African Journal of Biology and Medical Research
ISSN: 2689-534X
Volume 5, Issue 2, 2022 (pp. 94-103)
www.abjournals.org

FACTORS PREDICTIVE OF PSYCHIATRIC CONSULTATION-LIAISON PRACTICE IN THE GYNECOLOGY CLINIC OF A NIGERIAN TEACHING HOSPITAL

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Cite this article:

Oyewole A.O. (2022), Factors Predictive of Psychiatric Consultation-Liaison Practice in the Gynecology Clinic of a Nigerian Teaching Hospital. African Journal of Biology and Medical Research 5(2), 94-103. DOI: 10.52589/AJBMR-8ZQFMIOG

Manuscript History

Received: 5 Oct 2022

Accepted: 29 Oct 2022

Published: 9 Nov 2022

ABSTRACT: *There is a high rate of psychological distress among women attending gynecology clinics. Psychiatric morbidity among this group of patients has been studied but no clear-cut delineations in the association between psychiatric morbidity, established gynecological diagnosis and ongoing gynecological symptoms especially as guidelines for consultation-liaison practice in the gynecological unit. The objectives of this study therefore were to determine the prevalence of psychiatric disorders in this group of patients; to determine the association of psychiatric morbidity with ongoing gynecological complaints, gynecological diagnosis and psychosocial factors; and to delineate factors predictive of psychiatric consultation-liaison need in the gynecological clinic. Using structural questionnaires and employing a 2-stage screening methodology for patients attending the gynecological clinic of Ladoke Akintola University of Technology Teaching Hospital for about 12 weeks consecutively, a total of seventy eight patients were recruited invariably. The mean age of the study population was 35.9 years. Overall prevalence of psychiatric disorder was 55.3%. Depressive illness occurred in about 42.8% of the study population. No significant association between psychiatric morbidity, ongoing gynecological symptoms and established gynecological diagnosis. The commonest diagnosis was infertility. However, specific ongoing gynaecological complaints with psychiatric morbidity had 49.7% of those with inability to conceive (primary), 57.1% of those who had pains during intercourse, 71.4% of those with cessation of menses and 60% of those with irregular menses as opposed to lower scores among those with established gynecological diagnosis. Specific on-going gynecological complaints may impose graver consequences on the psychological wellbeing of a woman than established gynecological diagnosis. The consideration and management of ongoing gynecological complaints and social support may be issues for psychiatric consultation-liaison crucial in the management of such patients to reduce psychiatric morbidity amongst them.*

KEYWORDS: Psychiatric morbidity, On-going gynecological complaints, Gynecological diagnosis, psychosocial factors, Consultation-Liaison psychiatry.

Article DOI: 10.52589/AJBMR-8ZQFMIOG
DOI URL: https://doi.org/10.52589/AJBMR-8ZQFMIOG

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INTRODUCTION

Psychiatric disorders attributable to physical conditions have been estimated at 15-25% of all mental disorders in Africa.[1,2] A lot of psychiatric comorbidity probably still goes unrecognized by the attending physician.[3,4] The few studies that have investigated the problem of psychological distress in gynecology outpatient clinics have found that on average, about 50% of women who attend these clinics are estimated to show higher levels of psychological distress than have been found in studies of other general hospital outpatient clinics.[5] Gynecology clinics are an important outpatient setting because gynecologists provide services for women of reproductive age and beyond, thus functioning as primary care providers for many women.[6] Investigators found a high prevalence (10–53%) of psychological distress among women attending gynecology clinics.[7-12] However, the estimated incidence of psychological distress in developing and developed countries differed in studies using the same instruments, and the pattern of the relationship between distress and gynecological morbidity may also differ between developed and developing countries.[13]

Studies done in developed countries clearly show a high frequency of psychological distress among women attending gynecology clinics. Relatively few studies have been done among this group of patients in Nigeria but a particular study done in Nigeria using a two-stage screening method with General Health Questionnaire version 30 (GHQ-30) and the present State Examination was significantly associated with irregular menses, pelvic pain and having no children.[6] A particular study has clearly highlighted that a high proportion of women who attend gynecology clinics having specific complaints also reported significant psychological distress; hence emphasizing the importance of considering the psychological component of gynecological morbidity.[13]

The present study sets out to define prevalence of psychiatric disorders in this group of patients and consider subtle associations between psychiatric morbidity, on-going gynecological complaints, established gynecological diagnosis and psychosocial factors with the aim of enriching the practice of psychiatric consultation - liaison in the gynecological unit.

