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Perceptions and Attitudes of a Sample of Primary Care Patients Receiving Psychological Care from their PCP

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PERCEPTIONS AND ATTITUDES OF A SAMPLE OF PRIMARY CARE PATIENTS RECEIVING PSYCHOLOGICAL CARE FROM THEIR PCP

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Dissertation Approval

This is to certify that the thesis presented to us by Nadine Henzes Gowarty on the 21st day of April, 2016, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Dedication

This dissertation is dedicated to my late father, Frank J. Henzes, Jr. who instilled in me the importance of faith, family and kindness by the life he led and whom I miss every day.

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Abstract

With millions of Americans suffering from a mental health disorder and slightly more than half receiving treatment, the demand for psychological services far outweighs the number of practitioners available to provide direct care. Therefore, the majority of all primary-care visits are based on psychosocial factors; one third of a PCP's caseloads consist of patients with mental-health problems. Given the fact that PCPs provide comprehensive psychosocial care, it is important to determine the beliefs and perceptions of their patients. Results from this study identified numerous factors that influence the relationship between patients receiving mental health care from their PCP. Specifically, if a patient believes that he or she has a good relationship with the PCP, he or she is more likely to view the physician as a resource and, therefore, it is probable that the patient will seek guidance and treatment thru the PCP. Additionally, patients are more likely to seek services and discuss mental health concerns with their PCP if they perceive that a positive relationship exists between them. Also, a patient who perceives his or her PCP as empathic and as a resource for mental health is more likely to continue with mental health services as well as have better treatment results. Should a patient hold these perceptions and beliefs of his or her PCP, the patient is more likely to seek treatment, less likely to drop out of services and have overall better clinical outcomes. Results of this study highlight the need for additional education regarding the factors that contribute to positive clinical outcomes when treating patients with mental health concerns.

Keywords: psychological care, primary care patients, PCP, attitudes, perceptions,

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Chapter 1

Introduction

Statement of Problem

At present, more than 450 million individuals, globally, suffer from a mental disorder (NIMH, 2011). In the United States, according to the Substance Abuse and Mental Health Service Administration (2015), the prevalence of mental disorders is reportedly 43.6 million individuals or 18.1% of the population. Of those affected, 58.7% receive treatment (NIMH, 2011). Who provides treatment to these individuals remains a concern.

The demand for psychological services far outweighs the number of practitioners available to provide direct care. An estimated 70% of all primary-care visits are based on psychosocial factors (Olsen, 2014). With regard to a primary-care physician's (PCP) caseload, approximately 30.3% is made up of patients with mental-health problems (Faghri et al., 2010). Of those 30%, 58.1% of PCPs rank depression as the most common mental-health disorder, whereas 30% report it to be the second most common disorder (Faghri et al., 2010). Because depression, along with other mental-health problems, is treated by PCPs, why does there exist such a significant number of individuals who do not receive treatment?

Most patients have PCPs who provide treatment for the majority of their problems. However, many patients do not seek traditional psychological care for multiple reasons; among these are having solved the problem on their own, not being open to seeking outside help, lacking financial resources to pay for such services, or not trusting the health-care system (Rabinowitz et al., 1999). Another major reason that individuals

do not seek mental-health treatment is that the stigma or label of being “crazy” is often attached to mental illness (Corrigan, 2004).

As a result, PCPs are often sought out by patients who are experiencing psychological distress. This pattern of care-seeking is likely associated with a number of factors related to patient motivations described previously, as well as to characteristics of the PCP role. PCPs are committed to providing comprehensive biopsychosocial care and therefore often provide care for psychosocial problems. Yet, there is little research on the perceived quality, effectiveness of, and satisfaction with care for mental-health problems provided by PCPs.

Given the fact that PCPs provide comprehensive psychosocial care, it is important to determine the beliefs and perceptions of their patients. An investigation of patient beliefs on a number of parameters can help to clarify the reasons why patients may choose to seek care for mental-health issues from their PCPs. This study, then, is designed to answer several important questions related to this issue and investigate the perceptions of primary-care patients about seeking care for mental-health problems from PCPs; among these are the types of problems for which care is typically being sought; the perceived quality of psychosocial care being received; the perceived quality of the physician-patient relationship; perceived satisfaction with this care; and perceived effectiveness of psychological care for problems being treated.

Purpose of the study

The purpose of the present study was to examine the perceptions and attitudes of a sample of primary-care patients receiving psychological care from their PCPs. More specifically, this study was designed to gauge: 1) the perceptions and beliefs that PCP

patients hold about seeking care for psychological problems from their PCP; 2) the rated quality of care that is being received; 3) the quality of the physician-patient relationship and empathy; 4) the perceived satisfaction with this care; and 5) the perceived effectiveness of psychological care for problems being treated. Data from this study may be useful in understanding factors that relate to the perceived effectiveness of care being received as well as in educating both patients and PCPs about how these factors interact in predicting perceived helpfulness of services being offered. The findings may also prove useful in training primary-care physicians to meet the needs of their patients in the most effective possible manner. The following information provides the reader with information concerning the role that primary care serves in the treatment of mental-health problems and how that treatment may be improved, and result, ultimately, in increased compliance and overall more positive outcomes.

Chapter 2

Literature Review

What is Primary Care?

