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Original Research Article

Socio-Demographic and Clinical Profile of Patients Attending Psychiatry OPD of a New Tertiary Care Centre in Bodoland Territorial Region, Assam

Mustakim Ahmed[1], Sasanka Kumar Kakati[2], Mohammed Saiful Alam[3], Sriparno Patra[4]

[1]Associate Professor, Department of Psychiatry, Kokrajhar Medical College and Hospital, Kokrajhar, BTR, Assam, India

[2]Registrar, Department of Psychiatry, Kokrajhar Medical College and Hospital, Kokrajhar, BTR, Assam, India

[3]Assistant Professor, Department of Anatomy, Kokrajhar Medical College and Hospital, Kokrajhar, BTR, Assam, India

[4]Senior Resident, Department of Psychiatry, Kokrajhar Medical College and Hospital, Kokrajhar, BTR, Assam, India

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Corresponding Author: Dr. Mustakim Ahmed

Conflict of interest: Nil

Abstract:

Background: The Bodoland Territorial Region (BTR) in Indian state of Assam has historically lacked dedicated tertiary-level psychiatric care. With the establishment of Kokrajhar Medical College and Hospital (KMCH), a significant opportunity arose to understand the mental health needs of this previously underserved population.

Aim: To study the socio-demographic and clinical profile of patients attending the Psychiatry OPD of KMCH, a newly established tertiary care centre in BTR, Assam, India.

Objectives:

1. To assess the socio-demographic profile of patients attending the Psychiatry OPD.
2. To assess the clinical profile of these patients.

Methods: A retrospective, cross-sectional study was conducted using data collected over 21 months from the KMCH Psychiatry OPD. A total of 1005 patients were included. Demographic details (age, gender, education, occupation, religion, and residence) and clinical diagnosis (based on ICD-10 criteria) were analysed using descriptive statistics.

Results: The majority of patients were male (58.3%), with the most common age group being 21–30 years (28.7%). Most patients were Hindu (70%), followed by Muslim (26%) and Christian (4%). Mood disorders (F30–F39) were the most prevalent diagnostic group (24.4%), followed by neurotic, stress-related, and somatoform disorders (F40–F48, 22.8%), and schizophrenia, schizotypal, and delusional disorders (F20–F29, 17.3%).

Conclusion: The findings reflect a high psychiatric morbidity burden in the region, particularly among young adults. The data highlights the urgent need for strengthening mental health services, awareness programs, and community outreach in BTR.

Keywords: Psychiatry, Socio-demographic profile, Clinical profile, Bodoland, KMCH, Assam, OPD, Mental health.

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Introduction

Mental health disorders are a growing global public health challenge, significantly contributing to disability-adjusted life years (DALYs), with India alone accounting for about 15% of this burden. [1] The situation is alarming in Northeast India, including Assam, due to unique socio-cultural factors, limited healthcare access, and widespread mental health stigma. Establishing tertiary psychiatric facilities in underserved areas is essential to address this concern effectively.[2]

The Bodoland Territorial Region (BTR) in Assam is ethnically diverse with significant healthcare disparities. Historically, limited psychiatric care compelled residents to seek distant treatment, causing delayed interventions and poorer outcomes.[3] The recent establishment of

Kokrajhar Medical College and Hospital (KMCH) provides an opportunity to study region-specific psychiatric morbidities and their socio-demographic influences.

Socio-demographic factors like age, gender, religion, marital status, domicile, occupation, and education significantly impact the presentation, diagnosis, and outcome of mental disorders. Clinical profiling using standardized tools like ICD-10 helps identify regional morbidity patterns, enabling early diagnosis, reducing stigma, and guiding targeted interventions. [4,5] Studies from tertiary centres in Northeast India highlight mood disorders, schizophrenia, neurotic and substance use disorders as common, shaped by regional socio-cultural and demographic factors.[6] However, data from BTR is limited. This study aims to bridge the gap by analyzing the socio-demographic and clinical profiles of patients at the newly established Psychiatry OPD at KMCH, Assam.

Materials and Methods

This cross-sectional, retrospective study was conducted at the Psychiatry OPD of KMCH, Bodoland, from January 2023 to September 2024. Data from 1005 consecutive new patients with complete case records and ICD-10 diagnoses were included; follow-up cases and incomplete records were excluded. Information on age, gender, religion, marital status, residence, education, occupation, and clinical diagnosis was extracted from OPD registers and structured proformas.

