AN OBSERVATIONAL STUDY ON THE PROFILE OF PSYCHIATRIC DISORDERS IN ELDERLY PATIENTS ATTENDING PSYCHIATRY OPD IN A TERTIARY HEALTH CARE CENTRE

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ABSTRACT

Introduction: The global increase in life expectancy has led to a growing elderly population, accompanied by a rising burden of psychiatric disorders. Mental health problems among older adults are often under-recognized because of various social factors, and limited access to specialized geriatric mental health services, particularly in low- and middle-income regions. Data on the pattern of psychiatric morbidity among the elderly in North-East India remain limited. This study aimed to evaluate the pattern and distribution of psychiatric disorders among elderly patients attending the psychiatry outpatient department of a tertiary care centre in North-East India.

Methods: This hospital-based cross-sectional observational study included 100 patients aged 60 years and above attending the psychiatry outpatient department of a tertiary care hospital. Psychiatric diagnoses were made according to DSM-5 criteria after detailed clinical evaluation, and socio-demographic variables were recorded.

Results: Schizophrenia spectrum and other psychotic disorders were the most common diagnoses, affecting 28% of participants. Bipolar and related disorders and major and mild neurocognitive disorders were each observed in 18% of cases. Depressive disorders were observed in 14% of patients, while anxiety disorders were identified in 9%. Certain diagnostic categories were more frequently observed among financially dependent individuals, and variations were noted across rural and urban populations.

Conclusion: The study highlights a substantial burden of psychiatric morbidity among elderly patients attending tertiary psychiatric outpatient services and underscores the need for early identification, tailored interventions, and comprehensive mental health support systems for the geriatric population.

Keywords: Elderly Population in India, Geriatric Mental Health, Cognitive Impairment.

INTRODUCTION

As the elderly population in India continues to grow, understanding their mental health needs has become increasingly important.

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The United Nations has projected that by 2050, India will have approximately 324 million people aged over 60, highlighting a significant demographic shift that presents both challenges and opportunities in health care delivery. [1]Declining birth rates and increasing life expectancy are the two major factors contributing to the growth of the elderly population.Rapid changes in social structure and traditional value system are said to have a tremendous impact on the well-being of olderadults as well as on the social equilibrium of society itself.[2]The life expectancy of the average Indian increased from 36.7 years in 1951 to over 67 years in 2012.[3] The World Health Organization (WHO)has emphasized that poor mental health can severely impact the quality of life in older adults, and therefore requires comprehensive assessments and

interventional strategies.In India, studies have reported widely varying estimates of psychiatric morbidity among the elderly, ranging from 8.9% to 61.2% across different settings.[4]Older adults often experience multiple psychosocial stressors, physical illnesses, and social losses, all of which may increase vulnerability to mental health problems.Approximately 15-20% of the elderly have mental health problems and this proporiton is likely to increase further in the coming years.[5] In India, by tradition, sixty years is regarded as the beginning of old age. The elderly may be roughly divided into young-old (age 65-75 years), old-old (75-85 years), and oldest old (85 years & above). The risk of psychiatric illness increases with advancing age, and the burden of psychiatric morbidity is believed to be greatest among the oldest old. These trends highlight the need for comprehensive mental health services tailored to this population.[1]

Venkoba Rao (1981), in a study based on materials drawn from 'Geropsychiatric Clinic' of the Institute of Psychiatry, Government Rajaji Hospital and Madurai Medical College, Madurai, reported that 164 elderly people attended the clinic.They constituted 1.6% to 2.6% of the total attendance in the psychiatric clinic, with a male dominance (ratio 3:1). Among psychiatric diagnoses, organic brain syndrome and affective disorders were common with the latter leading a little over the former. Dementia, was predominantly seen over 75 years of age while affective illness was common in the sixties. The analysis of the type of family indicated that 52% came from extended family, 38% from joint family, while 10% were from nuclear family.[6]A meta-analysis has reported high rates of depression and anxiety in this age group, highlighting the substantial and often inadequately addressed burden of mental health problems among older adults.[7] Furthermore, a study conducted in Cuttack, Odisha, identified high rates of cognitive impairment and anxiety, asserting thatapproximately 50% of older adults had at least one mental health issue.[8]

