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Epidemiological Profile of Patients Sentatives of Achronic Psychiatric Disorder

Narjess Kaarar, Abdel Majid Bairi, Mohamed Boudef,
Ibtissem Chouba, Issam, Nessaibia and Abdelkarim Tahraoui

Applied Neuroendocrinology Laboratory, Departement of Biology,
Faculty of Science, University Badji Mokhtar 23000, Annaba, Algeria

Abstract: Psychiatric diseases as cause morbidity high in Algeria, the objective of this study is to describe the epidemiological profile of patients experiencing a chronic nature of their psychiatric disorder, know the reasons for this chronicity and assess the quality of care from the hospital to patients. The study was conducted on 100 patients admitted to the level of the inlet of the emergency psychiatric hospital Abu Bakr ER - Razi of Annaba, men and women from May 2011 until April 2013. The data resulted from medical records. Our workforce is predominantly male, aged 21 years to 30 years, the most common pathology is 65% schizophrenia. Among the reasons for relapse the quality of decision-making support which is different according to the pathology and which remains insufficient. Our investigation suggests modifications to support mostly schizophrenic patients and psychotic disorders induced in order to minimize their frequency of symptomatic relapse and especially to improve their quality of life.

Key words: Disorders Psychiatric · Chronicity · Relapse · Epidemiological Profile

INTRODUCTION

Mental disorders are not the lot of a particular group: they are universal. They occur in all regions, all countries and all societies. They affect men and women at all stages of their lives, the rich as the poor and the urban population as rural. It is wrong to think that mental disorders are problems specific to industrialized and relatively favoured parts of the world. It is also believed wrongly that they are absent from rural communities, relatively spared by the accelerated pace of life modern [1].

Psychiatric diseases are cause morbidity high in Algeria but low mortality. They affect more the population from 30 years and are more frequent in men than in women [2].

Among the reasons for hospital admissions to the CHU Bab El Oued in Algiers, 4.1% are due to mental disorders. Depending on the diagnosis, mental disorders represent the average length of longest stay with 17.5 days [2].

In 2002, the prevalence of chronic mental illnesses by age gender and the environment of residence in % according to Algerian family health survey revealed the extent of the problem of mental health in Algeria, 155000 people suffer from mental illnesses and 62000 people suffer from epilepsy [2].

According to Prof. Kacha F, Professor Algerian in Psychiatry; serious psychiatric diseases are universal. Establish a comparison between the number of cases of serious psychiatric pathologies in Algeria and throughout the world is impossible because the exact statistics are unavailable, however, he proposed to examine the subject in the study of the chronicity and the permanence of care of these disorders [3].

Join the effort of this reflection, such is the objective of this study. In fact, know and describe the epidemiological profile of the user of such care and try to know the reasons for this chronicity is a fundamental and inevitable step in the process of this research and finally, to assess the quality of care from the hospital to patients.

MATERIALS AND METHODS

The study was conducted on 100 patients men and women admitted to the level of the inlet of emergency psychiatric hospital Abu Bakr ER - Razi of Annaba, which consists of a dual activity: home and hospital. With a

Corresponding Author: Kaarar Narjess, Departement of Biology,Faculty of Science,
University Badji Mokhtar 23000, Annaba, Algeria.

capacity of 60 beds technical, this unit covers needs for psychiatric emergency of a population of over two million people, within the health region of Annaba (Wilaya of Annaba, El Taraf, Souk Ahras, Tébessa).

The main feature of these patients is that they are not strangers to this service, are experiencing a chronic nature of the disorder since the outbreak of the disease and a significant number of relapse and readmission in the service.

The survey of these patients began from May 2011 to April 2013, with the aim of establishing their epidemiological profile and especially to follow the development of their pathology during this study period.

The data resulted from medical record, they were made by a single person. The collection of information is done as follows:

- Consultation of the register of hospitalization to know the patient's record number
- Very thorough review and gather important information
- In the course of the study period, we observed and assessed the quality of support for these patients by the medical profession, from their first meeting to their arrived at the service, until their exit, this evaluation even continued after the release of the sick. For chronic patients who have relapsed during the study but were not introduced the hospital to receive the necessary treatment, have also benefited from the same principle.

