MEDICAL PRACTICE

Contemporary Themes

Attitudes to the Psychiatric Outpatient Clinic

D. H. SKUSE

British Medical Journal, 1975, 3, 469-471**Summary**

Fifty patients were interviewed before their first ever appointment at a psychiatric outpatient clinic about their attitude to the forthcoming visit. Many did not know that it was a psychiatrist they were to see at the hospital. Widespread misconceptions about the nature of a psychiatric consultation were uncovered. Many felt the referral carried an implicit threat of social stigma. Patient's misconceptions were relieved, and only 13% subsequently failed to attend the clinic compared with 30% of a control group.

Introduction

Many people referred to psychiatric outpatient clinics fail to keep their initial appointment and thus waste medical time. Studies of non-attenders have shown that misapprehensions about, and fears of, psychiatric departments are widespread deterrent influences. Burgess and Harrington¹ reported that, most commonly, patients were afraid of the implications of seeing a psychiatrist. Grold and Hill² investigated failure to keep appointments with an army psychiatrist. They concluded that the three most important influences which determined the likelihood that a patient would keep his appointment were the attitudes of the individual, of his environmental group, and of the initiator of the referral. Humphrey³ found one in four psychiatric outpatients had no idea of what to expect and only one-third thought their attendance at the clinic was fully justified.

Gillis and Egert⁴ reported similarly. Johnson⁵ found that a third of outpatients would not admit to psychological or emotional illness.

In this survey new patients were interviewed before they attended the outpatient clinic to discover both their feelings about the prospect of seeing a psychiatrist and the attitudes of their friends and relatives to the referral. Inquiries were made into their interaction with the referring doctor and into how much they considered a psychiatrist was likely to be of help with their problems. The study also aimed to find the effect that correcting patients' misconceptions would have on the likelihood of their subsequently attending the clinic.

Methods

Patients included in the survey were referred in September and October 1972 to the university department of psychiatry either at the University Hospital of South Manchester or at Manchester Royal Infirmary. They had ostensibly not had a previous psychiatric consultation and were referred by general practitioners. Within three days of a referral letter being received a letter was sent asking the patient for a home interview.

The interview was a discussion based on a short semi-structured questionnaire. Patients were asked how the referral had been initiated, about their knowledge of psychiatric practice and treatments, and about their expectations from the consultation. They were asked their attitudes to mental illness and their feelings about going to the clinic. Each patient was invited to discuss any aspect of the referral which interested him; he was assured that it was not the purpose of the visit to force him to keep his appointment.

To investigate whether the visits increased the likelihood of a patient's subsequently attending the clinic the attendance rate of those patients who had been visited was compared with that of another group who had been similarly referred in the preceding four weeks. The average waiting times between arrival of the referral letter at the department and the date for which the patient was given an appointment were similar for both groups.

Department of Psychiatry, Manchester University

D. H. SKUSE, Medical Student (Now M.B., CH.B.) (Present appointment: Senior House Officer in Medicine, Radcliffe Infirmary, Oxford)

Findings

Seventy patients fulfilled the criteria of selection. Of these 61 were interviewed; the others had refused to be seen, or had moved from the area, or had been admitted to hospital before the visit. One interviewed patient moved from the area before her appointment. Eight (13%) of the remaining 60 patients failed to attend the clinic. In the comparison group of 61, 18 patients (30%) failed to attend. The proportions of non-attenders in the two groups are significantly different (by a two-tailed test for comparison of two proportions on unpaired data $P < 0.05$). The patients who had been visited yet failed to come to the clinic were comparable in age, sex, and social class to the interviewed population as a whole. They were no less likely to feel a psychiatrist would be of assistance to their problems and had waiting times similar to the group as a whole. Failure to attend was probably due to different reasons for each individual.

Eleven interviewed patients turned out to have seen a psychiatrist on a previous occasion. Since their experience was not comparable with the others, analysis of the findings of the questionnaire was confined to the responses of the 50 patients without previous appointments.

