Research Article

DSM5-BASED DIAGNOSIS AND DEMOGRAPHICS OF THE PHILIPPINE MENTAL HEALTH ASSOCIATION INC.'S PSYCHIATRIC OUTPATIENTS

Uno-Rayco C, Soriano JR, Dela Cruz, LI, Noscal ME, Sanchez D, Santos A, Urbano M*

Philippine Mental Health Association, Inc. Philippines

Abstract

Background-The Philippine Mental Health Association, Inc. (PMHA) a non-profit, non-government institution is one of the few mental health service-providers in the country that caters mental health advocacy programs, out-patient diagnostic procedures, and rehabilitative care. These services are catered to a diverse population in terms of demographic characteristics. Several of the service-recipients of PMHA's CISD are found to be representative of psychiatric symptoms that construe much of the mental disorders out- lined on the DSM-5. The psychiatrists, case management officers, and the administrative assistant of PMHA exert coordinated efforts in securing and updating all Client-data records. Objective-This study was then conducted in view of organizing and understanding further the demographic features and frequency patterns of DSM-5-based mental disorders of out-patients serviced by PMHA. Method-This was a descriptive study consisting of out-patients with completed case-records referred for psychiatric consultation at PMHA since year 2017 until year 2021. Information such as age, gender, education level, employment status, civil status, religion and psychiatric diagnosis were organized and analyzed using frequency, percentage, and mean computations. Result. A total of 2,190 out-patient cases from year 2017 to year 2021 were organized. Prevailing age-range was 21 to 30 years, and majority was from NCR (76.4%). The most prevalent gender, civil status, educational attainment, occupation, and religion were female, single, college-undergraduate level, student, and Catholic, respectively. Majority of the out-patients were noted to be representative of Depressive Disorders (21%). Conclusion-Depressive disorders, schizophrenia, and neurodevelopmental disorders were found as the most common DSM-5 based cases handled by the psychiatric services of a non-government mental health facility in the Philippines.

Psychiatry Vol. 23S (Mental Health and Prevention), November-December 2022: 01-07.

Keywords: Mental disorders, Out-patient, Diagnosis, Demographics

Introduction

According to the World Health Organization (2020), 1,145,871 Filipinos suffer from Major Depressive Disorder, 520,614 are diagnosed with Bipolar Disorder, and annually, 5,570 suicide rates are completed. These statistics are crucial in providing proper treatment and implementing prevention programs for each mental disorder. However, a clear exigency in mental health professionals is evident in spite of the existence of primary care services in the Philippine health care system. It was found that among 100 million Filipino people, there are only about 133 practicing psychologists, 516 psychiatric nurses, and 548 psychiatrists in the country [1]. Additionally, Lally and colleagues (2019) shared that the Philippines persistently encounters various mental health related challenges, such as lack of professionals, underinvestment, and poor community psychological services [2].

Among the few existing local mental health care providers is the Philippine Mental Health Organization, Inc. (PMHA), a private, non-stock, non-profit organization that provides premier mental health services through education, advocacy, intervention and research. It was established in 1950 and has structured preventive mental health programs for the different sectors of society. At present, PMHA has eight Chapters all over the country that help cascade the association's advocacy to these areas. It is also a member of the World Federation for Mental Health. With its 72 years of experience in mental health advocacy; the Association have created and implemented programs for the youth, the family, and in more recent years, the grassroots level. The PMHA advocates mental health through its primary program, the Education, Advocacy and Research Department (EARD) and secondary program, the Clinical & Intervention Services Department (CISD).

Specifically, the CISD provides an out-patient basis, social, psychological, psychiatric, and allied mental health services to children, adolescents, and adults with emotional and behavioral problems and/or mental disorders. The Association provides holistic mental health services to clients and their families. The CISD professionals work together as a multi-disciplinary team to ensure that the client's mental health needs are properly addressed. The aforesaid department comprises a program manager, program coordinator, program officer, psychiatrists, psychologists, case management officers, allied mental health professionals, vocational assistants, and an administrative assistant.

The CISD provides quality mental health services to children, adolescents, and adult clients. As the frontline service of the CISD, professionals under the Social Services assess the needs of clients through intake interviews and make necessary recommendations and referrals to the members of the department's multidisciplinary team. CISD Psychologists conduct psychological assessments and psychotherapy services. On the other hand, CISD Psychiatrists provides diagnostic and treatment services through consultations, psychotherapy, and pharmacotherapy. Lastly, the department also offers occupational therapy and special education tutorials plus vocational skills training.

