EDITORIAL

A survey of clinical profile of the patients in the psychiatry department

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Valles S. A survey of clinical profile of the patients in the psychiatry department. Clin Psychiatry Neurosci.2021;4(3):02

DESCRIPTION

Currently, mental health disorders are one of the leading causes of disability worldwide. Psychiatric disorders are an upcoming problem, ranging from subclinical level to severe disorder level. Some of the mental health disorders are easily identifiable and may seek for early intervention. But most of the mental health disorders are subclinical/sub syndrome and may go unobserved either by the patient or by the care giver. This is because of level of knowledge about mental health and most of the population may not consider mental disorder as illness or need for consultation. Patients may or may not be identified in peripheral centre as most of mental health disorders may or may not be identified by no-psychiatric health workers, but seem to flock to a tertiary care centre in an almost consistent pattern. A National Mental Health Survey of India 2015-2016 reports, the overall weighted prevalence for any mental morbidity was 13.7% lifetime and 10.6% current mental morbidity. A meta-analysis of 13 epidemiological studies of 33,572 persons reported total morbidity of 58.2 per 1000 from India1. Another Meta analytical study by Gangly reports total morbidity of 73 per 1000 population. Among Indian population 20% of them will have one or the other mental health disorder and requires medical attention and intervention from a mental health professional.

This study was conducted by thinking, knowing the pattern and proportion of psychiatric disorder may help the mental health care professionals to plan and to conduct mental health awareness programme. By educating the general population, morbidity due to mental health disorders can be prevented by early identification, diagnosis and intervention for mental health disorders. Including-negative alterations in cognitions and mood, symptoms that relate to impairment in regulatory capacities following exposure to traumatic events the addition of three new symptoms, and a dissociative subtype. The limitations of these changes are discussed elsewhere.

Study was conducted in a tertiary care centre, BMCRI. It caters for large number of people coming from different socio-economic background, culture, language, different parts of the India, most of south India and also gets referred from other institutes, inter-departments of BMCRI. 6347 is a good number of case documentation during a study period of one year even after excluding the follow up/old cases. The documentations were maintained by junior resident doctors and diagnosis was made based on ICD criteria.

CONCLUSION

In this study from a tertiary care centre, in BMCRI, Bangalore, showed that there were more cases documented falling under categories F40-F49 (Neurotic, stress-related and somatoform disorder), F10-F19 (mental and behavioral disorders due to psychoactive substance use) and F30-F39 (mood/affective disorders). In seasonal variation, maximum number of cases (over all new cases) recorded during winter and spring. In spring months, more of affective/mood disorders (F30-F39) and behavioural syndromes associated with physiological disturbances and physical factors (F50-F59) AND during winter months, more cases of affective/mood disorders and DSH cases were documented. A more detailed study, including an analysis of the socio-demographic profile, stressors and other precipitating factors can be studied. If a probable pattern of presentation can be ascertained, it would help family members look for alert/ danger signs and seek early intervention. Since the study was conducted for one year, chronology of seasonal variation of psychiatric disorders for consecutive academic years is not assessed. If assessed, it would help the clinician and the health care worker to conduct awareness programme intensively during the seasons and inversely it may help in reduction in morbidity due to mental health disorders.

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Received date: *April 29, 2021;* ***Accepted date:*** *May 14, 2021;* ***Published date:*** *May 21, 2021*