Primary care is defined by the Institute of Medicine as “the provision of integrated, accessible healthcare services by clinicians who are accountable for addressing a large majority of personal health-care needs, developing a sustained partnership with patients, and practicing in the context of family and community” (Donaldson et al., 1994, p. 15). The purpose of primary care is to manage patients who often have numerous diagnoses and puzzling complaints that do not fall within known diagnoses and to provide treatment that improves overall quality of life and function (Starfield, 1998).

The Development of Primary Care.

Primary care emerged as a solution to the concern about fractionation of patient care. In the 1930s and 1940s, health care was provided primarily by pediatricians, internists, and general practitioners. The term "primary care" did not appear until the early 1960s (Donaldson et al., 1996). Although reports encouraged the establishment of family practice as a new primary-care specialty, there was a lack of adequate physicians in primary care and there continued to be a decline in the number of general practitioners (White et al., 1961). Donaldson et al. (1996) report that this growth was further stunted by the birth of programs for physician's assistants and nurse practitioners, which also began to appear around the same time. In the 1970s, a shortage of primary-care physicians was noted. In response to this shortage, the Institute of Medicine encouraged a change from the term “medical care” to “primary care.” Through the Alma-Ata

declaration, the World Health Organization brought primary care front and center. Through the mechanism of health maintenance organizations (HMOs), primary-care physicians became the gatekeepers for individuals seeking specialized care. In addition to being gatekeeper, PCPs hold numerous other roles each day while they are in practice (Donaldson et al., 1996).

Roles Served by PCPs.

Primary care physicians have, on average, approximately 18.53 minutes per office visit (Bruen, Ku, Lu, & Shin, 2013). Within this time, initial contact for care, continuity over time, comprehensiveness, and coordination of care with other healthcare providers needs to be achieved (Starfield, 1998). This is obtained while meeting the goals of managing biological, psychological, and social diagnoses and treatments; offering support to patients of all backgrounds and in all stages of illness and disease; educating them about diagnoses, evaluation, treatment, prevention, and prognosis; caring for patients with chronic illnesses; and preventing disability and disease through early detection, education, and preventative treatments (Goroll et al., 1987). The typical primary-care patient brings an average of three concerns to each appointment (Kaplan et al., 1995). With these responsibilities and goals under such time constraints, the physician-patient relationship is crucial for a positive experience. The ideal relationship between the physician and patient is described by Frank et al. (2004) as one in which the individuals have the autonomy to act and with the assumption that they seek and share responsibility. This is based on collective respect and unconditional positive regard (Frank et al., 2004). PCPs have significant roles and responsibilities that are further stressed by limited patient interaction. To gain additional knowledge of PCPs' treatment

of mental-health problems within the primary-care setting, it is necessary to have an understanding of the components of primary care.

Basic Tenets of Primary Care.

As defined by Taylor et al. (2003), the characteristics of primary care include comprehensive care, emphasis on physician-patient relationship, continuity of care, attention to psychosocial issues, and patient education. The emphasis on developing a solid relationship between the physician and the patient enhances a connection with a practitioner who not only understands the patient but also is someone whom the patient can trust.

Comprehensive care is the concept of providing health care to all ages and both sexes "from conception to resurrection" (Taylor et al., 2003, p. 5). It is important to have a complete understanding of the entire patient, not only of the symptoms presented at the time of the visit. This tenet focuses on having a thorough understanding of all factors that may impinge upon the patient's care (DiTomasso et al., 2010).

Next is the physician-patient relationship. Development of such a relationship is enhanced when a bond exists between the individuals before the patient becomes ill. Inquiring into the patient's personal life with questions such as how his or her spouse, partner, or children are doing, as well as the physician disclosing information about his/her family helps create and maintain the bond that results in the physician maintaining personal accountability (Taylor et al., 2003).

Continuity of care is the understanding that patients will have their care administered by one physician for their entire lives. Having the same physician who is familiar with the patient's medical and psychological well-being presumably provides the

patient with higher quality care (DiTomasso et al., 2010). There is also reason to believe that PCPs may then be able to detect the manifestation of psychological problems and distinguish between problems that are primarily psychological or primarily physical (DiTomasso et al., 2010).

Attention to psychosocial issues is also necessary. Primary care physicians urge their patients to discuss issues that are psychological and social, and that may be influencing their mental and physical functioning (DiTomasso et al., 2010).

Finally, patients need to be educated about problems, health, and wellness, which are considered basic to providing thorough health care. Patient education allows the patient to make informed decisions (DiTomasso et al., 2010).

Each of the six traits previously mentioned is necessary for the development of the successful physician-patient relationship. These tenets are not instinctive but rather obtained through extensive and arduous training.

Curriculum for Training PCPs.

According to Martin (2012), the primary-care physician generally completes a Bachelor of Science degree in courses such as biology, inorganic and organic chemistry, and anatomy. He or she will then attend medical school, which starts with two more years of course work. Subsequently, he or she will complete two years of clinical rotations focusing on such specialties as internal medicine, family medicine, and psychiatry. The medical student is then allowed to choose electives from several areas, including, but not limited to, family and community medicine, internal medicine, and pharmacology. Finally, the medical student becomes a resident for three years in family medicine training and preventive care; preventive and diagnostic procedures; office-based

procedures; minor surgical care; inpatient care and long-term care facilities; and diagnosis, treatment, and management of acute conditions (Martin, 2012). The primary-care physician provides wider, more deeply immersed knowledge of the diagnosis and treatment of all kinds of health problems.