These services are catered to a diverse population in terms of sociodemographic characteristics. Equally relevant, several of the service-recipients of PMHA's CISD are found to be representative of psychiatric symptoms that construe much of the mental disorders outlined on the DSM-5. The psychiatrists, case management officers, and the administrative assistant of CISD exert coordinated efforts in securing and updating all Client-data records. This study was then conducted in view of organizing and understanding further the demographic features and frequency patterns of DSM-5 based mental disorders of out-patients serviced by PMHA's CISD.

Methods

The study was descriptive in nature and included all out-patient data within a 5 year time frame (from year 2017 to year 2021) of PMHA's Clinical and Intervention Services Department (CISD). Eligibility criteria included out-patient cases handled by the psychiatric service of the department. Only those patients with updated patient-information (as registered on the department's database) qualified to be part of the study data.

Data Collection

Client/Patient socio-demographic data were documented and/accomplished by the department's Case Management Officers (CMOs). Client/Patient diagnostic-data were accomplished by the attending Psychiatrists; diagnosis was based on the DSM-V diagnostic criteria. All Client data found eligible were organized and encoded by the CMOs and the Research Team of the Association.

Data Analysis

Organized data were analyzed on Statistical Package for Social Sciences (SPSS) using descriptive statistics.

Results

Demographic Characteristics

The total number of out-patients serviced by PMHA's Clinical Intervention Services Department in five years was 2,190. In year 2017 total number of cases documented were 269 where as for the following years of 2018, 2019, 2020, and 2021, total number of cases documented were 598, 692, 402, and 229, respectively.

From the 2,190 out-patients, 938 (42.8%) were male and 1,252 (57.1%) were female (Table 1.1). Prevailing age-range of the patients were 21 to 30 years (Table 1.2) while single was noted as the prevailing civil status 1,817 (82.96%) (Table 1.3) Majority of the patients came from the National Capital Region (n= 1,676, 76.4%)(Table 1.4). Across the documented cases, college-undergraduate level (n=753, 34.38%) was noted as the most prevalent educational attainment (Table 1.5) and student as the most prevalent employment status (n= 662, 30.22%)(Table 1.6). About 68.03% (n=1,490) of the serviced out-patients are also of the Catholic religion (Table 1.7).

Below provided tables show specific demographic distributions for each year:

DSM5-Based Diagnosis

Throughout the serviced out-patients from year 2017 to year 2021, Depressive Disorders was the diagnosis in 21% of the cases, followed by Schizophrenia Spectrum and Other Psychotic Disorders in 12.28%, and Neurodevelopmental Disorders in 9.54% of the cases. The least prevalent diagnoses were Somatic Symptom and Related Disorders which made up 0.27% of the cases.

Table 2 shows the distribution of various psychiatric diagnoses in the study data per year. The most common

Table 1.1
Gender

	2017		2018		2019		2020		2021	
Classification	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
Female	133	49.40%	333	55.70%	380	54.90%	234	58.20%	172	75.10%
Male	136	50.60%	265	44.30%	312	45.10%	168	41.80%	57	24.90%

Table 1.2
Age-Range

	2017		2018		2019		2020		2021	
Classification	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
1-10 years	23	8.60%	34	5.7	26	3.80%	12	3.00%	3	1.30%
11-20 years	65	24.20%	164	27.40%	183	26.40%	93	23.10%	50	21.80%
21-30 years	81	30.10%	194	32.40%	239	34.50%	140	34.80%	124	54.10%
31-40 years	41	15.20%	83	13.9	115	16.60%	74	18.4	32	14%
41-50 years	28	10.40%	61	10.2	42	6.10%	30	7.50%	11	4.80%
51-60 years	15	5.60%	29	4.80%	51	7.40%	20	5.00%	4	1.70%
61-70 years	9	3.30%	21	3.50%	21	3.00%	23	5.70%	4	1.70%
71-80 years	5	1.90%	7	1.20%	12	1.70%	9	2.20%	0	0.00%
81-90 years	1	0.40%	3	0.50%	3	0.40%	0	0.00%	1	0.40%
91-100 years	1	0.40%	1	0.20%	0	0.00%	1	0.20%	0	0.00%
Not Specified	0	0.00%	1	0.20%	0	0.00%	0	0.00%	0	0.00%