Half (54%) of the patients were under 30 years old, half (54%) were unmarried, and half (50%) were from social class III. The ratio of males to females was 0.83:1.00. Referral had been first suggested by the general practitioner in 59% and by the patient himself in 26% of the interviewed population. The latter group will subsequently be called "self-referrers."

Of those who had not initiated referral themselves 38% said their doctor had never mentioned the word "psychiatrist" but had told them they would be seeing a "specialist" or "nerve specialist." Nearly half (49%) of these patients were distressed to discover that they were being sent to a psychiatric clinic. Two-thirds (64%) felt their practitioner had not told them anything about what to expect; this was often explained as reflecting the brief nature of their consultation with him.

IDEAS OF TREATMENT

Some questions inquired into the patient's knowledge of current psychiatric practice. A few had heard of more than one treatment, but 20% said they knew of none. A question was phrased in such a way as to discover what modes of therapy they would mention spontaneously. Hypnotism was a relatively popular response (22%), and there was a widespread belief that they would lie on a couch and be "taken back" to relive the unpleasant experiences of their childhood. Some patients feared needles; 10 out of 24 who mentioned electric-shock treatment thought they might be given it against their will. Occasionally lurid fears were revealed: "Mrs. A. told me they put things on your head and give you shock treatment, and examine your brain."

Patients did not usually distinguish between E.C.T. and aversion therapy. Though many said that talking to a psychiatrist might help them, only 20% mentioned this as a form of treatment, and only 16% suggested "tablets." Half (44%) of the patients did not realize that psychiatrists are medically qualified doctors. Some felt they had a purely physical complaint and considered that not only would the psychiatrist be uninterested in doing a physical examination; he would not be competent to do it. However, two-thirds (62%) thought he could be of help to their problem. Self-referrers tended to be more optimistic about the benefits of treatments than the others, and they were significantly more likely to feel their problem was soluble ($P < 0.025$). For statistical evaluation of this and subsequent comparisons a chi-square analysis was made using Yate's correction. Three-quarters had no clear idea of what help might be offered them at the clinic, usually because they had no idea what psychiatrists did; 80% were interested in discussing the outpatient clinic further.

Patients were also asked whether they felt ill or if their "nerves" were bad. One in four did not consider themselves

unwell in any way. Nearly half (44%) had been troubled by their problem for over one year. Those who had had the problem for over five years (22%) were significantly more likely to complain of somatic symptoms ($P < 0.01$).

INCIPIENT MADNESS

It was difficult to discover patients' feelings about coming to a psychiatric clinic. Many were defensive, and probably only a small proportion of those with fears and misapprehensions disclosed them at the interview. Most commonly the referral was held to imply incipient madness; one-half spontaneously mentioned this fear. Half (48%) of those who did not initiate the referral themselves were unhappy about it, though those aged under 30 were significantly less likely than others to be concerned ($P < 0.01$). Social stigma was cited often as a reason why patients were reluctant to attend the clinic: "There always seems to be a bit of a stigma about having been for mental treatment of any kind." Half those interviewed (58%) had told no one except those with whom they lived about their appointment; self-referrers were significantly more likely than other patients to have told someone about it ($P < 0.05$). One patient in seven had told nobody they were going to see a psychiatrist, but disguised the nature of their visit by saying, "I've got to see a specialist at the hospital." One-third of those who had told somebody said they had received an unsympathetic response, and this was significantly more frequently the case among the self-referrers ($P < 0.01$).

One-quarter (28%) of those whose referral had been initiated by some other person felt that the proposal had been put to them in an unsympathetic manner. Often it was the family doctor: "I hadn't been talking to him for a minute and he said, 'We'd better put you down to see a nerve specialist,' " though some were more tactful: "Would you like to talk to somebody who has more time than I do?" In one-quarter of the cases in which the patients themselves had requested a psychiatric opinion the initial suggestion had been rebuffed by their general practitioner. This was either because the doctor "didn't believe in psychiatry" or because he considered it necessary to conduct a therapeutic trial before referral.

