ISSN: 2663-7537

Volume 5 | Issue 2
December 2022

ARCHIVES of NIMH

The Official Journal of National Institute of Mental Health, Dhaka

ARCHIVES of NIMH

Editorial

Mental wellbeing of health care workers

Original Articles

Socio-demographic and clinical profile of the indoor patients of National Institute of Mental Health (NIMH), Dhaka, Bangladesh

Obsessive compulsive disorder during COVID-19 pandemic

Pattern of psychiatric morbidity in a tertiary care military hospital in Bangladesh

Patterns of psychiatric disorders in persons attending the Forensic Psychiatry Department of a tertiary care psychiatric hospital

Parental attitudes, knowledge and beliefs regarding the use and adverse effects of sychotropic medications on child and adolescent patients with psychiatric disorders

Prevalence of sexual dysfunctions in male patients of a tertiary hospital

Trends in using telepsychiatry service at a tertiary level psychiatric hospital in Bangladesh – a retrospective register study

Case Report

Rare presentation of conversion disorder: psychogenic blepharospasm

ARCHIVES of NIMH

The Official Journal of National Institute of Mental Health, Dhaka

Volume 5 | Issue 2 | December 2022

Table of Contents

Editorial

Mental wellbeing of health care workers 1-3
Mohammad Tariqul Alam

Original Articles

Socio-demographic and clinical profile of the indoor patients of National Institute of Mental Health (NIMH), Dhaka, Bangladesh 3-11
Saifun Nahar, Bidhan Ranjan Roy Podder, Mohammad Delowar Hossain, Mohammad Tariqul Alam

Obsessive compulsive disorder during COVID-19 pandemic 12-17
M A Mohit Kamal, Muhammad Zillur Rahman Khan, Nasim Jahan, Mahbub Mayukh Rishad, Mohammad Muntasir Maruf

Pattern of psychiatric morbidity in a tertiary care military hospital in Bangladesh 18-23
A S M Kowser, Munira Parveen, Mohammed Ali Chowdhury, Mohammad Taslim Uddin

Patterns of psychiatric disorders in persons attending the Forensic Psychiatry Department of a tertiary care psychiatric hospital 24-28
Mahfuza Yasmin, Abdullah Al Mamun, Afroza Rahman Lopa, A. K. M. Khaleequzzaman, Sharmin Sultana, S. M. Sazzadul Karim

Parental attitudes, knowledge and beliefs regarding the use and adverse effects of psychotropic medications on child and adolescent patients with psychiatric disorders 29-33
Saifun Nahar

Prevalence of sexual dysfunctions in male patients of a tertiary hospital 34-37
Anupam Das, Choity Malakar

Trends in using telepsychiatry service at a tertiary level psychiatric hospital in Bangladesh – a retrospective register study 38-41
Sadia Afrin Shampa, Helal Uddin Ahmed, Ahsan Aziz Sarkar

Case Report

Rare presentation of conversion disorder: psychogenic blepharospasm 42-44
Nusrat Mujtaba Maty, Md. Shahidul Islam, Md. Rashed Khan

Instructions for authors A4-8

ARCHIVES of NIMH

The Official Journal of National Institute of Mental Health, Dhaka

Volume 5 | Issue 2 | December 2022

Instructions for authors
Full instructions to authors are given at the end of this issue. You can also visit **www.nimh.gov.bd** for instructions.

Editorial Board

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka
Volume 5 | Issue 2 | December 2022

List of Reviewers

Md. Golam Rabbani
Former Director-cum-Professor
NIMH, Bangladesh

Md. Waziul Alam Chowdhury
Former Director-cum-Professor
NIMH, Bangladesh

Md. Enayet Karim
Former Professor, Psychiatry
NIMH, Bangladesh

Md. Shah Alam
Professor, Psychiatry
Popular Medical College, Bangladesh

M S I Mullick
Former Professor, Child & Adolescent Psychiatry
BSMMU, Bangladesh

Jhunu Shamsun Nahar
Former Professor, Psychiatry
BSMMU, Bangladesh

AHM Mustafizur Rahman
Former Professor, Psychiatry
NIMH, Bangladesh

Md. Faruq Alam
Professor, Psychiatry
Popular Medical College, Bangladesh

M. A. Mohit
Former Director-cum-Professor, Psychiatry
NIMH, Bangladesh

Md. Azizul Islam
Principal, US-Bangla Medical College
Former Advisor Specialist in Psychiatry
CMH, Dhaka, Bangladesh

Bidhan Ranjan Roy Poddar
Director-cum-Professor, Psychiatry
NIMH, Bangladesh

Abdullah Al Mamun Hussain
Former Professor, Psychiatry
Rajshahi Medical College, Bangladesh

Mohammad Robed Amin
Professor, Medicine
Line Director, NCDC, DGHS

MMA Shalahuddin Qusur Biplob
Professor, Psychiatry, BSMMU, Bangladesh

Sultana Algin
Professor, Psychiatry
BSMMU, Bangladesh

Kazi Shahnoor Alam
Professor, Nephrology
NIKDU, Bangladesh

Mohammad Shah Jahirul Haque
Professor, Clinical Neurology
NINS, Bangladesh

M Kamruzzaman Mozumder
Professor, Clinical Psychology
Dhaka University, Bangladesh

Rizwanul Karim Shameem
Associate Professor, Epidemiology
Rajshahi Medical College, Bangladesh

AKM Monwarul Islam
Associate Professor, Cardiology
NICVD, Bangladesh

Probir Kumar Sarkar
Professor, Pulmonology
Bangladesh Shishu Hospital & Institute, Bangladesh

Tanjina Hossain
Associate Professor, Endocrinology
Green Life Medical College, Bangladesh

Ramendra Kumar Singha
Associate Professor, Psychiatry
MAG Osmani Medical College, Bangladesh

Helal Uddin Ahmed
Associate Professor, Child, Adolescent & Family Psychiatry
NIMH, Bangladesh

Mekhala Sarkar
Associate Professor, Psychotherapy
NIMH, Bangladesh

Mohammad Tariqul Alam
Associate Professor, Geriatric & Organic Psychiatry
NIMH, Bangladesh

MM Jalal Uddin
Associate Professor, Psychiatry
NINS, Bangladesh

Mohammad Delowar Hossain
Associate Professor, Adult Psychiatry
NIMH, Bangladesh

Farzana Rahman
Associate Professor, Community and Social Psychiatry
NIMH, Bangladesh

Ahsan Uddin Ahmed
Associate Professor, Psychiatry
NIMH, Bangladesh

Md. Jahir Uddin
Associate Professor, Clinical Psychology
NIMH, Bangladesh

Md. Enayet Hussain
Assistant Professor, Neurology
NINS, Bangladesh

Shahana Parveen
Associate Professor, Psychiatry
NIMH, Bangladesh

Mohammad Muntasir Maruf
Assistant Professor, Addiction Psychiatry
NIMH, Bangladesh

Saifun Nahar
Assistant Professor, Psychiatry
NIMH, Bangladesh

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Editorial

Mental wellbeing of health care workers

Mohammad Tariqul Alam

Coronavirus disease 2019, known as COVID-19, caused by the SARS-CoV-2 virus, is a highly contagious respiratory disease was first identified in Wuhan, China, in December 2019 and has become a major public health concern in Bangladesh. Health care workers (HCWs) are indispensable part of the battle against this deadly virus. There is evidence that their wellbeing has been compromised during this pandemic and they are exhibiting higher rates of mental disorders than general population and normal time. Multisectoral and integrated strategies are required to ensure their wellbeing.

Declaration of interest: None

Coronavirus disease 2019, known as COVID-19, caused by the SARS-CoV-2 virus, is a highly contagious respiratory disease was first identified in Wuhan, China, in December 2019.[1] On March 11, 2020, the World Health Organization (WHO) declared the outbreak as a pandemic.[2,3] The first case of COVID-19 was found in Dhaka, Bangladesh on March 8, 2020. Given the dense population and other factors, COVID-19 has become a major public health concern in Bangladesh, as in other countries.[4] The Bangladesh government has introduced various measures to combat the spread of COVID-19, including lock-down, social distancing, isolation, quarantine, etc. From 26 March to 30 May 2020, the Government announced a nationwide lockdown extending it several times countrywide.[5]

Health care workers (HCWs) are indispensable part of the battle against this deadly virus. There is evidence that they exhibit higher rates of mental disorders than general population during the normal time.[6] In this pandemic era, the risk has been increased several times because of increasing work load, working outside of their usual workplaces, concern for the family, fear of infection, media report focusing on death of HCWs, experiencing illness and death of colleagues, lack of personal protective equipment, stigma, ethical and moral dilemma and exacerbation of illness in already vulnerable individuals.[7] British Medical Association published that 45% of UK HCWs are suffering from depression, anxiety, stress, burnout or other mental health conditions relating to, or made worse by, the COVID-19 crisis.[8]

A recently conducted study in Bangladesh on wellbeing of frontline HCWs published that 20.4% HCWs' reported having poor emotional wellbeing and 14.7% being dissatisfied with life.[9] Doctors scored significantly lowered than nurses and medical technologists in autonomy, competence and relatedness satisfactions. Being doctor, male gender, young adult (<40 years), unavailability of quality PPE, living alone while on duty, facing social stigma, no exercise or sports activity, history of mental illness and unavailability of mental health services were the factors found to be related with poor emotional wellbeing and life dissatisfaction.[9]

Based on these finding we recommend following strategies for the government of Bangladesh to promote wellbeing and life satisfaction among HCWs.

1. Adopt a comprehensive national strategy for pandemic preparedness, organize itself for success, and craft a budget commensurate to the challenge.

2. Adopt national policies and pandemic readiness standards to promote health equity in hospitals and health systems.

3. Include health and safety skills in personal and patient safety into education and training programmes for health workers at all levels.

4. Protect health care worker from social stigma and discrimination.

5. Ensure adequate environmental services such as water, sanitation and hygiene, disinfection and adequate ventilation at all health care facilities

6. Ensure appropriate and fair duration of deployments, working hours, rest break and minimize the administrative burden on health workers.

7. Establish HCWs' participation in decision making process.

8. Define and maintain appropriate safe staffing levels within health care facilities.

9. Focus on improving physical and mental health of HCWs.

10. Establish dedicated mental health service for HCWs.

Correspondence: **Mohammad Tariqul Alam,** Associate Professor, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh.
Email: sum.tariq@gmail.com

How to cite this article: Alam MT. Mental wellbeing of health care workers. [Editorial] Arch NIMH. 2022; 5(2): 1-2.

Received 5 Dec 2022, revised 15 Dec 2022, accepted 24 Dec 2022.

References

1. Yu X, Yang R. COVID-19 transmission through asymptomatic carriers is a challenge to containment. Influenza Other Respi Viruses. 2020; 14: 474–475.

2. World Health Organization. Coronavirus disease (COVID-19) pandemic. 2020 [cited 03 May 2020]. Available from: https://www.who.int/emergencies/diseases/novel-coronavirus-2019.

3. The Time. World Health Organization declares COVID-19 a "pandemic." Here's what that means. 2020. [cited 03 May 2020]. Available from: https://time.com/5791661/who-coronavirus-pandemic-declaration/

4. Institute of Epidemiology Disease Control and Research. COVID-19 status for Bangladesh. 2020 [cited 03 May 2020]. Available from: https://www.iedcr.gov.bd/

5. Dhaka Tribune. Restriction on public movement extended till August 31. [Retrieved August 7, 2020.] Available from: https://www.dhakatribune.com/health/coronavirus/2020/08/03/restriction-on-public-movement-extended-till-august-31.

6. Tawfik DS, Scheid A, Profit J, et al. Evidence Relating health care provider burnout and quality of care: A systematic review and meta-analysis. Ann Intern Med. 2019;171(8):555-567

7. De Kock JH, Latham HA, Leslie SJ, et al. A rapid review of the impact of COVID-19 on the mental health of healthcare workers: implications for supporting psychological well-being. BMC Public Health. 2021;21(1):104.

8. British Medical Association. The mental health and wellbeing of the medical workforce – now and beyond COVID-19. 2020.

9. Podder BRR, Ahmed HU, Sarkar M, et al. National assessment of the current status of mental wellbeing of the frontline health workers and identifying the needs for additional support in the era of COVID-19 in Bangladesh [Pre-published report]. Dhaka, NIMH Press; 2022.

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Original Article

Socio-demographic and clinical profile of the indoor patients of National Institute of Mental Health (NIMH), Dhaka, Bangladesh

Saifun Nahar, Bidhan Ranjan Roy Podder, Mohammad Delowar Hossain, Mohammad Tariqul Alam

Background: The National Institute of Mental Health (NIMH) is a 200-bed tertiary psychiatric hospital located in Sher-E-Bangla Nagar, Dhaka, Bangladesh. It has been maintaining a computer database to keep records of the indoor patients since 2020, based on which this study was carried out.

Objectives: To explore the proportion of patients with psychiatric disorders of inpatient departments of NIMH, with different clinical diagnosis according to ICD-10 4-digit code and the socio-demographic and other relevant profile of those patients.

Methods: : It was a retrospective medical record review conducted utilizing the computer database containing the data regarding clinical diagnosis and other relevant variables of the indoor patients of the NIMH, which were plotted there by the assigned office staff on a weekly basis, over the period from January 2021 to December 2021, from the records of the structured indoor patient data sheet, that was prepared by the teachers of NIMH. The data sheet was filled out daily before each patient's discharge by the duty doctors of the respective departments. Patients were diagnosed according to the ICD-10 4-digit code by the Professors, Associate Professors and Assistant Professors of the respective departments.

Results: In this study, the recorded data of 797 patients were analysed. Among them, (51.4%) of the patients were male and (48.6%) female. The patients' mean age (±SD) was 28.6±12.16 years. Thirty-five types of different clinical diagnoses were found. Schizophrenia (39%) and bipolar affective disorder (29.4%) were the most common diagnoses.

Conclusions: Findings of this study will act as an eye-opener for psychiatrists regarding a wide range of psychiatric diagnoses and future research.

Declaration of interest: None

Keywords: ICD-10 4-digit code, Psychiatric disorders, NIMH, Indoor patient data sheet, computer database.

Introduction

Across the world, people need mental health services yet have limited access to it. The World Mental Health Report, subtitled "Transforming Mental Health for All," aims to do just that by providing information and inspiration to help individuals everywhere take better care of their mental wellness. New studies and best practices from all over the world are utilized to illustrate why and where change is most necessary, as well as provide concrete examples of how this might be accomplished. By identifying the underlying reasons that have an impact on mental health

and taking the necessary precautions, the field of mental health promotion and prevention aims to lessen the likelihood of negative outcomes and increase mental resilience and well-being. Efficient and effective strategies require cross-sectoral effort and may involve altering either individuals or institutional influences.[1]

NIMH[2] is a 200-bed, tertiary psychiatric hospital located in the capital city of Dhaka, at Sher-E-Bangla Nagar. It employs over 300 personnel to deliver outpatient, inpatient, and emergency medical services for patients with psychiatric disorders. Besides treating patients and teaching the next generation of leaders in psychiatry, it persistently keeps a focus on research activities and mental health policy formation.

It has been maintaining a computer database to keep records of the indoor patients since 2020. This study was carried out based on the recorded data of that database. The objectives of this study were to explore the proportion of the patients with psychiatric disorders with different clinical diagnoses, admitted at NIMH and the socio-demographic and other relevant clinical information of those patients.

Methods

It was a retrospective medical record review carried out based on the information from the computer database that was developed to record data regarding clinical diagnosis, socio-demographic and other relevant variables of the patients of all six inpatient departments of NIMH, where data were plotted by the assigned office staff on a weekly basis, over the period from January 2021 to December 2021, from the structured indoor patient data sheet. This data sheet was prepared by the teachers of NIMH, where data were recorded daily before each patient's discharge, by the duty doctors of the respective departments. To the best of our knowledge, most of the previous studies in our country regarding the pattern of psychiatric disorders showed 15-25 diagnoses, only. But the US uses its own variant of the ICD-10 called the Clinical Modification (ICD-10-CM),[3] which has almost 70,000 diagnosis codes. The DSM-5,[4] in contrast, only lists 297 disorders. ICD, developed by the World Health Organization (WHO), is currently in its 11th iteration and will be fully implemented in 2027. So, with the purpose to see wide range of clinical diagnoses according to the International Classification of Diseases (ICD)-10 4-digit code.[6] Patients were diagnosed by the Professors, Associate Professors, and Assistant Professors of the respective departments. Data were analyzed by using Statistical Package for Social Science (SPSS) – version-16.

Ethical Issues: Research proposal was approved (Memo NO. NIMH/2022/2765, Date:27.11.2022) by the Ethical Committee of NIMH for this study but the patients/ patient's caregivers/ guardians were not informed about the purpose of filling the data sheet.

Results

Recorded data from 797 patients were analyzed in this study. Data regarding socio-demographic variables were plotted in Table 1. Among the patients, 410 (51.4%) were male and 387 (48.6%) were female. The Mean age (±SD) of the patients were 28.6±12.1 years, and the majority 460 (57.7%) of them were found in the age group of 19–35 years, followed by 164 (20.6%) in the age group 0–18 years, 161 (20.2%) in the age group 36–60 years, and 12 (1.5%) in the age group >60 years. A significant proportion of the patients 279 (35.0%) were unemployed, followed by housewives 196 (24.5%), students 194 (24.3%), private services 28 (3.5%), and so on. In this study, the level of educational attainment was up to primary 208 (26.0%), secondary 324 (40.7%), higher secondary 120 (15.1%), graduation and above 79 (10.0%), and no education 66 (8.2%). Most of the patients 403 (50.6%) were from a rural background, followed by urban 285 (35.8%), semi-urban 85 (10.6%), slum 14 (1.7%), and unknown 10 (1.3%). Among the patients, 377 (47.3%) remain unmarried, 363 (45.5%) married, and 2 (0.3%), 12 (1.5%), and 40 (5%) of the patients were widowed, separated, or divorced, respectively. In addition, 3 (0.4%) of patients' marital status was unknown (Table 1).