Table 1.3
Civil Status

	2017		2018		2019		2020		2021	
Classification	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
Single	213	79.20%	497	83.1%	574	82.9%	336	83.6	197	86
Married	45	16.70%	86	14.4%	97	14	55	13.7	27	11.8
Separated	4	1.50%	2	0.3%	8	1.20%	1	0.20%	1	0.40%
Divorced	1	0.40%	1	0.2%	1	0.10%	0	0.00%	1	0.40%
Widow	6	2.20%	12	2%	12	1.70%	10	2.50%	2	0.90%
Not specified	0	0.00%	0	0%	0	0.00%	0	0.00%	1	0.40%

Table 1.4
Region

Classsification	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
Region I	1	0.40%	2	0.3	2	0.30%	3	0.70%	5	2.20%
Region II	0	0.00%	0	0	1	0.10%	0	0.00%	0	0.00%
Region III	19	7.10%	47	7.90%	38	5.50%	32	8.00%	14	6.10%
Region IV-A	36	13.40%	66	11	89	12.9	54	13.4	54	23.6
Region IV-B	2	0.70%	4	0.70%	3	0.40%	1	0.20%	1	0.40%
Region V	4	1.50%	3	0.5	5	0.70%	1	0.20%	3	1.30%
Region VI	0	0.00%	2	0.3	0	0.00%	0	0.00%	0	0.00%
Region VII	1	0.40%	0	0	0	0.00%	0	0.00%	2	0.90%
Region VIII	0	0.00%	1	0.20%	0	0.00%	0	0.00%	2	0.90%
Region IX	0	0.00%	1	0.2	1	0.10%	0	0.00%	0	0.00%
Region X	0	0.00%	0	0%	0	0.00%	1	0.20%	2	0.90%
Region XI	0	0.00%	0	0	1	0.10%	0	0.00%	0	0.00%
Region XII	1	0.40%	1	0.20%	0	0.00%	0	0.00%	0	0.00%
Region XIII	0	0.00%	0	0	1	0.10%	1	0.20%	0	0.00%
NCR	204	75.80%	470	78.60%	549	79.60%	307	76.40%	146	63.8
CAR	0	0.00%	0	0	0	0.00%	2	0.50%	0	0.00%
BARMM	1	0.40%	0	0%	0	0.00%	0	0.00%	0	0.00%
Not specified	0	0.00%	1	0.20%	2	0.30%	0	0.00%	0	0.00%

Table 1.5
Educational Attainment

	2017		2018		2019		2020		2021	
Classification	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
Preschool	29	10.8%	47	7.9%	25	3.6%	11	2.7%	3	1.3%
Grade School	34	12.6%	83	13.9%	92	13.3%	57	14.2%	15	6.6%
High School	91	33.8%	170	28.4%	195	28.2%	112	27.9%	53	23.1%
Junior High School	9	3.3%	20	3.3%	23	3.3%	17	4.2%	5	2.2%
Senior High School	1	0.4%	9	1.5%	6	0.9%	5	1.2%	9	3.9%
Undergraduate Degree	64	23.8%	183	30.6%	238	34.4%	142	35.3%	126	55.0%

Graduate Degree	6	2.2%	13	2.2%	21	3.0%	9	2.2%	9	3.9%
Doctorate Degree	0	0.0%	0	0.0%	1	0.1%	1	0.2%	0	0.0%
Alternative LearningSystem	1	0.4%	1	0.2%	1	0.1%	0	0.0%	0	0.0%
Special Education	11	4.1%	20	3.3%	21	3.0%	13	3.2%	0	0.0%
Vocational Course	10	3.7%	20	3.3%	26	3.8%	17	4.2%	8	3.5%
Not applicable	9	3.3%	11	1.8%	2	0.3%	6	1.5%	0	
Not specified	4	1.5%	17	2.8%	27	3.9%	10	2.5%	1	0.4%
None	0	0.0%	4	0.7%	14	2.0%	2	0.5%	0	0.0%

