

Reactions to Psychiatry Referral in Patients Presenting with Physical Complaints to Medical and Surgical Outpatient Services

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ABSTRACT

Background: While it is well known that patients with psychiatric illness feel stigmatized, little is known about the reactions to a psychiatric referral among those who visit general hospital medical and surgical services for their complaints. **Materials and Methods:** This study assessed the sociodemographic details, psychiatric diagnosis, somatic symptom severity, and interview-based reactions to referral among patients referred to psychiatry services from other departments in a general tertiary hospital in North India. Fifty-nine males and 101 females were assessed over 6 months for this purpose. **Results:** A majority of patients were diagnosed with a psychiatric disorder and had significant somatic symptom severity. The themes explored were the decision to accept the referral, possibility of the presence of mental illness as signified by a psychiatric diagnosis and factors that enabled or impeded psychiatric treatment seeking. **Conclusions:** Results indicate that patients did not empower in decision-making, a reluctance to accept the possibility of a psychiatric diagnosis and accept medication and had poor knowledge about psychiatry. Referring clinicians and psychiatrists should be sensitive to patient perceptions so that better care is possible.

Key words: Consultation, general hospital, liaison, psychiatry, referral, stigma

INTRODUCTION


A physician or a surgeon may refer a patient to psychiatric services for the various reasons. These include the suspicion of or a known diagnosis of a mental disorder, or if the presenting physical symptoms are found to be without adequate explanation, or if the physician feels inadequate in dealing with the psychological symptoms.^[1] However, the general

public the world over usually has a negative opinion of mental illness, psychiatry, and psychiatrists.^[2] In health-care settings, this negative opinion is reflected in reluctance of patients and physicians alike for psychiatric referral.^[3,4] This despite the fact that there is a high prevalence of mental disorders in primary care and specialist treatment seekers across various specialties.^[5] This reluctance to enter treatment is

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also reflected in the rates of staying in treatment and completing it. For instance, about one-third of patients who do enter outpatient mental health care in the general medical setting in the United States do not complete it.^[6] The reasons for this reluctance to enter treatment are varied. Studies in this area have shown that while some physicians have more success in referring patients to psychiatric services, others do not.^[7] Patients with more complicated symptoms also tend to refuse psychiatric referrals.^[7] Patients may feel rejected by the primary physician and feel stigmatized.^[8] This is true in India as well.^[9] In addition, patients may feel that a psychiatric referral may be equivalent to an admission of personal weakness and that a diagnosis of mental disorder may lead to difficulties in employment and personal relationships.^[3] Patients may also have their own explanations of the distress they face, and these may be contrary to the explanations provided to them or implied by a psychiatric referral.^[10,11]

From the above review, it is obvious that the psychiatric referral for whatever reason in a patient presenting to a medical or surgical service setting is likely to be problematic for many of those who are referred. This is especially so in busy settings where the referring physician may not adequately explain the reasons for referral. While there are some data regarding people who refuse the referral, there are very little data on the reactions and attitudes to psychiatry referral in those who contact psychiatric services at least once. A psychiatrist may be unaware of the emotional state and cognitions aroused by the referral itself, and this may lead to a poor therapeutic alliance, treatment adherence, and outcome. There are no data on this topic from India to the best of our knowledge.

This study was designed to assess the reaction to the psychiatry referral among patients who had been referred to psychiatry services from other medical and surgical specialties and had at least one contact with the former.

Aims and objectives

The aim of this study was to assess the reactions of patients presenting to the psychiatry outpatient department (OPD) of a general hospital in North India on referral from other medical and surgical departments due to any reason. We also assessed the severity and extent of somatic symptoms, clinical psychiatric diagnosis and whether these variables had any impact on the reactions to psychiatry referral.

