

Survey of inpatient child and adolescent psychiatric referrals in a teaching hospital in Saudi Arabia

0

Fatima A. Al-Haidar, MBBS, KSUF.

ABSTRACT

Objective: To answer the question of which specialties utilize the service of child and adolescent liaison psychiatry and what are the problems that are likely to bring a child or an adolescent to the attention of psychiatry.

Methods: The case records of all inpatient children and adolescents younger than 18 years, who were referred to the psychiatric team at King Khalid University Hospital, Riyadh, Kingdom of Saudi Arabia over a period of 6 years between July 1992 and July 1998, were retrospectively reviewed in regard to sociodemographic data, referring specialties and reason for referral.

Results: Seven percent of referred patients were younger

than 18 years. Most were Saudi nationals. Females outnumbered males. Most of the referrals were by the neurologists, endocrinologists and gastroenterologists. The most common reasons for referral were behavioral disturbances and absence of physical findings that could explain the complaint.

Conclusion: Low utilization of child and adolescent liaison psychiatry, reflecting the ability of pediatricians and physicians to recognize psychiatrically disturbed children and adolescents compared to adults, may explain the small number of referrals.

Neurosciences 2003; Vol. 8 (1): 43-45

Setting-up of consultation-liaison services in general hospitals began in the late 1930's and is still developing in many countries.¹ The development of child psychiatric consultation-liaison services is just beginning in many countries and is still far from biopsychosocially integrated medical practice.^{1,2} Various definitions exist for both consultation and liaison. Willis and Pasnau³ defined consultation as the services performed for physically ill patients and families, often at the bedside, in a general hospital upon referral of the attending physician or other health professional.³ Liaison refers to the services provided for the physician and staff, tying together the treatment of the patient and family, using educational conferences, psychosocial

teaching rounds and holistic management plans.³ A wide variety of models of child liaison-consultation services have been described which vary from the provision of a consultation service only, through to liaison-consultation or staff being full and active members of the pediatric team.⁴ The purpose of this paper is simply to clarify the question of which specialties utilize the service of child and adolescent consultation-liaison psychiatry at King Khalid University Hospital (KKUH), Riyadh, Kingdom of Saudi Arabia (KSA) and what are the problems that are likely to bring a child or an adolescent to the attention of child and adolescent psychiatry.

From the Division of Psychiatry, King Khalid University Hospital, Riyadh, Kingdom of Saudi Arabia.

Received 19th May 2002. Accepted for publication in final form 7th September 2002.

Address correspondence and reprint request to: Dr. Fatima A. Al-Haidar, Assistant Professor and Consultant Psychiatrist, Division of Psychiatry #55, King Khalid University Hospital, PO Box 7805, Riyadh 11472, Kingdom of Saudi Arabia. Tel. +966 (1) 4671717. Fax. +966 (1) 4672571. E-mail: alhaidar4@hotmail.com

Methods. The case records of all inpatients, younger than 18, who were referred to the psychiatric team at KKUH, Riyadh, KSA over a period of 6 years between July 1992 and July 1998 were retrospectively reviewed in regard to demographic data, referring specialties and reasons for referral.

Results. A total of 2060 cases were referred to consultation-liaison psychiatry over 6 years. One hundred and forty-five patients (7%) were below the age of 18. Data was not available for 36 patients (1.7%), therefore, 109 cases (5.3%) were included in this study. Out of which, 42.2% were children below the age of 12 and 57.8% were adolescents between the ages of 12 and 18. The youngest was 9 months old and the eldest was 18 years old. **Table 1** provides data on sex, nationality and level of education. Neurologists (18.3%) made the majority of referrals, endocrinologists (17.7%) and gastroenterologists (11%). The rest were referred by other specialties. **Table 2** provides information on reasons for referral. The most frequent reason for referral among children was behavioral problems followed by

the presence of physical symptoms with no obvious underlying pathology, followed by psychiatric assessment. However, the most frequent reason for referral among adolescents was the presence of physical symptoms with no obvious underlying pathology followed by suicidal attempt and then behavioral problems.

Discussion. Only 7% use the referral services of children and adolescents. Resulting from restricted eligibility in KKUH for Saudi and teaching cases of non-Saudi's, Saudi nationals outnumber that of non-Saudi. Some studies have found that there is a strong relationship between neurological and endocrinal diseases and psychiatric disturbance.^{5,6} This study also shows a high percentage of referral from neurology and endocrinology. Most psychiatric disorders among children present as behavioral changes instead of verbal expression of what they suffer from,⁷ so it is not surprising that the behavioral problems represent the most frequent reason for referral. The limited tolerability of staff to behavioral problems in an open ward can be of additional significance.^{4,8} The results of this study in that regard are in agreement with other studies. Literature review shows that the rate of behavioral disturbance is likely to be higher than 20% in children with chronic illnesses.^{7,8}