Statistical analysis of cases was made on microcomputer equipped with statistical processing XLSTAT software version 7.5.2. The average values were presented with the standard deviation as dispersion index. Differences between means were appreciated by the Student's test. The level of statistical significance chosen p was 0.05.

RESULTS

Prevalence: During the period of study, 130 patients were admitted in Psychiatry met the criteria of recruitment to the study. At the same time, the total of the hospitalizations amounted to 1877. The hospital prevalence was 6.92%. Among the hospitalized 130 files, we identified 100 for this investigation, 30 others who were excluded because they were already out or completely refused contact, so could not have information on the patient.

Table 1: Distribution by age group and sex of the study sample

	Men		Women		Grand Total	
Age (years)	N	%	N	%	N	%
21-30years	28	45,90	12	30,77	40	40
31-40years	26	42,62	22	56,41	48	48
41-50years	4	6,56	3	7,67	13	13
50years and more	3	4,92	2	5,13	9	9
Grand Total	61	100	39	100	100	100

Socio-Demographic Characteristics: regardless of the year of study, our sample consisted mainly of men. Our workforce consisted of 61 male patients (61%) and 39 (39%) female patients, either (sex ratio of 1.56 for the male). The age of 21 years to 58ans patients. The average age of men was (32,23 ±7, 608 years) and that of women was (34, 513±7, 924 years), the difference between the average age of men and women was not significant (p = 0, 1). The number of urban patients was 20patients rate (20%) and that of rural patients was of 80 patients (80%) [Table 1].

The place of residence of patients has been recorded among the entire sample for a rate of 100% completeness. Abu Bakr ER-Razi psychiatric hospital mainly receives patients from Eastern Algeria (Annaba, El Taref, Guelma, Tebessa, Souk Ahras, Skikda) (Figure 1). The marital status of patients were noted among 100patients (100% of patients) (Figure2).The unmarried patients mean age of (30, 21±5, 32), while he was of (37, 09±8, 37) the bride and groom, with a significant difference between the two middle ages from ($p < 0.0001$).

The level of education of the patients were noted among the entire workforce is 100% completeness. 50% of patients had a medium level of education compared to 4% with a higher level and46% of illiterates (Figure3).

The rate of unemployment within the sample was important with 55%, this rate was recorded mostly in male subjects, however most women were women at home with 20% (Figure 4).

Clinical Features of the Patients: psychiatric pathologies who knew the most of chronicity and a permanence of care were the schizophrenia with 65%, followed by a nervous breakdown in 20% of patients (Figure 5).

Symptomatic relapse is a recurrence of the symptoms of the disease with significant intensity requiring psychotropic treatment resumed. Relapse was recorded in all of the sample at the time of the study, however, it does not require the same support on the part of the hospital for all patients, in fact, 100% of schizophrenics and patients suffering from induced psychosis were

