PSYCHIATRIC OUT-PATIENT IN A GENERAL HOSPITAL OF ADDIS ABABA DIAGNOSTIC AND SOCIODEMOGRAPHIC CHARACTERISTICS

SUDHIR K. KHANDEL WAL1
FIKRE WORKNEH2

SUMMARY

Delivery of mental care in developing countries has been awfully inadequate. General hospital psychiatric units can play a significant role in providing care to the mentally ill as well as in training aspects of the health professionals. The problems of mental illness are practically same all over as has been highlighted in the paper which discusses the functioning and diagnostic and demographic data of such a unit in Ethiopia. The paper also compares the diagnostic data with that of an Indian and a British study.

In the last two decades or so, there has been a shift in providing care to the mentally ill population in many countries. From mental hospital and custodial approach, the focus of care has shifted to ambulatory and community care. This has resulted into opening of small psychiatric units in general hospitals.

With regard to epidemiological data, Ethiopia has been quite fortunate and is ahead of many African countries because of monumental work done by Prof. R. Giel and associates (Giel and van Luijk 1969; Giel and van Luijk 1970; Dormaar, Giel and van Luijk 1974, Giel et al. 1974;). These studies have unequivocally shown the magnitude of the problem and the possible course of action to tackle it.

How to provide mental health care in developing countries, which have been perpetually besieged with problems of funds, resources and skilled man power, has remained a hot topic of discussion in many international forums (W.H.O. 1975; Baasher et al. 1975). The consensus is that the mental health services must be decentralized and integrated with the ongoing general health care delivery system. In many places this is being achieved by starting community psychiatric centres and psychiatric units in general hospitals (Wig 1978).

In Addis Ababa, such a psychiatric unit has been functioning in a general hospital since 1972 (Khandelwal and Workneh 1986). For this paper, diagnostic and sociodemographic characteristics of patients seen at Psychiatric outpatient of St. Paul’s Hospital, Addis Ababa in the year 1983 are being described and compared with two other significant studies.

Brief history and working of the psychiatric unit at St. Paul’s Hospital

Psychiatric out-patient services in general hospital setting were started by Fikre Workneh at Menelik II-Hospital, Addis Ababa in the year 1972, supported by the Faculty of Medicine, Addis Ababa University, Addis Ababa. Besides its regular clinical service, its other significant role was to organize teaching of psychiatry to the undergraduate medical students (Khandelwal and Workneh 1986). Since

1. Presently, Assistant Professor, Deptt. of Psychiatry All India Institute of Medical Sciences, New Delhi-110 029.
2. Assoc. Professor and Head, Deptt. of Psychiatry, Faculty of Medicine, Addis Ababa, Ethiopia.
that time the out-patient clinic and the teaching programme have been going on regularly. Owing to pressure of work and shortage of space at Menelik-II Hospital, the unit was shifted to St. Pauls' Hospital, Addis Ababa in the year 1982.

The patients come to the clinic either by themselves or after having been referred by other clinics or some health services. All the patients are thus registered in the clinic and thereafter the patient and available relatives are interviewed in detail by the psychiatrist to elicit history of illness, family and personal history and physical and mental status examination is carried out. Important sociodemographic variables are also noted down. The record remains permanently in the clinic and confidentiality is ensured.

Material and Methods

For the present paper, all the patients seen in the psychiatric clinic of St. Pauls' Hospital, Addis Ababa in the year 1983 were included (N = 1840).

The files of the patients were reviewed to ascertain diagnosis and sociodemographic features like age, sex, education, domicile (rural/urban), province, marital status, occupation and religion. For diagnosis, 9th revision of the International Classification of Disease, ICD-9 was followed. Results thus obtained have been discussed in detail as follows and diagnostic characteristics have also been compared with two important studies, one from India, a developing country (Wig, Verma and Khanna 1978) and another from Great Britain, a developed country (Hare 1971). Triennial Statistical Report, years 1967-69. The Bethlem Royal Hospital and the Maudsley Hospital, London; cited by Wig et al. (1978).

Results

Socio demographic characteristics

From Table 1 it is clear that majority of the patients fall in the age groups of 21-30 and 31-40. Together these two groups constitute 67% of the total patient population. Male patients greatly outnumbered female patients. Single patients account for more than half of the total sample. Christian patients are more than three-fourths of the total patient population. Significance of these findings will be discussed a little later in light of other studies and population characteristics of the country.