MATERIALS AND METHODS

This study was conducted in the OPD of the hospital. The usual patient load comprises primarily of voluntary

patients who approach psychiatry services followed by those referred from other service departments in the hospital. Often, patients who do not know what department to go to are guided regarding the same by personnel at the hospital reception. The usual procedure followed in the OPD is that the sociodemographic data (SD) of patients presenting to the OPD is recorded in an SD profile sheet. On the same day, an initial assessment is done by a psychiatrist in the walk-in clinic (WIC) after which a diagnosis is arrived at, and initial management started. At subsequent follow-ups, a detailed workup (DWU) is conducted within a few weeks by a trainee resident psychiatrist which is the discussed with a consultant psychiatrist. A clinical diagnosis is usually generated at the DWU which is then coded in the patient file and management is continued or changed as required. Patients referred from other departments or those who seek treatment on their own initiative follow the same procedure as outlined above.

Before starting the study, clearance was sought and received from the Institute Ethics Committee. The evaluation of the patients for the purpose of this study took place at the WIC level of contact. Consecutive patients presenting to the psychiatry OPD for 6 months on referral from other departments were approached for participation in the study. Written informed consent was obtained from them after explaining the nature and purpose of the study. Inclusion criteria were a willingness to participate in the study and age of ≥ 14 years. Exclusion criteria were refusal to participate in the study, current intoxication or cognitive dysfunction that would preclude the patient from participating in the study. During clinical interview, usual protocols were followed with respect to generation of diagnosis and treatment initiation. In addition, an unstructured interview was done in which patients were asked what they thought about their psychiatry referral and regarding the possibility that they may be diagnosed with a psychiatric disorder. Responses were written down in the form of case notes and common themes were identified. Somatic symptoms were assessed using a Hindi translation of the self-rated Patient Health Questionnaire-15 (PHQ-15).^[5,12] The PHQ-15 is a self-rated instrument with validity and provides somatic symptom severity estimates in the form of total scores which can then be used to classify somatic symptom severity into low, medium, and high categories. The provisional clinical diagnosis generated as per International Classification of Disease-10 at the WIC was taken as the psychiatric diagnosis.^[13]

RESULTS

Fifty-nine male (36.9%) and 101 female (63.1%) patients entered the study (total $n = 160$). Table 1

Table 1: Demographic and clinical profile of study group

Variables	Male	Female	P
Mean age in years (SD)	31.81 (11.30)	37.43 (10.45)	0.64
Mean years of education (SD)	11.45 (4.18)	8.46 (5.99)	<0.01
Diagnostic groups (ICD-10)			
F3X.XX	2	4	0.23
F41.XX	6	5	
F45.XX	47	90	
Other psychiatric disorders	2	0	
No psychiatric disorder	2	2	
Source of referral			
Medicine	43	76	0.62
Others	16	25	
PHQ-15 total score	10.23 (3.72)	11.69 (2.82)	0.03
PHQ-15 somatic symptom severity			
Low	24	22	0.03
Medium	26	63	
High	9	16	

P significant when ≤ 0.05 . SD – Standard deviation; PHQ – Patient Health Questionnaire-15; ICD – International Classification of Disease

Table 2: Major interacting themes from interviews

Acceptance of the referral
Because the doctor said so
Seemed reasonable
Need for treatment
No
Yes
Whatever as long as it helps
Possibility of the presence of a mental illness
No
Yes
Stress/tension
Maybe/if you say so/don't care
Enabling/impeding factors
Stigma: Self and external (family)
Knowledge and about psychiatric services

presents the demographic and clinical variables of the study population. Males were significantly more educated than females. However, this did not make any difference to the responses in the interview. There was no statistical difference between males and females on other sociodemographic parameters such as marital status, rural or urban background, and income. Ten patients (six females and four males, 6.25% of total) had a known medical or surgical diagnosis that was mentioned on the referral note.

The case notes of the interviews were evaluated by the authors, and the following interacting themes were identified and explored [Table 2].

In the following description of themes, “most” indicates that >50% of patients endorsed the same, “many” indicates 25%–50% endorsement, and “some” indicates 11%–24% endorsement, respectively.^[14] “Few” indicates <11%.

