International Journal of Biomedical and Health Sciences
Vol. 3, No. 3 September 30, 2007
Printed in Nigeria

0794-4748/2007 $12.00 + 0.00

http://www.asopah.org

IJBHS 2007039/3309

Attitude of Patients With Physical Illness To Psychiatric Referral: Case Series of twelve Patients

P. O. Ajiboye*

Department of Behavioural Sciences, University of Ilorin Teaching Hospital, Ilorin, Kwara state- Nigeria.

(Received May 31, 2007)

ABSTRACT: **Aim**: Both physicians and patients react with mixed feelings when the opinion of a psychiatrist is needed. It is more acceptable to have a medical or surgical problem than to have a mental problem. Many patients are reluctant to accept that their somatic symptoms may have psychological causes and that referral to a psychiatrist may be appropriate. This report is on the outcome of in-patient and out-patient follow-up management of 12 patients with the aim of exploring their attitude to mental illness.

Materials and Methods: a case series of 12 patients with psychiatric co-morbidity referred by other specialists, seen and managed to the point they were mentally stable in a consultation- liaison unit of the department of Behavioural Sciences, University of Ilorin Teaching Hospital, Nigeria. Patients were interviewed using a standardized diagnostic interview schedule- the PSE. Data were also collected on their demographic variables. Patients were followed up prospectively in the out patient clinic for 3 months after discharge.

Results: The average age of the 12 patient (±SD) was 35.8±19.3 years. Seven (58.3%) were married while 5 (41.7%) were single. More than half (58.3%) of the referral came from internal medicine department. Majority (91.7%) had no past psychiatric history and the commonest psychiatric diagnosis was acute organic brain syndrome. Six (50%) of the patients out rightly defaulted follow-up.

Conclusion: The high default rate recorded in this study is indicative of a negative attitude on the part of patients to being referred to a psychiatrist. Factors responsible for this negative attitude include the fear of being stigmatized and preference for traditional mental heath practitioners who share the same aetiological concept with them. More effort in increasing public awareness and education about mental illness to reduce stigma is recommended. Consultation – liaison psychiatric services could also be incorporated into the outpatient services of other non psychiatric specialties so that such patients could be seen by mental health professional where patients with physical illnesses are being attended to. There is also the need for increase collaboration with traditional mental heath practitioner to facilitate continuity of care for defaulting patients.

Key Words: Negative attitude, physical illness, mental illness, psychiatric referral, consultation- liaison psychiatry.

*All Correspondence to: P.O. Box 825 GPO,
Ilorin 240001, Ilorin, Kwara State, Nigeria.
E-mail: poboye203@yahoo.com

Introduction

Attitude is the predisposition to respond cognitively, emotionally or behaviourally to a particular object in a particular way. Put in other words, attitudes are likes and dislikes, favourable or unfavourable evaluations of and reactions to objects, people, situations or other aspects of the world including abstract ideas and social policies (1). Attitude of physicians to psychiatric referral has been reported on by a number of authors (2, 3, 4) but there is not much report on attitude of patients to the experience of being referred to psychiatrists. Many authors' report that patients either terminate their consultation, discharge themselves against medical advice or out rightly defaulted outpatient clinic appointment (5, 6,7) calls for more critical examination. This report on case series of 12 patients present the attitude of patients to psychiatric referral in a consultation- liaison setting in a Nigerian Teaching Hospital.

Methods

The patient population consisted of 12 patients who were managed in a consultation- liaison psychiatric unit of University of Ilorin Teaching Hospital (UITH). The patients were discharged to the outpatient clinic to be followed-up prospectively to determine the outcome of psychiatric intervention within the first 3 months after discharge. A standardized psychiatric interview schedule; the Present State Examination (PSE) (8) was used to interview each patient. Diagnoses were based on the 10^{th} edition of the International Classification of Disease (ICD-10) (9). Data were also collected on their sociodemographic profiles.