In this study, thirty-five types of clinical diagnoses according to the ICD-10 4-digit code were found among 796 patients and 1 patient was found with no psychiatric disorder, which was presented at Table 2. The most frequent 312 (39%) diagnosis were schizophrenia, followed by manic episodes, bipolar affective disorder and current episode manic with psychotic features, unspecified mood disorder, in total 276 (34.6%), neurotic and stress related disorders in total 58 (7.3%), depressive episode and recurrent depressive disorder 23 (2.9%), and specific personality disorder 22 (2.8%). Among the neurotic and stress related disorders, the most frequent was dissociative conversion disorder 43 (5.4%), followed by obsessive- compulsive disorder (OCD) 8 (1.0%), phobias and other anxiety disorders 4 (0.6%), reaction to severe stress and adjustment disorder 3 (0.4%). Substance-related mental and behavioral disorders were 19 (2.4%). Among them, most frequent were cannabinoids 8 (1.0%), followed by multiple drug use

and other psychoactive substances 5 (0.6%), alcohol 2 (0.3%), other stimulants including caffeine 2 (0.3%), opioids 1 (0.1%) and hypnotics 1 (0.1%). Among other psychiatric disorders, 8 (1.1%) were mental retardation, 4 (0.5%) were pervasive developmental disorders, 4 (0.5%) were conduct disorders, 2 (0.3%) were hyperkinetic disorders, 1 (0.1%) disorder was of social functioning with onset specific to childhood and adolescence, 1 (0.1%) were delirium not induced by alcohol and other psychoactive substances, 1 (0.1%) were other mental disorders due to brain damage and dysfunction. Among the recorded patient's information regarding 14 patients was incomplete.

Regarding treatment outcome, 395 (49.6%) were improved after receiving treatment from the hospital, 348 (43.7%) of patients were partially improved, 43 (5.4%) of patients showed no improvement after being admitted to the hospital, 5 (0.6%) of patients' conditions worsened, 1 (0.1%) was died, and 5 (0.6%) of patients' conditions remained unknown. (Table 3). In the current study, 452 (56.7%) of patients were discharged with advice, 289 (36.3%) of patients were released on request, and 33 (4.1%) of patients were released after posting a risk bond, 1 (0.1%) absconded from the hospital and 19 (2.4%) of inpatients were referred for proper management of other co-morbid physical conditions. Unfortunately, the reason for discharge for 3 (0.4%) of clients were unknown (Table 4). Regarding duration of hospital stay, 280 (35.2%) of the patients had been hospitalized for >1 to 2 weeks, 314 (39.4%) had been for >2 to 4 weeks, 177 (22.2%) had been for >4 to 8 weeks, 26 (3.2%) had been for >8 to 12 weeks. Median hospital stay was found 21 days (Table 5).

Table 1: Distribution of patients according to Socio-demographic variables (n=797)

Characteristic	Frequency (n)	Percentage (%)
Age group (in year)		
0-18	164	20.6
19-35	460	57.7
36-60	161	20.2
>60	12	1.5
Sex		
Male	410	51.4
Female	387	48.6
Education		
No education	66	8.2
Primary	208	26.0
Secondary	324	40.7
Higher secondary	120	15.1
Graduation and above	79	10.0
Occupation		
Unemployed	279	35
Businessman	15	1.9
Agricultural works	18	2.3
Private services	28	3.5
Govt. services	12	1.5
Housewife	196	24.5
Day labour	18	2.3
Student	194	24.3
Others	31	3.9
Unknown	6	0.8
Residence		
Slum	14	1.7
Urban	285	35.8
Rural	403	50.6
Semi-urban	85	10.6
Unknown	10	1.3
Marital status		
Unmarried	377	47.3
Married	363	45.5
Widow/Widower	2	0.3
Separated	12	1.5
Divorced	40	5
Unknown	3	0.4

Table 2: Distribution of patients according to major category of ICD-10 4 digit-code (n=797)

SL	ICD-10 Code	Diagnosis	Frequency (n)	Percentage (%)
1	F 05	Delirium, not induced by alcohol and other psychoactive substances	1	0.1%
2	F 06	Other mental disorders due to brain damage and dysfunction	1	0.1%
3	F 10	Mental and behavioural disorders due to use of Alcohol	2	0.3%
4	F 11	Mental and behavioural disorders due to use of opioids	1	0.1%
5	F 12	Mental and behavioural disorders due to use of cannabinoids	8	1.0%
6	F13	Mental and behavioural disorders due to use of hypnotics	1	0.1%
7	F15	Mental and behavioural disorders due to use of other stimulants including caffeine	2	0.3%
8	F19	Mental and behavioural disorders due to multiple drug use and other psychoactive substance	5	0.6%
9	F20	Schizophrenia	312	39%
10	F21	Schizotypal disorder	1	0.1%
11	F22	Persistent delusional disorder	8	1.0%
12	F23	Acute and transient psychotic disorders	33	4.1%
13	F25	Schizo-affective disorder	1	0.1%
14	F28	Other non-organic psychotic disorders	1	0.1%
15	F29	Unspecified non-organic psychosis	3	0.4%
16	F30	Manic episode	35	4.4%
17	F31	Bipolar affective disorder	6	0.8%
18	F 31.2	Bipolar affective disorder current episode manic with psychotic features	234	29.4%
19	F32	Depressive episode	16	2.0%
20	F33	Recurrent depressive disorder	7	0.9%
21	F39	Unspecified mood disorder	1	0.1%
22	F40	Phobic anxiety disorder	2	0.3%
23	F41	Other anxiety disorder	2	0.3%
24	F42	OCD	8	1.0%
25	F43	Reaction to severe stress and adjustment disorder	3	0.4%
26	F44	Dissociative conversion disorder	43	5.4%
27	F60	Specific personality disorder	22	2.8%
28	F66	Psychological and behavioural disorders associated with sexual development and orientation	1	0.1%
29	F70	Mild mental retardation	2	0.3%

SL	ICD-10 Code	Diagnosis	Frequency (n)	Percentage (%)
30	F71	Moderate mental retardation	2	0.3%
31	F72	Severe mental retardation	4	0.5%
32	F84	Pervasive developmental disorder	4	0.5%
33	F90	Hyperkinetic disorders	2	0.3%
34	F91	Conduct disorders	4	0.5%
35	F94	Disorders of social functioning with onset specific to childhood and adolescence	1	0.1%
37	F20+F71	Schizophrenia+ Moderate mental retardation	1	0.1%
39	F23+F63	Acute and transient psychotic disorders + Habit and impulse disorder	1	0.1%
40	Forensic Case	No Psychiatric disorder	1	0.1%
	Data could not be obtained	Unknown	14	1.8%
	Total		79	100%

Table 3: Distribution of patients according to treatment outcome (n=797)

Outcome	Frequency (n)	Percentage (%)
Improved	395	49.6%
Partially improved	348	43.7%
Not improved	43	5.4%
Deteriorated	5	0.6%
Died	1	0.1%
Unknown	5	0.6%
Total	**797**	**100%**

Table 4: Distribution of patients according to mode of discharge (n=797)

Mode of discharge	Frequency (n)	Percentage (%)
Discharge with advice	452	56.7%
Discharge on request	289	36.3%
Discharge on risk bond	33	4.1%
Absconded	1	0.1%
Referred	19	2.4%
Unknown	3	0.4%
Total	797	100%

Table 5: Distribution of patients according to duration of hospital stay (n=797)

Duration of hospital stay (in weeks)	Frequency (n)	Percentage (%)
>1-2	280	35.2%
>2-4	314	39.4%
>4-8	177	22.2%
>8-12	26	3.2%
Median hospital stay		21 days
Total	797	100%

Discussion

Recorded data of 797 admitted patients to all 6 inpatient departments of NIMH were analysed in this study. Among them, (51.4%) were male and (48.6%) were female. This could be because the NIMH has a (60%) male to (40%) female bed distribution ratio, and treatment seeking behaviour and priority is still common in case of male in our society. This result is comparable with findings of other studies, where (60.53%) were male, (36.47%) were female6 and (79.5%) were male, (20.5%) were male,[7] respectively. The majority (57.7%) of the patients were in the age group of 19-35 years. The predominance of this age group can be explained by the predominance of patients with schizophrenia and bipolar disorder. This finding is also consistent with another study, where majority (35.6%)

of the patients were in the age group 21-30 years followed by (23.3%) in the age group 31-40 years.[7]

In the current study, substantial proportion (35.0%) of the patients was unemployed. Unemployment has a bidirectional relationship with psychiatric disorders. Next to unemployment, housewives (24.5%) were most prevalent. Housewives are subjected to enormous stress as a result of child rearing practices, household chores, financial crises, and domestic violence. Third most prevalent were students (24.3%). Students experience study-related stress, and they are mostly young adults. This finding is almost similar with another study, where (26.0%) were unemployed, (23.3%) were students.[7]

This study found that level of educational attainment for majority of the patients were up to secondary (40.7%) followed by primary (26.0%), higher secondary (15.1%), graduation & above (9.9%), and no education (8.3%) (Table 1). This shows that our people are getting more educated day by day, and it will continue if the nation becomes aware of the need to remove the mental health and other barriers to education. This finding was in accordance with other study where (28%) completed SSC or more academic qualification.[8]

In the present study, most of the patients (50.6%) were from a rural background, followed by urban (35.8%), semi-urban (10.6%), slum (1.7%), and unknown (1.3%). This may be due to the fact that rural people are also gradually becoming aware of their mental health and mental health-related services day by day, and they are also aware of the services provided by the NIMH in Dhaka, Bangladesh. This finding is also comparable with another study, where (54.8%) were from rural background and (45.2%) from that of urban.[7]

Patients with mental illness have a right to marry and live a life with dignity. But, it's a social process where certain abilities are required for marriage to be a successful one. In the current study, almost half of the patients (47.3%) were found unmarried. On the other hand, (45.5%) of the patients were married. This finding contradicts the findings of another study, where (46.4%) were married and (32.8%) were unmarried.[8]

In our study, Table 2 presents the clinical diagnoses of the patients according to an ICD-10 4-digit code. Findings showed, the most frequent (39.0%) were patients with schizophrenia, followed by that of manic episode, bipolar affective disorder and bipolar affective disorder current episode manic with psychotic features, unspecified mood disorder in total (34.6%). Here, schizophrenia was highest at number, which indicates that schizophrenia is such a disease where proper management is not always possible at home and it demands hospital admission. So, attention should be paid to ensure an adequate number of beds for these groups of patients. This finding was consistent with other studies, where majority (32.7%) cases were Schizophrenia followed by (27.4%) bipolar mood disorder in one study7 and (40.8%) schizophrenia and other psychotic disorders followed by (36.8%) mood disorder in another study,[8] respectively.

Depressive episodes and recurrent depressive disorder were found to be (2.9%) in this study (Table 2), which reflects that a substantial portion of the patients with depressive disorders requires hospital admission for proper treatment. According to the findings of our National Mental Health Survey 2018-2109, the prevalence of depressive disorders was (6%),[9] which is double the finding of our study. This is due to the fact that current study is based on hospital records of the indoor patients of NIMH only.

Regarding the neurotic and stress related disorders (7.3%), this study found that the most frequent (5.4%) was dissociative conversion disorder, followed by obsessive-compulsive disorder (OCD) (1.0%), phobias and other anxiety disorders (0.6%), reaction to severe stress and adjustment disorder (0.4%). It indicates that, neurotic and stress related disorders are not less common. Findings of this study were in accordance with another study where anxiety disorders were (5.6%) dissociative disorders were (0.8%) and adjustment disorders were (0.8%).[8]

The prevalence of substance use is on rising trend in Bangladesh. Among the recorded patients, (2.4%) were due to substance use and related disorders. Among them, mental and behavioral disorders due to cannabinoids (1.0%) were most common followed by multiple drug use and other psychoactive substances (0.6%), alcohol (0.3%), other stimulants including caffeine (0.3%), hypnotics (0.1%) and opioids (0.1%) (Table 2). These findings were nearly similar to other research finding, where most frequently used substances were cannabinoids (42.7%), followed by alcohol (27.5%), amphetamine (15.2%), opioids (5.3%), sleeping pills (3.4%).[10] The existing discrepancies between these two studies might be due to the fact that our study is based on hospital records of one hospital only and the other study is a multi-centric community-based study. Our study was comparable to another study where findings revealed that among the drug-addicts, highest (95.2%) were addicted to

cannabinoids, followed by (61.9%) yaba, (50.0%) heroin, (47.6%) alcohol, (42.3%) phensedyl, (7.1%) cocaine and opium (2.3%).[11]

Among other psychiatric disorders, most frequent were personality disorders (PD) (2.8%). According to our national survey prevalence of PD is (0.1%).[9] This might be due to personality disorders are under-diagnosed and under-addressed in the community. Patients and/or their guardians usually seek help and take admission when their functional impairment is significantly high and to prevent devastating consequences of their illness.

Findings of this study showed (1.1%) patients were with mental retardation, (0.5%) pervasive developmental disorders, (0.5%) conduct disorders, (0.3%) hyperkinetic disorders, (0.1%) disorders of social functioning with onset specific to childhood and adolescence. In another outdoor based study conducted in Child Guidance Clinic of NIMH, Dhaka, Bangladesh, results showed hyperkinetic disorders were highest prevalent (27.09%), followed by mental retardation (18%), Pervasive developmental disorders (13.50%), conduct disorder (12.06%).[12] Our study findings were dissimilar to that study findings.

Rest of the patients were found (0.1%) with delirium not induced by Alcohol and other psychoactive substances, (0.1%) other mental disorders due to brain damage and dysfunction. (Table 2).

One patient out of 797 admitted patients was found to have no psychiatric disorder (Table 2); because this case had been referred to determine mental fitness for legal purpose.

Regarding treatment outcome, majority (49.6%) of the patients were improved and (43.7%) of patients were partially improved after receiving treatment from the hospital. So, it is evident that mental illness can be cured with treatment. On the contrary, (5.4%) of the patients had no improvement after being admitted to the hospital, (0.6%) of patients' conditions worsened following treatment. Further evaluation is necessary in this context. Only one (0.1%) had died which represents that death rate due to mental illness is very low (Table 3).

In terms of discharge, (56.7%) of patients were discharged with advice, (36.3%) of patients were released on request. This finding is consistent with another study findings, where (44.8%) respondents discharged home after completing treatment, (48%) discharged (DOR and DORB) without completing the treatment.[8] Moreover in the current study, (4.1%) of patients were released after posting a risk bond, (2.4%) were referred, data regarding (0.4%) were unknown and (0.1%) absconded from the hospital (Table 4). Further evaluation is required regarding these issues of concern. Our security staff should be more aware and cautious so that no patient could be absconded. In our study, median hospital stay was found 21 days (Table 5), which is consistent with other study that was carried out at an inpatient department of NIMH, where median hospital stay was found 19 days.[8] This finding reflects that NIMH is a short stay hospital.

To date, there is no such established comparable data regarding inpatients of Pabna Mental Hospital or Psychiatry departments of other hospitals in Bangladesh, we collected a short statistic of Pabna Mental Hospital, Bangladesh, where 1531 patients were admitted and 1541 patients were discharged in 2021. So, turnover rate of NIMH was found higher than that of Pabna Mental Hospital in 2021.

Implications

1. Applying ICD-10 4 digits in diagnosis we found 35 types of mental disorders; which is a wide variation in diagnosis. This will act as an eye opener for graduate and undergraduate doctors regarding the diagnoses of mental disorders.

2. Moreover, this computed data will ensure instant and secure access of data regarding clinical profile of the inpatients.

3. Coordination and collaboration with various government and private organizations will be easier.

4. It will help in data tracking and future research activities

Limitations

We searched for but could not obtain and compare our study findings with that of inpatient department of tertiary level psychiatric hospitals or medical colleges as there is no established/published data available regarding this, to knowledge. Bipolar disorder has a variable course characterized by recurrent episodes of depression and/or mania, and the major depressive disorders also have variable courses. Unipolar depression and bipolar depression could not be estimated separately in this study due to scarcity of data. Among the recorded patient's information regarding 14 patients was incomplete.

Recommendations

All medical colleges and tertiary level hospitals should maintain software to keep and maintain records of their patients. Data should be correctly filled up, recorded and checked with caution by the respective departments in that software.

Depression is a leading cause of disability around the world and contributes greatly to the global burden of diseases. Bipolar depression and major depressive disorder are quite different with differing treatment algorithms and prognosis, it is extremely important to make the differentiation between these two during data record. Special emphasis should be given to reduce suicide rates and global burden of diseases by early identification and effective management of depression, neurotic and stress related disorders by the all graduate, postgraduate doctors, medical students and other health care professionals of Bangladesh. Promotion of child and adolescent mental health and prevention of developmental disorders can be done by providing genetic counseling, managing obstetrical complications properly, creating awareness regarding high-risk pregnancies and policies and legislation, caregiver support, school-based programs, respectively.

Conclusion

Findings of this study will act as eye-opener for the psychiatrists regarding wide variation in patterns of psychiatric diagnoses. It will also help the policy makers for future planning and policy making in the field of mental health.

Saifun Nahar, Assistant Professor, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh; **Bidhan Ranjan Roy Podder,** Director-cum-Professor, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh; **Mohammad Delowar Hossain,** Associate Professor, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh; **Mohammad Tariqul Alam,** Associate Professor, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh.

Correspondence: Saifun Nahar, Assistant Professor, Psychiatry, National Institute of Mental Health, Dhaka, Bangladesh.
Email: saifunsumi@gmail.com

How to cite this article: Nahar S, Podder BRR, Hossain MD, Alam MT. Socio-demographic and clinical profile of the patients admitted in National Institute of Mental Health (NIMH), Dhaka, Bangladesh in 2021. Arch NIMH. 2022; 5(2): 3-11.

Received 4 Sep 2022, revised 22 Nov 2022, accepted 10 Dec 2022.