METHOD

All patients in the study attended the gynecological clinic of Ladoke Akintola University of Technology Teaching Hospital for about 12 weeks consecutively between March to June, 2016. This is the only Teaching Hospital in the metropolis upgraded from being a General Hospital and has been responsible for the bulk of medical needs of this area. Since it assumed this new status, patients that come are mainly referrals from other government general hospitals and private hospitals. Consent of the patients were obtained through the Ethical Research committee of the hospital and from individual patients that participated in the study.

Basic socio-demographic data, gynecology history, obstetric history, marital history and psychosocial history were obtained through a proforma designed by the author. The patient's occupation was classified according to the international standard classification of occupation by International Labour Organization (I.L.O).[14]

Article DOI: 10.52589/AJBMR-8ZQFMIOG
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Major Group 1: Legislators, Senior Officials and Managers

Major Group 2: Professionals

Major Group 3: Technicians and Associate Professionals

Major Group 4: Clerks

Major Group 5: Service Workers, Shop and Market Sales Workers.

Major Group 6: Skilled Agricultural and Fishery Workers.

Major Group 7: Craft and Related Trade Workers

Major Group 8: Plant and Machine Operators and Assemblers

Major Group 9: Elementary Occupations

Major Group 10: Armed Forces

Prevalence of psychiatric morbidity was determined through a two-stage screening procedure. The first stage of screening involved the use of the 30-item version of the General Health Questionnaire which has been previously used in detecting psychiatric morbidity in non-psychiatric settings.[15, 16.]

Literate patients completed the GHQ-30 either in English or Yoruba as appropriate. For the illiterate ones, the GHQ-30 questions were read to them and the responses recorded accordingly. The second stage assessment was conducted by the research psychiatrist only for those with significant psychiatric morbidity fixed for a cut off of 5 and above.

A detailed psychiatric assessment was done by obtaining a psychiatric history of each patient that qualified for the second stage screening and mental state assessed using the Structured for Clinical Interview according to DSM IV - Axis Diagnosis (SCID). DSM IV Axis I diagnosis were generated and data was analyzed using the Statistical Package for Social Sciences Version 10 (SPSS 10).

RESULTS

Basic Socio-demographic Data

For the period of the study covered, a total of 78 patients were seen. Sixty-seven (85.9%) of the patient population were aged 15-49 years and 11 (14.1%) were aged 50 years and above. The mean age of the study population was 35.9 years. The minimum age was 17 years while the oldest was 75 years with the majority of the patients 67 (85.9%) aged between 17-49 years. 52.6% were Muslims and 44.9% were Christians and 2.5% did not belong to any religion.

Twelve (15.4%) patients belonged to Occupational Group 2, seven (8.9%) to Group 3, 19 (24.4%) to major Group 5, 26 (33.3%) to Group 7, 2 (2.6%) to Group 9, 1 (1.3%) patient belonged to Group 1 and 4 respectively, while 10 of them were unemployed.

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Five (6.4%) of the patients were illiterates, 113 (16.7%) had primary school education, and 33 (42.3%) had post-secondary school education. Sixty-two (79.5%) were married, 6 (7.7%) were single, 3 (3.8%) were separated, 1 (1.3%) was divorced and 6 (7.7%) were widowed. For those who are married, 46 (58.9%) were in a monogamous settings while 23 (29.5%) were in a polygamous setting and 9 (11.5%) did not specify the marital setting.

In terms of level support, only 9 (11.5%) described the level of support as poor while 69 (88.5%) did not respond to this question. Sixty-seven (85.9%) of them however claimed that their relationship with their husbands had been quite cordial. Only 8 (10.3%) admitted to a negative change in the marital relationship within the last 6 months. Forty-seven (60.3%) admitted having regular intercourse with their husbands, while 17 (21.8%) claimed that sexual relationship had not been regular. The commonest reason for no regular sexual intercourse was the fact that they were not cohabiting 5 (6.4%).

Gynecological Data

Fifty (64.1%) of the patients were multiparous; while 28 (35.9%) were nulliparous. Fourteen (17.9%) described menstrual flow as scanty; 6 (7.7%) said it was heavy while 42 (55.3%) claimed it was normal. Twenty-eight (35.9%) complained of pain during menses; while only 1 (1.3%) admitted to a preceding history of premenstrual tension. Thirty (38.5%) have a history of miscarriage in the past while 18 (23.1%) admitted to having had induced abortions in the past.

In terms of the current major complaints that brought patients to the clinic, majority of them, 34 (43.6%), came because of inability to conceive; 20 (25.6%) presented due to disturbances in the pattern of menstrual flow; 6 (7.7%) complained of lower abdominal pain, 4 (5%) complained of leakage of urine per vaginum and 14(18.1%).