Psychiatric morbidityamong the elderly people is greatly influenced by prevailing socio-economic conditions, cultural background, family environment, societal attitudes towards older adults, and the availability ofsocial security systems. Research indicates that many mental health problems in this age group are incorrectly attributed to normal ageing, thereby perpetuating the cycle of neglect and stigma surrounding mental illness.[1] There is also a significant gap between the need for mental health services and their availability; a study noted that only 41.3% of elderly individuals with psychiatric disorders sought treatment. Also, there are only two institutions that currently offer specialized training in geriatric mental health, producing only four geriatric psychiatrists annually. Due to the skewed distribution of mental health professions, rural elderly populations are significantly underserved.[1] Research has highlighted that over 73% of older individuals are illiterate, which directly affects their ability to seek help and understand mental health conditions.[9]

Family structures also plays an important role in the mental health of older adults.Shifting societal attitudes and decreasing family support, particularly in urban areas, have been shownto negatively impact elderly mental health.[10] The breakdown of intergenerational support systems raises alarms about the need for community-based interventions aimed at revitalizing support for mental health in this age-group.

Given these challenges, the study was undertaken to assess the pattern and distribution of psychiatric disorders among elderly patients attending the psychiatry outpatient department of a tertiary care centre in North-East India. By focusing on clinical presentations in a real-world tertiary care setting, this study seeks to contribute to a better understanding of geriatric psychiatric morbidity in the region and to inform improvements in assessment, referral, and treatment services.

MATERIALS & METHODS

This was a hospital-based, cross-sectional observational study conducted among elderly patients aged 60 years and above, who sought psychiatric consultation at the outpatient department (OPD) of Assam Medical College and Hospital (AMCH). The research was conducted at AMCH, located in Dibrugarh, Assam. This hospital primarily serves patients from the districts of Tinsukia, Sivasagar, Jorhat as well as from the neighbouring state of Arunachal Pradesh. The OPD typically attends to approximately 50 to 60 patients per day.

The study was conducted from January 1. 2025 to June 30, 2025, and included 100 patients selected by consecutive sampling. Inclusion criteria were age 60 years or older, either gender and those who provided informed consent. Patients who refused consent, those whose detailed evaluation could not be completed because of non-cooperation, and critically ill patients were excluded. Data were collected using a socio-demographic proforma, a semi-structured clinical interview proforma designed by the authors to record relevant clinical variables, and DSM-5 criteria for the diagnosis of psychiatric disorders within the study population.

Psychiatric diagnoses in the present study were formulated in accordance with the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). Each participant underwent a detailed clinical psychiatric assessment using an unstructured clinical interview format consistent

with routine outpatient practice. The initial evaluation was performed by postgraduate trainees in psychiatry, who had been adequately trained in the application of DSM-5 diagnostic criteria. All cases were subsequently reviewed by a consultant psychiatrist, and the final diagnoses were confirmed during routine outpatient supervision.

A self-designed screening questionnaire was used only for preliminary assessment and collection of clinical variables; it was not used for diagnostic or symptom severity evaluation. Final psychiatric diagnoses were based on DSM-5 criteria following detailed unstructured clinical interviews, and consultant review.

Diagnostic decisions were based on a comprehensive appraisal that included the patient's clinical history, mental status examination, and collateral information from caregivers whenever available. Data were analysed using descriptive statistics and are presented as frequencies and percentages.

Given the heterogeneity of presentations in the geriatric population, cognitive limitations, and varying literacy levels, the use of lengthy standardized instruments was considered less practical in a busy psychiatry OPD. Therefore, a self-designed screening questionnaire was used to facilitate rapid and feasible preliminary assessment.Fully structured diagnostic interviews were not employed becausethey were considered impractical in this setting, particularly in the presence of cognitive impairment, sensory deficits, and varying literacy among elderly patients.

Institutional Ethical Committee approval was obtained for the study (vide notice No. AMC/EC/2025/394 dated 11 January, 2025).There were no conflicts of interest associated with this research.

RESULTS

1. Socio-demographic Characteristics of the Study Population

Table 1 summarizes the socio-demographic profile of the study participants. A total of 100 geriatric patients attending the psychiatry outpatient department of a tertiary care centre were included in the study. The mean age of the participants was 66.34 years (SD ± 6.03). Most patients belonged to the 60–69 years age group (67%), followed by those aged 70–79 years (30%) and ≥80 years (3%).

Males constituted 61% of the sample, while females accounted for 39%. The majority of participants belonged to the lower socioeconomic class (29%). Most patients were married (88%), whereas 8% were widowed and 4% were unmarried. Regarding educational status, 36% were illiterate and 53% had education below matriculation level, while only 11% had matriculation-level education or higher.