Table 1

Sex, age marital status, religion and domicile of the patients (in percent) (N = 1840)

| Sex  | 63  | 37  |
|------|-----|-----|
| Male |     |     |
| Female |     |     |

| Age (in years) |       |     |
|---------------|-------|-----|
| 11-20         | 19    |     |
| 21-30         | 46    |     |
| 31-40         | 21    |     |
| 41-50         | 8     |     |
| 51-60         | 4     |     |
| above 60      | 2     |     |

| Marital Status | 57  | 32  | 7  | 4  |
|----------------|-----|-----|----|----|
| Single         |     |     |    |    |
| Married        |     |     |    |    |
| Divorced       |     |     |    |    |
| Widowed        |     |     |    |    |

| Religion | 78  | 22  |
|----------|-----|-----|
| Christian |     |    |
| Muslim   |     |    |

| Domicile | 22  | 78  |
|----------|-----|-----|
| Rural    |     |    |
| Urban    |     |    |

People living in Addis Ababa have maximally utilized the services as 65% of the patients have come from Addis Ababa alone. It again proves the point that people tend to utilise a health service more often if it is situated near their
place. Similarly, though majority of the Ethiopian population is living in rural areas, 77.94% of the patient population is urbanite.

Table 2 shows that only 7.2% of the patients were illiterate. It could be because of two reasons: first, most of the patients have come from urban areas where educational facilities are better, secondly, it also reflects the success of the ongoing literacy campaign in the country. Table 3 shows detail break-up of occupation where worth-noting fact is that militias (volunteers of the farmers' cooperatives who are recruited and after a brief training sent to fight the secessionistic forces in the northern region of Ethiopia) have accounted for 7.92% of total sample.

**Diagnostic characteristics**

Significance of these cited in Table 4 and 5 will be discussed in the following

| Table 4 | Diagnostic breakdown (in percent) N = 1840 |
|---------|------------------------------------------|
| Organic Psychosis | 1.11 |
| Schizophrenia | 8.14 |
| Affective disorders | 8.84 |
| Other Psychosis | 2.28 |
| Neurosis (Total = 53.32%) | |
| Anxiety state | 14.71 |
| Depressive dementia | 22.41 |
| Hysteria | 9.88 |
| Hypochondriasis | 0.57 |
| Neurosis, N.O.S. | 5.75 |
| Personality disorder | 0.92 |
| Sexual inadequacy | 2.06 |
| Alcoholic dependence | 0.80 |
| Migraine | 8.62 |
| Mental retardation | 1.15 |
| Epilepsy | 4.55 |
| Behaviour disorders of childhood | 0.33 |
| Nil Psychiatry | 7.98 |

| Table 5 | Comparison of Diagnostic Characteristics of the three different centres (in percent) |
|---------|-----------------------------------------------|
| Organic brain Syndrome | St. Paul's Hospital Addis Ababa (N=1840) Chandigarh Maudsley, Addis Ababa (India) 1 London 2 (N=5213) (N=6433) |
| 1.11 | 4.63 | 4.4 |
| 8.14 | 22.01 | 4.4 |
| Affective disorders | 8.84 | 17.30 | 7.9 |
| Other psychoses | 2.28 | 2.11 | 0.1 |
| Neuroses | 53.32 | 43.73 | 40.1 |
| Personality disorder and drug dependent | 1.72 | 2.39 | 32.3 |
| Migraine/Psychosomatic | 8.62 | 2.57 | - |
| Mental retardation | 1.15 | 1.59 | - |
| Epilepsy | 4.55 | - | - |
| Nil psychiatry | 7.88 | - | - |

1 and 2: Total indicates attendance for 3 years and 4 years respectively.
section in light of Ethiopian data from previous studies and also in comparison with other international data.

Discussion

The present study is unique in the sense that it is the first report describing in detail the functioning and population characteristics of the first and the only psychiatric unit in general hospital of Addis Ababa.

The pioneering work done earlier by Giel, Fikre and others have mainly been epidemiological in nature where they have shown the extent of psychiatric morbidity in patients attending general outpatient services of a hospital (Giel and van Luijk 1969), psychiatric morbidity in rural (Giel and van Luijk 1970) and urban areas (Dormaar and Giel 1974) and also in specific religious community (Giel et al. 1974). Our data pertain specifically to the patients who were referred to or came of their own to the psychiatric clinic. Because of the different settings of previous studies and the present one, it is not possible to attempt a meaningful comparison of sociodemographic data of the two. However, in comparing our sociodemographic data with the national demographic characteristics, following significant information emerges.