Why they decided to accept the referral

Most of the patients decided to accept the referral because they thought that it was part of the evaluation being carried out by the referring doctor. These patients claimed that they did not really think about the department in which the referral was made. They would have followed the referral in the same way had it been made to any other department. Most patients said that they thought that after a check-up/clearance from the psychiatry department and other investigations/referrals, they would finally get some treatment that would relieve their symptoms. Some patients considered the nature of referral and decided to go through with it because they thought it was a reasonable thing to do. This was because they thought that their symptoms may have something to do with the stress/tension they were undergoing or because they may have a mental illness.

Most claimed that they had not been told why they were being referred, and nor did they ask because of paucity of time on the part of the referring doctor and out of feelings of trust and deference for the referring doctor. Some patients said that they were told that they may have some “tension-” related problem for which they should seek psychiatric consultation.

The possibility that they had been referred to the psychiatry department because they may have a mental illness.

The patients could be broadly divided into two groups.

The first group was of those who refused to consider the possibility that their presenting symptoms had anything to do with psychiatric illness. There were many patients in this group. 62 patients (38.8% of total *n*, 23 males and 39 females) refused to consider the possibility that they may have a mental illness. Almost all patients in this group asserted that their symptoms had a “physical” basis.

The second group comprised most of the patients, and they were not dismissive of the possibility of their having a mental illness. Among these patients, the responses were varied and were as follows.

Some patients accepted that they had “stress” in their lives. Another word commonly used for this was “tension.” Some of these patients said that their symptoms have a relationship with the “stress.”

Some patients were unsure and ambivalent about the possibility of a mental illness. They left it to the doctor to decide whether it was so and said that they did not care if this was so.

Finally, a few accepted that they may have a mental illness.

Need for treatment

Some patients said that thought that they did not need psychiatric treatment. This was because they did not accept that they have a psychiatric disorder. Some of those who thought that they had “stress/tension” and a few of those with mental illness also thought that they did not need psychiatric treatment. On further enquiry, some also said that they thought that psychiatric medicines could be habit forming and sedating, therefore, they would be reluctant to take the same. Wherever indicated, prescriptions were written for patients. We did not inquire as to whether these prescriptions were filled or not.

Most patients expressed that they may need and would benefit from psychiatric treatment. Some of these patients thought so because they thought that psychiatric treatment would help in the management of mental illness or “stress/tension.” Some accepted treatment because they wanted relief from symptoms no matter how it came about. Some also wanted prescriptions of sedatives or benzodiazepines for symptoms of insomnia or anxiety.

Enabling/impeding factors in treatment seeking

Many patients accepted that they would feel embarrassed and stigmatized if they were diagnosed with a psychiatric disorder and if they had to visit the psychiatric services on a regular basis. Some patients also said that their family members would feel stigmatized if this would happen. A few also did not approach treatment earlier because of this reason, but now that they had been referred, they were able to get a psychiatric consultation.

Some patients also expressed ignorance regarding the presence of psychiatric services and that had they known that this was available, they would have come directly rather through referral.

CONCLUSION

This study was carried out in a general hospital setting in North India. In this setting, patients are free to approach any service department and are free to decide whether or not to accept a referral. However, in the course of any ongoing treatment, a referral would need to be completed for better and holistic healthcare. Our patient group comprised those who actually completed the referral process. Our study was not designed to find out how many people were referred during this duration and the reasons behind those who decided not to complete the referral. Therefore, it is quite likely that

this study did not include those who strongly reacted to and disapproved of their referral to psychiatric services.

The patient profile was similar to other studies in the past on patterns of psychiatric referrals with a preponderance of somatoform disorders followed by other anxiety disorders.^[15,16] The PHQ-15 is a sound, well-validated brief measure of somatic symptom severity.^[12] The PHQ-15 scores in the study population suggest that the somatic symptom load was much higher than that would be expected in the general population and that women had significantly higher somatization than men.^[17] The mean scores indicate that most patients had at least medium or moderate symptom severity.^[18] Most patients were diagnosed with a psychiatric disorder. The above results indicate that the study population comprised patients with high somatic symptom severity with significant psychological morbidity. The study population was thus likely to benefit from psychiatry consultation and was fairly representative.