In terms of occupation, 39% of participants were self-employed. More than half of the participants (55%) lived in nuclear families. A large proportion of patients were from rural areas (74%), while 26% were urban residents. Religious distribution showed that 50% were Muslim, 49% Hindu, and 1% Christian. Most patients (79%) sought psychiatric consultation voluntarily, whereas 15% were referred from other departments and 6% were brought by family members or other authorities.

2. Distribution of Psychiatric Diagnoses

Table 2 presents the distribution of psychiatric diagnoses among the study participants based on DSM-5 criteria. Schizophrenia spectrum and other psychotic disorders constituted the most common diagnostic category and were observed in 28% of patients. Bipolar and related disorders and major and mild neurocognitive disorders each accounted for 18% of the sample.

Depressive disorders were present in 14% of patients, followed by anxiety disorders in 9%. Somatic symptom disorder accounted for 5% of diagnoses, while substance-related and addictive disorders were identified in 4% of patients. Insomnia disorder was diagnosed in 1% of the participants, and 3% of individuals did not meet criteria for any psychiatric diagnosis.

3. Distribution of Psychiatric Diagnoses across Socio-demographic Variables

Gender-wise Distribution

Figure 1 illustrates the gender-wise distribution of psychiatric diagnoses. Schizophrenia spectrum and other psychotic disorders were common among both males (26.2%) and females (30.8%). Bipolar and related disorders were slightly more frequent among females (20.5%) than among males (16.4%). Depressive disorders showed a near-equal distribution between males (14.8%) and females (12.8%). Anxiety disorders were observed in 9.8% of males and 7.7% of females. Substance-related disorders were noted exclusively among males, whereas insomnia disorder was identified in one male patient. Somatic symptom disorder was marginally more frequent among females.

Financial Dependence

Schizophrenia spectrum and other psychotic disorders were the most frequent diagnoses among both financially independent (25.9%) and financially dependent (29.3%) patients. Bipolar and related disorders (24.4%) and somatic symptom disorder (7.3%) were more common among financially dependent individuals, while substance-related disorders were observed only among financially independent patients (6.9%). Neurocognitive and depressive disorders showed a comparable distribution in both groups.

Distribution by Age Group

Schizophrenia spectrum disorders were most frequently observed in the 60–69 years age group and showed a declining trend with increasing age. In contrast, anxiety disorders and neurocognitive disorders demonstrated higher frequencies in older age groups, particularly among patients aged 70–79 years. Bipolar and depressive disorders were more common among the younger elderly and declined with advancing age.

Distribution by Place of Residence

Schizophrenia spectrum and other psychotic disorders were prevalent in both rural (28.4%) and urban (26.9%) populations. Bipolar and related disorders were more common among rural residents, while depressive disorders were slightly more frequent among urban participants. Major and mild neurocognitive disorders were similarly distributed across both settings. Somatic symptom disorder was observed only among rural participants, whereas insomnia disorder was reported exclusively among urban residents.

Marital Status

Schizophrenia spectrum disorders were most frequently observed among married and widowed individuals. Bipolar and related disorders were more common among married participants. Anxiety disorders showed higher representation among widowed individuals, while depressive disorders were predominantly observed among married patients. Insomnia and somatic symptom disorders, though infrequent, were relatively more common among widowed participants.

DISCUSSION

The present study describes the socio-demographic characteristics and diagnostic patterns observed among elderly patients attending the psychiatry outpatient department of a tertiary care centre. As this was a hospital-based OPD study, the findings reflect patterns among service-seeking elderly individuals and should not be extrapolated to the general elderly population.

Socio-demographic Characteristics

The mean age of patients attending the psychiatry OPD was 66.34 years and the largest proportion belonged to the 60–69 years age group. Similar age distributions have been reported in other hospital-based studies from India, where younger elderly individuals are more likely either to seek psychiatric consultation or be brought for evaluation [6]. Better mobility, relatively preserved functional status, and greater caregiver involvement may contribute to this pattern of OPD attendance.

A predominance of male patients was observed in the present clinical sample. Comparable gender distributions have been documented in other tertiary care–based studies, suggesting that elderly men may be more likely to access psychiatric services or be referred for evaluation[4].Sociocultural factors, gender roles, and differences in help-seeking behavior may influence this pattern among OPD attendees.

