

Patient's trust in their psychiatrist: a cross-sectional survey

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Abstract Investigating and characterizing the degree and correlates of patient's trust in their treating psychiatrists across a range of psychiatric disorders is of a great clinical relevance to enhance our therapeutic alliance, which has not been addressed in the literature. In this study, outpatients who visited one of the participating psychiatric clinics in Tokyo, Japan between October and November, 2010 were asked to complete the Trust in Physician Scale (TPS), an 11-item self-report questionnaire. A univariate

general linear model was used to examine the effects of the following variables on the TPS total score: age, sex, diagnosis, Global Assessment of Functioning score, educational background, physician's years of practice as a psychiatrist, duration of treatment with their current psychiatrists, sex concordance between patients and their psychiatrists, and whether patients were older than their psychiatrists. Five hundred and four patients were enrolled (mean \pm SD age = 42.8 ± 13.6 years; 176 men; Psychiatric diagnoses (ICD-10): F0 [$N = 8$], F2 [$N = 72$], F3 [$N = 252$], F4 [$N = 147$], F6 [$N = 22$]). A duration of treatment with their current psychiatrist of ≥ 1 year and a duration of their physician's clinical expertise as a psychiatrist for ≥ 10 years were associated with a greater degree of patient's trust in their psychiatrist. Furthermore, patients with a F3 diagnosis showed a significantly higher TPS total score than those with F4. These findings underscore an importance of paying close attention to patients who are relatively new and are not treated by well-experienced psychiatrists in terms of subjective trust. Furthermore, this likely holds more true for patients with neurotic disorders.

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Introduction

Trust has been considered to be an essential part in relationships between physicians and patients. Trust refers to be expectations of the public that those who serve them will perform their responsibilities in a technically proficient way (competence), that they will assume responsibility and

not inappropriately defer to others (control), and that they will make patients' welfare their highest priority (agency) [15]. In theory, trust and distrust influence the frequency and cost of transactions [4, 8, 12]. In settings of high trust, transactions occur more easily and fewer resources are needed for monitoring, negotiating, litigating, and enforcing formal agreements [7]. In settings of high distrust, transactions are infrequent and transactional costs are higher. These concepts can be directly extended to health care; patients who have higher levels of trust in health care should be more likely to seek health care and accept health care recommendations [4]. Therefore, health care transactions should be more effective because of better information exchange and stronger relationships. On the other hand, patients with high levels of distrust are expected to be more likely to avoid health care, less likely to maintain continuity of care, and more likely to need to monitor and verify their health care decisions [4].

Patient's trust in their physician is considered to be critical in order to maintain mutual therapeutic alliance, which results in a high degree of patient satisfaction, good adherence to treatment, and improved health status [16, 18]. Demographic and clinical characteristics of patients (e.g., sex, education level) as well as doctors (e.g., sex, sex concordance) have been found to relate to patient's trust in their doctor [5]. Further elucidation on factors that could influence the patient's trust is expected to enhance our understanding of the relationship between patients and their physicians in an effort to improve treatment outcomes. However, previous studies in the literature have mainly been conducted in primary care settings [5, 17, 19], and this important issue has not been addressed in patients with psychiatric illnesses to the best of our knowledge. Although magnitude of potential differences in the significance of trust between general practitioners and psychiatrists is still unclear, trust is expected to play a pivotal role also in psychiatric settings in light of the critical importance of better information exchange that is essential for the assessment and treatment of psychiatric disorders. Moreover, good adherence to treatment is a prerequisite condition especially for the effective management of psychiatric illnesses [1, 11, 13, 14]. Investigating and characterizing their trust in psychiatrists is, therefore, of a great clinical relevance to enhance our therapeutic alliance, which would translate into better adherence and treatment outcome.

We conducted a cross-sectional survey to investigate whether the effects of clinical and demographic variables that were previously found to be associated with patient's trust in their primary care physicians would be also applicable to psychiatric outpatients and to investigate the degree and correlates of patient's trust in their treating psychiatrist in outpatients across a range of psychiatric disorders.