Prevalence of Psychiatric Disorders

The overall prevalence of psychiatric disorders was 53.6%. The commonest psychiatric diagnosis was mild depressive illness 19 (24.4%), moderate depressive illness 13 (16.7%) and generalized anxiety disorder 9 (11.5%), severe depressive illness occurred in only 1 (1.3%). There was no statistically significant association made with gynaecological diagnosis, ongoing gynaecological complaints, parity and psychosocial factors.

DISCUSSION

In terms of age, there was no significant association between certain age groups and psychiatric morbidity. However, it should be appreciated that the majority of patients attending the gynecological clinic were premenopausal, having about 85.9% of the population studied within the 15-49 years age group. While only 7 (8.9%) were clinically postmenopausal and 5 (71.4%) of them actually had significant psychiatric morbidity. This forecloses the need to pay closer attention to this group of women anytime they ever come to the clinic.

A future study may also be necessary to clearly demonstrate the association between psychiatric morbidity and menopause, although a study had suggested increase in psychiatric morbidity in the premenopausal years for those attending gynecological clinic. This may be

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interesting in Africa where the issue of fertility (capacity to bear children) determines, to a large extent, a woman's relevance and attention; hence many women with post-menopausal complaints will not attend gynecological clinic and may explain under representation in this cohort.[17,18]

The prevalence of psychiatric disorders found in this study was 53.8% which is in support of the fact that there is appreciable psychiatric morbidity associated with gynecological problems. A previous study done in Nigeria put the prevalence at 35.2% for patients with definite psychiatric morbidity.[12.] The slight disparity may not be unconnected with the peculiarity of the group studied which is a gynecologic clinic of a tertiary hospital where cases that may have been managed at other levels of care including private hospitals are referred. It is therefore expected that the degree of psychological distress may be stronger in this group than some of the other cohorts' studied.[19]

The commonest psychiatric disorders found were Depressive disorders 42.8%; 24.4% as mild Depressive disorder, 16.7% as moderate depressive disorder, 1.3% as severe depressive disorder and 11.5% generalized anxiety disorder but none had schizophrenic illness or bipolar affective disorders. It is interesting to know that there are no major disruptive psychiatric disorders found in this group but less dramatic ones which may easily go unnoticed by the gynecologist and invariably not referred to the psychiatrists. This observation has been equally noticed by the author in a study of consultation-liaison practice in the same teaching hospital.[20] However the pattern of prevalence appears in keeping with previous studies especially having depressive disorder as the commonest diagnosis. Most studies have inadvertently lumped gynecological symptoms such as irregular menses, pelvic pain, and having no children with established gynecological diagnosis such as secondary infertility, primary infertility, dysfunctional uterine bleeding, uterine fibroids and vesico-vaginal fistula among others in the determination of prevalence of psychiatric disorders, test of significant associations with psychosocial factor in such a way that such efforts have not filtered appropriate clinical guidelines and delineations for consultation- liaison psychiatric practice in this cohort.[8-12]

For instance, not all cases of infertility will culminate into a psychological distress unless it is a primary infertility with irregular menses as ongoing gynecological complaints which are of grave concern to the patient. Some patients may have adjusted to earlier gynecological diagnosis and are just on routine checkup in the clinic without much psychological distress significant enough for psychiatric morbidity.[13] There is the need to analyze the associations of ongoing gynecological complaints with psychiatric morbidity because of the requisite spatial relationship between a stressful life–event and psychiatric morbidity. This may help to crystallize certain associations between gynecological complaints as different from established gynecological diagnosis that may invariably be necessary for consultation-liaison services in the gynecological unit. Most gynecological consultations usually do not end in definitive treatment; this is similar to a study done at the University College Hospital, Ibadan in which 79.1% of the patients attending the gynecological clinic did not receive definitive treatment but with recurrent gynecological complaints.[21]

This study attempted to separate relationships between psychiatric morbidity and gynecological diagnosis on one hand and psychiatric morbidity and specific ongoing gynecological complaints on the other. Psychiatric morbidity was not found to be statistically significant associated with any gynecological diagnosis although only 16 (47.1%) of those with

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infertility diagnosis had significant psychiatric morbidity as opposed to what has been reported in this environment.

Although this study did not demonstrate any statistically significant association between psychiatric morbidity and specific ongoing gynecological complaints; however, complaints of inability to conceive came as the commonest while complaints of disturbed menstrual flow, and pains during intercourse are very prominent. It is interesting however to note that of the fourteen that had pains during intercourse, 8 (57.2%) of them had significant psychiatric morbidity. Out of those that had complaints of disturbed menstrual flow, twelve (60%) of them had significant psychiatric morbidity. Although thirty-three complained of inability to conceive which was the commonest complaint, only 16 (49.7%) of them actually had significant psychiatric morbidity.