Acknowledgements

Md. Anwar Hossain, Assistant Programmer, NIMH

References

1. Freeman, Melvyn. "The World Mental Health Report: Transforming Mental Health for All." World Psychiatry, vol. 21, no. 3, Wiley, Sept. 2022, pp. 391–92. Crossref, https://doi.org/10.1002/wps.21018.
2. Ministry of Health & Family Welfare. Health bulletin 2016. Dhaka: Ministry of Health & Family Welfare; 2016.
3. World Health Organization. ICD-10-CM International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM -Synopsis)
4. http://www.cdc.gov/nchs/icd/icd-10-cm.htm
5. American Psychiatric Association. (2013) Diagnostic and statistical manual of mental disorders(5th ed.). http://doi.org/10.1176/appi.books.9780890425596
6. World Health Organization (1993). The ICD-10 classification of mental and behavioral disorders. World Health Organization.
7. A Fahmida, Wahab MA, Rahman MM. Diagnostic attain of psychiatric admitted patients admitted in a private psychiatric clinic. Bang J Psychiatry 2007;21(2):26-32
8. Bhowmik AD, Poddar BRR, Ahmed HU, Islam MM, Singha RK, Bashar MK. Diagnostic pattern and sociodemographic variation of admitted psychiatric patients in a Government Medical College Hospital in Bangladesh. Bang J Psychiatry 2011; 25(2): 34-38
9. Uddin MZ, Alam MS, Mohit M.A, Akhter R, Khan MZR. Demographic profile of patients admitted under psychotherapy department at National Institute of Mental Health (NIMH), Dhaka. Bang J Psychiatry 2011; 25(2): 25-33
10. National Institute of Mental Health, Dhak. National Mental Health Survey, Bangladesh 2018-1019. Accessed 21 Nov. 2022.
11. Alam MF, Sarker M, Alam MT, Ahmed HU, Bhowmik AD, Roy S. Prevalence of substance use in Bangladesh. Bang J Psychiatry 2018;32(1):1-8

12. Ahad AA, Chowdhury DM, Islam MB, Alam MF. Socioeconomic Status of Young Drug Addicts in Sylhet City, Bangladesh. IOSR J Humanit Soc Sci 2017; 22: 84-91

13. Sarkar M, Khan MZR, Rabbani MG, Alam FM, et al. Pattern of Psychiatric Morbidity Among the Children and Adolescents Attending Child Guidance Clinic of National Institute of Mental Health (NIMH), Dhaka. Bang J of Psy 2008; 22(1): 11-21

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Original Article

Obsessive compulsive disorder during COVID-19 pandemic

M A Mohit Kamal, Muhammad Zillur Rahman Khan, Nasim Jahan, Mahbub Mayukh Rishad, Mohammad Muntasir Maruf

Background: People with obsessive compulsive disorder (OCD) are likely to be more susceptible to the mental health impact of COVID-19.

Objectives: We aimed to investigate the socio-demographic and other factors of OCD and relation of its occurrence with COVID-19.

Methods: : This was a cross-sectional study carried out among the persons diagnosed as a case of OCD by a psychiatrist according to Diagnostic and Statistical Manual of Mental Disorders, version 5 (DSM-5) and attended at private chambers of psychiatrists during April 2022 – June, 2022. All the persons diagnosed with OCD, irrespective of gender and aged more than 18 years, were approached for the research. After having their consent, sociodemographic and other information were collected through face-to-face interview of the respondents. Completed data of 153 respondents were analyzed using Statistical Package for Social Sciences (SPSS), version 25. Ethical issues were addressed properly throughout the study.

Results: Mean age of the respondents were 29.3±12 years. More than half (54.9%) of the respondents were unmarried. About one-fifth (18.3%) of the respondents suffered from OCD symptoms for the first time after COVID pandemic occurred in Bangladesh. Among the respondents diagnosed as OCD prior to pandemic, more than one-third (36.8%) had treatment for the disorder. About one-fourth (23.5%) had family history of OCD. One-fifth (20.3%) had history of substance abuse. Suicidal attempt was reported by 19% of respondents. More than half (54.9%) had co-morbid physical illness.

Conclusions: A significant proportion of persons with OCD experienced their symptoms first time during COVID outbreak.

Declaration of interest: None

Keywords: OCD, COVID-19, sociodemographic factors.

Introduction

The COVID-19 pandemic has proven to be a tremendous stressor for both the general population and individuals with mental illness by now. Pandemics have struck human societies since ancient times and caused huge number of deaths, economic depressions and many more. World Health Organization (WHO) had declared a pandemic in March 2020 and since then many strategies have been imposed worldwide to limit the spread of SARS-CoV-2, including quarantines, physical distancing, maintaining hand hygiene, wearing protective facemasks etc.[1]

In one of the recent review articles, we can find that fear of the virus and various strategies to limit its spread might have a synergistic effect in exerting a negative impact on the mental health worldwide.[2]

COVID-19 has proven to be an enormous stressor for individuals with OCD. A wide body of literature now shows that that obsessive compulsive symptoms increased during the early stages of the pandemic, both in those with OCD and the general population. COVID-19 became a central theme for many people with OCD.[3] According to a review article, individuals who had been diagnosed with obsessive-compulsive disorder (OCD) prior to the current pandemic may be the group most affected by the pandemic among those with mental disorders.[2] High-risk groups include OCD patients in remission/recovery, geriatrics (i.e., people over age 65), pregnant women, children and adolescents, and healthcare professionals.[1] OCD is associated with reduced quality of life, various comorbid mental disorders and, with severe OCD, an increased risk of suicide attempts.[1]

As people with obsessive compulsive disorder (OCD) are likely to be more susceptible to the mental health impact of COVID-19, we aimed to investigate the socio-demographic and other factors of OCD and relation of its occurrence with COVID-19. General Objective of our study was to investigate sociodemographic and other factors of OCD during Covid pandemic and specific was to investigate relation of its occurrence with Covid pandemic.

Methods

It is a descriptive cross-sectional study conducted in a private consultation center of a Psychiatrist of Dhaka city. Study period was from April 2022 to June 2022. All the persons aged 18 years and above, diagnosed with OCD attending the consultation center and consenting for the study were included. A total of 153 patients were included purposively in the study. A Consent form, Diagnostic and Statistical Manual of Mental Disorders 5 (DSM - 5) and a Semi-structured questionnaire prepared by researchers after reviewing related articles from online search were used. Computer software program Statistical Package for Social Sciences (SPSS), version 25.0 for Windows were used for data processing and statistical analysis. All ethical issues were maintained properly.

Results

Mean age of the respondents were 29.32 (±12) years. Majority (62.8%) had education up to higher secondary standard and above. More than half (54.9%) of the respondents were unmarried. About one-fifth (18.3%) of the respondents suffered from OCD symptoms for the first time after COVID pandemic occurred in Bangladesh. Among the respondents diagnosed as OCD prior to pandemic, more than one-third (36.8%) had treatment for the disorder. About one-fourth (23.5%) had family history of OCD. One-fifth (20.3%) had history of substance abuse. Suicidal attempt was reported by 19% of respondents. More than half (54.9%) had co-morbid physical illness (Table 1).

About 81.7% of the patients were diagnosed with OCD before pandemic. Among them 51 (40.8%) was already on treatment but 74 (59.2%) needed treatment after appearance of COVID pandemic. New cases (n=28, 18.3%) among total cases was significant.

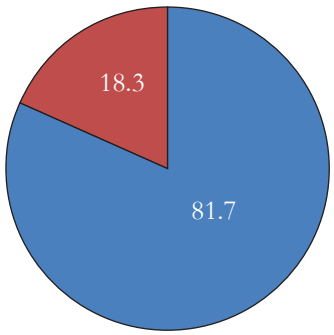

Figure 1: Proportion of new cases after pandemic among total cases (N= 153)

Table 1: Sociodemographic and relevant characteristics of the participants (N=153)

Variable	Frequency (n)	Percentage (%)
Age		
18-27	80	54.5
28-37	31	21.1
38-47	20	13.6
48-57	13	8.8
≥58	3	2.0
Sex		
Male	67	43.8
Female	86	56.2
Marital status		
Unmarried	84	54.9

Variable	Frequency (n)	Percentage (%)
Marital status		
Married	61	39.9
Divorced	6	3.9
Residence		
Urban	113	73.9
Rural	36	23.5
others	4	2.6
Education		
Illiterate	4	2.6
Primary	21	13.7
Secondary	32	20.9
Higher secondary	61	39.9
Graduate	17	11.1
Post-graduate	17	11.1
Others	1	0.7
Family history		
Yes	36	23.5
No	117	76.5
Substance abuse		
Yes	31	20.3
No	122	79.7
Suicide attempt		
Yes	29	19
No	124	81
Physical illness		
Yes	85	55.6
No	68	44.4

Physical comorbidity was absent in 68 participants (44.4%). Frequency of comorbidity found was diabetes mellitus 13 (8.5%), hypertension 9 (5.9%), lung disease 11 (7.2%), renal disease 1 (0.7%), thyroid disease 2 (1.3%), skin disease 27 (17.6%), neurological disease 1 (0.7%), Others 21 (13.7%)

Discussion

The etiology of OCD is largely unknown but probably -complex combination of both genetic, biological, and environmental factors. Stressful life events, comorbid mental-health disorders, a family history of OCD, and/or personality traits like perfectionism, intolerance of uncertainty, and threat overestimation are general risk factors to cause or trigger OCD.[1]

OCD has heterogeneous presenting symptom which might get aggravated in the presence of external stress or cues. There are various factors in this current COVID pandemic which may worsen the symptoms in patients who are already affected by OCD.[4] Commonly there is elevated levels of psychiatric symptoms following a stress. Decades of research demonstrated that mental health worsens after stressful events. Pandemic is one of such stressful time.[5] In this study during Covid pandemic our main finding was significant number of new cases of OCD patients and exacerbation of symptoms in old cases. Significant number of patients was found having suicidal ideation that could be due to appearance or aggravation of depressive symptoms. An online study conducted among general public living in the UK (N=406) investigated the development of obsessive compulsive (OC), anxiety and depressive symptom dimensions longitudinally at two time points during and after the first pandemic wave of Covid-19. They found increase in OC symptoms suggesting that this cannot be only adaptive protective behaviors during the pandemic and was present across multiple OC domains.[5] One of the studies conducted in the child and adolescent psychiatry department of Istanbul University evaluated OC symptom profiles from both during and before the COVID-19 pandemic in young subjects (N=61). More than half of the subjects (n=33; 54.09%) reported an increase in symptom severity. There was a significant increase in the frequency of contamination obsessions (p=0.008) and cleaning/washing compulsions (p=0.039) during the pandemic.[6] In another online study conducted in Germany among 394 participants with OCD recruited between March to May, 2020 showed that majority of participants (72 %) reported an increase in the severity of their OC symptoms.[7]

In Canada, 6041 individuals completed an online survey. Overall, 60.3% of respondents reported onset of OC symptoms and 53.8% had compulsions to wash hands during the COVID-19 pandemic.[8] A prospective study was conducted among students of the Xinxiang Medical University of China at three time points during the COVID-19 pandemic. They found that in survey 1 that is at the initial part of pandemic 11.3% of participants had OCD. In surveys 2 and 3 that is later on, 3.6% and 3.5% of participants had OCD respectively.[9] According to our national study prevalence of OCD in general adult population was 0.7% in 2018-19 that is pre pandemic period.[10]

In our study the proportion of OCD was high and interestingly about one fifth had appearance of symptom after Covid pandemic. Mean age of the respondents were 29.32 (±12) years. More than half of the respondents were unmarried (54.9%) and female (56.2%). Maximum were educated up to HSC (39.9%). To assess frequency of depression and OCD among the general population during COVID-19 pandemic in Saudi Arabia a cross-sectional study using social media platform was conducted (N=2187). They found that Increasing age had increased frequency of having OCD. Males showed more frequency of OCD (67.4%) than females (59.2%). Moreover, married individuals and higher income groups showed a higher incidence of OCD. Higher education levels and employed individuals were more likely to have OCD.[11]

In a study conducted in a private chamber of Bangladesh just before Covid pandemic (Feb 2018- Jan 2019) showed similar sociodemographic findings. Most of the patients were from 21-30 years of age group (34.4%) with female preponderance (60%). Majority of the patients were married (60%), students (38.4%) and completed up to HSC level (44.8%).[12] On the other hand, some study shows opposite result as well. Between April 1 and May 13, 2020, online questionnaires were distributed among the Netherlands cohorts showed that individuals with the greatest burden on their mental health tended to show a slight symptom decrease.[13] All OCD patients from the Israeli Center for OCD who had clinical assessments during April to May 2020 and during September 2020 were evaluated in a study. Symptom deterioration was not present in 84% of the patients at the 2-month follow-up and 96% of the patients at the 6-month follow-up. OCD patients who were under active ERP and pharmacological treatment did not experience exacerbated symptoms during COVID-19 at their 2- and 6-month follow-ups.[14]

In a study conducted in Bangladesh in 2018, 1.9% of OCD patients was found to have addiction.[15] In another study 7.77% of the respondents with severe mental illness had comorbid substance related and addictive disorders.[16] We found 20.3 % OCD patients having comorbid addiction. In another study 23 among 86 cases (26.7%) selected from 5 different hospitals and clinics of Dhaka city had family history of OCD. The cases having family history had higher prevalence of symptoms than those who did not have family history.[17] In our study family history was present in 23.5 % patients.

OCD has been considered to be associated with a relatively low risk of suicide previously. Recent studies, on the contrary, revealed a significant association between OCD and suicide attempts and ideation. A huge variation in prevalence rates, however, is reported. In clinical samples, the mean rate of lifetime suicide attempts is 14.2%. Suicidal ideation is referred by 26.3-73.5% of individuals. Predictors of greater suicide risk are severity of OCD, the symptom dimension of unacceptable thoughts, comorbid Axis I disorders, severity of comorbid depressive and anxiety symptoms, past history of suicidality and some emotion-cognitive factors such as alexithymia and hopelessness.[18]

Report suggested that every day almost 32 people committed suicide in 2019 but in 2015 and 2017 which was 29 and 30 respectively. The mortality rate of suicide found 39.6 per 100,000 (0.04%) in Bangladesh.[19] Approximately 4% adults in the general population report a history of DSH and up to 1% report frequent involvement in such behavior. DSH was found in about 20% of the adults and 40-80% of the Adolescences with psychiatric disorder.[20] In our study 19 % patients had suicidal attempt.

Respondents who showed OCD symptoms only since the start of COVID-19 were significantly more likely to have moderate/high stress, likely GAD and likely MDD. Similarly, respondents who engaged in compulsive hand washing were significantly more likely to have moderate/high stress and likely GAD but not likely MDD.[8] Associated anxiety and depression might be cause of increase suicidal ideation among patients having OCD during pandemic. Physical comorbidity was present among 55.6% of patients in our study. Diseases of the skin was present among 17.6% which was the highest among all comorbidities as expected, followed by 8.5% diabetes mellitus (DM), 7.2% respiratory problem including asthma and 5.9% hypertension (HTN). In a local study with patients having severe mental illness (N=1648) overall 42% of the respondents had physical comorbidity where DM (28.47%) was the most common followed by HTN (26.45%). Diseases of the skin was present among 1.73% of the respondents.[16]

A significant proportion of persons with OCD experienced their symptoms first time during COVID outbreak. People both with and without diagnosed OCD prior to the pandemic generally experienced worsened OCD symptoms during the COVID-19 pandemic. However, the responses are heterogeneous and many factors other than the pandemic seemed to be responsible. To prevent the impairment of symptoms and the development of new cases, close monitoring of patients with OCD and education of the general public is essential. Limitations of our study was small sample size and

purposive sampling. Literature is still limited so more national and multinational, cross-cultural, longitudinal studies are essential.

M A Mohit Kamal, Former Director-cum-Professor, Psychiatry, National Institute of Mental Health, Dhaka, Bangladesh; **Muhammad Zillur Rahman Khan,** Associate Professor, Psychiatry, Shaheed Suhrawardy Medical College and Hospital, Dhaka, Bangladesh; **Nasim Jahan,** Assistant Professor, BIRDEM General Hospital, Dhaka, Bangladesh; **Mahbub Mayukh Rishad,** Registrar, Internal Medicine, Popular Medical College, Dhaka, Bangladesh; **Mohammad Muntasir Maruf,** Assistant Professor, National Institute of Mental Health, Dhaka, Bangladesh.

Correspondence: M A Mohit Kamal, Former Director-cum-Professor, Psychiatry, National Institute of Mental Health, Dhaka, Bangladesh.
Email: shabdagharbd@gmail.com

How to cite this article: Kamal MAM, Khan MZR, Jahan N, Rishad MM, Maruf MM. Obsessive compulsive disorder during COVID-19 pandemic. Arch NIMH. 2022; 5(2): 12-17.

Received 5 Nov 2022, revised 5 Dec 2022, accepted 11 Dec 2022.

References

1. Linde ES, Varga TV and Clotworthy A. Obsessive-compulsive disorder during the covid-19 pandemic—a systematic review. Front. Psychiatry. 2022; 13: 806872.

2. Fineberg NA, Van Ameringen M, Drummond L, et al. How to manage obsessive-compulsive disorder (OCD) under COVID-19: A clinician's guide from the International College of Obsessive-Compulsive Spectrum Disorders (ICOCS) and the Obsessive-Compulsive and Related Disorders Research Network (OCRN) of the European College of Neuropsychopharmacology. Compr Psychiatry. 2020; 100: 152174.

3. Guzick AG, Candelari A, Wiese AD, et al. Obsessive–compulsive disorder during the covid 19 pandemic: a systematic review. Current Psychiatry Reports. 2021; 23: 71.

4. Chakraborty A, Karmakar S. Impact of COVID-19 on obsessive compulsive disorder (OCD). Iranian J Psychiatry. 2020; 15: 3.

5. Loosen AM, Skvortsova V, Hauser TU. Obsessive–compulsive symptoms and information seeking during the Covid-19 pandemic. Translational Psychiatry. 2021; 11: 309.