Methods

Subjects and assessments

In this cross-sectional study, all consecutive patients who visited either Oizumi Mental Clinic, Tokyo, Japan, or Asakadai Mental Clinic, Saitama, Japan, in October and November, 2010, respectively, were approached by one of the authors (AM). This investigator (AM) was not affiliated with either of these clinics or did not have any role in the treatment. The inclusion criteria were as follows: (1) age of 18 or older and (2) fluency in Japanese. We excluded patients who were incapable to provide consent or follow instructions. Subjects who agreed to participate in this study were asked to fill in the Trust in Physician Scale (TPS), Japanese version; the TPS is an 11-item self-report questionnaire that assesses patient's trust in their physician with regard to their dependability, confidence in their ability, and their confidentiality of information [2, 22]. All items are scored with a five-point scale and summed to yield a total score range from 11 to 55. A higher total score indicates the patient's greater degree of trust in their physician. Other information collected included age, sex, psychiatric diagnosis (according to the International Classification of Diseases-10th edition) [21] documented in the medical charts, duration of illness, duration of treatment with their current psychiatrists, and the highest educational qualification; their treating psychiatrists' age and sex and years of their clinical practice as a psychiatrist. The Global Assessment of Functioning (GAF) [3] were also used to assess overall psychiatric conditions.

The study was approved by the institutional review board at each participating site, and subjects provided written informed consent after receiving detailed information about the protocol. During the recruitment procedure, we assured potential subjects that all the responses they would make would be kept confidential to their practitioners. Those participating sites do not provide any special structured psychotherapy, but regular brief psychotherapy as well as psychopharmacological treatment.

Data analysis

Statistical analyses were carried out, using SPSS Version 18.0 (SPSS Inc., Chicago). First, as a preliminary analysis, a univariate general linear model was used to examine the effects of the following variables on the TPS total score: age group (i.e., <40 [young], 40–59 [midlife], or ≥60 [old]), sex, the highest educational qualification (junior high-school, high-school, college, or university or higher), GAF score (i.e., <60 or ≥60), physicians' years of clinical expertise as a psychiatrist (<10 or ≥10 years), duration of treatment with their current psychiatrists (<1 or ≥1 year),

sex concordance between patients and their psychiatrists, and whether patients were older than their psychiatrists. This model was generated with the main effects and all 2-way interaction terms. Following this preliminary analysis, the variables that were not found to have any significant effect, defined as P value ≥ 0.1 , on the TPS score were excluded from the subsequent model to enhance the statistical power. In the main analysis, another general linear model was generated with the rest of the main effects and all significant 2-way interaction terms. Degrees of freedom were described as numbers in brackets following F . When appropriate, we also examined group differences with pairwise comparisons, using Tukey–Kramer HSD (honestly significant difference). A P value < 0.05 was considered statistically significant and all tests were two-tailed.

Results

Demographic and clinical characteristics of the subjects

Five hundred and seventy three patients were approached; of these, 501 patients (87.4%) agreed to participate in this study. Demographic and clinical characteristics of the subjects are summarized in Table 1. ICD-10 Psychiatric diagnoses of subjects were as follows: F0: organic including symptomatic, mental disorders [$N = 8$], F2: schizophrenia, schizotypal, and delusional disorders [$N = 72$], F3: mood

(affective) disorders [$N = 252$], F4: neurotic, stress-related, and somatoform disorders [$N = 147$], F6: disorders of adult personality and behavior [$N = 22$]. These patients were all Asians and treated by a total of 29 psychiatrists. The overall TPS total score (mean \pm SD) was 42.9 ± 7.2 (5th percentile, 31; 25th percentile, 38; 50th percentile, 43; 75th percentile, 48.5; 95th percentile, 54).

Variables associated with the TPS score

A preliminary univariate general linear model showed that none of GAF score, the highest educational qualification, or whether patients were older than their psychiatrists was found to have any significant effect on the TPS total score (Corrected Model: $F_{(62, 414)} = 1.40$, $P = 0.032$, $R^2 = 0.17$), and these variables were excluded from the following main analysis. A univariate general linear model showed significant effects of ICD-10 diagnoses ($F_{(4, 483)} = 4.00$, $P = 0.003$), duration of physicians' clinical practice as a psychiatrist ($F_{(1, 483)} = 5.03$, $P = 0.025$), duration of treatment with their current psychiatrists ($F_{(1, 483)} = 8.01$, $P = 0.005$), and the interaction terms of ICD-10 diagnoses \times duration of physicians' clinical practice as a psychiatrist ($F_{(4, 483)} = 2.87$, $P = 0.023$) and sex \times sex concordance between patients and their psychiatrists ($F_{(1, 483)} = 5.53$, $P = 0.019$) on the TPS total score (Corrected Model: $F_{(17, 483)} = 3.55$, $P < 0.001$, $R^2 = 0.11$). Furthermore, according to post hoc analyses, a F3 diagnosis was associated with a significantly higher TPS total score than F4 (Table 2). No statistically significant effect was found