Results

This series involved six men and six women. The average age of the 12 patients (±SD) was 35.8 ± 19.3 years. Seven (58.3%) were married while 5 (41.7%) were single. Seven (58.3%) of the referrals were from internal medicine department, 2 (16.7%) each, were from departments of surgery and obstetrics and gynaecology respectively and 1 (8.3%) from paediatric department. Average duration of symptom before referral (± SD) 8.3 (± 6.6) days. Majority (91.7%) had no past psychiatric history. The commonest psychiatric diagnosis was acute organic brain syndrome. Six (50%) of the patients out rightly defaulted outpatient clinic follow-up. These findings are reported on Table 1. Even though all the patients benefited from the psychiatric management, cases 1, 2, 3, 4, 9 and 12 out rightly defaulted outpatient follow- up care and case 5 who also defaulted for the first 2 months and she only reported for follow- up because she had another obstetric complications after being discharged from the hospital. Also the behavioural problems in cases 1, 3, 4, 5, 9 and 12 were equally or more severe than the physical problems they came to the hospital with.

Discussion

The 12 patients presented in this case series illustrates some of the ways people could react to being referred to see the psychiatrist. It also establishes the fact that psychiatric disorders are common among patients with physical illness (10, 11, 12, 13, 3) and that such patient could benefit immensely from referral to the psychiatrists. Deprivation of patients of such care could result in medically unnecessary complications which include adverse effects on quality of life, poor compliance with effective medical treatments and possibly some effects on long –term physical morbidity and mortality (14).

Table 1: Summary of Case Histories of 12 patients followed-up for outcome of intervention.

Patient	Age (years)	Sex	Marital status	Occupation	Duration of symptoms (days)	Physical diagnosis	PSE symptoms	ICD-10 diagnosis	Psychiatric intervention	Outcome
1	22	F	Married	Trader	5	Ruptured uterus	Depressed mood and affect	Adjustment disorder with depressed mood	Counselling	Stable after 2 wk of psychiatric intervention but defaulted outpatient follow up
2	73	M	Married	Village Chief/ farmer	25	CVD secondary to Hypertension	None	No ICD-10 diagnosis. Had 'expected' somatic concern for his physical illness. Was reacting to situation around him.	Counselling for patient and education for the nursing staff and relatives on how to assist the patient.	Became cooperative through out his stay on the ward but did not show up for follow up.
3	54	M	Married	Farmer	7	Enteric fever	Second person auditory hallucination, persecutory delusion, and muteness.	Acute organic brain syndrome	Tab. Haloperidol.	Became symptom free within a week .Defaulted follow up.
4	28	F	Single	Trader	7	Necrotising fascitis of the left thigh.	Grandiose and persecutory delusion with unusual excitement.	Acute organic brain syndrome.	Tab. Haloperidol.	Delusion and hostility to nurses stopped after 2 weeks. Became mentally stable after 5 weeks and was discharged on the 6th week. Defaulted follow up.

Patient	Age (years)	Sex	Marital status	Occupation	Duration of symptoms (days)	Physical diagnosis	PSE symptoms	ICD-10 diagnosis	Psychiatric intervention	Outcome
5	29	F	Married	Seamstress	1	Post partum eclampsia	Restlessness, Visual and auditory hallucination, looseness, of association and poor orientation.	Acute Psychosis in peuperium.	Tab. Haloperidol.	Became mentally stable after 3 weeks of treatment. Defaulted follow up until 2 months after that she reported in the clinic with obstetric complication. Referred to see the Gynaecologist and to come for follow up in 2 weeks. She did not report back.
6	17	M	Single	Student	1	Overdose of diazepam	Feeling of guilt for his action	Deliberate self harm	Counselling	Promised not to repeat the same behaviour, and to have positive approach to life. Remain stable on out patient follow up.
7	42	M	Married	Business man	14	Hypoglycaemia	Auditory hallucination, derealization, neologism and undue irritability.	Relapse Paranoid schizophrenia.	Tab Haloperidol	Auditory hallucination and derealization stopped within a month and he became coherent. Kept follow up appointment and was stable beyond the 3 months for the study.
8	13	M	Single	Student	11	Viral encephalitis	Delayed sleep, restlessness, looseness of association and clouding of consciousness.	Acute organic brain syndrome.	Tab. Haloperidol	Mentally stable by the second week. Did well on outpatient management
9	21	F	Single	Student	3	Enteric fever	Blunted affect, muteness, negativism and abnormal posture.	Acute organic brain syndrome	Tab. Haloperidol	Became mentally stable after about 3 weeks of antipsychotic medication. Defaulted follow up.