Overall, the primary-care physician is trained to provide intricate distinct diagnoses, develop a treatment plan that addresses the diverse organ systems, and order and interpret tests within the context of the patient's overall health condition (Martin, 2012). As a specialty, primary care addresses the need for a coordinator of patient care to help patients navigate their way through the medical system.

Martin (2012) defined the professional requirements for family physicians as medical knowledge, interpersonal and communication skills, patient care, professionalism, practice-based learning and improvement, and systems-based practice.

Additionally, the responsibilities of the primary-care physician include continuity, which means seeing the patient on a regular basis over time for many, if not most of the patient's health issues. This is with the understanding that the physician is capable of dealing with significant comorbidity related to many chronic problems. The primary-care physician also arranges referrals and tests and gathers the results because he or she is the first person the patient contacts when a health concern develops. It is fundamental for the physician in primary care to practice evidence-based medicine and to complete necessary continuing education. Maintaining communication with the patient, with other health-care workers, and with specialty physicians also falls under the roles of the primary-care physician along with patient education, which in turn increases patient compliance with treatment (Kroenke, 1993).

For many years, physicians have been practicing within the biomedical model of care. The physician takes the symptoms presented by the patient at the time of the visit, provides a diagnosis, and initiates treatment based on medical knowledge (Toon, 1994). The biomedical model is described as viewing a disease as a physical burden that may be corrected by medication (Barber, 1995). This model has been effective for many years. However, with the ever-growing amount of research, more consideration has been given to the idea of the mind-body relationship and the effects that this has in the practice of medicine. This paves the way for the biopsychosocial model.

George Engel (1977) created the biopsychosocial model out of the need for physicians to attend, concurrently, to the biological, psychological, and social ranges of illness. Furthermore,

. . . the appearance of illness results from the interaction of factors, including those at the molecular, individual, and social levels. And the converse, psychological alterations may, under certain circumstances, manifest as illnesses or forms of suffering that constitute health problems, including, at times, biochemical correlates. (Borrell-Carrio et al., 2004, p. 577)

This model, which is often used, has many parts to its foundation. These anchors include self-awareness, trust, empathy, self-assessment to monitor and if necessary to eliminate prejudice, utilization of educated insight, and education on clinical matters that allow the patient to understand his or her medical condition. Engel has stressed the importance of the physician to attend to the biological, psychological, and social ranges of illness, which provides a more encompassing form of treatment (Borrell-Carrio et al.,

2004). With such a model, are the problems presented in primary care more physical or more psychological in nature?

Why People Seek Out PCPs.

In a classic and often-quoted study, Marsland, Wood, and Mayo (1977) conducted a study of the numerous health-care problems presented to primary-care physicians on a daily basis. Although obviously dated, they concluded that respiratory ailments are the main reason for individuals seeking treatment, followed by trauma and adverse effects of toxins. Mental and behavioral problems were eleventh. Marsland et al. (1977) reported that such problems represented 6.7% of all problems, yet previous studies indicate that mental and behavioral problems account for 20% to 30% of problems. What then accounts for the discrepancy? Upon review of records, researchers focused on low back pain. Thirty percent of patients who complained of low back pain also expressed behavioral problems, but these problems were not recorded. Marsland et al. (1977) concluded that this under- emphasis on documenting behavioral problems is a direct result of the lack of behavioral science education and training in medical school. They reported that it was necessary to create a curriculum for family medicine (Marsland et al. 1977).

Common Problems in Primary Care.

Physical problems. In primary care, physical problems may present as psychological problems. Such medical problems that may present to the practitioner as depression include Addison's disease, Cushing's disease, hyperthyroidism, hypoglycemia, multiple sclerosis, pancreatic carcinoma, and systemic lupus erythematous (Belar & Deardorff, 2009).

Psychological problems. On the other hand, psychological problems may present as physical symptoms. Common physical complaints that frequently mask psychological problems include tiredness, poor sleep, lack of energy, vague reports of aches and pains, worry, tension, inability to relax, poor memory, somatic complaints such as heart palpitations, headaches, and stomachaches (Craig & Boardman, 1997). These symptoms occur in addition to distress, due to anxiety or depression that develops from a lifelong illness or from chronic somatization disorders; coexisting with these are psychological and physical disorders that are primarily individualistic to each other, such as depression in a patient suffering from cardiac problems (Craig & Boardman, 1997). Therefore, problems seen by physicians in primary care are either medical or psychosocial in nature and these may be combined. It is difficult to separate the mind-body phenomena. The medical problems commonly seen are hypertension, obesity, diabetes mellitus type 2, and common psychosocial problems such as depression, anxiety, and domestic violence (Weiss, 1999).

Similarly, Kessler et al. (1985) researched the common psychiatric disorders presented in primary care. Major depression, minor depression, followed by phobia and generalized anxiety were also identified. Results indicate that recognition of such disorders was low overall. Only 20% were acknowledged by the physician during the first month, rising slightly to 30% at the six-month mark. Conversely, primary-care providers recognized mental or emotional disorders in five or six of the individuals who did not have this diagnosis. Therefore, it is concluded that the primary-care physicians' ability to identify and record such symptoms needs to be monitored more closely.

