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Evaluation of the Development of Psychosomatic Medicine in a Large University Hospital in Turkey

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A B S T R A C T

The purpose of this study was to evaluate the development of psychosomatic medicine at our university hospital in Istanbul, which has an inpatient capacity of 3.000. Changing patterns of utilization of psychiatric service were analyzed in two 1-year surveys five-year intervals (1998, n=888) – (2003, n=1609). Psychiatric referrals were analyzed with regard to rate of consultation, demographic characteristics, departments making referrals, reasons for referral, psychiatric diagnoses and patterns of psychiatric intervention. Psychiatric consultation request, consultation reply and medical psychiatric examination forms were used. In evaluating the data, consultation rate was seen to have doubled over the five intervening years. Significant changes were also noted in the demographic characteristics of patients (e.g., more men, older mean age). The most prevalent disorders in both groups were depressive disorder and adjustment disorders. Alcohol and substance abuse remained as a small group. The gradual increase in the utilization of psychiatric services can be attributed to service and education-related variables.

Key words*: psychosomatic medicine, consultation liaison psychiatry, psychiatric diagnosis, general hospital, consultation rate, Turkey*

Introduction

Historical and cultural roots of consultation liaison psychiatry in Turkish medicine

Turkish psychiatry and medicine are centuries old and have developed through the ebb and flow of empires. As such, they are culturally and geographically a synthesis of both east and west. They come from an area that cultivated the likes of Hipoccrates, Galen and Aesclepiades.

The history of mental health in Turkey begins with the Temple of Aesklepion – the first mental hospital in the world. It continues with treatment centers for the mentally ill in the form of the *Darülsifas* and *Bimarhanes* established during the Seljuk and Ottoman periods. Contemporary mental health care is now provided in Turkey[1]. Such indigenous pioneers as Hippocrates and Galen have been influential in the development of contemporary medicine and psychiatry in Turkey. Historical Turkish thinkers like Mevlana and Ibni Sina (Avicenna) emphasized the integrity of, and holistic interaction between, the mind, body and brain. Avicenna (980–1037), whom many scholars believe to be the founder of Turkish psychiatry, wrote about mind-body connections and asked that the insane be treated humanely. In his treatment of the mentally ill, he employed free association and a combined method of persuasion, psychotherapy and pharmacotherapy.

Hospitals integrating the cultural heritage of the geography and aiming to provide psychosocial treatment to medical patients were opened in Anatolia in the 1200s. What characterized these places was the integration of mental and physical care. They served both mentally and physically ill people, taking special consideration not to separate mental from physical health[2]. Early forms of therapy used in the treatment of mental patients included music therapy and water therapy. Psychiatric care began to be provided in general hospitals in the 1300s in Kayseri (central Anatolia). One example of this is the Gevher Nesibe Hospital, the first institution to integrate a medical school, and the practice of both psychiatry and general medicine. At the time, the mentally ill were protected and treated with kindness – and not discriminated, stigmatized or ostracized – by society.

The history of contemporary Turkish psychiatry dates back to the mid-1800s, a time marked by reforms

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designed to westernize the country. Turkish psychiatry has a special place in the 200 years of westernization of what is now Turkey. The discipline represents both westernization and a mode of development that incorporates the best of east and west. It has also been able to take advantage of the long tradition of looking at medicine and psychiatry holistically. The awareness that combines medicine and psychiatry exists in the cultural background of the region and peoples. It is within this structure of thought that preserves a holistic approach and that is in line with 150 years of contemporary development, that Consultation Liaison Psychiatry (CLP) has been able to make progress within a westernizing Turkish psychiatry.

Subsequent to the founding of the modern Turkish republic in 1923, and the university reforms in 1933, Turkish psychiatry began to make enormous progress. Adopting western values and standards, it has come to make major contributions in biological, dynamic and descriptive psychiatry[3]. Currently, there are five mental health hospitals and 50 medical faculties in Turkey. The total number of psychiatric beds in the country is around 6,000, with more than 5,000 of them in mental hospitals[4]. The majority of the medical faculties have psychiatry beds. Approximately 1/4–1/3 of all psychiatrists work in general hospitals.