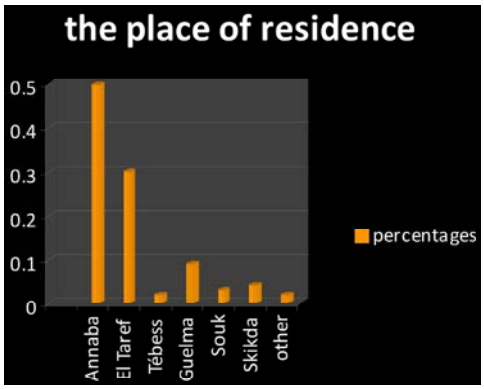

Fig. 1: Distribution of the sample according to the place of residence

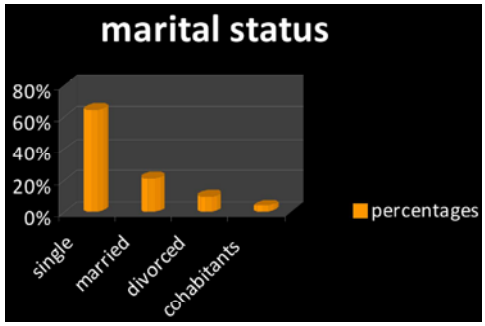

Fig. 2: Distribution of the sample according to marital status

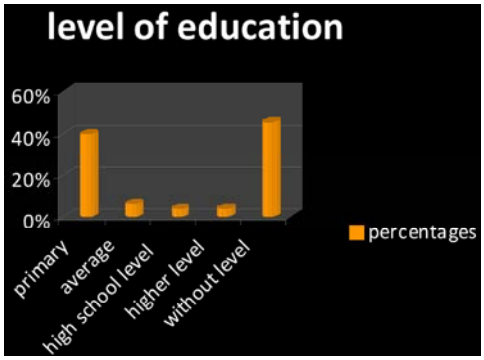

Fig. 3: Distribution of the sample depending on the level of schooling

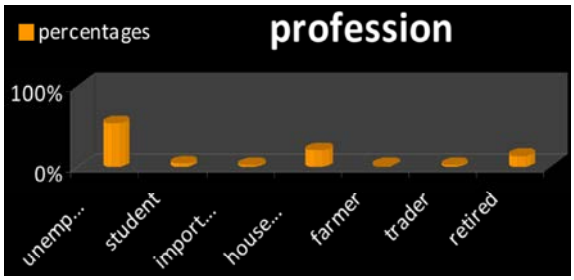

Fig. 4: Distribution of the sample according to professional status

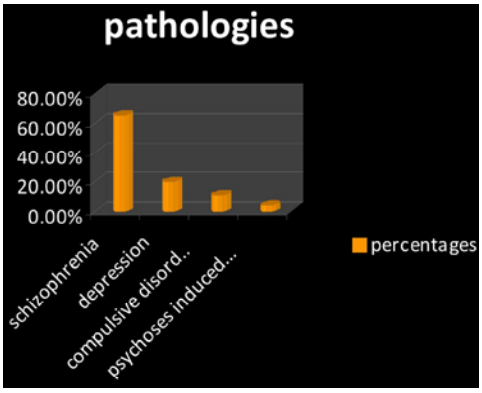

Fig. 5: Distribution of the sample according to the type of diagnosed pathology

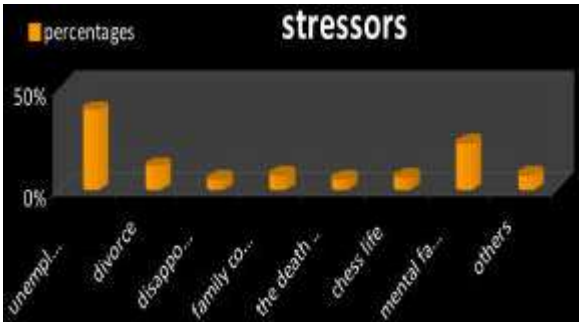

Fig. 6: Distribution of the sample according to stressors

Table 2: Presentation of the numbers of readmission of patients during the study

Number of Readmssion	Effective	Percentages
Schizophrenia :		
1	21	32,31%
2	14	21,54%
3	20	30,77%
4	10	15,38%
Grand Total	65	100%
Induced Psychoses :		
2	3	75%
6	1	25%
Grand Total	4	100%
Depression :		
1	2	10%
Grand Total	2	10%
TOC :	2	19%
Grand Total		19%

The legend of table 2 : TOC : obsessive-compulsive disorder

readmitted to the hospital emergency department to continue their treatment or repeat it after a dirty shutdownagainst 10% and 9% of depressed patients and who suffered from TOC in the order (Table 2).

Apart from the severity of psychiatric illness, all patients in this study met with stressful events that may cause these relapses (Figure 6).

Table 3: Treatments (drugs) prescribeby thedoctor depending onthe pathology andtheir generic names[a].