Table 1 Demographic and clinical characteristics of 501 subjects

Characteristics	Values
Age (years), mean \pm SD (range)	42.8 \pm 13.6 (19–91)
<40 years N (%)	223 (44.5%)
41–59 years, N (%)	216 (43.1%)
≥ 60 years, N (%)	62 (12.4%)
Male, N (%)	176 (35.1%)
CGI-S, mean \pm SD (range)	2.6 \pm 0.9 (1–5)
GAF, mean \pm SD (range)	68.3 \pm 9.7 (45–85)
Duration of practice of their psychiatrist	
<10 years	207 (41.3%)
≥ 10 years	294 (58.7%)
Duration of treatment with their psychiatrist	
<1 year	194 (38.7%)
≥ 1 years	307 (61.3%)
Sex concordance between patients and their psychiatrists	
Concordant	207 (41.3%)
Non-concordant	294 (58.7%)

SD standard deviation

Table 2 TPS total score in association with clinical characteristics

Characteristics	Values (mean \pm SD)
ICD-10 diagnosis	
F0	39.1 \pm 5.8
F2	43.3 \pm 7.9
F3	44.1 \pm 7.1 ^a
F4	41.0 \pm 6.6 ^b
F6	42.4 \pm 7.3
Duration of practice of their psychiatrist	
<10 years	42.1 \pm 7.3
≥ 10 years	43.5 \pm 7.1
Duration of treatment with their psychiatrist	
<1 year	41.7 \pm 7.2
≥ 1 years	43.7 \pm 7.1

SD standard deviation, TPS Trust in physician scale

See text for detailed statistics

^a $P < 0.001$ by the Tukey–Kramer HSD (honestly significant difference) vs. F4

^b $P < 0.001$ by the Tukey–Kramer HSD vs. F3

in sex ($F_{(1, 483)} = 0.02$, $P = 0.89$), age group ($F_{(2, 483)} = 0.76$, $P = 0.47$), sex concordance ($F_{(1, 483)} = 0.01$, $P = 0.92$), or age group \times duration of treatment with their current psychiatrists ($F_{(2, 483)} = 2.51$, $P = 0.08$).

Discussion

To our knowledge, this is the first study that examined a degree of psychiatric patient's trust in their treating psychiatrist. We found that a shorter duration of treatment with their current psychiatrist and a shorter career of their physicians as a psychiatrist were associated with a lower degree of subjective trust on the side of patients. Furthermore, patients with neurotic disorders seem to have a lesser trust in their psychiatrists, compared to those with mood disorders.

The magnitude of trust in psychiatric outpatients that we observed in the present study was comparable to the findings in prior studies conducted in primary care settings and in the field of internal medicine [5, 6, 9, 20]. In primary care settings, the mean \pm SD scores in the TPS of 42.7 ± 6.2 ($N = 217$), 48.1 ± 9.9 ; 51.3 ± 7.4 ($N = 160$), and 41.4 ± 7.8 ($N = 414$) were reported in North Carolina, North Carolina, and California, respectively [2, 5, 20]. Kayaniyil et al. investigated the trust in 202 cardiology patients, using the TPS, and also found a comparable score of 43.5 ± 6.3 (mean \pm SD) [9]. A similar score was also found in 741 patients with a rheumatic disease (mean \pm SD: 42.0 ± 7.3) [6]. These generally similar findings may be attributable to a potentially consistent nature of patients who regularly visit clinics and agree to participate in this type of survey. On the other hand, large SDs (i.e., variability) in the TPS total score in the previous studies as well as the present study may indicate that a subgroup of patients do not fully trust in their physicians, including psychiatrists. In light of the chronicity of many psychiatric illnesses that necessitates a long-term treatment, a good relationship between patients and their psychiatrists is critically important to enhance treatment adherence and improve therapeutic alliance [10]. It would therefore be ideal to assess patient's trust in their psychiatrist on a regular basis, using a simple assessment scale such as the TPS.