The establishment of medical schools has paved the way for the integration of psychiatric departments into general hospitals. It has also enabled psychiatry to be taken as a functional discipline by non-psychiatric departments.

The development and institutionalization of our CLP department

The first modern psychiatric department in a general hospital in Turkey was established in 1954 at the Istanbul University Faculty of Medicine. Up until the 1980s, psychiatric consultations in university hospitals were haphazard and mostly limited to emergencies (suicide attempts, psychotic excitations) as well as to cases where »no organic pathology« was detected. CLP was pioneered at the Istanbul University Faculty of Medicine, where the first CLP unit was formally established in 1989. It was officially recognized and approved as a specific academic discipline in 1997. This department has been integral in pioneering CLP in Turkey, where it is a rapidly developing area of practice and research. With the emphasis of CLP on the mind-body connection, the incorporation of consultation psychiatry into Turkish psychiatry brings psychiatry back to its historical and cultural roots[3].

Since 1998, the department of CLP at the Istanbul University Faculty of Medicine has undergone major transformations – particularly with respect to the characteristics and organization of CLP service. Two full-time senior faculty psychiatrists have joined the team. Professionals from different disciplines (liaison nurses, psychologists) have begun to participate in the provision of services and resident rotation has become regular. This has resulted in a dramatic improvement in the composition of the team from a small multidisciplinary medical consultation model to a much larger multidisciplinary one. There has also been an extension of liaison services throughout the hospital. Thus, routine joint case discussions and the making of ward rounds in the medical, surgical, oncology units have been made possible. Systematic training and educational programs have been added to major medical specialty clinics. Monthly seminars have been conducted at various medical departments and weekly multidisciplinary seminars have been held at the department of CLP. The hospital CLP bulletin has been published and distributed and educational programs for hospital nurses have been organized. Postgraduate courses have been conducted. The National Congress of CLP and Psychosomatics and most recently, The 8th Annual Scientific Meeting of The European Association of CLP and Psychosomatics were organized by the department and held in Istanbul.

By evaluating the changing patterns of psychiatric referrals over a five-year period, we intended to get an idea of the effect of patterns of service delivery, characteristics and composition of CLP service and educational programs on the rate, nature and context of psychiatric in-patient referrals.

Materials and Methods

All the consultations requested in 1998 and in 2003 were evaluated with regard to demographic characteristics, the source of referral, reason for referral (adopted from Mayou)[4], psychiatric diagnoses (according to DSM-IV)[5], and suggested treatment modalities. During the time of the study, hospital characteristics (the number of beds, physicians, nurses of the hospital, the number of hospital departments) were basically the same. For all consultations, we made use of a standard psychiatric consultation request form filled in by the referring physician, a psychiatric consultation reply form, and a medical psychiatric examination form that included physical-psychiatric interaction axes. The psychiatric consultation request form contained information concerning socio-demographic features, medical diagnosis, and reasons for psychiatric referral, laboratory data, and observation as to the behavioral characteristics of the patient. Psychiatric diagnosis was formalized according to the DSM-IV[5]. The reasons for referral are evaluated according to a system developed by Mayou[4], with the addition of two axes.

Data were analyzed using SPSS version 9.0. In this comparison study, significant differences between two groups were calculated using χ^2.

Results

Consultation rate

The number of patients referred for psychiatric consultation was 888 in 1998 and 1609 in 2003. The total number of patients admitted to the hospital during the

respective periods was 34,715 (1998) and 34,175 (2003). This means that the consultation rate in 1998 was 2.55, whereas in 2003, it was 4.70. The consultation rate nearly doubled from 1998 to 2003.

Demographic characteristics

The percentage of women referrals decreased in the five-year period. Over time, more men were referred than women ($p<0.01$). The mean age increased from 47.33±18.36 to 53.08±18.18. The percentage of older patients referred increased from 26.5% to 37.0% ($p<0.001$). The age distribution differed in both groups in that the percentage of consultations from old age group (>60) meaningfully increased over the five-year period (Table 1).