Knowing that PCPs are faced with psychological disorders in primary-care settings, what type of treatment is traditionally provided?

Treatment for Psychological Problems in Primary Care

Primary care physicians are more likely to provide psychiatric care than to refer patients to mental health specialists (Gray et al., 2005, Kolbasovsky et al., 2005, & Coyne et al., 2002). Over a 10-year period from 1987 to 1997, there has been an increase from 37.3% to 74.5% in patients receiving psychiatric medication prescribed by their primary care physician (Olfson et al., 2002). Craig and Boardman (1997) reported that effective treatment by general practitioners includes brief, structured counseling, education on relaxation techniques, and supporting patients with the use of self-help techniques. Research has shown that almost two-thirds of primary care physicians are taking on the role of psychiatric primary care physicians. With the development of safer psychotropic medications, primary care physicians feel more comfortable treating psychiatric disorders (Faghri et al., 2010). There are, however, problems with the treatment of psychiatric disorders in primary care, including overuse of medication, failure to diagnose common problems, misdiagnosis, and mistreatment. The U.S. Surgeon's Mental Health Report noted that primary care has reported lower rates in the recognition and treatment of depression, leading to unnecessary and expensive diagnostic procedures, specifically with patients who have vague somatic complaints (p. 269). However, the U.S. Surgeon General did encourage the treatment of mental disorders in primary care. The report observed that "primary care offers the potential advantages of proximity, affordability, convenience, and coordination of care of mental and somatic disorders and many older people prefer to receive mental health treatment in primary care" (p. 372).

Wang et al., (2005) also conducted research to assess treatment of mental health in the United States. It was determined that of those diagnosed with a mental illness, 41.1% had received some form of treatment in the previous 12 months, with 22.8% of that treatment being provided by a general medical provider. Cases treated in the mental health specialty sector tend to account for more visits than those treated in the general medical sector.

In a study by Faghri et al. (2010), the effectiveness of PCPs' psychiatric assessment and treatment practices were assessed. It was determined that the average number of patients for a PCP is 3,461, with 30.3% being mental health patients. Of these patients, 40.1% receive medication only; 29.6% received medication and referral to therapy; 17.2% were referred to a psychiatrist, and 12.8% were referred to therapy only. Prescribing medication was the primary form of treatment with the least common being referrals for therapy. A small 13.7% of PCPs do not refer their patients to treatment, and an even smaller 6.8% do not prescribe psychiatric medications at all.

Prevalence of Depression and Anxiety in Primary Care

The World Health Organization reports there are approximately 350 million individuals, worldwide, suffering with depression and approximately 265 million individuals, worldwide, suffering with anxiety (2016). Currently, approximately 34 million individuals experience a mental disorder but do not receive treatment (NIMH, 2011). Depression appears to be the predominant diagnosis, currently affecting 9.5% of the US adult population (NIMH, 2011). The diagnosis of depression is often accompanied by symptoms that result in a diagnosis of anxiety. This comorbidity is increasing in prevalence, resulting in changes in diagnosing. WHO reported that every

individual with a mental disorder did not seek treatment. However, those with a mental disorder are more likely than other patients to consult physicians (1997). WHO also reported that the following scenarios indicate an underlying mental health problem in a patient: inappropriate requests for urgent attention; an increase in the frequency of consultation or requests for tests; unexpected or excessive outbursts during an examination or excessive anxiety about another family member, or referring another relative as the patient. Younger males with severe disorders who have had some type of separation early in life, who have a co-occurring misuse of alcohol and or drugs, or who have suicidal ideation or attempts, who are also experiencing problems and have inappropriate responses to medical attention are more likely to be referred to a specialist by a primary care physician (World Health Organization, 1997).

As previously mentioned, depression alone currently affects 20 million Americans (NIMH, 2011). With this staggering number, it is conceivable that 60% of individuals with depression go undiscovered in primary care. The role the PCP plays in identifying, managing, and controlling depression cannot be overstated (Bland, 2007).

When reviewing the treatment of psychological disorders by a primary care physician, further exploration of those treatment modalities that appear most commonly utilized is beneficial. Different types of treatment were then investigated. According to the Substance Abuse and Mental Health Services Administration, (SAMHSA) of the individuals who received treatment for depression in the past year, 46.4% were prescribed medication and spoke with a professional; 13.6% spoke with a professional only and 6.7% were only prescribed medication (2014). When reviewing the type of professional seen by adults for treatment, General Practitioner or Family Physician was

number 1 with 57.2%, and Psychiatrist/Psychotherapist was second at 35% (SAMHSA, 2014). When considering treatment for a psychological disorder, primary care physicians commonly pursue one of two choices: medication or talk therapy. Medication is typically prescribed by a physician. There are five groups of medications utilized in the treatment of major depressive disorder: selective serotonin reuptake inhibitors (SSRIs), or serotonin and norepinephrine reuptake inhibitors (SNRIs), norepinephrine-dopamine reuptake inhibitors (NDRIs), tricyclic antidepressants, and monoamine oxidase inhibitors (MAOIs) (Kalat, 2009). A group of so-called non-antidepressant adjunctive agents is also prescribed in addition to, or at least taken in combination with, certain drugs from the aforementioned groups (Kalat, 2009).