Patient	Age (years)	Sex	Marital status	Occupation	Duration of symptoms (days)	Physical diagnosis	PSE symptoms	ICD-10 diagnosis	Psychiatric intervention	Outcome
10	62	F	Married	Trader	7	Seizure disorder	Looseness of association, negativism and hallucinatory behaviours	Acute organic brain syndrome.	Tabs. Haloperidol and Carbamazepine	Repeated seizure stopped in the first week. Behavioural abnormalities stopped the second week. Kept out patient appointment and remain stable through out follow up period.
11	45	M	Married	Farmer	12	TB arthritis	Delayed sleep, visual and auditory hallucination which was initially present had stopped.	Acute organic brain syndrome in remission.	Tab. Diazepam for a few days.	Stable within the first 2 weeks. Discharged to the out patient clinic and was stable through out the follow up period.
12	23	F	Single	Student	7	Typhoid enteritis	Auditory and visual hallucination, talkativeness, selective mutism and inadequate sleep.	Acute organic brain syndrome	No medication was given because symptoms had almost subsided when she was seen.	Did not honour out patient appointment.

Six out of the 12 patients presented in this series out rightly defaulted out patient clinic follow – up management and an additional one patient only showed up for follow–up 2 months after her discharge from the hospital and this was because she had obstetric complication. This finding would suggest negative attitude on the part of the patients to psychiatric referral and care. One possible reason for this negative attitude could be the fact the primary reason for bringing the patients to the hospital was for a physical illness and since they were free of psychiatric symptoms at discharge they did not see any reason for attending out patient follow-up clinic. Another reason for this negative attitude as reported by Byre (15) might be due largely to the fear of being stigmatized. Stigma has damaging effects on the patient and these effects include damage to self-esteem, difficulty in making friends and difficulty in finding good jobs, safe housing, satisfactory health care and reluctance to admit to mental illness (16, 17). The stigma could be both public stigmas (negative beliefs about a group such as dangerousness, incompetence, character weakness etc) and self- stigma (negative beliefs about self such as character weakness, incompetence, low self-esteem, low self- efficacy etc) (16). It has also been suggested that stigma make patient to conceal their illness, particularly to their employers and that this could affect their compliance with treatment and follow-up (17). There is therefore the need for more effort in increasing public awareness and education about mental illness to help reduce stigma felt by sufferers. It has been suggested that this should be an important component of any health policy for now (18). Consultation- liaison psychiatry services could also be incorporated into out patient services of other specialties so that such patients who have psychiatric co-morbidity with physical illness could be seen by mental heath professionals where other patients without mental illness are attended to.

The preference patients have for traditional mental health practitioners in keeping with their belief in the supernatural causation of mental symptoms and illness could be another reason for the negative attitude of the patients (19, 20, 21). It has also been reported that a supernatural view of the origin of mental illness may imply that orthodox medical care would be futile and that help would be more likely to be obtained from spiritualists and traditional healers (18). It is recommended that some form of working relationship between orthodox mental health practitioners and the traditional mental health practitioners should be established. Such collaborative efforts may facilitate continuity of care for defaulting patients.