Referring clinics

There was a significant difference in the distribution of psychiatric requests in relation to the clinics of the hospital between 1998 and 2003 (Table 2). Psychiatric referrals increased with regard to the departments of internal medicine ($p<0.001$), cardiology ($p<0.05$), algology ($p<0.05$), obstetrics & gynaecology ($p<0.05$). Psychiatric referrals decreased from the departments of oncology ($p<0.001$), respiratory disorders clinic ($p<0.05$), and emergency surgery ($p<0.001$).

Patterns of reasons for referral

Table 3 shows the comparison of the patterns of referrals in years 1998 and 2003. A significant increase in groups 1, 2 and 6 were recorded. A meaningful increase in referrals for psychiatric consequences of physical disorder ($p<0.05$), and co-morbid psychiatric disorder ($p<0.05$) is noted. There is a decrease in referrals for psychiatric disorders presenting with physical symptoms ($p<0.01$).

Psychiatric diagnostic characteristics

In the distribution of psychiatric diagnoses of referred patients, depressive disorder was the most prevalent psychiatric disorder in 1998. This was replaced by adjustment disorder in 2003. The percentage of dementia increased ($p<0.05$) from 1998 to 2003. The ranking of the category »No psychiatric diagnosis« remained roughly the same, as did the distribution of such psychiatric diagnoses as substance abuse, personality disorder, and psychosis (Table 4).

Past psychiatric history

In majority of referred cases, no psychiatric history was defined in either group.
80% of patients that developed psychiatric problems in medical settings did not have a past psychiatric history.

Psychiatric treatment patterns

In both groups, psychotropic medication was the most prevalent intervention. This has increased to an even greater extent over the five-year period (72.7%–75.8%) ($p<0.01$). The application of supportive therapy was the second most prevalent intervention in both groups. Referral to inpatient psychiatry hospitalization was low in both groups.

Discussion

Consultation rate

While hospital characteristics have remained the same, the rate of consultation has almost doubled over the five-year period (from 2.55 in 1998 to 4.70 in 2003). It has steadily increased ever since the establishment of the CLP department in 1989[6–8]. Recent studies indicate the range of the rate of psychiatric consultation to be 0.5–9.1[9–11]. Worldwide reports concerning the rate of consultation indicate a range of 0.74%–5.8%[9,12–20], depending on the research population, hospital and the country.

The average annual rate of consultation rate in Europe is reported to be 1.4%[21,22]. Rigatelli and Ferrari[22] have reported a consultation rate of 3% (from 1.48 in 1989 to 3.6 in 2002). Studies in this regard generally report a more static rate over time. Creed et al[23] reported a 36% increase in rate of consultation. In a 10-year longitudinal observational study, Diefenbacher and Strain[24] re-

TABLE 1
DEMOGRAPHIC CHARACTERISTICS

	1998 (N=888) N	%	2003 (N=1609) N	%	Δ (%)	p
Gender						
Women	476	53.6	775	48.2	25.4	p<0.01*
Men	412	46.4	834	51.8	+5.4	p<0.01*
Age						
Young (<40)	343	38.6	451	28.0	–10.6	p<0.001*
Middle-aged (40–60)	310	34.9	562	34.9	0	p>0.05
Old (>60)	235	26.5	596	37.0	+10.5	p<0.001*
Age, X±SD (range)	47.33±18.36 (17–100)		53.08±18.18 (17–98)			