The duration of pharmacological treatment of depression varies depending on the individual, and on the severity of his or her condition. Anderson (2003) reported that clinical judgment, along with familiarity with the research on the length of use, is crucial when considering antidepressant use. He noted that the clinician must take the risk of relapse into consideration when determining the appropriate duration of antidepressant use. Therefore, the severity of the individual's diagnosis, the duration of the disorder, the persisting symptoms, and the patient's social and personality factors need to be taken into consideration when the treatment duration is determined (Anderson, 2003).

Overall, the length of treatment for the use of antidepressants should be addressed on an individual basis. A course of treatment for an adult female may be different from the course of treatment for a male of the same age. Treatment teams need to maintain contact with all involved parties, especially the client, to ensure the most effective treatment outcome.

According to SAMHSA (2008), perceived helpfulness of treatment for depression depended upon which treatment the individuals received. Those who received medication in addition to speaking with a professional, considered the treatment as extremely helpful or as helping a lot. Also, of the subjects who spoke with a physician or other professional about their depression, 40.5% felt it was extremely helpful or helping a lot; 29.2% reported that speaking with a physician or other professional offered some help, and 30.2% speaking with such individuals was little or no help. Finally, of those who received only medication for their depression, 50.7% reported it as extremely helpful or helping a lot; 28.0% reported that it offered some help, and 19.3% reported it was little or no help (SAMHSA, 2008). In addition to medication, counseling is used in primary care treatment of major depression.

Counseling Service to Patients.

Chilvers et al. (2001) conducted a study to determine the effectiveness of counseling versus antidepressant use in primary care treatment of major depression. The study compared the efficacy of antidepressant drugs and generic counseling for treating mild to moderate depression in general practice. The 323 subjects, who ranged in age from 18 to 70, were recruited from 31 general practitioners' practices. Follow-up was completed at eight weeks and 12 months with a review of the practitioners' notes. Chilvers et al. reported that psychotherapy for mild to moderate depression seems to be as effective as a prescription of antidepressant medication, although patients may reach recovery from depression with the use of antidepressants sooner than with psychotherapy (2001).

To further determine the effectiveness of counseling treatment by primary care physicians, Seligman reviewed the results of the Consumer Reports Study of 1994 (1995). Consumer Reports surveyed readers on the effectiveness of psychotherapy and psychotropic medication in a version of its 1994 questionnaire. The survey was provided to the 180,000 readers; of those, 7,000 subscribers responded. In all, 4,100 reported going to some combination of mental health professional, family doctor, and support group. Of the 4,100 respondents, 1,000 were seen by family physicians; 1,300 joined self-help groups, and the remaining 2,900 were seen by a mental health professional. Family doctors, by comparison, did as well as mental health professionals in the treatment of mental health issues on a short-term basis but worse in the long term, which is considered six months or longer. Seligman (1995) noted complaints about mental health treatment received by patients. Specifically, 22% of the respondents reported that their doctors had not provided emotional support; 18% stated their doctors were too busy to spend time talking to them, and 15% stated that their doctors seemed uncomfortable discussing emotional issues. In discussing primary care physicians providing care for mental health concerns, the belief was that long-term care is inferior to long-term care by mental health professionals. This raises the questions of the public's perception of the treatment of mental health disorders.

Seeking Care for Psychological Problems from PCPs.

Schindler, Berren, Hannah, Beigel, and Santiago (1987) reviewed the public's perception of the treatment of mental health disorders by nonpsychiatric physicians, compared with other professions. When provided with ten different patient types, primary mental health professionals were rated as significantly more competent to treat these

patients as were nonpsychiatric physicians. However, physicians were considered higher on caring and professionalism. Still, physicians, who are often the initial and sometimes the only professional that the patient visits with psychological problems, received the lowest ratings (Schnidler et al., 1987). Schindler et al. also reported that the reasons nonpsychiatric physicians tend to treat these patients for brief periods may range from rapid improvement on the part of the patient to the physicians' discomfort with in-depth mental health treatment (1987).

Wells reported that nearly half of all patients receiving some form of mental health care in a given year will receive that care exclusively from nonpsychiatric physicians (as cited in Schindler, et al., 1987). The data, however, suggested that patients feel nonpsychiatric physicians lack the skills to treat emotional problems. Half of these patients receiving this treatment are treated by that same professional (as cited in Schindler, et al., 1987).

Similar, Jorm et al. (2000) conducted a study to survey the public's beliefs about the effectiveness of treatment for mental health disorders. When given two vignettes, one of a depressive patient and one of a patient with schizophrenia, subjects felt the general practitioner was the one identified as most helpful. Interestingly, treatment such as antidepressants and antipsychotics were viewed as harmful rather than helpful, and non-standard treatment such as physical exercise, relaxation, and stress management was rated as more helpful (Jorm et al., 2000). This provides somewhat of an overview of the general populations' view of the question, "Does the view of mental health treatment change as one ages?"

Oxman and Dietrich (2002) reviewed the fundamental roles of PCPs in mental health care for the elderly. Common barriers to improved identification and treatment of mental health problems noted by physicians include inadequate time to deal with the range of competing demands faced in their practices (Klinkman, 1997). One barrier in the treatment of mental health disorders identified in the elderly population is the hesitation to accept antidepressants, and further, those that do take the medications often stop taking them before reaching acceptable doses (Sirey et al., 2000). Oxman and Dietrich reported that increasing interaction between physician and patient within the primary care setting had been noted to improve overall treatment results. Additional interventions include using appropriate assessments such as the depression self-report measures, maintaining treatment flow charts to monitor progress, providing patient with education that is easily understood by the patient, conducting patient follow-up and referring the patient to a psychiatrist on an as needed basis (Oxman and Dietrich, 2002).