Table 1.6
Employment Status

	2017		2018		2019		2020		2021	
Classification	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
Employed	61	22.70%	157	26.3%	198	28.6%	105	26.1%	97	42.4%
Self-employed	7	2.60%	14	2.3	43	6.20%	32	8.00%	14	6.10%
Unemployed	81	30.10%	111	18.6%	139	20.1%	50	12.4 %	42	18.3%
Student	91	33.80%	177	29.6%	202	29.2%	132	32.8%	60	26.2%
Retired	7	2.60%	17	2.8%	17	2.50%	16	4.00%	2	0.90%
Not applicable	10	3.70%	85	14.2%	53	7.70%	45	11.20%	12	5.20%
Not specified	12	4.50%	37	6.2%	40	5.80%	22	5.50%	2	0.90%

Table 1.7
Religion

	2017		2018		2019		2020		2021	
Classification	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
Ang Dating Daan	1	0.40%	0	0.00%	1	0.10%	0	0.00%	0	0.00%
Agnostic	4	1.50%	3	0.50%	6	0.90%	4	1.00%	4	1.70%
Assemblies of God	0	0.00%	0	0.00%	1	0.10%	0	0.00%	0	0.00%
Atheist	0	1.10%	1	0.20%	2	0.30%	2	0.50%	4	1.70%
Baptist	3	4.80%	6	1.00%	3	0.40%	2	0.50%	2	0.90%
Born Again Christian	13	0.40%	29	4.80%	32	4.60%	15	3.70%	14	6.10%
Buddhist	1	0.70%	0	0.00%	2	0.30%	0	0.00%	0	0.00%
CAT	2	1.10%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	18		42			65.9	28	70.6	13	60.7
Catholic	6	69.10%	5	71.10%	456	%	4	%	9	%
Christian	12	0.40%	37	6.20%	49	7.10%	38	9.50%	17	7.40%
Evangelical	1	4.80%	3	0.50%	5	0.70%	0	0.00%	0	0.00%
Iglesia ni Cristo	13	0.40%	21	3.50%	35	5.10%	7	1.70%	5	2.20%
Jehovah's Witness	1	0.40%	5	0.80%	9	1.30%	4	1.00%	2	0.90%
Jesus Miracle Crusade International Ministry (JMCIM)	1	0.40%	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Methodist	1	0.00%	3	0.50%	1	0.10%	0	0.00%	2	0.90%
Mormon	0	0.70%	1	0.20%	0	0.00%	1	0.20%	0	0.00%
Islam	2	0.70%	5	0.80%	2	0.30%	2	0.50%	1	0.40%
None	2	8.90%	1	0.20%	11	1.60%	8	2.00%	0	0.00%
										14.8
Not specified	24	0.00%	48	8.00%	63	9.10%	26	6.5	34	%
Pagan	0	0.00%	0	0.00%	0	0.00%	0	0.00%	1	0.40%
Pentecostal	0	0.70%	1	0.20%	0	0.00%	1	0.2	0	0.00%
Protestant	2	68%	5	0.80%	7	1.00%	3	0.70%	3	1.30%
Reformed Baptist	0	0.00%	0	0.00%	1	0.10%	0	0.00%	0	0.00%
Seventh-day Adventist	0	0.00%	1	0.20%	3	0.40%	1	0.2	0	0.00%
Sikh	0	0.00%	0	0.00%	0	0.00%	1	0.2	0	0.00%
The Church of Jesus Christ of Latter-day Saints	0	0.00%	3	0.50%	2	0.30%	2	0.50%	1	0.40%
Aglipayan Church	0	0.00%	0	0.00%	1	0.10%	1	0.2	0	0.00%

diagnoses in year 2017 were Schizophrenia Spectrum and Other Psychotic Disorders (16.4%), while Depressive Disorders was consistently prevalent for year 2018 until year 2021. Year 2019 outlines the most number of out-patients that underwent psychiatric diagnostic services while a drop in clientele can be observed from year 2020 to year 2021. The sum of the proportions of the DSM5-based disorders assigned on this study's Patient-cases are less than 100% since 24.33% (n=533) from the 2,190 cases included on this study have unspecified if not indefinite