*significant

TABLE 2
THE DISTRIBUTION OF THE CLINICS THAT REQUESTED CONSULTATION

Referring Departments	1998 (N = 888) N	%	2003 (N = 1609) N	%	Δ (%)	p
Internal medicine	212	23.9	529	32.6	+8.7	p<0.001*
General surgery	143	16.1	285	17.7	+1.6	p>0.05
Oncology – Hematology	90	10.1	14	0.9	–9.2	p<0.001*
Orthopedics	75	8.4	107	6.7	–1.7	p>0.05
Emergency surgery	70	7.9	71	4.4	–3.5	p<0.001*
Physical rehabilation clinic	54	6.1	121	7.5	+1.4	p>0.05
Respiratory disease clinic	53	6.0	61	3.8	–2.2	p<0.05*
Neurology-Neurosurgery	52	5.9	88	5.5	–0.4	p>0.05
Cardiology	37	4.2	106	6.6	+2.4	p<0.05*
Medical emergency unit	33	3.7	66	4.1	+0.4	p>0.05
Intensive care unit	29	3.3	34	2.1	–1.2	p>0.05
Algology	12	1.4	40	2.5	+1.1	p<0.05*
Urology	12	1.4	38	2.4	+1.0	p>0.05
Obstetrics-gynaecology	8	0.9	35	2.2	+1.3	p<0.05*
Dermatology	8	0.9	19	1.2	+0.3	p>0.05

* siginificant

TABLE 3
COMPARISON OF THE TWO GROUPS WITH REGARD TO REASONS FOR CONSULTATION REQUESTS

Reason for request	1998 (N=888) N	%	2003 (N=1609) N	%	Δ	(%) p
Group 1	611	68.8	1170	72.7	+3.9	p<0.05*
Group 2	66	7.4	161	10.0	+2.6	p<0.05*
Group 3	101	11.4	122	7.6	–3.8	p<0.01*
Group 4	59	6.6	88	5.5	–1.1	p>0.05
Group 5	6	0.7	8	0.5	–0.2	p>0.05
Group 6	8	0.9	33	2.1	+1.2	p<0.05*
Group 7	37	4.2	27	1.7	–2.5	p<0.001*

* significant. Group 1 – encompasses psychiatric consequences of physical disorder, mainly differential diagnosis and management of disturbed behavior associated with delirium and dementia. Group 2 – includes physical and psychiatric disorders occurring together by chance, e.g., patient referred to the C-L service simply because a past history of schizophrenia came to light through routine history taking. Group 3 – comprises psychiatric disorder presenting with physical symptoms, for instance, somatoform and anxiety disorders. Group 4 – refers to physical complications of psychiatric disorder, for example, factitious disorders, alcohol and drug abuse, parasuicide. Group 5 – concerns psychosomatic disorders, such as ulcerative colitis, asthma, peptic ulcer. Group 6 – report medico-legal request with mental health examination. Group 7 – pre-op assessment.

ported a static consultation rate (1.2%) over time. The most distinctive finding of our study is the gradual and persistent increase in the rate of consultation, with its 2003 level being the highest reported in Europe.

The factors that play a role in the rate of consultation differ depending on countries and institutions; societal attitude towards psychiatry; communication and collaboration between psychiatrists and other physicians; and the existence and availability of consultation-liaison and psychosomatic service[25]. In our study, hospital and social factors remained the same. It was the establishment and recognition of CLP as a separate and special unit, the training of non-psychiatric physicians to recognize psychiatric problems in the medical setting and the ongoing liaison connections that had a major role to play in the increased rate of psychiatric consultations.

Demographic characteristics

The demographic profile of the referred patients in terms of gender and age displayed changed over the five-year period, with more male patients being referred for psychiatric consultations. The literature reports a preponderance of female patients[9,12,16,19,26]. Our study was in sharp contrast to this, a point that needs to be investigated further by taking into consideration the changes in the value system in society. Over time, the average age of referred patients increased. This has much to do with the change in the general age distribution of the population in general. The increase in psychiatric consultations from among the old age (>60) group is a reflection of this. These two findings, the changes of the demographic characteristic of patients in terms of gender and