Pathologies	Psychotropes	Generic names ® (International Nonproprietary Name)
Schizophrenia	Neuroleptics	solian®(amisulpiride),
Induced psychoses	Antidepressants	nozinan®(lévomépromazine),
By cannabis	Anxiolytics	haldol®(halopéridol),
	Sedatives	tranxene®(clorazépatedipotassique),
	Antiepileptics	risperdal® (rispéridone),
		tegretol®(carbamazépine),
		dépakine® (valproate de sodium),
		valium®(diazépam),
		largactil®(chlorpromazine),
		zyprexa®(olanzapine),
		atarax®(hydroxyzine),
		phenergan®(prométhazine)
Depression	Antidepressants	Dépakine®(valproatede sodium),
TOC	Anxiolytics	risperdal® (rispéridone),
		Sedativestegretol® (carbamazépine),
		valium® (diazépam),
		atarax® (hydroxyzine),
		laroxyl® (amitriptyline),
		deroxat® (paroxétine),
		tranxene®(clorazépatedipotassique),

[a] : has can be found several psychotropic drugs prescribed to the same patient

The Support of Patients: The quality of support for patients in Psychiatry and most important of them patients experiencing a persistence of disorder and a high rate of relapse, can be indicative of the symptomatic evolution.

Arrival of the patient at the psychiatric hospital: accompanied by his family, in an ambulance or accompanied by police officers.

Interview with the psychiatric doctor: because these patients are known to the Department of Psychiatry, the psychiatrist seeks to know the factors that were induced to relapses (figure), reapparus symptoms and decide their internment or not.

Support Chemotherapeutic: The treatment prescription psychotropic was a necessity to relieve the symptoms recurred patients, they are admitted or not.

Table 3 illustrates the treatments prescribed according to the pathology.

All depressive patients and those suffering from TOC, were subjected to a single type of antidepressant or antipsychotic but generally accompanied by an anxiolytic. 84% of schizophrenic patients were under first generation antipsychotics and 90% of them were subjected to an association of two or three Neuroleptics. The most common type of association in these patients was Haldol-Nozinan with 85%, this combination did not depend on the therapeutic interest of these two Neuroleptics or symptoms but is a prescription for routine or usual (this was revealed by a psychiatrist of the service).

Psychological Support: The doctor was conducting a cognitive-behavioural therapy for depressive patients and suffering from TOC in order to:

Targeting the source of the problem to treat, re-establish contact with reality, inform the patient about these symptoms in order to master (phobias, fear exaggerated, etc.), expose patients to situations that cause a mild anxiety or moderate, prevent relapses, inform the patient on treatment (nature, duration, efficacy, adverse effects and their impact).

For schizophrenia and psychosis induced by cannabis: we have registered no psychological approach, of course, patients took part in a few chores, under the direction of agents of cleanliness and the paramedical body, or inform the patient on the risks associated with the use of cannabis or other harmful substances.

These patients had daily consultations, the sole concern of the doctor was to know the effect of the treatment and including these adverse effects. Also, it also decided to change treatment and its path of assimilation according to need. Consultation by patient did not exceed 5 min.

The duration of the stay is different according to the pathology: (65, 43±47, 51 days) for schizophrenics, (25±5, 84 days) for depressive, (25±5, 91 days) for patients suffering from TOC (50, 50±12, 36 days) in patients suffering from psychosis induced by cannabis. Attempted suicide within the service were recorded only in schizophrenics with a rate of 10%.

The Support after the Release of the Patient: The release of the patient was under medical advice after a clinical course of symptoms, no output was against medical.100% of patients remained under treatment and medical control after the release. They had regular appointments with the physician. The purpose of the visit was to follow the State of mental health of the patient outside the hospital structure, adjust the treatment or decide to progressive therapeutic shutdown in the event of total recovery. We recorded the rate of relapse in schizophrenic patients and patients suffering from psychosis induced by cannabis were 100% after their release from the hospital, compared with 75% in patients diagnosed for TOC and 40% in the depressive whether or not they were admitted in psychiatry.

Time to relapse in schizophrenia and induced psychoses is one month after their release, however in the depression and TOC relapse is after 6 months in 1years.