Table 2
Diagnosis

	2017		2018		2019		2020		2021	
	(f)	%	(f)	%	(f)	%	(f)	%	(f)	%
Anxiety Disorders	10	3.70%	38	6.20%	61	8.80%	45	11.20%	5	2.20%
Bipolar and Related Disorders	23	8.60%	56	9.10%	51	7.40%	32	8.00%	8	3.50%
Depressive Disorders	24	8.90%	101	16.50%	205	29.60%	108	26.90%	22	9.60%
Disruptive, Impulse-Control, and Conduct Disorders	5	1.90%	4	0.70%	5	0.70%	2	0.50%	1	0.40%
Neurocognitive Disorders	6	2.20%	7	1.10%	2	0.30%	1	0.20%	0	0.00%
Neurodevelopmental Disor- ders	35	13%	67	10.90%	67	9.70%	36	9.00%	4	1.70%
Obsessive-Compulsive and Related Disorders	1	0.40%	2	0.30%	2	0.30%	2	0.50%	0	0.00%
Personality Disorders	0	0	2	0.30%	3	0.40%	1	0.20%	1	0.40%
Schizophrenia Spectrum and Other Psychotic Disorders	44	16.40%	73	11.90%	95	13.70%	54	13.40%	3	1.30%
Sleep-Wake Disorders	0	0	3	0.50%	3	0.40%	2	0.50%	0	0.00%
Somatic Symptom and Related Disorders	1	0.40%	4	0.70%	1	0.10%	0	0.00%	0	0.00%
Substance-Related and Addictive Disorders	0	0.00%	2	2.60%	4	0.60%	1	0.20%	0	0.00%
Trauma- and Stressor-Related Disorders	12	4.50%	16	2.70%	21	3.00%	14	3.50%	2	0.90%

diagnosis while some were recorded on the Patient-charts to have multiple diagnosis (11.68%; n=256).

Discussion

Main Findings

This study was undertaken to review and appraise the demographic features and diagnostic profile of out-patients in a non-government mental health facility. This was a descriptive study consisting of out-patients with completed case-records referred for psychiatric consultation at PMHA since year 2017 until year 2021.

Across the 2,190 cases included on this study from the period of year 2017 to year 2021, majority were in the 21–30 years age range (n=778), with a percentage computation of 35.52%. This observation is consistent with the study of Gustavson and colleagues (2018) that asserted that common mental disorders are highly prevalent among young adults in their twenties and somewhat less prevalent in young adults in their thirties/forties [3]. Considerably, early adulthood situates varying life-challenges that could strain the young adult's psychological resources. In the recently released Deloitte Global's 2022 Gen Z and Millenial Survey, young people from 46 countries born between January 1995 to December 2003 (ages 19 to 27) and those born between January 1983 to December 1994 (ages 28 to 39) were found to report higher levels of stress and anxiety associated to worrying over finances, mental health, and family problems. Specific to the Filipino community, the Deloitte 2022 survey in- forms that 60% of the Filipino Gen Z's and Millennials pointed four lead contributors to their stress and anxiety experiences: their longer-term financial future, their day-to- day finances, mental health issues, and family/personal relationships. Apparently, to- day's young adults are confronted with such concerns that tend to put a strain on their mental health [4].

As for this study's gender distribution, female dominance (57.41%) was noted, which finds support in Alibudbud's (2022) research that mentioned Filipino young women have higher rates of certain mental disorders than men. Unique social experiences and contexts including violence, discrimination, cultural expectations, and social roles were discussed by Alibudbud (2022) as relevant to the variation in incidences of anxiety, depression and stress across genders [5].

Unmarried (single) clients/service-recipients was moreover found prevalent in the analyzed data. Grundstrom and colleagues (2021) suggests that compared to being married, singlehood or being divorced/widowed were associated with depressive symptoms at every age in men whereas for women, being single but not being divorced/ widowed was associated with depressive symptoms [6].

Addedly, this study found higher clientele rate in the NCR. In a selected literature review done by Gruebner and colleagues (2017), it was noted that risk for serious mental illness is generally higher in cities than in rural areas; issues like poverty, social isolation and discrimination were informed as significant contributors to mental health burden experienced in the city [7]. This study nonetheless placed into consideration the fact that the Association (PMHA) is based on one of the chief cities (Quezon City) in NCR, hence, majority of the study-data collected and analyzed were Patient-cases from surrounding areas.