Most patients belonged to lower socioeconomic strata and had low educational attainment. These factors are frequently reported in hospital-based geriatric psychiatry studies and may influence both vulnerability to mental illness and pathways to care[8]. Lower levels of education may also affect symptom recognition and delay treatment-seeking, resulting in more advanced presentations at tertiary care facilities[4].

More than half of the patients lived in nuclear families, reflecting ongoing shifts in family structure. Reduced familial support in nuclear households may contribute to emotional distress and increased reliance on institutional care among elderly individuals presenting to psychiatric services[7]. Notably, a majority of patients sought consultation voluntarily, suggesting gradual improvement in awareness and acceptance of mental health services among older adults attending tertiary centres, despite persistent stigma at the community level[4].

Distribution of Psychiatric Diagnoses

Within this OPD-based sample, schizophrenia spectrum and other psychotic disorders constituted the largest proportion of diagnoses. Although these disorders often begin earlier in life, their continuing representation among elderly OPD attendees likely reflects their chronic course and the need for long-term psychiatric follow-up[1112]. This finding underscores the importance of sustained care models for ageing patients with severe mental illness in tertiary settings.

Bipolar and related disorders and major and mild neurocognitive disorders were also frequently encountered. In geriatric clinical practice, overlapping affective, cognitive, and behavioural symptoms often complicate diagnosis, particularly in outpatient settings with limited time for evaluation[1314]. Depressive disorders accounted for a substantial proportion of OPD diagnoses, consistent with previous clinical studies identifying depression as a common reason for psychiatric consultation among elderly patients[15].

Anxiety disorders were less frequently diagnosed in this sample, which may reflect under-recognition during routine outpatient assessments, where anxiety symptoms are often overshadowed by somatic complaints or medical comorbidities[14 16]. Substance-related and addictive disorders and insomnia were documented in only a small number of patients, possibly because of underreporting or lack of systematic screening in busy OPD settings. A small proportion of patients did not receive a psychiatric diagnosis, highlighting the complexity

of geriatric presentations and the need for longitudinal assessment in this population.

The diagnostic pattern observed in the present hospital-based sample may be contrasted with findings from community-based studies, where depressive and anxiety disorders are often reported in a larger proportion of elderly individuals. For instance, community-based and epidemiological studies from India have documented a considerable representation of depressive and anxiety disorders among older adults[4 8 19]. In contrast, tertiary care settings tend to encounter a higher proportion of severe mental illnesses, including schizophrenia spectrum and bipolar disorders, likely reflecting referral patterns, illness severity, and help-seeking behavior[5 11]. These differences underscore the influence of study setting on the observed distribution of psychiatric diagnoses and highlight the need to interpret hospital-based findings within their clinical context. Such differences are expected, as hospital-based studies are influenced by referral bias and tend to capture individuals with more severe or persistent psychiatric conditions.

Gender-wise Distribution of Psychiatric Diagnoses

Gender-based differences were evident in the diagnostic profile of elderly OPD attendees. Substance-related disorders were more frequently encountered among male patients, consistent with hospital-based studies reporting higher rates of substance use among elderly men in India[17]. This finding emphasises the need for targeted screening and intervention strategies for substance use among older males presenting to psychiatric services.

Depressive disorders were observed in both males and females in broadly comparable proportions, reinforcing the evidence that depression is a significant clinical concern across genders among elderly patients seeking care[18]. Bipolar disorders were slightly more frequentamong female patients, a finding that aligns with reports suggesting that certain bipolar spectrum conditions may be more readily recognized in women, while underdiagnosis may occur in men[4].

Anxiety disorders were distributed across both genders, indicating that anxiety-related presentations are clinically relevant in elderly men and women alike. Neurocognitive disorders were encountered in nearly equal proportions among males and females, consistent with clinical studies suggesting comparable representation in hospital-based samples[18]. Somatic symptom disorder was more frequently observed among female patients, supporting earlier observations that psychological distress in elderly women may be more likely to present with somatic complaints.

Influence of Age, Residence, Marital Status, and Financial Dependence

Age-related variation in diagnostic patterns was noted among OPD attendees. Schizophrenia spectrum disorders were more frequently represented among patients in the 60–69 years age group, while anxiety and neurocognitive disorders constituted a greater proportion of diagnoses in older age groups. This pattern reflects the shifting clinical profile encountered in geriatric psychiatric practice, with cognitive and anxiety-related conditions becoming more prominent with advancing age.