A longer duration of treatment with the current psychiatrist was associated with a higher degree of trust. Thom et al. conducted a cross-sectional survey that examined the level of trust, using the TPS, in primary care settings ($N = 414$) and also showed that the TPS score got higher with a longer treatment duration [20]. The finding in the present study may be due to a unique feature of psychiatric treatment; psychiatric patients and psychiatrists discuss not only physical concerns, but also their personal issues. The

longer a successful therapy proceeds, the more ready patients are likely to disclose themselves, which in turn would be expected to result in a better treatment relationship as well as a higher sense of trust although this statement is still speculative and well-designed prospective studies are warranted.

Another positive association that we found with better trust is a longer duration of physician's practice as a psychiatrist. Contrary to our results, Bonds et al. found that the TPS score of patients treated by resident physicians was comparable to that in those treated by physicians with a longer career in internal medicine [5]. This difference may again be attributable to a specific nature of psychiatric disorders. Psychiatrists may need a longer career to effectively understand their patients' distress and sympathize with them. In addition, experienced psychiatrists may demonstrate a sense of more confidence, which can lead to patient's greater trust in them. Although these preliminary findings need to be replicated in other psychiatric settings, they may point to the need of development of an educational program for psychiatrists in training to enhance a patient–psychiatrist relationship in terms of trust. The first step may be to provide educational sessions on patient–physician relationship with a special focus on trust.

It is not surprising that a F4 diagnosis was associated with a significantly lower TPS total score than a F3 diagnosis. There is a possibility that anxiety symptoms stemming from these illnesses may hamper the establishment of a good therapeutic alliance between patients and psychiatrists. Furthermore, if patients with neurotic disorders have experienced traumatic events, it is very likely difficult for them to maintain a good relationship with others with trust. Caring and comfort have been shown to play important roles in enhancing patient's trust in their physician in family practices [19]. Although this finding has not been reported in psychiatric patients, it may plausibly be beneficial to provide such positive attitudes, especially to patients with neurotic disorders in order to improve their trust.

The results of our study must be interpreted in light of a number of limitations. First, the total number of subjects included in the present study was relatively large; however, the sample size in each diagnostic group (e.g., F1, F5) was still small, which may limit the statistical power to further detect differences in the TPS total score among various diagnostic groups. Second, we failed to gather the clinical and demographic information of the patients who did not agree and reasons why they refused to participate. Although the high response rate of 87.4% can verify good representativeness of the sample, we cannot entirely negate a possibility that patients who refused to participate could be different from those who agreed. Third, the R squared value of 0.11 was not high in the general linear models that

we performed in this study. This indicates that while there is a statistically significant relationship between the TPS score and the predictor variables contained in our model, a large amount of variability is still not fully explained by these factors. It would have been ideal to evaluate other clinical characteristics such as personality traits and prescribed medications that could influence patient's trust in their psychiatrist. Furthermore, the use of more comprehensive assessment scales for psychopathology could have identified specific symptoms associated with the degree of trust. Moreover, individual effects of 29 psychiatrists included in the present study were not evaluated although some characteristics of the psychiatrist and of the psychiatrist–patient relation were included, which needs to be acknowledged when the data are interpreted. In addition, while a statistically significant association of the interaction term of sex \times sex concordance was found, either of them did not show any significant effect on the TPS total score. It was with difficulties to discuss what clinical significance is associated with this statistically significant finding under this condition, which warrants further investigations. Fourth, this study failed to evaluate impression on the side of psychiatrists to their patients. This is important since psychiatric treatment is a human-to-human interaction. Finally, this study did not evaluate longitudinal outcomes due to the nature of the cross-sectional study design, which needs to be addressed in prospective trials.

In conclusion, the present study found that greater trust in their psychiatrists by patients with psychiatric illnesses was associated with a longer duration of treatment with their current psychiatrist and a longer duration of their psychiatrists' career. Conversely, these findings highlight the need to pay more attentions to patients who are relatively new and those who are not treated by well-experienced psychiatrists with respect to trust in order to establish a good relationship. Furthermore, this may hold more true for patients with neurotic disorders. Although these preliminary results in this study should be replicated in other clinical settings to provide robust findings on the patient–physician relationship, they may emphasize the need of an educational program for younger and lesser experienced psychiatrists to enhance a patient–psychiatrist relationship in terms of trust, which will in turn contribute to better treatment adherence and outcomes of psychiatric illnesses.

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