PSYCHIATRIC MORBIDITY IN COLLEGE STUDENTS AND ILLITERATE YOUTHS

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The profile of psychiatric morbidity in university students in a general hospital psychiatric clinic was studied and compared with age matched illiterate youths. Students represented 5.1% of the clinic population and illiterate youths represented 3.1%. The majority of ill students were males, unmarried and from a rural area. In both groups 75% of cases sought medical help on their own, but 42% of students solicited psychiatric help directly, in contrast to 11% of illiterate youths. Students reported relatively high role specific stress factors. In contrast to results of student surveys and university health centers, we found an equal representation of psychoses and non-psychoses, a lower representation of problems of under achievement and no representation of alcohol or drug abuse.

Key words: psychiatric morbidity, college students, illiterate youths.

INTRODUCTION

It is estimated that about 10% to 30% of university students have emotional problems (Ramani & Sathyvathi, 1971; Farnsworth, 1975; Chandrashekar et al, 1980; Thacore & Gupta, 1972). Psychiatric morbidity in the formative years of student life may result not only in poor academic performance but can also lead to poor status in life and prolonged morbidity.

In India, epidemiological studies concerning university students have mainly focussed attention on clinical phenomenon like drug abuse (Sethi & Manchanda, 1977; Mohan et al, 1980; Dube et al, 1977; Singh, 1979; Agarwal et al, 1980; Ponnudurai et al, 1984; Varma et al, 1977), smoking (Gupta & Sethi, 1977), suicide (Rao & Chinnaian, 1972), psychological distress (Chandrashekar et al, 1980; Thacore & Gupta, 1972) and personality factors (Agarwal et al, 1980; Chowdhary et al, 1987; Singh, 1979; Channabasavanna & Bhatti, 1977). There have also been some studies concerning psychiatric morbidity in university health centers (Wig et al, 1971; Sharma et al, 1988).

In the present study, the pattern of psychiatric morbidity in students in a general hospital psychiatric clinic was studied in comparison to age matched illiterate youths. This may help in identifying group specific illness and associated factors.

MATERIAL AND METHODS

One hundred consecutive students attending a general hospital psychiatric clinic were evaluated for socio-demographic factors, source of referral, stress factors, psychiatric illness, duration of illness, family and past history of mental illness. All cases were evaluated in detail by a psychiatrist and a psychologist using a modified Mayer-Gross proforma which was being utilized routinely in the clinic. The evaluation was done after a good rapport was established. Thus, the information obtained was elaborate and clinically reliable. Diagnoses were ascribed according to ICD-9.

Stress factors were enquired using a check list prepared by items in presumptive Stressful Life Events Scale (Singh et al, 1983) and new items were added to suit a student population. There was an open question to provide for uncovered factors. Stress factors were then divided as role related and unrelated depending upon the occupational status. The cases were followed up for six months and the findings were compared with hundred cases of age matched illiterate youths and statistically evaluated.

RESULTS

Psychiatric morbidity:

Out of 4000 total cases registered in the clinic, 239 and 125 cases were students and illiterate youths forming 5.1% and 3.1% of clinic population respectively.

Sociodemographic factors:

These details are given in Table 1. The age ranged from 18 to 30 years and the mean age was 21.26 yrs (SD 2.28) in students and 22.66 yrs (SD 2.55) in illiterates. The majority of students were males (88%), unmarried (99%) and from rural areas (68%), whereas in the illiterate group male and female (50:50), rural and urban (54:46) and unmarried and married (41:59), were almost evenly represented. Differences on the above variables were statistically significant (p<.001).

Table 1
Socio-demographic details

Characteristics	Group I (n=100)	Group II (n=100)	Statistical significance
Age (Mean)	21.3(2.28)	22.7(2.55)	P<.001**
Sex			
Male	88	50	
Female	12	50	P<.001*
Residence			
Rural	68	54	
Urban	32	46	P<.001*
Religion			
Hindu	91	84	
Muslim	7	15	
Christian	2	1	NS
Marital Status			
Married	1	59	
Unmarried	99	41	P<.001*

** =t test;*= Chi square test

Table 2
Source of Referral

Source of Referral	Group I (n=100)	Group II (n=100)	Statistical significance (X^2)
Direct	42	11	
Other Sources	31	65	p<.001
Family Members	27	24	

Table 3
Specific psychiatric illness

Diagnoses	Group I (n=100)	Group II (n=100)	Statistical significance (x^2)
Psychoses	47	33	P<.05
MDP-depression	34	16	
MDP-mania	3	5	
MDP-mixed	0	6	
Schizophrenia	10	2	
Others	0	4	
Non- Psychoses	53	67	
Neurotic depression	19	24	*
Hysterical neurosis	0	17	
Anxiety neurosis	12	2	
Unspecified depression	7	15	
Others	10	6	

Table 4
Stress factors in students and illiterates

Stress factors	Group I	Group II
Role Related	27	14
Educational	11	0
Financial	10	4
Non-fulfilment of ambition	5	0
Increased responsibility	1	10
Role unrelated	24	32
Family and social	12	17
Bereavement	4	7
Marital and sexual	1	2
Health	1	0
Failure in love	5	4
Others	1	2

Source of referral:

In both the groups 75% of patients sought medical help on their own as shown in Table 2. The remaining cases were brought to hospital by their family members or friends. Out of the voluntary group, 42% of students and 11% of illiterate youths came to the psychiatric clinic directly (p<.01), and the rest were referred from other departments.