6. Tanir y, Karayagmurlu A, Kaya I, et al. Exacerbation of obsessive-compulsive disorder symptoms in children and adolescents during COVID-19 pandemic. Psychiatry Research. 2020; 113363.

7. Jelinek L, Moritz S, Miegel F, et al. Obsessive-compulsive disorder during COVID-19: Turning a problem into an opportunity? Journal of Anxiety Disorders. 2021; 77 (2021): 102329.

8. Abba-Aji A, Li D,Hrabok M, Shalaby R, et al. COVID-19 Pandemic and mental health: prevalence and correlates of new-onset obsessive-compulsive symptoms in a Canadian Province. Int. J. Environ. Res. Public Health. 2020; 17: 6986.

9. Ji G, Wei W, Yue K, et al. Effects of the COVID-19 pandemic on obsessive-compulsive symptoms among university students: prospective cohort survey study. J Med Internet Res. 2020; 22(9): e21915.

10. NIMH Fact sheet. https://www.who.int/docs/default-source/searo/bangladesh/pdf-reports/cat-2/nimh-fact-sheet-5-11-19.pdf?sfvrsn=3e62d4b0_2

11. Alhusseini N, Sajid M, Altayeb A, et al. Depression and obsessive-compulsive disorders amid the COVID-19 Pandemic in Saudi Arabia. Cureus. 2021; 13(1): e12978.

12. Delowar MH, Ferdush R, Rahman S. Unusual presentation of patients with obsessive compulsive disorder. Bang J Psychiatry. 2017; 31(2): 48-50

13. Pan KY, Kok AAL, Eikelenboom M, et al. The mental health impact of the COVID-19 pandemic on people with and without depressive, anxiety, or obsessive-compulsive disorders: a longitudinal study of three Dutch case-control. Lancet Psychiatry. 2021; 8(2): 121-129.

14. Carmi L, Ben-Arush O, Fostick L, et al. Obsessive compulsive disorder during Coronavirus Disease 2019 (COVID-19): 2- and 6-month follow ups in a clinical trial. International Journal of Neuropsychopharmacology. 2021; 24(9): 703–709.

15. Chowdhury ADMR, Hossain MD, Haq IA, et al. Psychiatric morbidity in patients with obsessive-compulsive disorder. Arch NIMH. 2020; 3 (2): 16-20

16. Alam MF, Ahmed HU, Alam MT, et.al. Physical comorbidity in persons with severe mental illness in Bangladesh. Arch. NIMH. 2019; 02 (2): 07-18

17. Mozumder MK, Begum R. Symptomatology of obsessive-compulsive disorder in Bangladesh. Bangladesh Psychological Studies. 2008; 18: 1-10.

18. Albert U, Ronchi DD, Maina G, et al. Suicide Risk in obsessive-compulsive disorder and exploration of risk factors: a systematic review. Current Neuropharmacology. 2019; 17(8): 681-96.

19. Ferdous MZ, Alam ASMM. Present situation of suicide in Bangladesh: A review. medRxiv preprint. 2021.

20. Motin MA, Chowdhury AR, Royle RKS, et al. Personality disorders in adult population with deliberate self-harm. Arch NIMH. 2020; 3 (1): 18-23.

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Original Article

Pattern of psychiatric morbidity in a tertiary care military hospital in Bangladesh

A S M Kowser, Munira Parveen, Mohammed Ali Chowdhury, Mohammad Taslim Uddin

Background: Behavioral and mental disorders accounted 12% of global burden of disease (GBD). Treatments for all these disorders are as available as efficacious. However, these disorders are remarkably undertreated worldwide.

Objectives: To find out the pattern of psychiatric morbidity of patients attending at the psychiatry outpatient department.

Methods: : This was a cross sectional study carried out in the Department of Psychiatry at Combined Military Hospital (CMH), Chattogram from January 2022 to June 2022. For this purpose, 1297 respondents attending in psychiatry outpatient department of CMH Chattogram were enrolled in the study by using convenient sampling technique. Psychiatric diagnoses of the patients were assigned by the consultant psychiatrist as per Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria. Structured questionnaire was used to collect socio-demographic data. Statistical analyses were carried out by using the Statistical Package for Social Sciences version 23.0 for Windows (SPSS Inc., Chicago, Illinois, USA). The quantitative observations were indicated by frequencies and percentages. Ethical issues were maintained all through the study.

Results: The most common psychiatric morbidity among the respondents was depressive disorder (36.9%) followed by anxiety disorders (19.8%), obsessive-compulsive & related disorder (16.3%) and somatic symptom and related disorder (11.3%). The results showed that majority (26.6%) were from the age group of 31-40 years with female preponderance (59.1%). More than half of the patients were referred from different branches of Medicine (65%). Referral from Internal Medicine was 25.2%, Cardiology 13%, Gastroenterology 12.3%, Nephrology 10.6% and Physical Medicine 3.3%, respectively. The rest were from branches of Dermatology and Venereology, Surgery, Orthopaedics, Paediatrics and Gynaecology and Obstetrics.

Conclusions: Neurotic cases were predominant in psychiatric outpatient department. Referrals patients of psychiatric disorders came mainly from Medicine and allied branches. Results of this study may help in the planning for better mental health service integrated with primary healthcare system of our country.

Declaration of interest: None

Keywords: CMH; Global burden of disease (GBD); psychiatric referral; sociodemographic characteristics; DSM-5; DALY.

Introduction

'Health is a state of complete physical, mental, social and spiritual well-being and not merely an absence of disease or infirmity'.[1] Behavioral and mental disorders accounted 12% of global burden of disease (GBD). It was estimated that 10% of the adult population was suffering from some kind of behavioral and mental disorder globally and it was 4 out of 10 leading causes of disability.[2] Mental disorders are highly prevalent in all regions of the world which causes a significant source of disability and social burden. Treatments for all these disorders are as available as efficacious. However, these disorders are remarkably undertreated worldwide. As per World Health Organization (WHO) more than 25% individuals show one or more mental disorders in their lifetime. Mental & neurological disorders will likely account for 14.4% of all global disability-adjusted life year (DALY) and 25.4% of non-communicable diseases by 2030. WHO also estimates that one mental disorder member in 1 of 4 families worldwide.[3] Depression is expected to become the leading cause of disability by 2030.[4]

In Bangladesh, prevalence of psychiatric disorder is 16.8%. Out of which depressive disorders are (6.7%), anxiety disorders are (4.5%) & somatic symptom and related disorders is (2.1%). Surprisingly the treatment gap estimated is 92.3% and majority are treated by general physicians.[5]

Due to scarcity of epidemiological studies, there was limited data on pattern of psychiatric morbidity. With the world's eighth largest population with 160 million people, extensive research and studies are required to prepare the country to lessen the silent burden of mental disorders. This study was designed with the aim of determining psychiatric morbidity that contributes to mental health and raise awareness among all physicians integrated with primary healthcare system of our country.

Methods

This was a cross sectional study and carried in the outpatient department (OPD) of Psychiatry at Combined Military Hospital (CMH), Chattogram from January 2022 to June 2022. Patients attending Psychiatry OPD of CMH Chattogram were assigned by purposive sampling method. Both male and female who gave consent to participate in the study were included. An informed written consent was taken from each participant of the study population by using consent form. In case of minor, their legal guardians gave written consent. The patients who were not interested in participating in the study, suffered from acute physical illness and acute confusional state, patients who had visual or hearing impairment to such extent that they could not participate in the study were excluded from the study. Pre-designed structured questionnaire was prepared to determine the socio-demographic characteristics such as age, sex, residence, education, marital status etc. The quantitative observations were indicated by frequencies and percentages. Ethical issues were maintained all through the study. Finally, psychiatric diagnoses of the patients were assigned by the consultant psychiatrist as per Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) criteria.[6] Besides pattern of referrals were also counted in this study. Statistical analyses were carried out by using the Statistical Package for Social Sciences version 23.0 for Windows (SPSS Inc., Chicago, Illinois, USA).

Results

In this study, maximum (26.6%) respondents were in 31-40 years of age (Table 1). There were 41% male and 59.1% female. Most of the respondents were Muslims (89%), married (78.6%), reported from urban areas (59.7%) and completed SSC education (40%). Regarding occupation, highest number of respondents were housewives, (36.8%), service holders (33%), followed by students (17.5%). (Table 1)

Table 1: Distribution of the respondents according to sociodemographic characteristics (N=1297)

Variable	Frequency (n)	Percentage (%)
Age group		
0-10	93	7.2
11-20	157	12.1
21-30	256	19.7
31-40	345	26.6
41-50	296	22.8
51-60	121	9.3
Above 61	29	2.2
Sex		
Male	531	41.0
Female	766	59.1

Variable	Frequency (n)	Percentage (%)
Religion		
Islam	1154	89.0
Hindu	110	8.5
Others	33	2.6
Educational level		
Illiterate	51	3.9
Primary	30	2.3
Secondary	110	8.5
SSC	519	40.0
HSC	455	35.1
Graduation and above	132	10.2
Occupational status		
Service holder	428	33.0
Business	51	3.9
Farmer	31	2.4
Housewife	477	36.8
Student	227	17.5
Unemployed	83	4.9
Marital status		
Married	1019	78.6
Unmarried	266	20.5
Divorced	12	0.9
Social background		
Rural	523	40.3
Urban	774	59.7

During the study period and after exclusion criteria a total of 1297 respondents agreed to participate in the study. The findings of the study were presented in different tables. The most prevalent DSM-5 diagnosis was major depressive disorder (36.9%) followed by anxiety disorders (19.8%), obsessive compulsive and related disorders (16.3%), somatic symptom and related disorders (7.5%) (Table 2).

Table 3 shows total 123 patients were referred by doctors of different disciplines and more than half of them (61%) were referred by medicine and allied branches. Out of them (25.2%) were from Internal Medicine, (13%) from Cardiology, (12.3%) from Gastroenterology, Nephrology (10.6%), Dermatology and Venereology (10.6%) and Gynecology and Obstetrics (8.9%).

Table 2: Distribution of the respondents according to psychiatric disorders (N=1297)

Psychiatric Disorders	Frequency (n)	Percentage (%)
Major depressive disorder	479	36.9
Anxiety disorders	257	19.8
Obsessive-compulsive and related disorders	212	16.3
Somatic symptom and related disorders	97	7.5
Seizure disorder	45	3.5
Intellectual disability	45	3.5
Bipolar and related disorders	38	2.9
Schizophrenia spectrum disorders	35	2.7
Autism spectrum disorders	27	2.1
Post-traumatic stress disorder	22	1.7
Attention-deficit/ hyperactivity disorder	14	1.1
Substance related disorders	13	1.0
Functional neurological symptom disorder	13	1.0

Table 3: Distribution of the respondents referred by specialists (n = 123)

Discipline	Frequency (n)	Percentage (%)
Internal medicine	31	25.2
Cardiology	16	13.0
Gastroenterology	15	12.3
Dermatology & Venereology	13	10.6
Nephrology	13	10.6
Gynecology and Obstetrics	11	8.9
Pediatrics	9	7.3
Otolaryngology	6	4.9
Orthopedics	5	4.1
Physical Medicine	4	3.3

Discussion

The aim of this study was to determine pattern of psychiatric morbidity of psychiatry OPD in CMH, Chattogram. During the study period, 1297 respondents agreed to participate in the study. Major Depressive Disorder (MDD) was the most common psychiatric diagnosis found in this study i.e., 36.9% which was similar to other studies.[7,8] Depression is one of the major causes of health burden worldwide affecting approximately 264 million people.[9] In Bangladesh, it is the most common psychiatric diagnosis affecting 6.7% population.[5]

Rests of the disorders were anxiety disorders (19.8%), obsessive compulsive disorder (16.3%), somatic symptom & related disorders (7.5%), and so on. Another study conducted by Firoz et al. also showed that among all psychiatric disorders, depressive disorders are highest in number in Bangladeshi population.[10]

In this study it was found that among the respondents, highest percentage (26.6%) had age group in between 31-40 years. It is comparable with another study done in our country.[7] In our study, majority of the respondents were females (58.7%) which is similar to findings from other studies.[7,8,11] This might be due to distress about the bodily changes resulting from menstruation, pregnancy, childbirth and menopause.

Education level in this study showed maximum 40% respondents were up to secondary level. Similar results reported by Algin et al.[12] It indicated that mental health awareness is increased among literate people.

In the present study, majority respondents were housewives (36.8%). This finding commensurate with several other studies.[7,8,12,13] This pattern might be the reflection of the socio-cultural suppression and somatization of the mental problems of the unemployed females.[8]

Marital status of our respondents shows 78.6% married, 20.5% unmarried and 0.9% divorced cases. Studies done in Bangladesh,[8] Nepal[14] and America[15] reported similar results.

This study found that majority respondents were from urban background (59.7%). Similar finding was reported by Algin et al.[12] Location of hospitals in commercial area made treatment more accessible for urban population group.

In the present study more than half of the patients have been referred from medicine and allied branches (61%) and this finding comparable to other studies done in Bangladesh[8,12,16] and India.[17,18,19,20] The referral is highest from Department of Internal Medicine (25.2%). The reason behind this may be lack of awareness, information about availability of psychiatric services, stigma about psychiatric disorders which lead them to somatize their psychological complaints. Other common sources were from Cardiology (13%), Gastroenterology (12.3%), Nephrology (10.6%), Dermatology and Venereology (10.6%), Gynecology and Obstetrics (8.9%), Pediatrics (7.3%) and Otolaryngology (4.9%) which were consistent with other study.[7]

There are few limitations of the current study including short duration, only military personnel and few serving civilians with their family members (wife, children, batman and parents in law) were included in this study. So, study population might not represent the whole community. Moreover, the psychiatric diagnoses were assigned by the consultant psychiatrist as per DSM-5. If structured interview techniques and standardized rating scales can be used, the reliability and validity of the results were expected to be better.

Conclusions

Despite a number of limitations, this study provided the baseline information about patterns of psychiatric morbidity, sociodemographic correlates and referrals in a tertiary care military hospital of Bangladesh. The morbidity was consistent with the findings of studies done in the Indian sub-continent and other parts of the world as well. More than half of referrals were from Medicine and allied branches. More than one fifth of the participants who had depression among psychiatry outpatients which was prevalent in the health-care service often went undiagnosed and unmanaged. This study may enlighten for a better comprehensive mental health action plan integrated with primary health care system in our country in the future days to come.

A S M Kowser, Lieutenant Colonel of Bangladesh Armed Forces, Classified Specialist in Psychiatry, Combined Military Hospital cum Associate Professor of Psychiatry, Army Medical College Chattogram, Chattogram Cantonment; **Munira Parveen,** Lieutenant Colonel of Bangladesh Armed Forces, Commanding Officer, 18 Field Ambulance, Chattogram Cantonment; **Mohammed Ali Chowdhury,** Brigadier General of Bangladesh Armed Forces, Commandant, Combined Military Hospital, Chattogram Cantonment; **Mohammad Taslim Uddin,** Colonel of Bangladesh Armed Forces, Deputy Commandant, Combined Military Hospital, Chattogram Cantonment.

Correspondence: A S M Kowser, Lieutenant Colonel of Bangladesh Armed Forces, Classified Specialist in Psychiatry, Combined Military Hospital cum Associate Professor of Psychiatry, Army Medical College Chattogram, Chattogram Cantonment.
Email: kowser1973@gmail.com

How to cite this article: Kowser A S M, Parveen M, Chowdhury M A, Uddin M T. Pattern of psychiatric morbidity in a tertiary care military hospital in Bangladesh. Arch NIMH. 2022; 5(2): 18-23

Received 14 Oct 2022, revised 02 Nov 2022, accepted 11 Nov 2022.

References

1. Park K. Park's textbook of preventive and social medicine. 25th ed. Pune: Banarsidas Bhanot 2019; p.75.

2. Gururaj G, Girish N, Isaac M K. Mental, neurological and substance abuse disorders: Strategies towards a systems approach. NCMH Background Papers. Burden of Disease in India 2010: 226-50.

3. Boland R, Verduin M L, Ruiz P. Kaplan & Saadock's synopsis of psychiatry 12th ed. New York: Wolters Kluwer 2022; p. 875.

4. World Federation for Mental Health. Depression: A Global Crisis: World Mental Health Day. Accessed on 25 March, 2018. Available at URL:http://www.who.int/mental_health/management/depression/wfmh_ paper_depressionwmhd_2012.pd f?ua=1.

5. National Institute of Mental Health. National Mental Health Survey Bangladesh 2019 - Provisional Fact Sheet [Internet] 2019: p. 4. Available from: https:// www.who.int/docs/default-source/searo/bangladesh/pdf-reports/cat-2/nimh-fact-sheet-5-11-19.pdf?sfvrsn=3e62d4b0_2

6. American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 5th Ed, Arlington, VA: American Psychiatric Association; 2013.

7. Monzur MS, Maruf MM, Roy S, et al. Pattern of psychiatric morbidity among patients attended at psychiatry outpatient department in a private medical college hospital. Bang J Psychiatry 2016; 30(1): 10-13.

8. Jahan N, Maruf MM, Kauser S, et al. Pattern of psychiatric morbidity among referred inpatients in a tertiary care hospital of Bangladesh. Bang J Psychiatry 2020; 31(2): 38-42.

9. James SL, Abate D, Abate KH, et al. Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990-2017: a systematic analysis for the Global Burden of Disease Study 2017. Lancet; 392(10159): 1789-858.

10. Firoz AHM, Karim ME, Alam MF, et al. Community based multi centric service-oriented research on mental illness with focus on prevalence, medical care, awareness and attitude towards mental illness in Bangladesh. Bang J Psychiatry 2006; 20(1): 9-32.

11. Fariduzzaman S, Bakar MA, Biswas DM, et al. Consultation-liaison psychiatry in a medical college hospital. Bangladesh Med J Khulna 2014; 46 (1-2): 21-3.