Award and Pronznouski noted that referral to child psychiatry was more likely to be made when the symptoms were of unknown etiology, depression was suspected or behavioral problems arose in the ward.⁹ Campo and Fritsch found that medically unexplained physical symptoms are common in childhood and include in descending order frequency of headache, recurrent abdominal pain, limb pain, chest pain and fatigue.^{10,11} In this study, pseudo-seizure contributes 6.4% of the total reason for referral and this is comparable with other studies as the most commonly reported conversion symptom in child and adolescent psychiatric literature is pseudo-seizure.^{7,12}

Although a wide variety of psychosocial problems have been identified among children and adolescents including parental marital conflicts or separation, parental distress or illness, illness in other family members and family dysfunction, one frequently unrecognized pathology is within the families of children with acute or chronic illness.^{4,13,14} Hence, a low percentage 1.8% of the total referrals in this study, being due to family conflict, is not surprising.

In conclusion, there is an association between neurological and endocrinal disorders of children and psychiatric disturbance. In addition, presence of behavioral problems or physical symptoms with no obvious underlying pathology should indicate psychiatric evaluation. The results of this study cannot be generalized because it is a retrospective study with a small number of patients conducted at a single teaching hospital.

Table 1 - Sociodemographic data (N = 109).

Data	n (%)
Sex	
Male	42 (38.5)
Female	67 (61.5)
Nationality	
Saudi	99 (90.8)
Arabs	7 (6.4)
Non Arabs	3 (2.8)
Education	
Educated	80 (73.4)
Non educated	29 (26.6)

Table 2 - Reasons for referral.

Reason	n of children 0-12 years n (%)	n of adolescents >12-18 years n (%)	TOTAL n (%)
Physical symptoms with no obvious underlying pathology	8 (7.3)	13 (11.9)	21 (19.2)
Behavioral problem	11 (10.1)	9 (8.3)	20 (18.4)
Psychiatric assessment	8 (7.3)	4 (3.7)	12 (9.2)
Suicidal attempt	-	10 (9.2)	10 (9.2)
Poor compliance	4 (3.7)	5 (4.6)	9 (3.8)
Depressed mood	1 (0.9)	6 (5.5)	7 (6.4)
Others	14 (12.8)	16 (14.7)	30 (27.5)
TOTAL	46 (42.2)	63 (57.8)	109 (100)

References

1. Ortiz P. General principles of child liaison consultation service: A literature review. *Eur Child Adolesc Psychiatry* 1997; 6: 1-6.
2. Mrazek DA, Anderson IS, Strunk R. Disturbed emotional development of severely asthmatic preschool children. *J Child Psychol Psychiatry* 1985; 26: 81-94.
3. Wellisch D, Pasnau R. Psychology interns on a consultation-liaison service. *Gen Hosp Psychiatry* 1979; 1: 287-294.
4. Lask B. Pediatrics liaison work. In: Rutter M, Taylor E, Herson L. *Child and Adolescent psychiatry*. 3rd ed. London (UK): Blackwell Scientific Publications 1994; 996-1005.
5. Kaplan H, Sadock B, Grebb J, editors. The Brain and behavior. In: Kaplan and Sadock's *Synopsis of Psychiatry*. 7th ed. New York (NY): Lippincott William & Wilkins; 1994. p. 87-156.
6. Kaplan H, Sadock B, Grebb J, editors. Delirium, dementia, amnesic and other cognitive disorders and mental disorders due to a general medical condition. In: Kaplan and Sadock's *Synopsis of Psychiatry*. 7th ed. New York (NY): Lippincott William & Wilkins; 1994. p. 336-373.
7. Knapp P, Harris E. Consultation-liaison in child psychiatry: A review of the past 10 years. *J Am Acad Child Adolesc Psychiatry* 1998; 37: 17-25.
8. Eiser C. Psychological effects of chronic disease. *J Child Psychol Psychiatry* 1990; 31: 85-98.
9. Award G, Pronanski E. Psychiatric consultation in a pediatric hospital. *Am J Psychiatry* 1975; 132: 915-918.
10. Afford DR, Boyle MH, Szatmari P, Rae-Grant NI, Links PS, Cadman DT et al. Ontario child health study II: six month prevalence of disorders and rates of service utilization. *Arch Gen Psychiatry* 1987; 44: 832-836.
11. Campo J, Fritsch SL. Somatization in children and adolescents. *J Am Acad Child Adolesc Psychiatry* 1994; 33: 1223-1235.
12. Fritz G, Fritz S, Itagino O. Somatoform disorders in children and adolescents. *J Am Acad Child Adolesc Psychiatry* 1997; 36: 1329-1337.
13. Garralda E, Bailey D. Psychiatric disorders in general pediatric referrals. *J Pediatric* 1989; 64: 1727-1733.
14. Dulkan M, Costello E, Costello A, Edelbrook C, Brent D, Janiszewski B. The pediatrician as a gatekeeper to mental health care for Children. *J Am Acad Child Adolesc Psychiatry* 1990; 29: 453-458.