The interviews with the patients revealed several interacting themes with varying levels of firmness with which they were held. It is likely that these change from time to time and this was indeed observed even within the interview situation. However, the statements of the patients do demonstrate their general attitude towards the issues that were explored.

First, most patients trusted the referring doctor’s judgment regarding their referral even when their own opinion regarding its utility or indication was at variance. Many patients chose to disregard their own doubts thinking that this was a part of the treatment of the referring doctor and that following the referral; they would continue their treatment with the referring doctor. On realizing that their symptoms may not have a “physical” basis and that they would be advised to continue treatment with psychiatry services, many expressed reluctance. We, however, did not follow-up the patients to find the rates of repeat visits to psychiatry services. Nonetheless, in our setting, there are feelings of trust and deference toward the primary treating doctors that overcome even personal doubts on many occasions. However, when patients were confronted with the possibility that their symptoms may not be “physical,” many patients were uncomfortable and maintained that their symptoms were “physical” in nature. We did not explore the feelings of patients towards their referring doctors after confronting this possibility.

The desirability of a patient-empowered approach in clinical decision making is generally accepted.^[19] The above results show that patients in our settings do not feel empowered to participate in the decision-making

process. As has been pointed out earlier, this may be due to a perceived lack of control on the situation on the part of the patient, personality aspects of the treating physician, lack of an emotional connect between patient and doctor, and systemic and structural impediments in health-care services.^[20] It is probable that all of these factors would have played a part. However, it is probable that the ingrained cultural aspects of deference to authority figures such as doctors ensured that most patients did complete the referral. The patients completing the referrals were acting more as recipients rather than participants in their health care. Our study underlines the urgency of examining patient-empowerment as a paradigm in health care and then trying to integrate it into routine health care in our settings.

Our results indicate that even in patients who completed the psychiatric referral; there was mostly a denial of the possibility of mental illness or at most the acceptance of stressful life events that may have a bearing on the symptomatology. These results indicate that the possibility of a mental illness and possibly psychiatric treatment are stigmatizing to patients. Many patients also said that they and their relatives would be embarrassed to be taking treatment from psychiatric services. While it is known that severe mental disorders are stigmatizing in Indian conditions, our findings are indicative of the fact that this is true for patients who are referred to psychiatric services from other departments as well. However, most patients did accept that they would be willing to take medication due to a variety of reasons. This included the need for sedative prescriptions, the notion that medications may help in managing life “stress” better and because that as long as the medications helped, it did not matter how and where they came from. There may have also been some degree of social desirability in these answers in that while most patients were quite assertive in emphasizing their not having a mental illness, being prescribed medications that may help and could be discontinued if they did not be probably not as bad and keeping the doctors in good humor. Some patients, however, were accepting of the fact that due to poor awareness they could not either label their symptoms as psychological in origin or if they did, they did not know where to go.

The biopsychosocial approach was supposed to put a more holistic model of understanding human illness into place both for health-care providers and for patients thus doing away with the stigma surrounding mental illness.^[21] It is obvious from our results that this has not happened at the level of the patients. The stigma and avoidance of psychological explanations of somatic distress continue much as before. There is

a need to think of newer more acceptable models of psychiatry and mental health that can mainstream and destigmatize it.

Finally, our study population comprised a special group of patients who did not expect to reach psychiatric services when they sought treatment. Health-care providers of all hues should be sensitive to this fact and that these patients may not be as comfortable and receptive to treatment as voluntary patients. A more participatory and educative approach may be useful in this group of patients. Our study indicates the need to examine referral processes and how to handle patient participation in treatment settings in a more balanced and participatory manner.

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Conflicts of interest

There are no conflicts of interest.

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