The study was initiated following approval from the Institutional Ethics Committee (H).

Statistical Analysis: Data were entered in Microsoft Excel and analysed using SPSS v25.0. Frequencies and percentages were used for categorical data.

Results

Table 1: Socio-demographic Characteristics of Psychiatry OPD Patients (n=1005)

Variables	Categories	Frequency (n)	Percentage (%)
Gender	Male	586	58.3
	Female	419	41.7
Age (years)	≤20	112	11.1
	21–30	288	28.7
	31–40	232	23.1
	41–50	151	15.0
	>50	222	22.1
Religion	Hindu	703	70.0
	Muslim	263	26.1
	Christian	39	3.9
Residence	Rural	761	75.7
	Urban	244	24.2
Marital Status	Married	645	64.2
	Unmarried	311	30.9
	Widowed/Separated	49	4.9
Education	Illiterate	263	26.1
	Primary	320	31.9
	Secondary/Higher	310	30.9
	Graduate & above	112	11.1
Occupation	Unemployed	222	22.1
	Homemaker	255	25.4
	Farmer/Labourer	294	29.3
	Student	112	11.1
	Others	122	12.1

Table 1 describes the majority of patients were males (58.3%), aged 21–30 years (28.7%), Hindus (70%), and from rural areas (75.7%). Most were married (64.2%) and had primary-level education (31.9%), reflecting the typical demographics of BTR.

Table 2: Clinical Diagnosis according to ICD-10 of Psychiatry OPD Patients (n=1005)

Diagnostic Category (ICD-10)	Frequency (n)	Percentage (%)
F30–F39: Mood (affective) disorders	246	24.4
F40–F48: Neurotic, stress-related, and somatoform disorders	230	22.8
F20–F29: Schizophrenia, schizotypal and delusional disorders	174	17.3
F10–F19: Substance use disorders	114	11.3
F70–F79: Intellectual disability	59	5.9
F50–F59: Behavioural syndromes (physiological disturbances)	46	4.6
F80–F89: Disorders of psychological development	33	3.3
F90–F98: Childhood behavioural/emotional disorders	26	2.6
Others/Unspecified	77	7.6

Table 2 describes that mood disorders were most common (24.4%) [Among these, major depressive disorder accounted for 53.3%, bipolar affective disorder for 33.3% and mania without psychosis for 13.3%], followed by neurotic (22.8%) [Within this group, generalized anxiety disorder (GAD) comprised 42.9%, somatoform disorder 27.1%, and other anxiety spectrum disorders collectively accounted for 30%.

Specifically, panic disorder constituted 10%, phobic disorders (including social and specific phobia) made up 8.6%, and adjustment disorder accounted for 11.4%] and schizophrenia spectrum disorders (17.3%) [Schizophrenia alone constituted 84.9%, while the remaining 15.1% included delusional and schizoaffective disorders]. Substance use disorders (11.3%) [Alcohol use disorder as the most prevalent at 71.4%, followed by cannabis use disorder (14.3%), tobacco dependence (8.6%), and opioid dependence (5.7%)], highlight the region's addiction-related public health challenges. We have got total 20 patients with dementia.

In our OPD dataset, unique/culture-bound and other rare syndromes collectively accounted for ~3–4% of all psychiatric presentations. Within this group, Dhat syndrome constituted 0.6% of cases, Koro syndrome 0.4%, and delusional parasitosis 0.6%. Additional uncommon conditions observed were Ganser syndrome (0.2%), factitious disorder (0.2%), and trichotillomania (0.4%), kleptomania (0.2%), internet addiction (0.4%), and sleep–wake disorders consistent with parasomnias (~0.6%).

Table 3: Cross-tabulation of Age Groups and Major Psychiatric Diagnoses (n=1005)

Age (years)	Mood Disorders	Neurotic Disorders	Schizophrenia Spectrum	Substance Use Disorders
≤20	34 (10.7%)	40 (12.9%)	26 (11.3%)	17 (11.4%)
21–30	109 (33.3%)	101 (32.9%)	76 (32.1%)	66 (42.9%)
31–40	77 (24.0%)	73 (24.3%)	64 (28.3%)	43 (28.6%)
41–50	47 (14.7%)	39 (12.9%)	34 (15.1%)	13 (8.6%)
>50	56 (17.3%)	49 (17.1%)	28 (13.2%)	13 (8.6%)

Table 3 shows a high prevalence of psychiatric disorders among young adults (21–30 years), especially in substance use (42.9%), reflecting vulnerability linked to socio-economic stressors. Mood disorders and schizophrenia also peaked in this age group, consistent with typical onset patterns.