TABLE 4
PSYCHIATRIC DIAGNOSES ACCORDING TO THE CATEGORIES OF DSM-IV

Psychiatric Diagnosis	1998 (N=888) N	%	2003 (N=1609) N	%	Δ	(%) p
Depressive disorders	184	20.7	329	20.4	–0.3	p>0.05
Adjustment disorders	182	20.5	516	32.1	+11.6	p<0.001*
No psychiatric diagnosis	157	17.7	270	16.8	–0.9	p>0.05
Delirium	127	14.3	181	11.2	–3.1	p<0.05
Anxiety disorders	101	11.4	97	6.0	5.4	p<0.001*
Somatoform disorders	36	4.1	47	2.9	–1.2	p>0.05
Psychotic disorders	30	3.4	48	3.0	–0.4	p>0.05
Sleep disorders	28	3.2	29	1.8	–1.4	p<0.05*
Dementia	13	1.5	41	2.5	+1.0	p<0.05*
Alcohol and substance use disorders	13	1.5	22	1.4	–0.1	p>0.05
Personality disorders	5	0.6	15	0.9	+0.3	p>0.05
Dissociative disorders	5	0.6	4	0.2	–0.4	p>0.05
Bereavement**	4	0.5	4	0.2	–0.3	p>0.05
Mental Retardation	2	0.2	3	0.2	0	p>0.05
Factitious disorders	1	0.1	1	0.1	0	p>0.05
Eating disorders	0	0	1	0.1	+0.1	p>0.05
Impulse control disorder	0	0	1	0.1	+0.1	p>0.05

*significant, **under the category of situations that may be of clinical interest

age are different from European and USA studies[12,27]. Most authors[17] generally report that the demographic features of patients do not change meaningfully over the years.

Referring clinics

In both groups, the largest number of consultations is from the department of internal medicine. While since 1989 the highest proportion of referrals has always been from the department of internal medicine[6,7], the percentage has increased over time.

Over the years, more and more consultations have been requested by departments of general surgery, physical rehabilitation clinic, cardiology, algology, emergency department, urology and obstetrics-gynaecology. As liaison psychiatry becomes increasingly accepted by physicians within non-psychiatric in-patient units of the hospital, it has begun to be used with greater frequency. Exceptions to this trend, include oncology, where the percentage of requests has decreased. But this is because there already exists a specific department of psychooncology that provides psychiatric service within the department of oncology. The requests included in this study are, hence, those that are made during »off hours« on an emergency basis.

In most accounts in the literature[6,14,24,27–29] the highest proportion of referrals comes from the department of internal medicine. In one review[9], a range of 41.7% – 90% was reported. The overall range of percentages in the literature for referrals is 10%–90%[9,11]. The second greatest source of referrals is the department of general surgery, which is the case in most general hospital consultation settings[6,24,29]. In a review conducted by Hengeveld et al[6]., referrals from such settings ranged between 7% and 34.7%. A more recent study[30] reports a figure of 25.5%. Grant and Meller[29] reported that it was the intensive care unit that was the second-most-likely department to consult psychiatry. Generally, a static source of pattern of referrals is reported[27,29]. Those who reported change in the source referrals attribute these to various factors, including liaison activities, the approach of the physicians and specific health system variables[12,17,24].

The finding of low consultation referral rates from obstetric and gynecology department was quite similar to results obtained in other studies[12,31]. The rate of consultation from obstetric-gynaecology moderately increased between 1998 and 2003, most likely a reflection of the collaborative studies and education programs conducted during that time. In the past, the consultations from obstetric and gynecology department were limited to patients presenting major behavioral outbursts or those with psychiatric history[7].

The change in source referrals over the years stems from the development of our service and liaison connections.

Patterns of reasons for referral

The percentage of Group 1 in total consultation requests is the highest in both our groups. It is even higher in the 2003 group. This percentage is higher than other studies reported in the literature[12,23,32]. Our finding that psychiatric consequences of physical disorder is the most frequent reason for consultation coincides with what is

found in the literature[9,12,23,32]. In our 1989–1991 study[6], the most frequent reasons for psychiatric requests were the referring physician's difficulty in making a diagnosis and previous psychiatric illness in the patient. Altogether, it reflects the improvement in the understanding that physical and psychological disorders co-exist and psychiatric consultations are not limited to »diagnostic evaluation« or to case presenting a past history of psychiatric disorder and suicide, which basically had been the case until the establishment of CLP service.