Specific psychiatric illness:

Psychotic and non-psychotic illnesses were almost equal in students (47% and 53%), whereas in illiterates non-psychotic illnesses (67%) outnumbered psychotic illnesses (33%) (p<.05). Among psychoses, affective illness and among non-psychoses, depressive neurosis were frequent in both groups as shown in Table 3.

Duration of illness:

By the time psychiatric consultation was sought, patients in both groups had suffered for a considerable length of time. However, mean duration of illness was 716.28 days (SD 870) and 496.86 days (SD 968.88) in the student and illiterate group respectively (p<.05).

Other details:

There was a high loading of family history of mental illness in students (28%) in contrast to illiterates (14%) (p<.02). A past history of mental illness was present in 10% of students and 5% of illiterates.

Stress factors:

Stress factors were present in 32% of students and 38% of illiterate youths as shown in Table 4. Role related (27) and unrelated (24) stress factors were

almost equal in students, whereas role unrelated stress factors (32) were more frequent than role related (14) stress factors in illiterate youths (p<.05). Educational difficulties (11), financial difficulty out of educational needs (10), non-fulfillment of ambition (5), and additional responsibility (1) were role related stress factors in students. In illiterate youths, increased family responsibility (10) and financial difficulty (4) were role related stress factors. Family and social problems, bereavement and failure in love were role unrelated stress factors in both groups.

Follow up:

After the initial visit, 33% of students and 27% of illiterate youths dropped out. Over a period of 6 months, mean follow up visits in students was 3.97 (SD 7.07) and 2.38 (SD 2.9) in illiterate youths (p<.001).

DISCUSSION

Psychiatric morbidity:

Psychiatric morbidity of 5.1% in students in a psychiatric clinic is low when compared to psychiatric morbidity in university health centers (Wig et al, 1987; Sharma et al, 1988). This under utilization of psychiatric facility may be due to following reasons: (1) Taboo of attending psychiatric clinic (2) Belief that they may overcome their problem on their own (3) Non-referral of such cases from other specialties, and (4) Distance from treatment facility.

Sociodemographic factors:

High representation of male students is in agreement with the study of Wig et al (1971). This may be due to their high expressive nature. High representation of rural students is in agreement with studies of Wig et al (1971) and Sharma et al (1988). They had to adjust more to demands of university and urban style of living. Unmarried status of students is understandable in our culture as marriage is postponed till one's education is completed.

Duration of illness:

Youth in general (students or illiterate), seek psychiatric help after a long duration of illness. It may mean that general education may not improve one's psychiatric help seeking behavior. Studies in university health centers reporting short duration of psychiatric illnesses (Wig et al, 1971; Sharma et al, 1988) may be ascribed to the screening procedures adopted in such centers. However, after consultation, students come for follow up for longer period than illiterates.

Source of referral:

A relatively high percentage of self-referral to a psychiatric clinic in students is an indication that they are aware of the emotional nature of their distress. They seem to delay seeking help in the hope that they may get over problems on their own. Family members not accompanying youths whether they are students or not might be due to the failure of youths in informing their family members. It could also be due to the belief that young people will have no emotional problems, if they have problems, it would be minor and complacence that the youth are capable of taking care of their problems themselves. The responsibility placed on youths to sort out their emotional problems on their own during their phase of individualization may increase emotional stress in some cases.

Stress factors:

Students usually have more role related stress factors. Therefore, they may possibly benefit from education counselling.

Specific psychiatric illness:

Equal representation of psychoses and non-psychoses in our psychiatric clinic is in contrast to the larger number of non-psychotic cases in epidemiological studies and university health centers (Wig et al, 1971; Sharma et al, 1988). This may be due to preference of general health clinics by non-psychotics, non perception of non-psychotic illnesses (Rao & Begum, 1991) and the feeling that one may get over psychiatric distress on their own. High frequency of family and past history of mental illness in students in our sample could be due to the relatively high number of psychotic cases. Absence of alcohol and substance abuse among students, though it may be ascribed to the absence of collateral and reliable information, would not have totally escaped detection during a structured and elaborate interview. Apart from this, the absence of students volunteering for treatment of alcohol or drug dependence and under achievement is, in itself, a disturbing fact.

CONCLUSION

Though generalization is not valid as this is a clinic based study, yet some definite trends have been found which are of research and clinical significance. If what is found in surveys is not found in clinics, it reflects on health definition and help seeking behavior. Differences between clinic samples and university health centers and surveys suggest

that detection of non-psychotic illness and substance abuse in students can be better accomplished on enquiry in a general set up. However in such settings, care should be taken to detect early cases of psychotic illnesses. To decrease taboo and increase awareness about psychological well being, health education to this segment of youths will be helpful.

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