12. Algin S, Ahmed SN, Hossain R. Pattern of psychiatric referrals in a tertiary care hospital in Bangladesh. Bangladesh J Medicine 2020: 30(2); 76-80,

13. Hossain MJ, Giasuddin NA. The pattern of psychiatric referrals in a tertiary care hospital. Archives of NIMH 2019; 2(2): 24-8.

14. Ranjan S, Poudel R, Pandey P. Pattern of psychiatric referral from emergency department of a tertiary level hospital in Nepal. J Univers Coll Med Sci 2016; 3(2): 5-9.

15. Lipowski Z J, Wolston E J. Liaison psychiatry: Referral patterns and their stability over time. Am J Psychiatry 1981; 138(12): 1608-11.

16. Uddin MJ, Chowdhury MJH, Islam MJ, et al. Referral pattern of patients to Psychiatry Department at Neuroscience Institute in Bangladesh. J Natl Inst Neurosci Bangladesh 2015; 1(1): 8-11.

17. Tekkalaki B, Tripathi A, Arya A, et al. A descriptive study of pattern of psychiatric referrals and effect of psychiatric intervention in consultation-liaison set up in a tertiary care center. Indian J Soc Psychiatry 2017;33(2):165.

18. John S, Thomas S M. Referrals P, et al. A study of pattern of referrals in liaison psychiatry. Indo American journal of pharmaceutical research 2017; 7(10): 2-7.

19. Mudgal V, Rastogi P, Niranjan V, et al. Pattern, clinical and demographic profile of inpatient psychiatry referrals in a tertiary

care teaching hospital: a descriptive study. General Psychiatry 2020; 33: e100177.

20. Keertish N, Sathyanarayana MT, Kumar HBG, et al. Pattern of psychiatric referrals in a tertiary care teaching hospital in Southern India. Journal of Clinical and Diagnostic Research 2013; 7(8): 1689-91.

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Original Article

Patterns of psychiatric disorders in persons attending the Forensic Psychiatry Department of a tertiary care psychiatric hospital

Mahfuza Yasmin, Abdullah Al Mamun, Afroza Rahman Lopa, A. K. M. Khaleequzzaman, Sharmin Sultana, S. M. Sazzadul Karim

Background: A significant number of patients are referred in Forensic Psychiatry Department for civil and criminal law related reasons. Knowing their reasons for referral can help in improving service delivery.

Objectives: To estimate the proportion of different psychiatric disorders along with reasons for referrals in persons attending the Forensic Psychiatry Department of National Institute of Mental Health, Dhaka.

Methods: A cross-sectional study was conducted in National Institute of Mental Health, Dhaka in between July 2017 and December 2018. By convenient sampling technique 127 participants aged 18 and more were enrolled in the study. Sociodemographic data and reasons for referrals were collected and psychiatric disorders were diagnosed according to International Classification of Diseases (ICD) 10th edition.

Results: Of the total 127 participants, 80 (63%) were civilians seeking forensic psychiatry services; common reasons were psychiatric assessment followed by getting certificate (20.5%), getting fitness certificate (15.7%), eligibility for getting pension (11.8%) and treatment for psychiatric disorders (11%). Of the 47 (37%) participants who had criminal charges against them were referred for getting court report (20.5%), psychiatric treatment (11%), fitness to plead (3.1%) for both court report and treatment (2.4%). In the study population, schizophrenia was the most common diagnosis (34.6%), followed by bipolar affective disorders (18.1%) and mental retardation (15%). About 5.5% of the referred participants had no psychiatric disorders.

Conclusions: Nine out of ten patients referred to Forensic Psychiatry Department received a psychiatric diagnosis.

Declaration of interest: None

Keywords: Psychiatric disorder, forensic psychiatry department, Bangladesh

Introduction

Forensic psychiatry deals with both criminal and civil laws. Forensic patients can be defined as patients subjected to a criminal law trial procedure or cases for whom a court decision has been taken at the time of treatment. The patients can appear in a psychiatric hospital during pre-trial or post-trial phases for examination to establish a court report, for treatment purpose, as substitution for remand prison or when referred for psychiatric treatment.[1] Around three-quarters of forensic patients are charged with or sentenced for violence against the person, burglary, criminal damage, robbery and sexual offences.[2] Although the link between criminality and mental disorders is complex, mentally disordered individuals are over-represented in prison. Mullick et al., examined a

consecutive series of 67 male prisoners and found 91% offenders had psychiatric disorders.[3] A review of 62 surveys from 12 countries on 23,000 prisoners found around 4% had psychotic illness, 10% major depression and 65% a personality disorder.[4]

Forensic psychiatrists are also asked to submit written reports on a patient's mental state in relation to civil law. Testamentary capacity, power of attorney and receivership, some aspects of family laws, torts and contracts regulation, fitness to drive are some of the reasons for which mental state examination might be required. One of the most difficult clinical-ethical decisions encountered by forensic psychiatrists is how to balance the duty of care to their patients with the need to serve the society. To strike this balance and ensure good-quality service, information on current pattern of psychiatric disorders in forensic patients is necessary. Keeping this in mind, this study was carried out to find out the distribution of different psychiatric disorders in forensic patients.

Methods

A cross-sectional study was conducted at the indoor and outdoor units of Department of Forensic Psychiatry in National Institute of Mental Health, Dhaka in between July 2017 and December 2018. Beforehand, ethical clearance was taken from the respected authority and informed written consent or guardian's permission was taken for each participant. Patients referred to Forensic Psychiatry Department, aged 18 and more were enrolled by convenient sampling. Non-communicable patients due to severe illness were excluded from the study. A semi-structured questionnaire was used to collect sociodemographic data along with criminal records and current offence. Psychiatric disorders were diagnosed according to International Classification of Diseases (ICD) 10th edition. Statistical analysis of the results was done by using computer based statistical software, SPSS-IBM version 22.

Results

A total of 127 patients referred to the Forensic Psychiatry Department were enrolled for this study. Among them 47 (37%) were charged with criminal offenses and 80 (63%) were referred for other reasons like getting fitness certificate, obtaining power of attorney, pension related issues, etc. Mean age was 33.2±11.6 years with a range between 18 and 80 years. The sample was predominantly male (89%). Table 1 presents the sociodemographic characteristics of patients.

Table 1: Distribution of forensic patients according to sociodemographic variables (N=127)

Variable	Frequency (n)	Percentage (%)
Age (years)		
18-24	30	23.6
25-34	40	31.5
35-44	41	32.3
45-54	10	7.9
>55	6	4.8
Gender		
Female	14	11
Male	113	89
Education		
Below SSC	67	52.8
SSC	42	33.1
HSC	10	7.9
Graduation	4	3.1
Post-graduation	4	3.1
Religion		
Islam	118	92.9
Hindu	9	7.1
Marital status		
Married	67	52.8
Unmarried	60	47.2
Occupation		
Unemployed	48	37.8
Business	12	9.4
Agriculture	10	7.9
Student	6	4.7
Service	46	36.2
House wife	4	3.1
Others	1	0.8
Types of family		
Nuclear	78	61.4
Joint	49	38.6

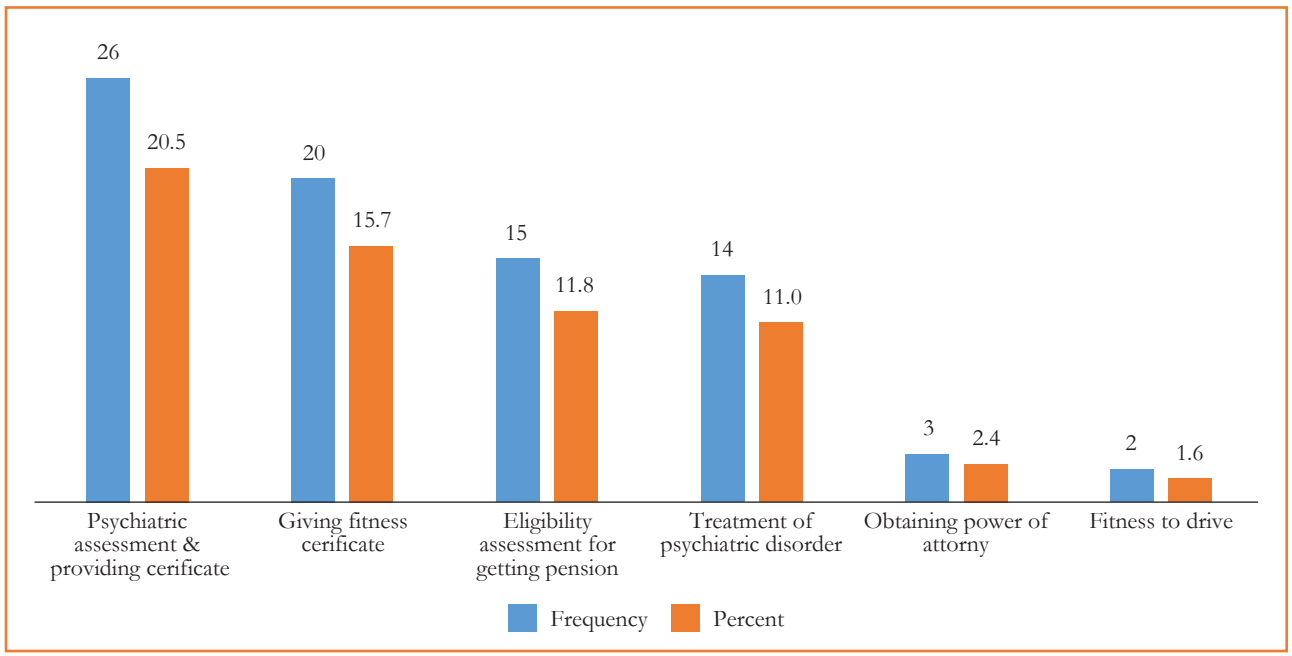

Figure 1: Frequency distribution of the respondents without criminal charge according to reasons for referrals (n=80)

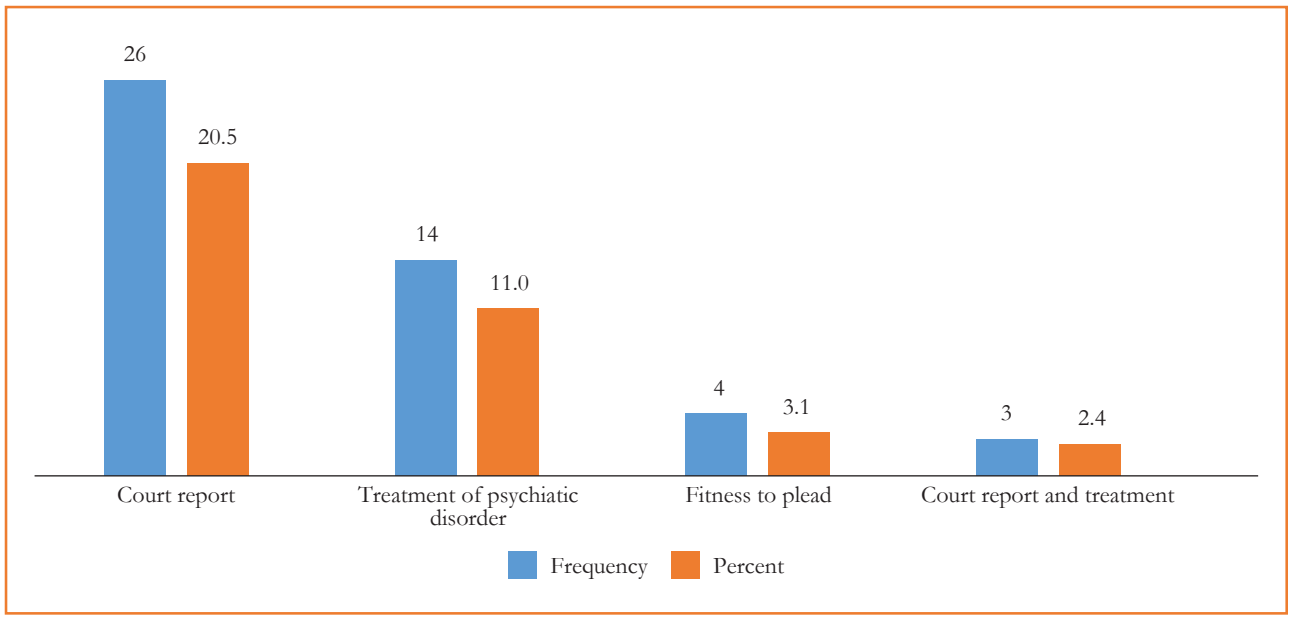

Figure 2: Frequency distribution of the respondents with criminal charge according to reasons for referrals (n=47)

Among the study respondents without criminal charges, common reasons for referrals were psychiatric assessment followed by getting certificate (20.5%), getting fitness certificate (15.7%), eligibility for getting pension (11.8%) and treatment for psychiatric disorders (11%) (Figure 1).

Among the study respondents with criminal charges, about 20.5% respondents were referred for court report, 11% for psychiatric treatment, 3.1% for fitness to plead and 2.4% for court report and treatment (Figure 2).

Table 2: Distribution of patients according to major category of ICD-10 4 digit-code (n=797)

ICD Code	Psychiatric Diagnosis	Frequency (n)	Percentage (%)
F20	Schizophrenia	44	34.6
F31	Bipolar affective disorder	23	18.1
F72	Mental retardation	19	15
F29	Unspecified nonorganic psychosis	11	8.7
F32	Depressive episode	7	5.5
F19	Mental and behavioral disorder due to multiple drug use	4	3.1
F00	Dementia in Alzeimer's type	2	1.6
F23	Acute and transient psychotic disorders	2	1.6
F06	Other mental disorder due to brain damage	1	0.8
F09	Unspecified organic mental disorder	1	0.8
F22	Delusional disorder	1	0.8
F25	Schizoaffective disorder	1	0.8
F03	Unspecified dementia due to brain injury	1	0.8
F42	Obsessive compulsive disorder	1	0.8
F60	Emotionally unstable personality disorder	1	0.8
F91	Conduct disorder	1	0.8
	Total	**120**	**100**

Schizophrenia was the most common diagnosis (34.6%), followed by bipolar affective disorders (18.1%) and mental retardation (15%). About 5.5% of the referred participants had no psychiatric disorders. Table 2 shows the distribution of participants according to their diagnoses.

Discussion

We observed that in our sample, majority were in early adulthood to early middle age, males, educational level below SSC and married-unmarried ratio was near one to one. Previously, Mullick et al. (1998) studied 67 male prisoners at BSMMU, Dhaka, age ranging from 22 to 55 years with the mean age of 34.2 years, majority of the respondents were in the group of 30-39 years, 94% were males and 61% were married.[3] A study on 250 female prisoners conducted in Bangladesh revealed the point prevalence of mental disorder was about 66%.[5] In that study, majority (47%) of the female prisoners were in the range of 20-29 years, about 45% were divorced, 47% were illiterate Another study conducted on 48 forensic psychiatry patients at the same institute revealed the age ranged from 15 to 65 years with the mean age 33.9 years; 42 respondents were males and rest were females.[6] Crime is predominantly an male activity and antisocial traits can be seen in youths long before they commit crime; hence our study sample is predominantly male with younger adults.[7] The reasons behind male and young age predominance are described as complex interaction between biological factors with family, psychological and social factors.[7] Also we assumed, as economic activities is mainly concentrated among males in low-and-middle income countries – they are more likely to referred for fitness certificates for variety of reasons.

Among the participants, we observed schizophrenia, bipolar affective disorders, mental retardations, unspecified psychosis and major depressive disorder were the prevalent conditions. Mullick et al. (1998) observed in 67 male prisoners, schizophrenia (45%), bipolar disorder (18%), depressive disorder (9%), substance related disorder (11%), anxiety disorder (5%), adjustment disorder (5%) were the most frequent diagnoses. In 2005, a similar type study was conducted in same institute where schizophrenia (37%), substance related disorder (15%), bipolar disorders (8%), major depression (2%), obsessive

compulsive disorder (2%), brief psychotic disorder (2%), psychosis NOS (8%), dementia (2%), intellectual disability (4%), acute stress disorder (2%) were the frequent diagnoses.[6] A review article reported presence of high levels of psychiatric disorders in forensic patients with criminal charges against them where high prevalence of personality disorders (50-90%), mood disorders (20-60%) and psychotic disorders (15-20%) coupled with substance abuse disorders are observed.[10]

Schizophrenia patients are 4 to 6 times more likely to be involved in violent crime; however, Fazel et al. (2009) reported the likelihood increased only when there is comorbid substance abuse involved.[8] Similarly, patients with bipolar affective disorders are significantly more likely than community members to be charged with, convicted of, and be found guilty of, violent, non-violent and intermediate level criminal offences.[9] In Bangladesh as individuals with mental retardations receive disability allowance and certain other benefits, a good number of participants were referred for getting disability certificates. Limitations of the study include cross-sectional study design, which limits the strength of causal relationship. Also, sample was enrolled from a single center, so generalizability might be an issue.

Conclusions

Findings revealed nine out of ten patients referred in Forensic Psychiatry Department received a psychiatric diagnosis. Forensic Psychiatry is still in its infancy in Bangladesh – our findings emphasized the need for legal, organizational and clinical reorganization of forensic psychiatry services in Bangladesh.

Mahfuza Yasmin, Registrar, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh; **Abdullah Al Mamun,** Registrar, Psychiatry, NIMH, Dhaka, Bangladesh; **Afroza Rahman Lopa,** Registrar, Psychiatry, NIMH, Dhaka, Bangladesh; **A. K. M. Khaleequzzaman,** Registrar, Psychiatry, NIMH, Dhaka, Bangladesh; **Sharmin Sultana,** Registrar, Psychiatry, NIMH, Dhaka, Bangladesh; **S. M. Sazzadul Karim,** Assistant Registrar, Psychiatry, NIMH, Dhaka, Bangladesh.

Correspondence: Mahfuza Yasmin, Registrar, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh.
Email: molymmc40@gmail.com

How to cite this article: Yasmin M, Mamun AA, Lopa AR, Khaleequzzaman AKM, Sultana S, Karim SSM. Patterns of psychiatric disorders in persons attending the Forensic Psychiatry Department of a tertiary care psychiatric hospital. Arch NIMH. 2022; 5(2): 24-28.