In general, the second-most-frequent reason for consultation is »psychiatric disorders presenting with physical symptoms[12,23,32]. In our study, the increase in Group 2 over time is noteworthy. As for Group 4 (physical complications of psychiatric disorder), there were considerable differences compared to what has been reported in the literature. In both our groups, the percentage was lower (6.6%–5.5%) than other studies[12,23]. Suicides, parasuicide, and deliberate self-harm are meaningfully low in our country due to cultural and religious factors. At the same time, alcohol and, more specifically, drug abuse are also still quite low. Therefore, a psychiatric consultation due to physical complications of psychiatric disorder is low in our study.

Diagnostic characteristics

There is a general trend in both groups towards depressive disorder, adjustment disorder, no major psychiatric diagnosis, and delirium. These comprise approximately 2/3 of the cases. In the 2003 study, the percentage of adjustment disorders reported is higher than it was in 1998. In our study, the determination of »no psychiatric diagnosis« means that the patient has been referred for psychiatric consultation but the assessment did not indicate the presence of a psychiatric disorder. The distribution of the most frequent diagnostic characteristics of patients in European and American studies indicate depressive disorder, adjustment disorder, delirium, somatoform disorder, anxiety disorder and alcohol and substance disorder, in differing ranks[12,29,30–39]. Adjustment disorders and depression are the most frequently encountered disorders among hospital psychiatry cases in both the national and international literature[13,33–39]. Depression of various kinds and subtypes constitute the most prevalent psychiatric diagnosis in inpatient psychiatric referrals[13,37].

The percentage of delirium is comparatively less in our groups, compared with other studies[9,12,17,23,27,41]. Organic brain syndrome had been reported to be between 12%–27%[33,41–43]. The decrease in the incidence of delirium can be explained by the fact that we have established ongoing liaison collaboration with the departments of oncology, intensive care unit, transplantation, hemodialysis, which means that routine psychiatric service is given. The increase in dementia can be explained by the increase in the age groups overall. A more recent study, covering a period of more than 10 years, by Diefenbacher and Strain[24] reports that organic mental disorders (delirium, dementia and substance-induced organic mental disorders) account for the majority of cases. This is followed by depressive disorder (including adjustment disorders) and by substance-use disorders, respectively. In our study, problems related to alcohol, and especially substance abuse, are extremely rare since these kinds of problems are uncommon in Turkey. The very low percentage of substance abuse in our referrals is a reflection of the general situation in the country.

Past psychiatric history

To our knowledge, no relationship between a request for consultation and past psychiatric history has been established. Up until the department of CLP was established, the majority of requests were for »functional« syndromes or for those with psychiatric history. During the first few years, more than half of the consultation requests were for the differential diagnosis »organic-functional« and for those defining past psychiatric treatment[6]. However, the results of both of our study groups reflect that the vast majority of referred cares defined no past psychiatric treatment. This reflects an improvement in CL services in that the concept of co-morbidity has developed in physicians of the hospital and psychiatric care of medical patients is becoming more of an issue.

Psychiatric intervention

The most likely employed treatment modalities are the use of psychotropics and follow-up. The most frequently administered drugs are, in order of frequency, SSRIs, anxiolytics and low-dosage antipsychotics. The potential and the safety of the new psychotropics in medical patients compared to previous conventional medications is obvious[44]. In liaison settings, long-term psychotherapy mostly cognitive-oriented psychotherapy becomes the second modality. Psychological support and crisis intervention therapy is the third most prevalent treatment modality. There has been an increase in the administration of psychotropic drugs – a phenomenon attested to by studies published since 1990–1991[12,27]. Overall, psychopharmatics and education and psychological support are the most prevalent bedside psychiatric help. Education here includes informing the patient and explaining to the physician the nature of the patient's situation. Brief crisis intervention psychotherapy is included here.