Data of this descriptive study moreover displayed literacy rate of about 94.74%, while only 0.91% of the cases was found to have no formal education. Majority of the patient-cases though had reached until college but have not necessarily completed their degree (34.38%). Munoz and Lozada (2021) on their study that investigated educational attainment and serious psychological distress reported that in a society where college completion is a challenging endeavor due to increasing costs of college education alongside the complex connection between

income, employment, and access to healthcare, those with some college education may have worse health due to the burden of incompletion and associated stressors that could have been mitigated by finishing a college degree [8]. The likelihood of limited employment opportunities, economic burden, and personal life-goal setbacks that co-occur with having not completed a college education pose as strong threats against one's mental wellbeing.

Relatively, student as an occupational status proved most prevalent this study's Patient-cases' data (30.22%). Pre-schoolers, elementary students, and those who are in high school and in universities were noted to have been consistently serviced by the Association from year 2017 to year 2021. Malolos and colleagues (2021) reviewed that among Filipino children aged 5 to 15, 10% to 15% are affected by mental health problems and 16.8% of Filipino students aged 13 to 17 have attempted suicide at least once within a year before the 2015 Global School-based Student Health survey. Child labor and abuse, pandemic related challenges, and natural disasters like typhoons were discussed by Malolos and colleagues (2021) as relevant to the remarkable incidence rate of mental problems among Filipino children and adolescents [9]. Also, in a systematic review (Storrie, Ahern, & Tuckett, 2010) on emotional and mental health problems among university students worldwide, the study's collected and reviewed research articles underscored that among students suffering mental illness, 51% started experiencing mental illness before they attended college with the rest having the illness start during college and that depression, eating disorders, self-harm and obsessive compulsive disorders were commonly reported while anxiety, depression and psychotic disorders were most experienced [10].

With regards to the prevailing religion, 68.03% of the serviced out-patients were identified to be of the Catholic religion. While a bulk of existing literature attest of the buffering effect of religion in the emergence and experience of mental problems, there are a few yet noteworthy studies that discuss how some religious beliefs and/or values can affect mental health among of which is a religiously reinforced mental health stigma. For one, Peteet (2019) pointed out that religion could cause misattribution of psychopathology. Some of the examples Peteet (2019) discussed include patients with bipolar disorder believing they are being directed by God, patients with depression believing they have committed an unpardonable sin, or patients with obsessive-com- pulsive disorder feeling guilty of imagined sexual indiscretions. Peteet (2019) then gave an invaluable endorsement that clinicians should approach psychopathological misattribution sensitively, addressing their dynamic and pathological sources of distress without unnecessarily challenging the patient's faith, although at times they may need to be direct, for example in insisting on needed medication. He further elaborated that when differentiating cultural and normative religious expression from psychopathology tends to be challenging, consultation and collaboration with members of the patient's faith community can be helpful, and that the patient's family of faith can become an important ally in fostering insight and adherence to treatment [11].

In terms of the DSM5-based psychiatric cases documented on this study, Depressive Disorders was found most common (21%), seconded by Schizophrenia Spectrum and Other Psychotic Disorders (12.28%), followed by Neurodevelopmental Disorders (9.54%). These findings corroborate with the prevalence data released by WHO (2020) that outlined Major Depressive Disorder as the lead mental disorder in the Philippines (n= 1,145,871) that comprises 1.1% of the Filipino population. The WHO 2021 data also showed Schizophrenia (n=213,422; 0.2%) as another prevalent mental disorder in the Philippines [1]. Taking into account as well that a large number of students (children, adolescents and young adults) were part of this study's Patient-cases' data, Neurodevelopmental Disorders as the third most prevalent cluster of diagnosis was made evident on this study. The observed clientele decrease since year 2020 until 2021 is mostly attributed to the emergence of the COVID-19 pandemic where for a number of months, psychiatric consultation at PMHA had temporarily paused and where information about the materialization of an online service-platform at the Association was not immediately disseminated to prospective mental health consumers.

Some literature (e.g. Lim, et.al., 2018; Patel, et.al., 2018) noted that low to middle in- come countries has higher incidences of depression [12, 13] . Ridley and colleagues (2020) informed of the bidirectional causal relationship between poverty and mental disorders like depression and anxiety; they explained that presence of mental illness like depression and anxiety reduces employment that then affects income then affecting receipt of psychological interventions that demand economic costs; at the same time negative economic shocks cause mental illness [14]. In the Philippines, though Flores and colleagues (2018) cited an observation that depression, anxiety, and distress are strongly prevalent in their study sample living in low-income communities, no certain directions in the identified associations were made nor were there any inferred causality and mediation pathway between outcomes of interests [15]. Essentially, economic situations and their direct relationship to the emergence and persistence of the prominence of mental disorders like depression in a developing country like Philippines are yet to be thoroughly investigated.