Demographic characteristics of Ethiopian population in year 1980 (National Atlas of Ethiopia 1981) show that out of a total population of 29.46 million, only 11.4% is urban population. There are 104 males to every 100 females. Male to female ratio in rural areas is same as the national ratio. However, in urban areas, there are approximately 95 male to 100 females. Age wise breakdown shows 15.7% in age group 0-4 years, 24.7% in 5-14 years, 55.5% in age group of 15-29 years and only 4.1% above 60 years of age. Overall literacy rate is 38.4%. Thus, on comparing national data with our clinic data, it is clear that those people who had better awareness, opportunity and accessibility to visit the psychiatric clinic have utilized its services maximally. That is why there has been an over-representation of male patients coming from Addis Ababa or other urban areas. Also a greater number of the patient population is literate and employed in contrast to the national population.

Detail diagnostic break up of our data (Table 4) shows that schizophrenia comprised roughly 8%, affective psychosis 9%, organic psychosis less than 2%, anxiety state 15%, depressive neurosis 22%, hysteria 10%, epilepsy 5%, migraine nearly 9% and patients with no psychiatric disturbance constituted approximately 8% of the total sample. Personality disturbances and alcoholism constituted less than 1% each. Sexual inadequacy contributed 2% of the total and it included premature ejaculation and impotence only. Masturbatory guilt and psychological reactions to masturbation are characteristically absent. It could be because prostitution is very rampant and sexual intercourse is available to even a young adolescent. One Indian study (Nakra et al. 1977) reported nearly 15% of males attending psychiatry outpatient as having potency disorders. There was no case of sexual deviation or perversion and no case of drug abuse or dependence other than alcohol. Significance of this breakdown becomes clear when it is compared with the findings of two other studies, one Indian and one British. They were chosen for comparison for the fact that they too have reported data of out-patient services.

Comparison among the three studies (Table 5) brings out following information and comments.
Organic psychosis in Addis Ababa is in equal proportion with the British series and is much less than the Indian figure. It is a bit surprising as one would expect in a developing country like Ethiopia more cases of organic psychosis consequent upon primary physical illness like infections and toxic diseases. It is possible that these cases are treated as inpatients in other specialities without coming to psychiatric out-patient services. Prevalence of schizophrenia is again much lower than the Indian figure and slightly higher than the British one. The proportion of schizophrenia in present series is low because of two facts: first, there is no supportive inpatient psychiatric service available to provide care to acutely disturbed psychotic cases, second, the presence of mental hospital in Addis Ababa itself, where admission is almost certain for such a patient. Hence acutely ill cases are taken there directly. The Chandigarh unit is supported by an in-patient service and hence caters to all kind of cases. In western countries there is probably tendency to commit schizophrenic patients to state hospitals, which perhaps explains lower figure of schizophrenia at O.P.D. level in British series. The proportion of affective psychotics in our series is similar to that of London series and is lower than the Indian series. It perhaps reflects the disparity between the diagnostic practices in three centres. However, consequently proportion of depressive neurosis is much higher in our series and British one as compared to Indian series. Proportion of neurosis is much higher in our series as compared with the other two. It is consistent with the findings of Giel et al. (1969) where they found that a large number of patients attending outdoor services of a general hospital are suffering from psychoneuroses. It perhaps is a reflection of the illness behaviour and social phenomenon. Personality disorders, sexual deviations and alcohol and drug dependence show very striking differences among the three series. The British series has a very high proportion of these disorders while ours in much closer to the Indian one. This may be due to actual difference in the prevalence of these disorders in developed and developing country (Wig et al. 1978). It also indicates that patients of these disorders in developed countries certainly seek treatment owing to greater awareness and availability of psychiatric and social services. In our series we did not come across a single case of sexual deviation/perversion while it accounted for nearly 18% in British series. Also, alcohol and drug dependence comprise nearly 14% of patients in British series, it is less than 1% in our series, that too limited to alcohol only. In our centre, fairly large number of cases have sought treatment for disorders like epilepsy and migraine indicating flexible attitude in registering cases at our treatment facility. Perhaps this also explains nearly 8% of cases where no psychiatric illness was found on examination. It is worthwhile to note here that the latter category includes a large number of those cases who came to psychiatric facility primarily to obtain a medical certificate for some gain in social, occupational or educational areas.

**Conclusion**

It is clear from the above details that psychiatric morbidity in Ethiopia is not very different from other areas of the world. This is in consistency with the findings of other studies too (German 1972; Giel and Harding 1976). Another significant point which has emerged is the maximum utilization of clinic services by the people who are aware of them and who are living near them. Hence we wish to
reemphasize that if we have to take care of psychiatrically ill population in Ethiopia, we must integrate mental health services with the existing health care delivery system which can reach farthest into community. However, nothing can be achieved without properly trained manpower and an adequate budget for drugs. General practitioners, health officers, nurses and health assistants should be trained and familiarised with major illnesses and limited range of psychotropic drugs to achieve the goal of better mental health care in the population. It practically holds true for nearly all the developing countries of the world.

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