In our study, the referral rate to psychiatry inpatient service is low in both groups. Only a tiny percentage of patients (most of which were psychotic cases) were referred for psychiatric hospitalization. The literature, on the other hand, reports a higher percentage of patients recommended for psychiatric hospitalization (a range of between 8%[14]–12.6%[9]. The lower rate we found is primarily due to the relatively few cases of substance abuse and suicide, which may need emergency hospitalization. Nevertheless, in daily practice, the actual number of patients in need of psychiatric hospitalization was actually higher. There are many patients who cannot or should not be hospitalized in medical clinics due to situational or structural factors. In addition, inpatient psychiatry departments experience a number of difficulties in receiv-

ing certain kinds of patients – for example, pregnant patients with psychosis, cancer patients with melancholic and suicidal features, and MI patients with severe panic attacks. Therefore, we believe that it is clinically necessary to establish medical psychiatric inpatient liaison service.

An evaluation of the patterns of referrals reflects a consistent and gradual increase in consultation rate, an increase in consultation request from departments where training programs are carried out and in the pattern of referral favoring co-morbidity.

Controlling for hospital characteristics, the increase in rate, nature and context of psychiatric inpatient referrals can be attributed to the effects of service delivery, characteristics and composition of CLP service and educational programs, which were the major changes and developments that occurred during the period of the study.

The establishment of CLP as a separate unit, the change in the composition and the increase in the size of the CLP team, whereby it became a larger multidisciplinary model; the training of non-psychiatric physicians in the recognition of psychiatric problems in the medical setting; and the establishment of liaison connection all played a role in the recognition of psychological disorders in the medically ill, generating a willingness for collaboration, producing an increase in requests for consultation and rational utilization of psychiatric services. While the factors behind this development cannot be substantiated 100%, it can be argued that the aforementioned reasons and developments are major factors relevant to our experience and observation. Benefits and potential of »active« approach cannot be overlooked[25].

This is the first study of its kind from Turkey. Our experience in establishing and developing a CLP service that has a larger multidisciplinary team and liaison connections and large scale of educational programs will contribute to the establishment of CLP in general hospitals in the country.

Our experience has also suggested that a larger multidisciplinary CLP service[45] and liaison work will contribute to the improvement of psychiatric referrals, hence enabling more patients with a wider variety of clinical problems[46] to be seen. In addition, the quality of both service given and psychiatric request made will improve since physicians will be able to detect psychiatric morbidity in their patients earlier on and obtain more effective collaboration.

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PROCJENA RAZVOJA PSIHOSOMATSKE MEDICINE U VELIKOJ SVEUČILIŠNOJ BOLNICI U TURSKOJ

S A Ž E T A K

Cilj ovog istraživanja bio je procijeniti razvoj psihosomatske medicine na sveučilišnoj bolnici u Istambulu, s kapacitetom za 3 000 pacijenata. Promjene u načinima korištenja psihijatrijske djelatnosti analizirane su tijekom dva jednogodišnja istraživanja s razmakom od 5 godina (1998, n=888) – (2003, n=1609). Pacijenti upućeni na psihijatriju analizirani su u odnosu na učestalost konzultacija, demografske karakteristike, odjele koji su ih uputili na psihijatriju, razloge upućivanja, psihijatrijske dijagnoze i obrasce psihijatrijskih intervencija. Korišteni su upitnici za psihijatrijsku konzultaciju, psihijatrijski odgovor na konzultaciju i upitnik za psihijatrijski pregled. Kod procjene rezultata vidljivo je da je da se učestalost konzultacija udvostručila tijekom petogodišnjeg razdoblja. Značajne promjene također su uočene kod demografskih obilježja pacijenata (npr., više muškaraca, starija dobna skupina). Najučestaliji poremećaji u obje grupe bile su depresija i poremećaji prilagodbe. Zlouporaba alkohola i opojnih droga zadržala se u maloj grupi ispitanika. Postupno povećanje korištenja psihijatrijske djelatnosti može se pripisati unapređenju psihijatrijske djelatnosti i edukacijskim čimbenicima.