionnaire was administered to 400 patients. We requested every available patient attending the clinic to participate in the study and those who agreed were included.

There were more women than men, with a mean age of 37 years, the majority were married, better educated and socio-economically placed than the rest of the population (Table 1).

Psychiatric illness in the family was reported by 175 (43.7%) participants, with depression as the most common disorder among the top five diagnoses (Table 2). Substantial reluctance to accept a psychiatric diagnosis was reported (Table 2).

Table 1 Demographic profile of the study population for 400 Pakistani participants on perceptions of psychiatric illness ($n = 400$)

	Parameter	Number (%)
1	Sex:	
	Males	153 (38.0)
	Females	247 (62.0)
2	Mean age (SD [†]) (in years)	37.6 ± 12.43
3	Marital Status:	
	Single	63 (15.8)
	Married	330 (82.5)
	Others (e.g. divorced)	7 (1.7)
4	Educational Status:	
	Illiterate	61 (15.3)
	Primary	39 (9.8)
	Secondary	27 (6.8)
	Matriculation	74 (18.5)
	Intermediate	49 (12.3)
	Graduate	119 (29.8)
	Post-graduate	27 (6.8)
	Diploma	3 (1.2)
Not known	1 (0.4)	
5	Occupational status:	
	Private service	77 (19.3)
	Government service	21 (5.3)
	Self-employed	48 (12.0)
	Student	23 (5.8)
	Laborer	10 (2.5)
	Unemployed	21 (5.3)
Others including housewives	200 (50.0)	

[†] Standard deviation.

Table 2 Psychiatric illness suffered by Pakistani family members and reluctance to accept ($n = 175$)

	Psychiatric illness/reluctance in its acceptance	Number (%)
1	Psychiatric illness:	
	Depression	85 (48.57)
	Mania/psychosis	32 (18.28)
	Dementia	16 (9.10)
	Conversion disorder	16 (9.10)
	Not specified	26 (14.85)
2	Reluctance in accepting a psychiatric diagnosis	68 (38.85)

Table 3 Patient perceptions about psychiatric illness in a Pakistan study ($n = 400$)

	Perception	Number (%)
1	Psychiatric illness is a stigma	296 (74.0)
2	Reluctance to consult a psychiatrist (in the past)	109 (27.3)
3	Willingness to see a psychiatrist in future, if required	376 (94.0)
4	Treatment of psychiatric illness maybe harmful	42 (10.5)
5	Psychiatric illness is caused by supernatural powers and spirits	120 (30.0)

Table 4 Health care providers who diagnosed the psychiatric illness in a Pakistan study ($n = 175$)

	Health care provider	Number (%)
1	Psychiatrist	110 (62.85)
2	Family Physician	37 (21.14)
3	Others	28 (16.00)

Patient perceptions about psychiatric illness are listed in Table 3.

The psychiatrist diagnosed the illness in the majority of the cases, followed by family physician and other health care providers (Table 4).

The respondent's views on the alternate remedies for psychiatric illness are listed in Table 5.

Discussion

Substantial psychiatric morbidity was present among our study subjects and their families. As the information on the prevalence of psychiatric morbidity is

Table 5 Alternate remedies for the treatment of psychiatric illness as evidenced in a study in Pakistan ($n = 108$)

	Health care provider	Number (%)
1	Hakim practitioners [†]	49 (12)
2	Spiritual healers	49 (12)
3	Family support	10 (0.02)

[†] A Hakim is a wise man, a physician, especially a mohammedan (Source: Websters dictionary).

based on the diagnosis given to the patients by the health care providers, recall bias may have confounded the results as the information provided is based on the memory of the patients. We also lack details on the accuracy of the diagnosis. In addition to this, we conducted the survey at a tertiary level teaching hospital. Our sample population was well educated and better placed socioeconomically. This exposes the study results to biases, but we believe that patients visiting the tertiary hospital come from all strata of the society and therefore offer a more homogenous group for any study.

Despite these inherent shortcomings in the study, we believe that the data points towards the prevalence of significant psychiatric morbidity in this society.

Reluctance to accept a diagnosis of psychiatric illness has been reported earlier in published reports.¹² There is a need to educate our patients as it has been shown that an understanding of the disease helps bring about acceptance of the diagnosis.¹³

In primary care settings, depressive disorders, anxiety disorders, cognitive impairment and substance-related disorders have been reported as common psychiatric disorders.¹⁴ This may be explained on the basis that cognitive disorders are more prevalent in the developed world because of the aging population. Also alcohol-related disorders are more common in developed society. The higher prevalence of conversion disorder in our study, may be on account of inhibitions in the society, not allowing people to express their feelings freely. These explanations are assumptions that need confirmation.

Family physicians still provide care to the bulk of patients with psychiatric disorders. This raises the questions of improving the competence and skills of family physicians in dealing with common psychiatric disorders.

It is well documented that negative opinions overemphasize social handicaps that accompany mental disorders, leading to social isolation, distress and difficulties in employment.¹⁵ It has been argued that culturally determined causal beliefs of mental distress contribute to attitudes towards seeking professional help for psychological problems for Asians.¹⁶ It

has been reported that because of stigma attached to depression, patients often characterize their symptoms as part of a physical illness or fail to report them to clinicians at all.¹⁷ Moreover, in patients with severe mental illness, dealing with stigma and discrimination are shown to be essential parts of the process of recovery.¹⁸

It has been said that if the public is informed that psychiatric illness can be effectively treated, stigma associated with it may be reduced.¹⁹ Patient education therefore again assumes importance as an intervention strategy and is likely to raise the levels of acceptance of diagnosis and treatment of psychiatric disorders. The increasing closeness of psychiatry to the rest of medicine has had a greatly beneficial impact, not only

on stigma but also on diagnosis and treatment.¹³ The findings of our study suggests that earlier claims that stigma with psychiatric illness is less in Islamic society may be inaccurate.⁸

Further studies are needed to understand why the treatment of psychiatric illnesses are considered harmful.

Conclusion

We have found considerable psychiatric morbidity among our patient population and that there is stigma attached to it. Based on the findings of our study, we recommend improvement in psychiatric services, as well as patient education programs.

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