Received 5 May 2022, revised 11 Dec 2022, accepted 24 Dec 2022.

References

1. Sestoft DM, Gottlieb P. Retslige patienters status i sundhedsvaesenet [Status of forensic patients in the health system]. Ugeskr Laeger. 1994; 156(29): 4224-4228.
2. Rutherford M, Duggan S. Forensic mental health services: facts and figures on current provision. Sainsbury Centre for Mental Health; London: 2007.
3. Mullik MSI, Khanam M, Nahar JS. Psychiatric profile of the prisoner referred for psychiatric assessment. Bang J Psychiatry. 1998; 12(2): 69-75.
4. Fazel S, Danesh J. Serious mental disorder in 23000 prisoners: a systematic review of 62 surveys. Lancet. 2002; 359(9306): 545-550.
5. Hasan MK, Jahan NA, Khanam M, Begum AA. Study on prison population: Psychiatric morbidity among female prisoners. Bangladesh Journal of Psychiatry. 2004;18(2): 41-54.
6. Hamid MA, Hossain MD, Ahmed HU, Rahman MM, Karim ME. Types of psychiatric disorder among patients attended in forensic psychiatry department of National Institute of Mental Health, Dhaka. Bangladesh Journal of Psychiatry. 2005; 19(2): 51-57.
7. Mundia L, Matzin R, Mahalle S, Hamid MH, Osman RS. Contributions of sociodemographic factors to criminal behavior. Psychol Res Behav Manag. 2016; 9: 147-156.
8. Fazel S, Långström N, Hjern A, Grann M, Lichtenstein P. Schizophrenia, substance abuse, and violent crime. JAMA. 2009; 301(19): 2016-2023.
9. Daff E, Thomas SD. Bipolar disorder and criminal offending: a data linkage study. Soc Psychiatry Psychiatr Epidemiol. 2014; 49(12): 1985-1991.
10. Palijan TZ, Muzinić L, Radeljak S. Psychiatric comorbidity in forensic psychiatry. Psychiatr Danub. 2009; 21(3): 429-436.

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Original Article

Parental attitudes, knowledge and beliefs regarding the use and adverse effects of psychotropic medications on child and adolescent patients with psychiatric disorders

Saifun Nahar

Background: The use of psychotropic medicines is stigmatized, which makes it difficult for the clinicians to treat children and adolescents in a suitable and efficient manner.

Objectives: To find out parents' attitudes, knowledge and beliefs about the use and adverse effects of psychotropic medication on child and adolescents with psychiatric disorders.

Methods: A cross-sectional descriptive study was conducted from January 2018 to December 2019, in a private chamber of a psychiatrist, Bangladesh among 80 parents of children and adolescents with psychiatric disorders whose minimum level of education was up to secondary level were selected purposively. A structured, self-administered questionnaire in English for socio-demographic variables and items related to parents attitudes, knowledge and beliefs about the use and adverse effects of psychotropic medications was applied. Data were collected by face-to-face interview.

Results: 80 parents with children and adolescents with psychiatric disorders participated in the study. Mean (+SD) age of the parents were 34.4(+ 8.44) years. Among the respondents 25% preferred use of medicines, 62.5% preferred medicine use as last alternative, 31.25% knows that psychiatrists unnecessarily use high doses of medicines, 60% believed that psychotropics might have brain damaging effects, 62.50% believed that psychotropics might cause dependence, 7.50% believed that psychotropics might cause damage to physical health, 15% believed that psychotropics might affect learning abilities and 41.20% knows that psychotropic drugs are dangerous.

Conclusions: Parents must be educated about the potential risks and benefits of psychotropic medications on children and adolescents in order to reduce the stigma associated with this.

Declaration of interest: None

Keywords: Parental attitude, knowledge, belief, psychotropic medications, children and adolescents.

Introduction

The use of psychotropic medicines is stigmatized, which makes it difficult for clinicians to treat children and adolescents in a suitable and efficient manner.[1-3] In addition, the paucity of systematic, controlled research evaluating the effectiveness and safety of psychiatric medications for children adds to parents' hesitation and resistance to prescribing such drugs.[4] Several studies point out that parents are dissatisfied with pharmacotherapy since they were not given complete information regarding the risks and benefits of psychotropic medications.[5-7] The

general public's current negative attitudes are also felt by child psychiatrists, and their reluctance affects the parents' acceptance of drug therapies.[4] Current literature review revealed there is unexpected scarceness of discussion on attitudes,[8] knowledge and beliefs regarding the use and adverse effects of psychotropic medication for children's mental health disorders.[9] Moreover in Bangladesh no research evidences are available in this area, so far. The findings of this study might provide baseline information for future studies in a broad spectrum. Therefore, the objectives of this research were to investigate the attitudes of the parents towards the use of psychotropic medications on children and adolescents with psychiatric disorders as well as to assess the beliefs and knowledge of the parents towards the adverse effects of psychotropic medications on children and adolescents with psychiatric disorders.

Methods

Using a structured interviewing method, a cross-sectional descriptive study was conducted at a private chamber of a psychiatrist at Labaid Cardiac Hospital, which is a tertiary level corporate hospital located at the heart of Dhaka city of Bangladesh, among adult male or female parents who came for outpatient treatment of their children and adolescents with psychiatric disorders were included in this study. Eighty parents of child and adolescent patients with psychiatric disorders, with different clinical diagnosis according to ICD-10, whose minimum level of education was up to secondary level, were selected purposively over a period from January 2018 to December 2019 for this purpose. Data were collected by face-to-face interview applying a two-part questionnaire. Part One Questionnaire, was the structured, self-administered data sheet which contains the socio-demographic profile of the responding parents and age and clinical profile of their children and adolescents that was developed by the researcher that included a range of variables such as: gender, age, marital status, level of education, occupation, place of residence, and monthly income of the parents and age of the children and adolescents with psychiatric disorders. Part Two Questionnaire, consisted of a 10-item questionnaire in English, concept of which was obtained and modified from the research study "parental attitudes and opinions on the use of psychotropic medication in mental disorders of childhood"[10] and the questionnaire was pretested on 10 parents whose minimum level of education was up to the secondary level. Almost all ten parents could easily understand the questionnaire, and they were excluded from the main study. On that questionnaire, 5 items were on attitudes about use of psychotropics and 5 items were on knowledge and beliefs regarding adverse effects of psychotropic medication on children and adolescents. Statistical analysis was done by utilising Statistical Package for Social Sciences (SPSS), version-16. For ethical purpose informed written consent was taken from the parents. Participants were assured about the confidentiality of the collected data and that it will be used only by the researcher for the purpose of the current study.

Results

A total of 80 respondents responded with a response rate of 100%. In this study, age range of the respondents was from 24 to 50 years with the mean age (±sd) of 34.4±8.4 years. Fifty-five parents of the respondents were female parents and rest of them were male parents. Among the respondents 98% were married and 2% were divorced. Regarding habitat 65% of them were from urban areas and 35% from rural areas. Among the responding parents 45% were graduates, 40% studied up to secondary level and 15% were post-graduates. Regarding occupation 72.5% were employed and rest of them were house-keepers. 62.5% had monthly income of >50,000 BDT and 25% had that of >20,000 BDT and rest of them had that of <10,000 BDT (Table 1).

Table 2 is showing the different clinical diagnosis among the child and adolescents with psychiatric disorders according to ICD-10. Among the children and adolescent patients with psychiatric disorders 25 (31.25%) were in the age group of <5-12 years and 55 (68.75%) patients were in the age group of 13-18 years. Table 3 is reflecting the results regarding the attitude about the use of psychotropics on children and adolescents among the respondents; 25% preferred use of medicines, 62.5% preferred medicine use as last alternative, 31.2% believed that psychiatrists unnecessarily use high doses of medicines, 68.7% preferred only psychotherapy as first step, 75% preferred vitamins and herbals.

In the current study, Figure 1 is reflecting the knowledge and beliefs of the responding parents about the adverse effects of psychotropics on children and adolescents. Sixty percent of the respondents have knowledge and beliefs that psychotropics might have brain damaging effects, 62.5% of the respondents were afraid of potential dependency, 15% believed that psychotropics might affect learning abilities, 7.5% of those believed that they might cause damage to the physical health and 41.2% parents believed that psychotropic drugs are dangerous.

Table 1: Sociodemographic profile of the respondents (N= 80)

Characteristic	Frequency (n)	Percentage (%)
Gender		
Female	44	55
Male	36	45
Marital status		
Married	78	98
Divorced	2	2
Habitat		
Rural	28	35
Urban	52	65
Education		
Secondary	32	40
Graduate	36	45
Post-graduate	12	15
Occupation		
Employed	58	72.5
House-keepers	22	27.5
Monthly Income (BDT)		
<10,000	10	12.5
>20,000	20	25
>50,000	50	62.5

Table 2: Diagnosis of child/adolescent patients according to ICD-10(N=80)

ICD-10 code	Diagnosis	Age of child/adolescent (yrs.) <5-12 n (%)	13-18 n (%)
F32	Depressive episode	5 (6.25)	17 (21.25)
F41	Anxiety disorders	2 (2.5)	1 (1.25)
F60	Specific personality disorders	-	18 (22.5)
F70	Mild mental retardation	-	1 (1.25)
F71	Moderate mental retardation	4 (5)	2 (2.5)
F72	Severe mental retardation	1 (1.25)	4 (5)
F84	Pervasive developmental disorders	10 (12.5)	8 (10)
F91	Conduct disorders	3 (3.75)	4 (5)
	Total	25 (31.25)	55 (68.75)

Table 3: Regarding attitude about the use of psychotropics on children and adolescents among the respondents (N=80)

Attitudes regarding use of psychotropics	Yes Frequency (%)	No Frequency (%)
Preferred use of medicines	20(25%)	60(75%)
Preferred medicine use as last alternative	50(62.5%)	30(37.5%)
Psychiatrists unnecessarily use high doses of medication	25(31.25%)	55(68.75%)
Preferred only psychotherapy as first step	55(68.75%)	25(31.25%)
Preferred vitamins and herbals	60(75%)	20(25%)

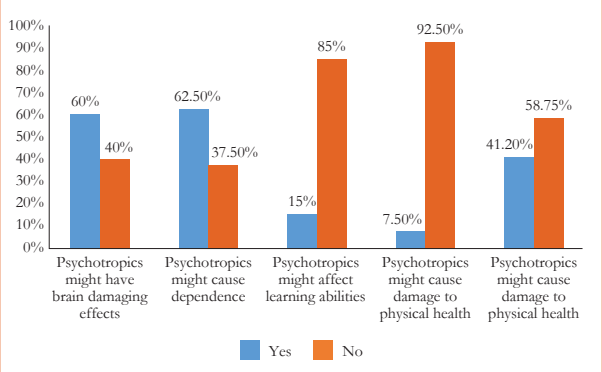

Figure 1: Regarding parents' beliefs and knowledge about the adverse effects of psychotropics on children and adolescents among the respondents (N=80)

Discussion

In this study, among the respondents, female parents (55%) were more than male parents (45%). In was consistent with another study finding.[10] This might be because mothers frequently worry more about the health of their children. In our country, individuals from rural areas typically prefer local doctors for their convenience, or sometimes they don't know where to go for professional services for their children's mental illness. This may be why majority (65%) of them were from urban areas and only 35% were from rural areas.

Where the educational level was higher, parents were expected to be closer to the scientific point of view

regarding the use and adverse effects of psychotropic medication. Though in this study, 45% were graduates, 40% studied up to secondary level and 15% were post-graduate; it seemed that they are not well informed regarding that. Treatment-seeking behaviour is closely linked to a person's socioeconomic status. In this study, majority (72.5%) of the parents were employed and rest of them were house-keepers. Among the respondents, 62.5% had monthly income of >50,000 BDT and 25% had that of >20,000 BDT and rest of them had that of <10,000 BDT (Table 1), which goes in favour of their treatment seeking from a tertiary level corporate hospital located in the heart of Dhaka city.

Findings of this study shows that majority (68.75%) of the child and adolescent patients were in the age group of 13-18 yrs. and rest of them were in the age group <5-12 yrs. Among <5-12 yrs. age group pervasive developmental disorders were most prevalent (12.5%) followed by depressive disorders (6.25%), moderate mental retardation (5%), conduct disorders (3.75%). Among the age group of 13-18 yrs. specific personality disorders were most prevalent (22.5%) followed by depressive disorders (21.25%), PDD (10%) and so on (Table 2). Correlation between parents' attitude, knowledge and beliefs regarding use and adverse effects of psychotropic medication on children and adolescents with children's psychiatric disorders were not evaluated in this study.

In this study, Table 3 shows the attitude of the use of psychotropics on children among the respondents that a significant proportion of parents have a negative attitudes regarding use of psychotropic medication for treating their children's mental health disorders; only 25% preferred medicine use as necessary, 31.2% had attitudes that psychiatrists unnecessarily use high doses of medication, 62.5% preferred medicine use as last alternative, 75% of the respondents preferred vitamins and herbals. These findings were consistent with another study findings.10 Moreover, in this study, most (68.75%) of the parents preferred to start with psychotherapy sessions rather than to give psychotropic medication as a first step (Table 3). Other studies confirm these findings.[11,12]

Results of this study plotted in Fig 1 reflects the beliefs and knowledge about the adverse effects of psychotropics on children and adolescents among the respondents. Sixty percent (60%) of the parents believed that psychotropics might have brain damaging effects, 15% believed that psychotropics might affect learning abilities which was consistent with another study findings.[13] In this study, 41.2% parents believe that psychotropic drugs are dangerous. Similarly, the research carried out by Lazaratou et. al. revealed that majority of parents believed that psychotropic drugs are dangerous.[10] In this study, 62.5% of the respondents were afraid of potential dependency and 7.5% of those believed that they might cause damage to the physical health, this is consistent with the belief that psychiatric medicine promotes dependence and physical harm is among the opinions expressed.[14]

A potential limitation is about generalization, as the study sample was conveniently taken from one selected institution with a relatively small sample size, and parents whose minimum level of education was up to the secondary level were selected only for the study. A 10-item modified questionnaire for the assessment of parental attitudes, knowledge, and beliefs on the use of psychotropic medication and its adverse effects was used. It was in English.

Conclusions

According to study findings, parental attitudes, knowledge, and views on the use of psychotropic medications for treating mental health illnesses in children are not compatible with the state of science. Parents and youth must be educated about the possible risks-benefits as well as the safety and efficacy of the psychotropic medications in order to lessen stigmatizing attitudes and to improve treatment compliance of this group of patients. Lack of parental knowledge about the use of psychotropic medications in children can have a profound negative impact on children's development, educational achievements, and ability to live productive lives.[15] Child psychiatrists must inform parents in a scientifically sound manner about the benefits and risks of psychotropic medications, and they must also take into account the family's opinions and beliefs. They must also make sure that both parents are present when discussing medication in order to avoid disagreements and to increase compliance.

Saifun Nahar, Assistant Professor, Psychiatry, National Institute of Mental Health (NIMH), Dhaka, Bangladesh

Correspondence: : Saifun Nahar, Assistant Professor, Psychiatry, National Institute of Mental Health (NIMH), Sher-E-Bangla Nagar, Dhaka-1207, Bangladesh.
Email: saifunsumi@gmail.com

How to cite this article: Nahar S. Parental attitudes, knowledge and beliefs regarding the use and adverse effects of psychotropic medications on child and adolescent patients with psychiatric disorders. Arch NIMH. 2022; 5(2): 29-33.

Received 5 Oct 2022, revised 22 Nov 2022, accepted 2 Dec 2022.

References

1. Shidhaye R, Lund C, Chisholm D. Closing the treatment gap for Mental, Neurological and Substance use disorders by strengthening existing health care platforms: strategies for delivery and integration of evidence-based interventions. Int J Ment Health Syst 2015; 9: 40.

2. LinkBG, Cullen FT, Struening E, et al. A modified labeling theory approach to mental disorders: an empirical assessment. Am. Sociol. Rev. 1989; 54(3): 400–423.

3. Pescosolido BA, Monahan J, Link BG, et al. The public's view of the competence, dangerousness, and need for legal coercion of persons with mental health problems. Am J Public Health. 1999; 89(9): 1339-1345.

4. Tsiantis J. The challenges of child psychiatry in the rising of new curriculum [in Greek]. Paediatriki 2000, 63: 186-190.

5. Makoul G, Arntson P, Schofield T. Health promotion in primary care: physician-patient communication and decision making about prescription medications. SocSci Med 1995, 41: 1241-1254.

6. Ziegler DK, Mosier MC, Buenaver M, et al. How much information about adverse effects of medication do patients want from physicians? Arch Intern Med 2001, 161: 2387-2392.

7. Counsell AM, Geddis DC, Smith AR. Parental perceptions of information about medication prescribed for their children. N Z Med J. 1993; 106(956): 205-206.

8. Zito JM, Safer DJ, DosReis S, et al. Psychotropic practice patterns for youth: a 10-year perspective. Arch PediatrAdolesc Med. 2003; 157(1): 17-25.

9. Bastiens L. Compliance with pharmacotherapy in adolescents: effects of patients' and parents' knowledge and attitudes towards treatment. J Child Adolesc Psychopharmacol. 1995; 5: 39–48.

10. Lazaratou H, Anagnostopoulos DC, Alevizos EV, et al. Parental attitudes and opinions on the use of psychotropic medication in mental disorders of childhood. Ann Gen Psychiatry. 2007; 6: 32.

11. Rappaport N, Chubinsky P. The meaning of psychotropic medications for children, adolescents, and their families. J Am Acad Child Adolesc Psychiatry. 2000; 39(9): 1198-1200.

12. Psychiatric Medications for Children and Adolescents Part III: Questions to Ask. American Academy of Child and Adolescent Psychiatry. Website https://www.dhhs.nh.gov. Published 2004.