Criticisms

Primary care physicians are more often becoming primary psychiatric care physicians due to demand, providing mental health treatment to their patients rather than referring them to specific mental health providers (Faghri, Boisvert, & Faghri, 2010). Reasons for the primary care physicians assuming treatment include a lack of mental health providers, limited insurance to cover psychiatric treatment, or patients' unwillingness to access available psychiatric services due to the correlated stigma (Cunningham, 2009). Primary care physicians increased the number of patients to whom they prescribe psychiatric medication from 37.3% in 1987 to 74.5% in 1997. However, even with the increase of patients receiving psychiatric medication from primary care

physicians, theses same physicians have been criticized for over-prescribing medication (Gray, Brody, & Hart, 2000), for failing to diagnose common disorders such as depression and anxiety (Brody, 2003), for failing to identify comorbid conditions properly (Zimmerman, 2008), and for under-diagnosing, misdiagnosing, and mistreating (Wells, Sherbourne, & Schoenbaum, 2000).

Perceptions and beliefs that patients hold about seeking care for psychological problems from their PCP.

Van Vorhees et al. (2003) explored the effects of the care-seeking process and treatment exposure of differences in attitudes concerning treatment between the mental health setting (MHS) and primary care physician groups. Patients that recognized a need for treatment and received a referral to an MHS were analyzed along with those who did not receive a referral, in order to measure whether or not PCPs tended to refer those with more favorable attitudes to MHS treatment. The patients, who received mental health treatment from their primary care physicians had the perception that not receiving treatment was acceptable, compared with receiving treatment from a mental health specialist. More than 70.6% of those seen by an MHS and a PCP felt attending individual therapy was common versus 72.5% of those who saw only an MHS (VanVorhees et al., 2003).

Additionally, Van Vorhees et al. (2003) reported that having received mental health services exclusively from a primary care provider was directly correlated with evidence-based treatments for depression not being chosen, as well as with a lower perceived need for care. Visiting with a primary care physician for mental health services was also related to lower educational levels and lower household income. The recognized

need for treatment was associated with a preference to be treated either by a psychiatrist or by MHS for depression.

Similarly, many patients who are more hesitant to receive mental health treatment select general medical providers because they do not believe they are receiving "psychiatric care" (Young, Klap, Sherbourne, & Wells, 2001; Leaf, Bruce, Tischler, Freeman Jr, Weissman, & Myers, 1988; Greenly & Mechanic, 1976). Being treated by a primary care physician and not receiving psychiatric care may be reassuring to many patients because it does not threaten their sense of autonomy (Wood, 2000; Kessler et al., 1999; Krosnick & Petty, 1995). Vorhees et al. (2003) concluded that PCPs need to recognize the fact that up to half of their patients with depression may be hesitant to accept evidence-based treatment, resulting in their lack of compliance with their physician's recommendations.

Kravitz et al. (2011) also conducted a study to identify attitudinal and interpersonal barriers to depression care-seeking and disclosure in primary care. This study reported that participants voiced skepticism of the PCP's aptitude to meet their mental health needs. Distinct impediments included problems with PCP competence and openness or communication, as well as patient–physician trust. Few questioned PCPs' knowledge of mental health disorders and believed that mental health concerns fell outside the parameters of this medical specialty. These barriers may prevent patients with depression from seeking care or admission to a mental health facility (Kravitz et al. 2011).

Likewise, Kravitz et al. (2011) report that among those who want help, barriers which are organizational, interpersonal and relational in nature, play a significant role in

the individuals not seeking help. Such organizational obstacles include the inability to access care, short visit times, limited resources, maintaining continuity with a single physician, and negotiating the complexities of healthcare organizations. Also, interpersonal barriers such as social distance (Buetow et al., 2009; Schouten & Meeuwsen, 2006; Willems et al., 2005) and low patient-physician trust may be important. Kravitz et al. report that participants also emphasized three distinct relational barriers: concerns about competence, openness, and trust.

The major finding of this study per Kravitz et al. (2011) is that despite increasing recognition of primary care as the essential source of mental health services for the majority of Americans (Schurman et al., 1985), and broadened focus on the evaluation and treatment of mental health conditions in primary care residency training (Leigh et al., 2006), many participants reported gaps in care and regarded the primary care model for diagnosis and treatment of depression with concern. Despite development of competent models for the delivery of high-quality depression care (Rost et al., 2002; Wells et al., 2000; Katon et al., 1995), individuals reported inconsistency in treatment and perceived the primary care model for diagnosis and treatment of depression with apprehension. Patients' inability to negotiate these previously mentioned barriers successfully, such as the lack of health insurance and poor access to care, contribute to this problem. Patients with depression may be hesitant to seek care or pursue treatment due to relational barriers such as negative perceptions of PCPs' mental health-related capabilities and interests or to lack of trust.