Conclusion

Depressive disorders, schizophrenia, and neurodevelop-mental disorders were found as the most common DSM-5 based cases handled by the psychiatric services of the Philippine Mental Health Association, Inc. The organized and analyzed demographic characteristics of the study data relatively helped outline the vulnerable groups in mental

health for which advocacy and prevention programs could be devised and prioritized.

Conflicts of Interest

The authors declare no conflict of interest regarding the publication of this paper.

References

1. World Health Organization. Philippines WHO Special Initiative for Mental Health Situational Assessment: Updated March 2020. World Health Organization; 2020.
2. Lally, J., Tully, J., & Samaniego, R. Mental Health Services in the Philippines. BJPsych International, 2019;16:62-64.
3. Gustavson, K., Knudsen, A.K., Nesvåg, R. et al. Prevalence and stability of mental disor- ders among young adults: findings from a longitudinal study. BMC Psychiatry 2018:18.
4. The Deloitte Global Gen Z and Millenial Survey 2022.
5. Alibudbud, R. Gender in mental health: Comparison of the rate and social factors of depression, anxiety, and stress among young adult Filipino heterosexual cisgender men and women and LGBT+ individuals. International Journal of Social Psychiatry. 2022
6. Grundström, J., Konttinen, H., Berg, N., &; Kiviruusu, O. Associations between relationship status and mental well-being in different life phases from young to middle adulthood. SSM Population Health, 2021;14:100774.
7. Gruebner, O., Rapp, M. A., Adli, M., Kluge, U., Galea, S., et al. Cities and mental health. Deutsches Ärzteblatt International, 2017;114:121.
8. Muñoz, I. G., & Santos-Lozada, A. R. Educational attainment and psychological distress among working-age adults in the United States. SSM-Mental Health, 2021:1;100003.
9. Malolos, GZ, Baron, MB, Apat, FA, Sagsagat, HA, Pasco, PB, et al. Mental health and well-being of children in the Philippine setting during the COVID-19 pandemic. Health Promotion Per- spectives, 2021:11;267-270.
10. Storrie, K., Ahern, K., Tuckett, A. (2010). A systematic review: Students with mental health problems—A growing problem. International Journal of Nursing Practice 2010:16;1-6.
11. Peteet, JR. Approaching Religiously Reinforced Mental Health Stigma: A Conceptual Framework. Psychiatric Services, 2019:70;846-848.
12. Lim, G., Tam, W., Lu, Y., Ho, C., Zhang, M., et al. Prevalence of Depression in the Community from 30 Countries between 1994 and 2014. Scientific Reports, 2018;8:2861.
13. Patel, V., Burns, J., Dhingra, M., Tarver, L., Kohrt, B. et al. Income inequality and depression: a systematic review and meta-analysis of the association and a scoping re- view of mechanisms. World Psychiatry 2018:17;76-89.
14. Ridley, M., & Rao, G. Poverty, depression, and anxiety: Causal evidence and mechanisms. Science, 2020:370
15. Flores, JL., Hernandez, MA., Leyva, EW., Cacciata, M., Tuazon, J., et al. (2018). Prevalence and correlates of depression, anxiety, and distress among Filipinos from low-income communities in the Philippines. Philipp J Nurs. 2018;88:8-13.

Correspondence author: ***Soriano JR, Philippine Mental Health Association, Inc., Philippines***

Email: jrjsoriano@pmha.org.ph

Received: 13-Dec-2022, Manuscript No. AJOPY-22- 83282, **Editor assigned:** 14-Dec-2022, PreQC No. AJOPY-22- 83282 (PQ), **Reviewed:** 19-Dec-2022, QC No. AJOPY-22- 83282 (Q), **Revised:** 21-Dec-2022, Manuscript No. AJOPY-22- 83282 (R), **Published:** 25-Dec-2022, DOI. 10.37532/ajopy.2022.23(2).1-7