This actually suggests that on-going gynecological complaints may impose graver psychiatric distress on the patients more than established gynecological diagnosis in patients who may have psychologically adjusted to the problem in the context of spatial relationship. Studies have shown that psychological distress is highest shortly after miscarriage and decreases with time. One explanation of this difference may be the difference in timing of the assessment and that the earlier the assessment, the more severe the psychological morbidity.[22]

Previous studies done in Nigeria did not clearly delineate the relationship between psychiatric morbidity and classical ongoing gynecological complaints as opposed to gynecological diagnosis. This becomes very important because certain study that has actually established significant psychological distress among patients attending a gynecological clinic with specific ongoing gynecological complaints as opposed to those with gynecological diagnosis on follow up visits.[13]

For instance, miscarriage in women with a history of infertility assisted conception, and planned pregnancy is often associated with increased psychological morbidities because miscarriage as an ongoing gynaecological complaint rather than a definitive gynaecological diagnosis would further worsen already existing psychological symptoms. This has been elucidated by stress studies that have shown that a woman who miscarried, the presence of living children may afford psychological support indirectly, by presenting evidence of reproductive success in the past so infertility in itself as a diagnosis is not enough a factor of precipitation for psychiatric morbidity.[23]

The cordiality question as a measure of social support is often interpreted to carry the meaning of regular sexual intercourse. About 67 (85.9%) claimed the relationship was cordial which may not be unconnected with the issue of having regular intercourse of which 47 (60.3%) claim they do have and 17 (21.8%) do not have regular intercourse because of distance, and not because of relationship problems. This interpretation may need to be viewed within the context of the African culture where a woman should not refuse her husband's sexual advances even if the marital relationship is flawed because sexual intercourse is perceived as a legitimate marital responsibility. This absurdity can be better appreciated when the majority of the respondents 69 (88.5%) did not respond to the question assessing the quality of support in the marital relationship. For future studies, a more specialized instrument assessing the level of support or better still a mixed quantitative-qualitative approach may be necessary to explore the association between level of support in the marital relationship and psychiatric morbidity among this group of patients.[12, 23]

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The limitation of this study was the relatively small population size which may have affected establishment of definite relationships. However, the understanding of the populace, particularly the meaning attached to attendance of a gynecological clinic in a teaching hospital where there are alternative general hospitals with free medical services, may be responsible for the attrition of our original population size.

Confirmation of the issues raised in this study may clearly help to delineate groups of patients possibly in terms of specific ongoing gynecological complaints against the background of functional psychosocial support that may benefit from psychiatry consultation.

Table 1: Gynecological Diagnosis

Diagnosis	N=78	%N
Primary infertility	5	6.4
Secondary infertility	29	37.2
Pelvic inflammatory disease	4	5.1
Uterine fibroid	6	7.7
Vesico vaginal fistula	5	6.4
Uterine prolapse	5	6.4
Dysfunctional uterine bleeding	3	3.8
Dyspareunia	3	3.8
Regular Clinic check up	18	23.1

Table 2: Percentage of patients with specific on-going Gynecological complaints with Psychiatric Morbidity

Variable	**N**	**%N with psychiatric morbidity**
Cessation of menses	7	(5) 71.4%
inability to conceive	34	(16) 47.1%
disturbed menstrual flow	20	(12) 60.0%
pains during intercourse	14	(8) 57.2%

Table 3: Marital Settings

Variable	**N**	**%N with Psychiatric morbidity**
Polygamous	23	29.5
Monogamous	46	58.9

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www.abjournals.org

Table 4: Sociodemographic Characteristics

Age (years)	**N=78**	**%N**
10-19	6	7.7
20-29	42	53.8
30-39	11	14.1
40-49	8	10.3
50-59	8	10.3
60-69	2	2.6
70-79	1	1.3
Occupational Group	**N=78**	**%N**
Major Group 1	1	1.3
Major Group 2	12	15.4
Major Group 3	7	8.9
Major Group 4	1	1.3
Major Group 5	19	24.4
Major Group 6	-	-
Major Group 7	26	33.3
Major Group 8	-	-
Major Group 9	2	2.6
Others	10	12.8
Religion	**N=78**	**%N**
Christian	35	52.6
Muslim	41	44.9
Others	2	2.4
Type of Relationship	**N=78**	**% N**
Married	62	79.5
Single	6	7.7
Separated	3	3.8
Divorced	1	1.3
Widowed	6	7.7

Table 5: Psychiatric Disorders

Diagnosis	**N=78**	**% N**
Mild Depression	19	24.4
Moderate Depression	13	16.7
Severe Depression	1	11.3
Generalized Anxiety Depression	9	11.5
Normal	36	46.2

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