Gonzalez et al. (2011) reviewed the relationship regarding attitudes toward the treatment of mental health with consideration of age, gender, ethnicity/race, and

education. Of the 5,691 subjects, 30% were estimated to have had previous mental health treatment by a specialist, and 10% reported the use of general medical providers, only, for mental health treatment. Overall attitudes toward mental health treatment were positive. However, patients who had been diagnosed with emotional problems and were followed by general medical physicians, reported reluctance to see mental health specialists; this was reportedly due to fearing the label of the psychiatric patient and the related stigma. Also, persons who reported having a less than high school education is associated with preferring mental health treatment in a general medical setting.

Elwy et al. (2011) reviewed patients who sought treatment for depression and examined and identified their feelings of depression, their view of effective treatment, and consequences of not seeking treatment. Also, the reasons why patients have a difficult time seeking help was also reviewed. Patients who did not obtain treatment insisted that treatment would not be effective, and felt that the depression would be short term and did not disrupt their everyday lives. Elwy et al. (2011) concluded that patients who sought depression treatment articulated their knowledge of depression, the belief that treatment would work, and the negative consequences of not receiving treatment. Those patients who did not define a clear understanding of depression indicated that treatment would not be effective, felt that depression would not last very long, and believed that depression did not affect their everyday lives. One's ability to identify and determine the severity and potential consequences of the symptoms, in addition to patients' emotional responses to these symptoms, played a significant role in pursuing or not pursuing treatment for depression.

Rated quality of care that is being received.

Buszewicz et al. (2006) identified which aspects of general practitioner consultations that patients presenting with psychological problems experience as *helpful* or *unhelpful*. Patients highly valued genuine interest and empathy, as well as a continuing relationship. Patients also described how the general practitioner helped them make sense of, or resolve their problems and supported their efforts to change. The researcher also reported that routine general practitioner consultations for psychological problems can have a significant impact, at least in the short term. Based on the results, important areas reported by patients include: developing a working relationship; showing interest and listening; showing understanding and acceptance; providing continuity; facilitating change; making sense of problems; advising and facilitating decision-making; and supporting action and progress. Patients reported that they were helped by clear explanations of their problems, specifically the physical complaints of anxiety and depression (Morriss et al., 1999) and by simple advice and support. The second group of patients acknowledged a collaborative decision-making style. Buszewicz suggests that avoiding an analytical problem-solving method, common to the one used in this study, may be more effective in the examinations completed in a primary care setting.

Quality of the physician-patient relationship and level of empathy provided by PCPs

Murphy et al. (2001) examined how patients of PCPs are responding to a changing healthcare environment. The assessment survey scales measured relationship quality, specifically: communication, interpersonal treatment, physician's knowledge of the patient, patient trust, and organizational features of care, which include financial access, organizational access, visit-based continuity, and integration of care over a three-

year period. There were significant declines in communication, interpersonal treatment, and trust and organizational access. Improvement was observed in physicians' knowledge of the patient and visit-based continuity. There were no significant differences in financial access and the combination of care models. It is reported by Murphy et al. (2000) that the quality of physician-patient relationships affects health outcomes (Greenfield et al., 1988; Greenfield et al., 1985; Kaplan et al., 1989), and patients' willingness to comply with medical treatment (DiMatteo, 1994; Francis et al., 1969), and influences patients' seeking of malpractice suits (Penchansky & Macnee, 1994; Beckman et al.,1994). The most significant declines were noted in interpersonal treatment, followed by declines in the quality of communication and trust.

Murphy et al. (2001) reported that the ability of patients to see their regular physicians for routine care and appointments when sick increased throughout the three years. However, these patients go on to report that the quality of the consultation declined. With changes in healthcare, what impact wills an individual's ability to see his or her PCP have on mental health treatment and satisfaction? Access to care is a defining feature of primary care (Institute of Medicine Primary Care, 1996; Palmer, 1991) and an important correlate of patient satisfaction (Harpole et al., 1996; Harris, 1999).

Similarly, Pollak et al. (2011) sought to determine if a physician's use of specific motivational interviewing techniques such as reflective listening and empathy increases patient satisfaction with the physician and with perceived autonomy. They assessed patient satisfaction and how much the patient felt the physician supported patients' desires to change. Results indicate that patients whose physicians were rated as more empathetic reported higher levels of satisfaction than those individuals whose physicians

were less empathetic. Patients whose physicians made any reflective statements were more likely to experience high autonomy. When physicians were empathetic, patients were more likely to report high satisfaction with the physician. These results suggest that physician training in motivational interviewing techniques could potentially improve patient perceptions and outcomes.

Reiss et al. (2012) analyzed whether or not an innovative empathy training protocol based on neuroscience could improve physician empathy, as rated by patients. The group trained in empathy received greater changes in patient-rated scores on the Consultation and Relational Empathy measure than the control group. Therefore, a short training in empathy significantly enhanced patients' ratings of physician empathy, proposing that physician provided quality of care could be improved by incorporating empathy training into medical education.

Hojat et al. (2002) conducted a study to review the structure of the Jefferson Scale of Physician Empathy (JPSE). The findings of this study suggest that physician empathy is a multidimensional concept involving, at least, three components: perspective taking, compassionate care, and standing in the patient's shoes. The second and third are specific to the patient-physician relationship.