Conclusion

The high default rate recorded in this study is indicative of a negative attitude on the part of patients to being referred to a psychiatrist. Factors responsible for this negative attitude include the fear of being stigmatized and preference for traditional mental heath practitioners who share the same aetiological concept with them. More effort in increasing public awareness and education about mental illness to reduce stigma is recommended. Consultation –liaison psychiatric services could also be incorporated into the outpatient services of other non psychiatric specialties so that such patients could be seen by mental health professional where patients with physical illnesses are being attended to. There is also the need for increase collaboration with traditional mental heath practitioner to facilitate continuity of care for defaulting patients. A study on patients' attitude to psychiatric referral is recommended for future investigation.

References

1. Atkinson RL, Atkinson RC, Smith EE, Daryl BJ, Nolen-Hoeksema S. Attitudes In: Hilgard's introduction to psychology 13th edition. Harcourt College Publishers, Orlando.2000; 620-7.
2. Steinberg H, Torem M, Saravay SM. An analysis of physicians' resistance to psychiatric consultation. Arch Gen Psychiat 1980; 37: 1007-1012.
3. Aghanwa HS, Morakinyo O, Aina OF. Consultation- liaison psychiatry in a general hospital setting in West Africa. East Afr Med J 1996; 73: 133-6.
4. Adeyemi JD, Olonade PO, Amira CO. Attitude to psychiatric referral: A study of primary care physicians. The Nigerian Postgraduate Medical Journal. 2002; 9: 53-8.
5. Clarke DM, Smith GC. Consultation- liaison psychiatry in general medical units. Aust-N.Z. J Psychiat.1995; 30: 424-32.
6. Dunsis A, Smith GC. Consultation- liaison psychiatry in obstetric service. Aust-N.Z J Psychiat. 1996; 30: 63-73.
7. Odejide AO, Olatawura MO, Makanjuola ROA. Psychiatric services in a Nigerian general hospital. Afr J Psychiat. 1978; 4: 97-102.

8. Wing JK, Cooper JE, Sartorius N. The description and classification of psychiatry symptoms. An instruction manual for the PSE and CATEGO system. London Cambridge University press. 1974.
9. World Health Organisation. The 10th revision of the International Classification of Disease (ICD-10) Clinical description and diagnostic guideline, Geneva 1992.
10. Silverstone PH. Prevalence of psychiatric disorders in medical in- patients. J Nerv Ment Dis. 1996; 184: 43-51.
11. Mayou RA, Hawton KE. Psychiatric disorder in the general hospital. Br J Psychiat. 1986; 149: 172-190.
12. Abiodun OA, Ogunremi OO. Psychiatric morbidity in medical and surgical wards of a Nigerian general hospital. J Psychosom Res. 1990; 34: 409-414.
13. Abiodun OA, Adetoro OO, Ogunbode OO. Psychiatric morbidity in a gynaecology clinic in Nigeria. J Psychosom. 1992; 36: 485-90.
14. Mayou RA. Psychiatry, medicine and consultation- liaison. Br J Psychiat. 1997; 171: 203-4.
15. Byre P. Stigma o f mental illness. Changing minds, changing behaviour. Br J Psychiat. 1999; 174: 1-2.
16. Corrigan PW, Watson AC. Understanding the impact of stigma on people with mental illness. World Psychiatry 2000; 1:16-20.
17. McCarthy J, Prettyman R, Friedman T. The stigma of psychiatric in- patient care. Psychiat Bull. 1995; 19: 349-51.
18. Gureje O, Lasebikan VO, Ephraim- Oluwanuga O, Olley BO, Kola L. Community study of knowledge of and attitude to mental illness in Nigeria. Br J Psychiat. 2005; 186: 436- 41.
19. Makanjuola AB, Adelekan ML, Morakinyo O. Current status of traditional mental health practice in Ilorin Emirate Council Area, Kwara State Nigeria. West Afr Med J. 2002; 19: 43-9.
20. Abiodun OA. Pathways to mental health care in Nigeria. Psychiat Service. 1995; 46: 823-26.
21. Gureje O, Acha RA, Odejide OA. Pathway to psychiatric care in Ibadan, Nigeria. Tropical and Geographic Medicine. !995; 47: 125-29.