Patients from both rural and urban backgrounds accessed the psychiatry OPD. Psychotic disorders were commonly encountered in both groups, while bipolar disorders were more frequently observed among rural patients and depressive disorders were slightly more frequent among urban attendees. These differences may reflect variations in access to care, referral pathways, social support, and environmental stressors that influence help-seeking behavior[19,20].

Marital status appeared to influence diagnostic patterns, with anxiety and somatic symptom disorders being more frequently encountered among widowed patients. Loss of spousal support, loneliness, and social isolation are well-recognized contributors to psychological distress among elderly individuals seeking psychiatric care. Financial dependence was associated with greater representation of bipolar and somatic symptom disorders, highlighting the psychological impact of economic insecurity and reduced autonomy among elderly OPD attendees.

Clinical Impression

During routine clinical evaluation, it was observed that several patients with psychotic and bipolar disorders had long-standing illness with onset in early or middle adulthood, whereas neurocognitive disorders and some depressive disorders appeared to have later-life onset. As age at onset and illness duration were not assessed using standardized measures, these observations were not included in formal analysis in order to minimize recall bias and misclassification.

Overall, this hospital-based study highlights the diverse range of psychiatric diagnoses encountered among elderly patients attending a tertiary care psychiatry outpatient service. The findings emphasise the influence of socio-demographic factors on clinical presentation and service utilization and underscore the need for comprehensive, geriatric-sensitive psychiatric care within tertiary settings. Interpretation of these findings should remain restricted to elderly individuals seeking outpatient psychiatric services and should not be generalized to the broader elderly population.

Strengths and implications of the study

This study provides useful real-world data on psychiatric morbidity among the elderly in North-East India, an under-researched region. Itoffers an overview of common geriatric psychiatric disorders and their socio-demographic correlatesin a tertiary care psychiatry outpatient setting. As the study used a standardized geriatric age cut-off, the findings reflect routine clinical presentations and help-seeking patterns, identify vulnerable subgroups, and emphasises the need for early recognition and timely management of mental health problems in older adults. The results may help inform the planning and strengthening of geriatric mental health services, including specialized clinics, improved referral pathways, and appropriate resource allocation, while also providing a foundation for future large-scale, community-based and longitudinal research on comorbidity patterns and outcomes in the elderly.

Limitations of this study:

Being hospital-based and conducted in a tertiary care psychiatry outpatient department, the findings may not be generalizable to the community-dwelling elderly population and are subject to referral and selection bias. The relatively small sample size may also limit external validity.The use of a self-designed screening questionnaire instead of standardized validated instruments represents another limitation of the study. Although diagnoses were based on DSM-5 criteria following comprehensive clinical evaluation, the absence of structured scales such as GDS or MMSE limits direct comparison with other studies and highlights the need for future research incorporating standardized assessment tools. Only the primary psychiatric diagnosis was recorded, and psychiatric as well as physical comorbidities were not systematically assessed, which may have led to underestimation of the true burden of illness. Substance use was not analysed according to individual substance types, and the absence of a structured assessment of age at onset limited differentiation between late-onset and long-standing psychiatric disorders.In addition, certain conditions such as mildcognitiveimpairment and subsyndromal disorders may have been underreported because of stigma, caregiver reporting, or limited patient insight.

CONCLUSION

This hospital-based study provides insight into the socio-demographic profile and diagnostic patterns observed among elderly patients attending a tertiary care psychiatry outpatient department. The findings indicate that a wide range of psychiatric disorders are encountered in geriatric OPD settings, with schizophrenia spectrum and other psychotic disorders, bipolar and related disorders, neurocognitive disorders, and depressive disorders constituting a substantial proportion of clinical diagnoses among service-seeking older adults.

The study also highlights the influence of factors such as age group, gender, marital status, financial dependence, and rural–urban background on the distribution of psychiatric diagnoses among elderly patients presenting for care. Chronic severe mental illnesses were commonly encountered among younger elderly patients, while anxiety and neurocognitive disorders were more frequently observed in older age groups. Gender-related differences and socio-economic vulnerabilities were also evident in clinical presentations within the OPD context.

These findings underscore the importance of strengthening geriatric mental health services at tertiary care centres, with emphasis on early identification, comprehensive assessment, and continuity of care tailored to the unique needs of older adults. Given the hospital-based outpatient design, the results reflect patterns among elderly individuals seeking psychiatric consultation and should not be extrapolated to the general elderly population. Future studies using larger samples, standardized assessment tools, and community-based designs are warranted to further clarify the mental health needs of the ageing population.

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