13. Dawood E, Mitsu R, Fozan Al H, et al. Parental opinions and beliefs toward use of psychotropic drugs for treatment of mental health problems in children. Saudi J Nurs Health Care, Dec, 2020; 3(12): 372-381.

14. Hatzimanolis I, Alevizos V. Attitudes and opinion of non-psychiatric physicians and a general population sample about psychotropic drugs [in Greek]. Psychiatry 1999, 10: 135-141.

15. Child and adolescent mental health. World Health Organization. http://www.who.int/mental_health/maternal-child/child_adolescent/en/retrived.Published 2017. Accessed October 10, 2017.

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Original Article

Prevalence of sexual dysfunctions in male patients of a tertiary hospital

Anupam Das, Choity Malakar

Background: Sexual dysfunctions is commonly experienced as having a devastating effect on familial, vocational, psychological, or social lives of sufferers. Irrespective of high prevalence of sexual dysfunction; only little number of patients seeks psychiatric consultation. Some patients are ambivalent over getting professional help because of attached social stigma that leads to delayed or negating consultation. However, there is a paucity of studies investigating the prevalence of PSD, particularly in Indian context.

Objectives: To determine the prevalence and pattern of sexual dysfunctions.

Methods: This was a cross-sectional analytical study carried in the Outpatient Department of Psychiatry, Khwaja Yunus Ali Medical College, Sirajgonj from October 2019 to September 2020. Data were collected from face-to-face interview; a semi structured questionnaire was used. After collection, all data were checked thoroughly for consistency and completeness. Data were cleaned, edited and verified daily to exclude any error or inconsistency before coding and entering them into a database. Statistical analysis was performed using compatible computer software.

Results: This study observed erectile dysfunction (31%), premature ejaculation (25%), dhat syndrome (18%), and erectile dysfunction with premature ejaculation (17%) as the common sexual dysfunctions.

Conclusions: This study shows the common sexual dysfunctions were erectile dysfunction (ED), premature ejaculation (PME), dhat syndrome (DS) and ED with PME.

Declaration of interest: None

Keywords: Sexual dysfunction, male patients, tertiary hospital, Bangladesh.

Introduction

Sexual dysfunctions are a term which may simply refer to a sexual problem that is psychological, rather than physiological in origin. "Psychosexual disorders" was a term used in Freudian psychology. Sigmund Freud has contributed to the idea of psychosexual disorders and furthered research of the topic through his ideas of psychosexual development and his psychoanalytic sex drive theory. Too much stimulation at a certain stage of development could lead to regression when that individual is in distress, also possibly leading to sexual dysfunctions. Behaviorists view sexual dysfunctions as the outcome of conditioned response and learned interpersonal behavior.[1,2]

Sexual dysfunctions can result from a wide variety of psychological and physical causes.[3-5] Presence of psychiatric condition with SD can further complicate the situation as both conditions may likely to coexist in a related or unrelated fashion.[6] Moreover, experiencing sexual problems could lead to psychiatric symptoms, and

psychiatric symptoms can function as an antecedent to sexual problems.[7] As a general agreement sexual dysfunctions is multifactorial[8] as normal sexual function relies on the coordination of psychological, hormonal, neurological, vascular, and cavernosal factors. Therefore, an alteration in any one or combination of these factors may contribute to sexual problem.[9,10]

Even with increasing literacy, sex is still a taboo in Bangladesh and sexual knowledge is poor among most of the individuals. The exact data regarding prevalence and comorbidity of psychosexual disorders with other conditions is inconsistent and is not well known in Bangladesh. The purpose of the present study was to evaluate the pattern of sexual dysfunction.

Methods

This was a cross-sectional analytical study. The study was conducted from October 2019 to September 2020. Total 100 male patients were included by purposive consecutive sampling technique. Detailed family history of any substance uses and psychiatric illness was produced. History regarding substance abuse was extracted along with detailed evaluation of any recent or ongoing stressor, past and presenting psychiatric illness and co-morbid physical ailments. History of any indigenous medicines taken by these patients for the treatment of their psychosexual problem was assessed along with the prior types of consultations for the psychosexual problems. The diagnosis as assessed by the treating psychiatrist using standard definitions and criteria in accordance to international classification of diseases version 10 (ICD-10) were evaluated. Data were collected from face-to-face interview; a semi structured questionnaire was used. After collection, all data were checked thoroughly for consistency and completeness. Data were cleaned, edited and verified daily to exclude any error or inconsistency before coding and entering them into a database. Statistical analysis was performed using compatible computer software. The analyzed data are presented in tables. All data are expressed as the frequency, percentage.

Results

This study shows the mean age of 31.4±8.9 years (range: 18-70). About 51% and 47% of subjects belonged to middle and lower socio-economic status respectively. Only 14% of subjects were staying alone. Psychiatric illness apart from the sexual problems was observed in 23%. Most of the subjects were suffering from depression (15%), followed by anxiety disorder (4%) and psychosis (2%). Of the various sexual dysfunctions observed in our study, erectile dysfunction (ED) was most commonly reported (31%), followed by premature ejaculation (PME) in 25% subjects and dhat syndrome (DS) in 18% subjects. Among the subjects having more than one psychosexual disorder, ED with PME was most commonly reported (17%).

Table 1: Socio-demographic characteristics of participants (N=100)

Characteristic	Frequency (n)	Percentage (%)
Age (years)		
18-25	22	22
26-40	47	47
41-55	24	24
>56	7	7
Marital status		
Married	67	67
Divorced	33	33
Education		
Illiterate	12	12
Primary	7	7
Secondary	14	14
SSC	42	42
HSC	22	22
Graduate	3	3
Resident		
Urban	91	91
Rural	9	9
Family type		
Nuclear	53	53
Joint	33	33
Alone	14	14
Socio-economic status		
Lower	47	47
Middle	51	51
Upper	7	8

Table 2: Clinical features of study participants (N=100)

Parameter	Frequency (n)	Percentage (%)
History of stress		
Absent	34	34
Present	66	60
Any other psychiatric disorder		
Psychosis	2	2
Depression	15	15
BPAD	1	1
Anxiety disorder	4	4
Epilepsy	1	1
None	77	77
Presence of physical illness		
Yes	3	3
No	97	97
Prior consultation with physician		
Yes	47	47
No	53	53

Table 3: Prevalence of different sexual dysfunctions among participants (N=100)

Psychosocial disorders	Frequency (n)	Percentage (%)
Premature ejaculation (PME)	25	25
Erectile dysfunction (ED)	31	31
Dhat syndrome (DS)	18	18
ED+PME	17	17
ED+DS	5	5
PME+DS	4	4

Table 2: Clinical features of study participants (N=100)

Substance	Frequency (n)	Percentage (%)
Alcohol	2	2
Cannabis	4	4
Others	8	8
No use	86	86

Discussion

This study shows the mean age of patients were 31.4±8.8 years. Highest number (47%) of patients were in the age group of 26-40 years with married patients (67%) being more predisposed to develop various forms of sexual dysfunction. This states that married patients are suffered more from sexual dysfunctions and middle adulthood is the common age group. This information supported by other study also. In the study by Mittal et al.[11] showed mean age of sexual dysfunctions patients around 32 years (i.e., middle age group) with majority (80%) of the affected patients were married stating that sexual dysfunctions are mostly diagnosed during married life or phase of being sexually active.

This study observed that ED was the most commonly reported sexual disorder (31%), compared to PME (25%), DS (18%) and ED with PME (17%). Some previous studies present similar pattern of data although with variable frequencies.8-10 Similar study found PME was the commonest sexual dysfunctions (35.2%).[11]

In contrast to this study previous studies had noted dhat syndrome to be the most frequent form of psychosexual disorder in India.[12] In another study performed by Gupta et al.[13] who clinically assessed 150 patients attending dermatology outpatient department for psychosexual problems, the most common PSD was ED (34%) followed by PME (16.6%), dhat syndrome (15.3%), and nocturnal emission (14%).

Majority of patients were from urban area (91.7%). This may be due to the ignorance regarding the treatment facilities of such problems available in general hospital in rural area or due to more stigma/myths/ lack of knowledge regarding the nature of the illness in rural area. In this study, commonest psychiatric illness in patients presenting with sexual dysfunctions was depression (15%),

which is in concordance with study by Verma et al. reporting neurotic depression to be 15%.[1] But while that study found anxiety disorders in similar proportion (16%), whereas this study observed only in 4% cases. Although one study reported prevalence of anxiety and depressive disorders in 30% and 20% individuals with sexual disorders, respectively,[14] another study found anxiety state (17%), schizophrenia (16%), and reactive depression (16%) as common psychiatric conditions.[1]

Among substance users, cannabis was the most common substance (4%) causes sexual dysfunctions individually. 86% respondents could not take any substance. Another study reported cannabis may cause sexual dysfunctions in the long term in high doses.[14] Among substance users, premature ejaculation was the most common sexual dysfunction. It was also found that in individual consuming more than 1 substance, either erectile dysfunction or more than one sexual dysfunction was present. Other studies have also reported slight predominance of premature ejaculation among alcohol users.[11]

Conclusions

This study shows the common sexual dysfunctions were erectile dysfunction (ED), premature ejaculation (PME), dhat syndrome (DS) and ED with PME. It was also observed that maximum patients were 26-40 years age group and lower economic status.

Anupam Das, Professor, Psychiatry, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh; **Choity Malakar,** Student, Transfusion Medicine, Bangabandhu Sheikh Mujib Medical University, Dhaka, Bangladesh.

Correspondence: : Anupam Das, Professor, Psychiatry, Khwaja Yunus Ali Medical College, Sirajganj, Bangladesh.
Email: adanup@yahoo.com

How to cite this article: Das A, Malakar C. Prevalence of sexual dysfunctions in male patients of a tertiary hospital. Arch NIMH. 2022; 5(2): 34-37.

Received 8 Oct 2022, revised 29 Nov 2022, accepted 5 Dec 2022.

References

1. Banerjee S, Das S, Roy AK. Pattern of psychosexual disorders among male patient attending dermatology OPD in a tertiary care center - a descriptive study. Journal of Pakistan Association of Dermatologists. 2017; 27(4): 368-374.

2. Verma R, Mina S, Ul-Hassan S, Balhara YS. A descriptive analysis of patients presenting to psychosexual clinic at a tertiary care center. Indian J Psychol Med 2013; 35: 241-247.

3. Sadovsky R, Nusbaum M. Sexual health inquiry and support is a primary care priority. J Sex Med 2006; 3: 3–11.

4. Kalyani KH. Herbs in the treatment of diabetes induced erectile dysfunction. J Pharm Phytother 2013; 1(2): 2 – 8.

5. Nagaraj AKM, Pai NB, Rao S. A comparative study of sexual dysfunctions involving risperidone, quetiapine, and olanzapine. Indian J Psychiatry 2009; 51: 265-271.

6. Seidman SN, Roose SP, Menza MA, et al. Treatment of erectile dysfunction in men with depressive symptoms: results of a placebo-controlled trial with sildenafil citrate. Am J Psychiatry 2001; 158: 1623–1630.

7. Zamboni BD, Crawford I. Minority Stress and Sexual Problems among African-American Gay and Bisexual Men. Arch Sex Behav 2007; 36: 569–578.

8. Bleustein CB, Arezzo JC, Eckholdt H, et al. The neuropathy of erectile dysfunction. Int J Impotence Res 2002; 14: 433–439.

9. Agarwal A, Nandipati KC, Sharma RK, et al. Role of Oxidative Stress in the Review Pathophysiological Mechanism of Erectile Dysfunction. J Andr 2006; 27: 335- 347.

10. Nehra DK, Kumar P, Sharma VR, et al. Prevalence of Psychosexual Disorders in North India: A Retrospective Study Delhi Psychiatry Journal 2018; 21:(1): 1-8.

11. Mittal AK, Gupta V, Kapoor A, et al. Sexual dysfunctions in rural population as indicators of psychiatric and addiction problems. Int J Sci Study. 2014; 2: 86-90.

12. Bhatia MS, Jhanjee A, Srivastava S. Pattern of psychosexual disorders among males attending psychiatry OPD of a tertiary care Hospital. Delhi Psychiatry J. 2011; 14: 266-269.

13. Gupta SK, Dayal S, Jain VK, et al. Profile of male patients with psychosexual disorders. Indian J Sex Transm Dis. 2004; 25: 33-37.

14. Basu D, Mattoo SK. Epidemiology of substance abuse in India: Methodological issues and future perspectives. Indian J Psychiatry 2014; 41: 145-153.

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Original Article

Trends in using telepsychiatry service at a tertiary level psychiatric hospital in Bangladesh – a retrospective register study

Sadia Afrin Shampa, Helal Uddin Ahmed, Ahsan Aziz Sarkar

Background: Telemedicine has been gaining worldwide popularity lately. Bangladesh is also a part of this venture. Effective service planning depends on knowing the trends of service use.

Objectives: To identify the trends in using telepsychiatry service at a tertiary level psychiatric hospital.

Methods: This was a retrospective study in which data were collected from telepsychiatry service patient records of a tertiary psychiatric hospital. In between 2018 and 2021, 270 patients took the service. All were included and the record contained their name, age, gender, diagnosis and treatment.

Results: Mean age of the patients was 31.6±14.5 years with a range between 4 and 75 years and around 50% of the patients were in the 20-40 years age group. Male patients constituted 46.5% of the sample. Majority of the patients took services for neurotic, stress related and somatoform disorders. Sertraline and benzodiazepine were found to be most commonly used medication.

Conclusions: The study showed that majority taking telepsychiatry care were having neurotic or stress related and somatoform disorders. Pharmacotherapy was the main way of treating patients.

Declaration of interest: None

Keywords: Telepsychiatry, tertiary hospital, Bangladesh.

Introduction

Telemedicine is the remote delivery of healthcare services through telecommunication infrastructure. When psychiatric services are provided in this way it is termed telepsychiatry. Telepsychiatry allows mental health professionals to evaluate, diagnose and treat patients without the need to inpatient visit. The patients can communicate with physicians from their homes by using their own personal technology or by visiting a dedicated telehealth setup. Provision of remote service delivery, easier access to specialists, convenience, cost effectiveness, time effectiveness are the reasons behind its rising popularity.[1,2]

Praava Health, Tonic, Maya, Sebaghar, LifeSpring, Synesis Health, Pulse Healthcare are among the private organizations providing telemedicine services in Bangladesh. Other than these non-government institute in recent times Bangladesh government has put a lot of emphasis in this sector. In continuation of this a process a telepsychiatry center was opened in 2018 in National Institute of Mental Health, a specialized tertiary care psychiatric hospital.

Bangladesh has limitations regarding manpower, infrastructure, integration and budget. Countrywide only

350 psychiatrists are serving nearly 170 million people.[3] These limitations have made most of the population unable to access mental health care services. Despite that the country has a strong telecommunication sector. Mobile phone users and internet users are increasing. There were 52.5 million internet users in Bangladesh in January 2022. This sector can be used in creating awareness and delivering mental health care service by maximizing our limited resource. Keeping this situation in mind, we conducted a study to identify the trends in using telepsychiatry service in a tertiary care psychiatric hospital.

Methods

This was a retrospective study in which data were collected from telepsychiatry service patient records of a tertiary psychiatric hospital. In between 2018 and 2021, 270 patients took the service. All were included and the record contained their name, age, gender, diagnosis and treatment. Following data entry, it was analyzed using SPSS 28 version. Chi-square test was conducted to see differences in service using pattern across demographic variables.

Results

A total of 270 patients received telepsychiatry services in between 2018 and 2021. The mean age of the patients was 31.6±14.5 years. It ranges between 4 to 75 years. Age-wise child and adolescent patients constituted 20.4%, geriatric patients (>60 years) 6.7% and around 50% of the patients were in the 20-40 years age group. Male patients constituted 46.5%.

Majority of the patients took services for neurotic, stress related and somatoform disorders followed by mood disorders and schizophrenia spectrum disorders (Figure 1). Age-wise break down of distribution of mental disorders also shows that in all three groups – child and adolescent, adult and geriatric – most common reasons for seeking services were neurotic, stress related and somatoform disorders and mood disorders (Table 1).

In reference to treatment pattern, we observed 72 (26.5%) patients were prescribed a single drug while 197 (72.4%) were prescribed more than one drug. Risperidone, haloperidol, olanzapine and trifluoperazine were the most commonly prescribed antipsychotics. Among the SSRIs - fluoxetine, escitalopram and sertraline and TCAs – amitriptyline, nortriptyline and clomipramine were the most commonly prescribed drugs. A significant number of patients received benzodiazepines (42.6%) along with one/more psychotropics drugs.