Discussion

Most previous studies into the attitude towards psychiatry of patients referred to the psychiatric outpatient clinic have confined themselves to questioning those who failed to attend. Such people have disclosed much mistrust and suspicion of psychiatry. However, all the fears and misapprehensions discovered and enumerated by Burgess and Harrington¹ are reflected in the population interviewed in this survey, the great majority of whom subsequently came to the clinic. The significantly greater rate of attendance of the patients interviewed seems to have been due to the opportunity they were given of discussing the referral with someone who was in a position to understand their feelings and enlighten them about what would happen at the clinic. The potential value of a home visit by a representative of the clinic must not be underestimated, since missed appointments are so costly and inefficient. However, this enlightenment could be given by the general practitioner. Fear of social stigma, as has been described by previous workers, was found to be a common concern, but it was never cited as a sufficient reason to prevent attendance. The friends and relatives of self-referrers were particularly unsympathetic. They felt great alarm and often strong disapproval when an individual voluntarily asked to see a psychiatrist.

The eight patients who were seen but failed to attend the clinic could not be differentiated from the group as a whole by demographic criteria or by interview responses. This finding seems to preclude any chance of identifying such patients in advance of their appointment.

One in four patients claimed they did not consider themselves ill in any way. Johnson⁵ has reported a similar finding in a comparable population. The patient's concept of his "sick role" is particularly relevant in this context.

"TOLD NOTHING"

Virtually all patients had seen their family doctor shortly before the interview and knew that specialist referral had been arranged. Yet a third claimed they had been told nothing about why this had been done nor what was involved. Ley and Spelman⁶ have shown that patients remember relatively little of their interview with a doctor, and it is possible that the above reports merely reflect a failure of retention of information. However, in view of their otherwise detailed accounts of the consultations at which referral had been arranged this explanation does not seem likely. It is much more probable that general practitioners do not sufficiently prepare their patients for the psychiatric consultation they are arranging. Balint⁷ and Shepherd *et al.*,⁸ have commented on the difficulties experienced by a practitioner in expressing to his patient the need for a psychiatric opinion. Kessel⁹ suggests that few family doctors know what psychiatrists do, and their individual attitudes towards the psychiatric services vary widely.¹⁰

For the practitioner to disguise the nature of the referral may allow his interview to run more smoothly or comfortably at the time, but it can gain nothing in the long run. It is not necessary for the referring doctor to have an extensive knowledge of psychiatry in order to enlighten his patient. The great majority of people interviewed (80%) used the opportunity of

the research visit to discuss their concerns and misapprehensions about seeing a psychiatrist. They would have welcomed and should have had, the chance to have talked about these feelings to their family doctor. The mystery surrounding the psychiatric clinic should be dispelled. Implementation of these simple measures might go a long way to improving the present poor attendance rate for new patients.

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Hospital Topics

Tolerance of Debility in Elderly Dependants by Supporters at Home: Its Significance for Hospital Practice

J. R. A. SANFORD

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Summary

Some 12% of all geriatric admissions to University College Hospital and Whittington Hospital are for patients whose relatives or friends can no longer cope with them at home. The person principally involved with home support was interviewed in 50 such cases. The causes of inability to cope were identified on a quantitative and qualitative basis. The supporters were asked to assess which of the problems identified would have to be alleviated to restore a tolerable situation at home; 46 (92%) were able to do so. Identification of the "alleviation factors" forms a therapeutic and prognostic guideline in

this type of admission and may have far-reaching social and economic implications.

Introduction

To some extent social considerations affect all patients admitted to a geriatric unit and in many cases they predominate. For example, admissions are sometimes undertaken to enable relatives to take a holiday or because the patient can no longer manage alone. Another consideration, which forms the subject of this study and which gives rise to a large proportion of all geriatric admissions, is that those who live with and support the patient at home may no longer be able to cope.

There is little documented information on the type and frequency of problems encountered by supporters or their attitude to the long-term welfare of their dependant. Which problems do they feel able to cope with? Which do they regard as an absolute barrier to home management? Until these questions are answered in individual cases it is not possible to organize therapy or make a rational assessment of prognosis.

University College Hospital, London, and Whittington Hospital, London

J. R. A. SANFORD, M.B., M.R.C.P., Senior Registrar