Support of Patients Not Admitted in Psychiatry: 10% and 9% of depressive patients and who were suffering from TOC, had regular appointments with their doctor dealing with and they benefited from the same support that patients suffering from the same symptoms admitted to the Emergency Department.

DISCUSSION

This investigation took place in a hospital, the characteristic that makes this research is the originality of the topic, indeed, no study prepared in this establishment is interested at this point.

In our series, subjects were predominantly men with 61%, the more likely to explain this result explanation is the difference that exists between men and women in the brain.

The research reveals that stress-related diseases affect men and women differently, it also explains that the amygdala, a structure responsible for the treatment of emotions and the regulation of secretion of hormones, is present both in the left hemisphere and the right hemisphere among both sexes [4], but the different physiological treatment of negative or positive stimuli of the two cerebral hemispheres according to the emotional valence of stimuli [5]. Brain scans show that stress does not activate the same parts of the amygdala in men and women [4].

Also the stressors faced by men and women in their daily lives are natures and different intensities. Indeed, the most affected age group among men was [21-30], in our society this category is facing serious financial difficulties, because the problem of unemployment is very identified with them.

The most represented pathology was schizophrenia with 65%, followed by depression 20%, then the obsessive compulsive disorders 11% and finally the psychotic disorders induced 4%.

This fact affirms once again that schizophrenia is the most disabling disease [6], with the highest risk of chronicity [7] and it lasts a lifetime [8] if one takes into consideration the duration of persistence of the disease (3173±2780, 1days).

With regard to the need for readmission at a symptomatic relapse, there also schizophrenia and induced psychotic disorders are ranked first with 100% of readmission during the study period.

These data do not exclude the fact that other disorders have their share of severity, but that change here is the quality of support for these pathologies.

These results demonstrate the quality of poorly insured support especially for schizophrenia and induced psychotic disorders and is in favor of frequent relapses.

Many work argue that psychotropic treatment should be combined with a non-pharmacological treatment to promote compliance and improve the experience of the patient [6]. It must therefore be pharmaco-psycho-social.

The chemotherapeutic approach meets it also some limits, more than 80% were under typical Neuroleptics, despite the interest therapeutic medication [9], but the introduction of more second generation antipsychotics (atypical) ca would bring better results, what has already been proven [10].

Researchers have said that beyond the reduction of anxiety, the typical antipsychotics have the ability to restore most of the psychotic symptoms such as hallucinations, but more often leave the negative symptoms as withdrawal [11]. Antipsychotics atypical are beneficial on the negative symptoms, pharmacologically. their advantage is attributed to the fact that they violate not only to dopamine, but they are [12] serotonin blockers.

This investigation discovered also (66%) of prescription of haldol-nozinan, this high rate of prescription was not due to the therapeutic interest that brings this association to pathology [9], but this is only a routine prescription (this was revealed by a psychiatrist of the service).

The hospital structure was not solely responsible for relapse, the rejection and incomprehension on the part of the families was also responsible, after their release from the hospital, patients were or stray in nature, either folded in a corner, because their evolution in time did any means to re-insertion or resocialization, researchers say that when patients receive little support from their relativesWhen latter is incredulous toward them, blame them, or inculcate them, their symptoms could worsen and their adaptive capacity decreased [13, 14]. There is now scientific evidence that well informed parents are able, not only to contribute significantly to the reduction of the schizophrenic patient relapses, but also to improve their own quality of life [15].

There had also many therapeutic judgments by patients following the improvement of their condition and felt without medical advice, that case was also due to the inflated prices of certain drugs, most of which were not reimbursed by social security.

Researchers have recorded a worsening of schizophrenic symptoms in 73% of patients who did not properly take their treatment, which induced to hospitalization [16].

These cases are also due to the lack of appropriate information about the nature of the illness and the expected benefits of treatment [16].

Unemployment, illiteracy, poverty, adding the drugs and alcohol [16], these factors also contributed to relapse.