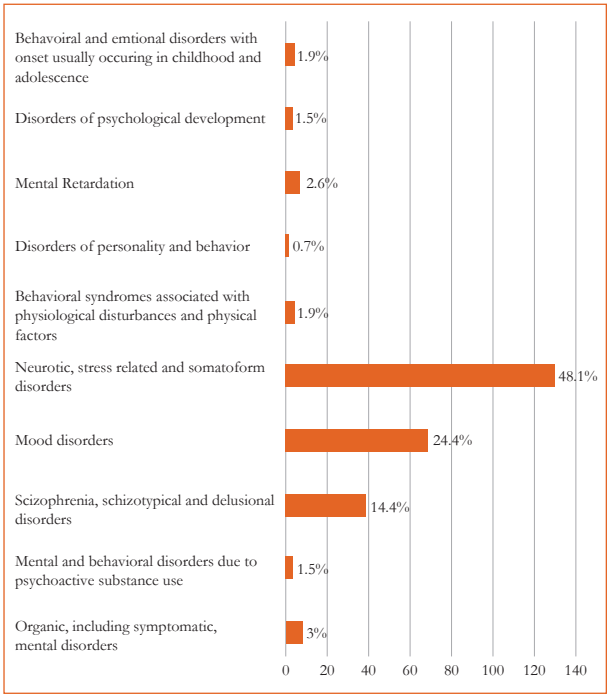

Figure 1: Graphical representation of various mental disorders among the patients

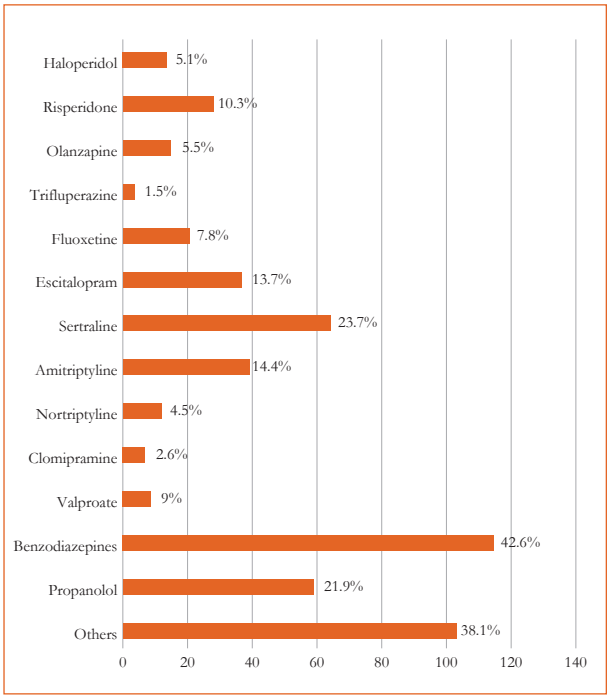

Figure 2: Commonly prescribed drugs in telepsychiatry service

Table 1: Distribution of mental disorders across various age groups taking telepsychiatry service from NIMH (N=270)

Diagnosis	Child and adolescent (n=55)	Adult (n=197)	Geriatric (n=18)
Organic, including symptomatic, mental disorders	2 (3.6)	2 (1.5)	3 (16.7)
Mental and behavioral disorders due to psychoactive substance use	-	4 (2)	-
Schizophrenia, schizotypal and delusional disorders	7 (12.7)	32 (16.2)	-
Mood disorders	9 (16.4)	49 (24.9)	8 (44.4)
Neurotic, stress related and somatoform disorders	24 (43.6)	100 (50.8)	6 (33.3)
Behavioral syndromes associated with physiological disturbances and physical factors	-	5 (2.5)	-
Disorders of adult personality and behavior	-	2 (1)	-
Mental retardation	6 (10.9)	1 (0.5)	-
Disorders of psychological development	2 (3.6)	1 (0.5)	1 (5.6)
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	5 (9.1)	-	-

Cell values are frequency (percentage)

Males were more like to seek consultations for schizophrenia spectrum disorders and females for mood disorders and neurotic, stress related and somatoform disorders; however, the difference was statistically insignificant (X^2=12.6, p=0.1770) (Table 1). In both groups most common reasons for seeking consultations were mood and neurotic, stress related and somatoform disorders.

Discussion

Telepsychiatry was introduced in National Institute of Mental Health, Dhaka in 2018. In this programme, communication between this tertiary psychiatric hospital and upazila health complexes were made through telemedicine programme. Patients are referred from remote areas, where psychiatric services are not available and connect via video teleconference equipment available in the upazila health complex. During consultation over video call a health care person remains present with the patient on the patient's end. Maintaining this model patients are served using telepsychiatry.

We observed that, adults were more like to use telepsychiatry services. People who were born before 1990s are less likely to use telepsychiatry services because of technological naivete.[4] In our study, most of the patients sought services for neurotic, stress related and somatoform disorders or mood disorders. In children most common reason for seeking telepsychiatry service was neurotic, stress related and somatoform disorders whereas in adults the most common reasons were neurotic, stress related and somatoform disorders or mood disorders. Dham et al. (2018) also observed similar trend in developed country like Australia where depression and anxiety were the most common diagnoses.[5] We didn't observe any significant difference in diagnoses between male and female patients. Rahman et al. (2022) while studying telehealth service noted, males are more likely to use such services.[6]

Previously it was reported that telepsychiatry improves patients' adherence to treatment, follow-up rates, clinical symptoms, helps in overcoming stigma and discrimination and save cost expenses accessing health care with better satisfaction and usability outcomes.[7] Telepsychiatry service is gaining popularity in Bangladesh. To make it more effective and available few measures can be taken. The following measures would improve the service delivery system and patient satisfaction.

1. Developing telemedicine policy and law for Bangladesh.

2. Establishment of a licensing requirement for providers.

3. Ensuring patients' privacy and confidentiality.

4. Improving technological infrastructure and efficiency for better service delivery.

5. Evaluating patients' satisfaction and research on telepsychiatry.

6. Campaigning about telepsychiatry facility among mass population

7. Strengthening the existing telepsychiatry service both in government and non-government mental health sector

8. Providing psychological treatment through government facilities.

Technology can solve the issues like lack of health service in community level and integration among health care system in low to middle income countries. Telepsychiatry can address these problems if implemented properly. Findings also emphasized creating skilled mental health professionals for managing neurotic, stress related and somatoform disorders and mood disorders in telepsychiatry setting.

Sadia Afrin Shampa, Medical Officer, National Institute of Mental Health, Dhaka, Bangladesh; **Helal Uddin Ahmed,** Associate Professor, Psychiatry, National Institute of Mental Health, Dhaka, Bangladesh; **Ahsan Aziz Sarkar,** Assistant Registrar, Psychiatry, National Institute of Mental Health, Dhaka, Bangladesh.

Correspondence: : Sadia Afrin Shampa, Medical Officer, National Institute of Mental Health, Dhaka, Bangladesh.
Email: sadiaafrinbm2828@gmail.com

How to cite this article: Shampa SA, Ahmed HU, Sarkar AA. Trends in using telepsychiatry service at a tertiary level psychiatric hospital in Bangladesh – a retrospective register study. Arch NIMH. 2022; 5(2): 38-41.

Received 4 March 2022, revised 13 Oct 2022, accepted 11 Nov 2022.

References

1. Kvedar J, Heinzelmann PJ, Jacques G. Cancer diagnosis and telemedicine: a case study from Cambodia. Ann Oncol. 2006; 17 Suppl 8: viii37-viii42.

2. Mair FS, Haycox A, May C, et al. A review of telemedicine cost-effectiveness studies. J Telemed Telecare. 2000; 6 Suppl 1: S38-S40.

3. Hasan MT, Anwar T, Christopher E, et al. The current state of mental healthcare in Bangladesh: part 1 – an updated country profile. BJPsych International. 2021; 18(4): 78-82.

4. Gardner MR, Jenkins SM, O'Neil DA. et al. Perceptions of video-based appointments from the patient's home: A patient survey. Telemed J E Health; 2015. Apr; 21(4): 281–285.

5. Dham P, Gupta N, Alexander J, et al. Community based telepsychiatry service for older adults residing in a rural and remote region- utilization pattern and satisfaction among stakeholders. BMC Psychiatry. 2018; 18(1): 316.

6. Rahman S, Amit S, Kafy AA. Gender disparity in telehealth usage in Bangladesh during COVID-19. SSM Ment Health. 2022; 2: 100054.

7. Naik SS, Manjunatha N, Kumar CN, Math SB, Moirangthem S. Patient's Perspectives of Telepsychiatry: The Past, Present and Future. Indian J Psychol Med. 2020; 42(5 Suppl): 102S-107S

ARCHIVES of NIMH
The Official Journal of National Institute of Mental Health, Dhaka

Case Report

Rare presentation of conversion disorder: psychogenic blepharospasm

Nusrat Mujtaba Maty, Md. Shahidul Islam, Md. Rashed Khan

Abstract: Blepharospasm is an abnormal uncontrolled contraction of eyelid muscles and can be a presenting motor symptoms of conversion disorder. Here is a case about 40 years old Muslim housewife from rural background presenting with the complaints of difficulty in opening eyes for 6 months and pseudo-seizures for 2 months. Her symptoms could not be explained by any known medical conditions. Both psychological and pharmacological intervention was given for the management of the patient.

Keywords: Blepharospasm; conversion disorder; rare disorders.

Introduction

Conversion disorder, also called functional neurological symptom disorder in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), is an illness of symptoms or deficits that affect voluntarily motor or sensory function, which suggest another medical condition, but that is judged to be caused by psychological factors because the illness is preceded by conflicts or other stressors.[1] Conversion disorder is a historical conceptual sequel of hysteria. In the later years of nineteenth century Charcot, a French neurologist suggested at first the symptoms of hysteria were caused by a functional disorder of brain.[2] Later Pierre Janet conceptualized hysteria as a dissociative disorder.[2] Janet's contemporary Sigmund Freud also considered as a trauma-based disorder. However, Freud later conceptualized that somatoform symptoms of hysteria as a result of a neurotic defense mechanism and referred to them as conversion disorder whereby hidden, unexpressed emotion transformed into physical symptoms.[2]

The prevalence of conversion disorder in the general population is difficult to determine and estimate vary widely. A review of 5 studies indicates an incidence rate of 5-12 per 100000 per annum.[3] Conversion disorder is two to three times more common in female as per DSM-5.[3] One study from Bangladesh reported that motor symptoms present in 19% of patient with conversion disorder.[4] Blepharospasm is one of the motor symptoms of conversion disorder. Blepharospasm is an uncontrolled spasmodic contraction of the orbicularis muscles of the eye resulting in an abnormal tic or twitch of eyes.[5] It usually lasts for seconds to minutes but in severe cases eyes may be closed for hours. It may be essentially benign or secondary due to lesion in basal ganglia, pyramidal tract and trauma, local pathology in the eyes or drug induced. One effective treatment is intramuscular injection of botulinum toxin and this treatment is effective in 90% cases.[6,7]

Case Report

A 40-year-old, homemaker, Muslim married woman, educated up to class 5 hailing from a rural area of Bangladesh was admitted in National Institute of Mental Health with episodic difficulty in opening of eyes most of the day with associated eye irritation and pain and the problems were increasing in intensity for last 6 months. It was not associated with photophobia, blurring of vision, watery discharge or diurnal variation. Sometimes her symptoms relieved spontaneously. There was also history of fit like attack - 5 times in last 2 months which lasted for variable durations and was not association with tongue bite, frothing, urinary incontinence, injury, cyanosis, amnesia, etc. It always occurred in front of family members and never occurred in sleep. She also complained about tension type headache associated with neck pain for several years which is relieved by taking medication. No aggravating factor was reported. Five years back she had a history of fit like attack which occurred 6 days following a

road accident. She consulted with a general physician and treated by flupentixol and melitracen combination. She continued it for 5 years then discontinued this medication for last 6 months after developing unusual muscle twitching at lower eyelid & adjacent part of face in the right side. But her symptoms were deteriorating even after discontinuation. In the meantime, she also consulted with an ophthalmologist and a neurologist. She was treated by several antibiotics, steroid eye drops and low dose of antidepressant for last 1 year but her symptoms were increasing day by day. Lastly, she was diagnosed as a case if essential blepharospasm of right side one month back and Inj. botulinum 25 unit was given. But no improvement occurred.

The patient had three sisters & two brothers. She was 4th among them. Her younger brother died five years back due to physical illness. She has been married for 24 years. Her husband lived in his working place and used to come home every 2 months. Both of them said to be satisfied with their sexual life. her son is studying in honors & daughter is in class 11. She had a history of spontaneous miscarriage one year back. Relationship with her family & neighbors was good. Her father had psychiatric illness and took medicine but couldn't mention details except occasional outgoing tendency but his functional status was normal.

On mental state examination, her eyes were closed and she entered into the room with the assistance of her daughter, was trying to open her eyes by fingers. While interviewing, occasionally, she was opening her eyes by her own, eye to eye contact was established for a while but didn't sustain. Her facial expression was anxious. Her mood was euthymic and affect was mood congruent. Regarding thought she was anxious about her eye problems. She stated that she had eye problems and couldn't understand the cause but she need treatment. General and neurological examination reveals no abnormalities. All her routine investigations including complete blood count, TSH level, CT scan of head were within normal limit. Her treatment was started with cognitive behavioral therapy, then with sertraline and mirtazapine. Psychoeducation to her family members were given to reduce reinforcement. Few days after starting the medications, she was able to open eyes on her own most of the day. She was advised to continue regular medications and follow up.

Discussion

This case highlights several important issues and challenges. Diagnosis of the patient was one of them. In a metanalysis, the common conversion symptoms found were motor symptoms, sensory symptoms, pseudo seizure and mixed type.[8] In another study Guz and his colleagues found that nearly 45% of patient had a combination of symptoms (a mixed presentation). In this study researchers also found seizure or convulsion (25.3%), motor symptoms (25.3%) and sensory symptoms (4.6%).[9] In a Dutch study it was found that motor symptoms were highest (56%) among the respondents followed by mixed symptoms (30%), seizure (8%) and sensory symptoms (6%).[10]

In this case, the patient was presented with blepharospasm and fit like attack (pseudo-seizure) and initially diagnosed as benign essential blepharospasm by an ophthalmologist on the basis of history, clinical examination and exclusion of other disease. Though she was initially treated by injection botulinum (25U) single dose which is the standard treatment for BEB,5 but her symptoms were not improved. Then she consulted with a psychiatrist. After careful history taking and mental state examination, we found she had episodic difficulty in opening eyes most of the day with association of eye irritation and pain in increasing intensity and duration which was not associated with photophobia, blurring of vision, watery discharge or diurnal variation. Sometimes her symptoms relived spontaneously. There is also history of fit like attack (pseudo-seizure) 5 times in last 2 months with variable duration. It always occurred in front of family members and never occurred during sleep.

As the patient took flupentixol and melitracen combination for 5 years, one differential diagnosis we considered was tardive dystonia. Studies reported that tardive dystonia occurs in 0.04%-4% of the persons treated with dopamine receptor antagonist.[11,12] Blepharospasm is more common among patients with tardive dystonia. But tardive dystonia was excluded after failure of botulinum toxin injection. On the basis of these symptoms diagnosis made was conversion disorder with mixed symptoms, Persistent without psychological stressors. Blepharospasm may present in a few cases of conversion disorder and fit like attack present in 33% cases of conversion disorder.[4] In this case, no specific stressor could be identified. As per recommendation, cognitive behavior therapy was initially applied for management of conversion disorder but there was little improvement. Patient was then prescribed sertraline which was found effective on conversion disorder in some studies at 25 to 300mg of doses.[13] In this case, the patient was given 50 mg once daily dose. Due to patient's sleep problem, mirtazapine was added at night at 15mg dose. Then her symptoms started to improve gradually.

As we can see, early recognition of conversion disorder could limit unnecessary tests and medications. The existing medical literature supports a multidisciplinary treatment approach with specific interventions for conversion disorders with rare presentations. Long-term benefit likely requires a comprehensive treatment approach, recognition of risk factors and treatment of comorbid conditions with a focus on cognitive styles that perpetuate symptoms.

Nusrat Mujtaba Maty, FCPS Part 2 Trainee, National Institute of Mental Health (NIMH), Dhaka, Bangladesh; **Md. Shahidul Islam,** MD Phase-B Psychiatry Resident, NIMH, Dhaka, Bangladesh; **Md. Rashed Khan,** MD Phase-B Psychiatry Resident, NIMH, Dhaka, Bangladesh.

Correspondence: : Nusrat Mujtaba Maty, FCPS Part 2 Trainee, National Institute of Mental Health (NIMH), Sher-E-Bangla Nagar, Dhaka-1207, Bangladesh.
E-mail: nusratmaty1@gmail.com

How to cite this article: Maty NM, Islam MS, Khan MR. Rare presentation of conversion disorder: psychogenic blepharospasm. Arch NIMH. 2022; 5(2): 42-44.

Received 20 Nov 2022, revised 6 Dec 2022, accepted 9 Dec 2022.

References

1. Diagnostic and Statistical Manual of Mental Disorders: DSM-5. Washington, DC: American Psychiatric Association, 2013.

2. Raynor G, Baslet G. A historical review of functional neurological disorder and comparison to contemporary models. Epilepsy Behav Rep. 2021; 16: 100489.

3. Peeling JL, Muzio MR. Conversion Disorder. [Updated 2022 May 15]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2022 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK551567/

4. Ahsan MS, Mullick SI, Sobhan MA, et al. Subtypes of dissociative (conversion) disorder in two tertiary hospitals in Bangladesh. Mymensingh Med J. 2010; 19(1): 66-71.

5. Das S, Sreedharan RP, Remadevi PS, Saji CV. Psychogenic Blepharospasm: A Diagnostic Dilemma. Shanghai Arch Psychiatry. 2016; 28(6): 346-348.

6. American Academy of Ophthalmology. Botulinum toxin therapy of eye muscle disorders: safety and effectiveness. Ophthalmology. 1989; 96: 37–41.

7. Tucha O, Naumann M, Berg D, et al. Quailty of life in patients with blepharospasm. Acta Neurol Scand. 2001; 103: 49–52.

8. Strassnig M, Stowell KR, First MB, et al. General medical and psychiatric perspectives on somatoform disorders: separated by an uncommon language. Curr opin Psychiatry. 2006; 19: 194-200.

9. Guz H, Doganay Z, Ozkan A, et al. Conversion and somatization disorders dissociative symptoms and other characteristics. J Psycho Somat Research. 2004; 56: 287-291.

10. Roelofs K, Hoogduin KAL, Keijsers GPJ, et al. Hypnotic susceptibility in patients with Conversion disorder. J Abnorm Psychol. 2002; 111(2): 390-5.

11. Adityanjee, Aderibigbe YA, Jampala VC, et al. The current status of tardive dystonia. Biol Psychiatry 1999; 45: 715-30.

12. Kiriakakis V, Bhatia KP, Quinn NP, et al. The natural history of tardive dystonia: A long-term follow-up of 107 cases. Brain 1998; 121: 2053-66.

13. Stonnington CM, Barry JJ, Fisher RS. Conversion disorder. Am J Psychiatry. 2006;163(9):1510-1517.

The Official Journal of
National Institute of
Mental Health, Dhaka

This journal is approved by
Bangladesh Medical & Dental Council (BM&DC)

This Journal is Published by
National Institute of Mental Health, Dhaka