Discussion

This retrospective study offers key insights into the socio-demographic and clinical profiles of patients at the Psychiatry OPD of the newly established KMCH in BTR, Assam, highlighting important trends and comparisons with national and global studies.

In our study, males constituted the majority (58.3%) of patients, aligning with similar findings from previous studies across India that reported a male predominance in psychiatric OPD attendance.[1,7] This may be due to higher societal exposure and substance use among males, increasing their mental health vulnerability.[8] The predominant age group was 21–30 years (28.7%), highlighting young adults' vulnerability to mental illness, consistent with findings by Mudgal et al. in tertiary care settings.[4] This age group faces significant socio-economic stressors, including educational pressures, employment instability, relationship dynamics, and transitions into adulthood, potentially exacerbating psychiatric morbidity.[9,10] Our study found higher rural attendance (75.6%), unlike Bora et al., who reported 52.06% urban attendance at Assam Medical College.[6] However, our results align more closely with findings from studies by Ghosh et al. in Assam where rural populations predominated.[11] This rural predominance highlights the urgent need for strengthened rural mental healthcare services and outreach initiatives.

Hindus comprised 70% of patients, aligning with regional demographics and findings by Bora et al. [6], reflecting socio-demographic trends rather than religious predisposition. Mood disorders (24.4%) were the most common diagnosis, aligning with national and global studies, including the NMHS 2016, which reported high rates of depression and anxiety.[5] Comparable findings were documented by Ghosh et al. (2019) and Adhikari P et al. (2016) emphasizing similar regional trends.[11,12] Neurotic, stress-related, and somatoform disorders (22.8%) were also common, echoing findings by Math et al. and Gautham et al., and reflecting regional socio-cultural influences.[13,5]

Schizophrenia and related disorders (17.3%) ranked third, consistent with Mudgal et al. and Singh et al. highlighting its major role in psychiatric morbidity in Indian tertiary settings.[4,8] These conditions often necessitate continuous and specialized psychiatric care, underlining the need for sustained community awareness and de-stigmatization programs. Substance use disorders (11.3%) were notable but lower than rates reported by Bora et al. (39.09%) and Kena et al. (77.62% opioid dependence) in Arunachal Pradesh.[6,14] Such differences could be attributed to distinct socio-cultural dynamics, substance accessibility, and regional variations in substance preferences. In some tribal and rural areas of Northeast India, alcohol use is culturally normalized, often seen as part of tradition, which can reduce awareness of its harmful effects and delay help-seeking. Most patients had primary or secondary education, consistent with studies by Mudgal and Gowda et al., linking lower education to higher psychiatric morbidity.[4,15] Lower education often limits awareness and help-seeking, highlighting the need for targeted educational interventions. Occupational analysis indicated farmers and laborers represented the largest occupational group, reflecting similar findings by Nayak and Sonaliya.[16] Limited employment and Lesser income is significantly associated with high rate of mental disorder.[5] The pattern of culture bound syndrome/ rare syndrome in our study accords with DSM-5's framing of cultural concepts of distress and contemporary reviews showing Dhat and Koro as low-prevalence, context-bound presentations. [17,18]

Our findings underscore the significance of socio-demographic correlates such as age, gender, education, and occupation as critical determinants of psychiatric morbidity, emphasizing the importance of targeted interventions addressing these specific vulnerabilities.

The variations noted compared to other studies underscore regional peculiarities and the need for localized mental health strategies, ensuring effective management tailored to regional demographics and clinical profiles.

Limitations

1. **Limited sample size and footfall:** Being a newly established tertiary care center, KMCH had a relatively low OPD footfall during the study period, which may not capture the full psychiatric morbidity burden of the region.
2. **Retrospective design:** The use of existing OPD records limited control over data quality, with potential for incomplete or inconsistent documentation.
3. **Exclusion of follow-up cases:** The study included only new patients, missing out on chronic or recurrent cases that form a significant part of psychiatric service utilization**.**

Conclusion

The study demonstrates a diverse burden of psychiatric illnesses in the BTR region, predominantly affecting young rural males. With KMCH being the first tertiary psychiatry centre in this area, the findings provide a foundational understanding for planning mental health services, training programs, and awareness initiatives tailored to regional needs.

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