CONCLUSION

This Study Has Allowed to Us:

- To identify the epidemiological profile of patients admitted to psychiatric hospital Abu Bakr ER-Razi presenting a chronic nature of their disorders and continuing care: it is a fasting man (61%) aged between 21-30 years, residing in Annaba, single, without education or employment. It's a schizophrenic patient (65%) re-entered in the Department of Psychiatry following a relapse symptomatic more than 3 times during the study period.
- To target the reasons for chronicity of the psychiatric disorder in these patients are: social stress; rejection and incomprehension of the symptoms on the part of the families of the sick and especially a hospital very limited support.
- To suggest modifications to support mostly schizophrenic patients and induced psychotic disorders in order to minimize their frequency of symptomatic relapse and especially to improve their quality of life.

REFERENCES

1. OMS (Organisation Mondiale de la Santé), 2001. Rapport sur la Santé dans le monde. La santé mentale Nouvelle Conception, nouveaux espoirs. Geneva: OMS. In line : http://www.who. int/ whr/ 2001/ chapter 2/fr/index2.html
2. Santé mentale Algérie. Rapport annuel du Ministère de la Santé, 2004. In line : www. sfapsy. com/ images/ stories/...pdf/Sante-mentale-Algerie.pdf
3. Kacha, F. Psychiatrie, 2009. Santé mentale et société en Algérie. L'entretien Du moi, pp: 7.
4. Mammouth Magazine, Number 6, March, 2009. In line :www. stresshumain.ca/mammouth-magazine. html.
5. Sirigu, A., Étude du rôle différentié de l'amygdale et du cortex ventro-médian dans le traitement des émotions chez l'homme « Analyse neuropsy chologique, métabolique et électrophysiologique ». Rapport de fin de recherche. In line : https://hal. archives-ouvertes. fr/docs/.../ Sirigu _ COG _ 152 _ 4BB.pdf.
6. Llorca, P.M., La Schizophrénie. In : Orphanet. In line:https://www.orpha.net/data/patho/FR/fr-schizo. pdf.
7. Rössler, W., 2011. Epidémiologie de la schizophrénie1. Forum Med. Suisse, 11(48): 885-888
8. Jean Desclin, 2006. LA SCHIZOPHRENIE. Ce que les familles et les proches des malades devraient savoir. In line : http://www.mens-sana.be/docu/schizof.pdf
9. Hogarty, G.E., C.M. Anderson, D.J. Reiss, S.J. Kornblith, D.P. Greenwald, R.F. Ulrich and M. Carter, 1991. Family Psychoeducation, Social Skills Training and Maintenance Chemotherapy in the Aftercare Treatment of Schizophrenia. Archives General Psychiatry, 48(4): 340-347.

10. KHAN, A.N., 2005. Prévalence et caractéristiques de l'association de neuroleptiques chez une cohorte de patients psychotiques, thesis. Geneva University. Geneva.
11. Wolkowitz, O.M. and D. Pickar, 1991. Benzodiazepines in the treatment of schizophrenia: a review and reappraisal. Am. J. Psychiatry, 148 : 714-726.
12. Christine, C. and D.W. Gispen, 2000. Stress in schizophrenia: an integrative view. European Journal of Pharmacology, 405 : 375-384.
13. Desmeules, J. and D.Maltais, 2005. Les médias en temps de catastrophe. In Intervention sociale en cas de catastrophe, Eds. Maltais, D and Rheault ; MA. Canada : PUQ, pp: 373.
14. Boisvert, W. 2000. L'état de stress post-traumatique. Le médecin du Québec, 35(8): 51-57.
15. Lalonde, P., 2004. Le modèle Vulnérabilité-Stress et les interventions efficaces dans la schizophrénie. In line :http://www.espace socrate.com/ Soc Pro Accueil/ Document % 5 C Rehabilitation % 5 Ca _ modele _ vulnerabilite _ stress _ les _ interventions _ efficaces. pdf
16. Nicolas, FRANCK, 2010. Traitement de la schizophrénie. In line : http://www. isc. cnrs. fr/jea/ Traitementschizophressentiel2010.pdf