Hojat et al. (2003) define empathy as "an ability to 'stand in the patient's shoes' without leaving one's personal space; empathy is a capacity to view the world from a patient's perspective, without losing sight of one's personal role and responsibilities" (p. 27). It is crucial for the physician to understand the patient so that empathy may exist within this relationship. Empathy is the primary element in the physician-patient relationship. If a patient is aware that the physician understands him or her, this has

positive effects including increasing clinical outcomes and compliance (Hudson, 1993). Empathy which is provided verbally or non-verbally, between physician and patient, encourage a more positive physician-patient relationship

Hojat (2003) also reports that such individual characteristics as interpersonal and communication skills and listening convey empathy to patients. Hojat felt it necessary to distinguish sympathy from empathy because they are often used, incorrectly and interchangeably. Sympathy is the act or the ability to enter into or feel the emotion of another person. Therefore, objectivity in diagnosis and treatment may become obscured should exaggerated sympathy occur (Aring, 1958). Hojat (2003) proceeds to define physician empathy: "A cognitive (as opposed to affective) attribute that involves an understanding of the inner experiences and perspectives of the patient, combined with a capability to communicate this understanding to the patient" (p 27).

Studies have shown that there are gender distinctions concerning empathy (Davis, 1983 and Hogan, 1969). Because women are thought to exhibit more caring attitudes than men toward their children (Trivers, 1972), and are considered to be more receptive to emotions than men (Buss, 1993; Bjorklund & Kipp, 1996), this can be applied to other functions. Women are more receptive than men to emotional signals (Trivers, 1972), a characteristic that can lead to a better understanding and an increased empathic communication (Hatcher et al., 1994). Zinn (1993) reports that women are more likely than men to provide emotional support and understanding, resulting in amplified empathic relationships.

Hojat (2003) questioned whether or not physicians in "people-oriented" specialties, which included family medicine, internal medicine, pediatrics, obstetrics and

gynecology, psychiatry, and medical subspecialties, would receive higher scores on the JSPE than those physicians in “technology-oriented” specialties, which included anesthesiology, radiology, pathology, surgery, and surgical specialties. It was determined that physicians in “people-oriented” specialties scored higher than those in “technology-oriented” specialties routinely in all items of the scale (Hojat et al., 2003). Hojat also reported that although psychiatrists received the highest scores on the JPSE, these were not significantly different from family medicine, internal medicine, pediatrics, and emergency medicine specialties (2003).

As previously mentioned, empathy contains the idea of perception on the part of the patient. Therefore, Hojat (2010) felt it was important to look more deeply into the relationship between patient perceptions of physician empathy and resulting reactions, such as satisfaction with physicians, interpersonal trust between physician and patient, and compliance; these would give credence to the notion of empathic engagement resulting in positive outcomes in patient care. Hojat’s (2010) findings suggest that a physician’s approach for preventive measures can contribute to a more positive perception of physician empathy based on patients feeling that their physicians understand and care about their health. It is patient-perceived physician empathy that is positively associated with clinical outcomes and not professionals’ self-reported empathy (Hojat, 2010 and Thorton and Thorton, 1995). Additional studies support the importance of empathy in the quality of a physician-patient relationship.

Kim et al. (2004) discussed patient perceived empathy as having two parts: cognitive and affective. “The cognitive aspect of physician empathy is defined as the physician’s ability to accurately apprehend the mental state of his or her patients (the

ability to take another person's point of view) and to effectively communicate this perspective back to the patients. The affective aspect of physician empathy is defined as the physician's ability to respond to and improve his or her patients' emotional state" (Kim et al., 2004, p. 239). Within their research, they hypothesized that "cognitive information exchange," perception expertise, partnership, and trust would directly influence satisfaction and compliance.

Kim et al. (2004) did determine that a physician's empathic communication skills significantly and substantially influenced patient satisfaction and patient compliance and that emotional aspects of the physician's communicative behaviors played the most important roles in increased satisfaction and compliance.

Perceived satisfaction with this care.

Jackson et al. (2001) researched patient satisfaction at varying points in time, utilizing a survey with 2-week and 3-month follow-ups in a general medical walk-in clinic. Data included patient symptom characteristics, symptom-related expectations, functional status, mental disorders, symptom resolution, unmet expectations, satisfaction, visit costs and health utilization, as well as receiving an explanation of the likely cause of and the expected duration of the presenting symptom. Patient expectations not being met were indicators of satisfaction throughout the study. Indicators of satisfaction soon after the doctor visit included patient-doctor communication such as physician providing the patient with an explanation of the root of the symptom, expected length of illness and meeting expectations. Satisfaction was obtained at 2-weeks and 3-months, with symptom resolution, need for repeat visits, and functional status. The following are a list of specific barriers which led to a decrease in satisfaction: deficits with both verbal and non-verbal

communication, patient's psychological state (Greenley, Young, & Schoenherr, 1982), depression (Linn & Greenfeld, 1982; Hansson, Borgquist, Nettelbladt, & Nordstrom, 1994; Wyashak & Barsky, 1995) personality disorders (Hueston, Mainous, & Schilling, 1996).Lower satisfaction has also been found among elderly, disabled Medicare beneficiaries (Hermann et al., 1998). Unmet patient expectations may also affect satisfaction. Jackson et al. report type, duration, symptom severity, character or number of expectations that individuals have before the visit or the amount of financial burden during the visit in correspondence with satisfaction (2001).

Redmond et al. reviewed the experiences of racial/ethnic minorities' treatment with specialty service providers (2009). Results determined that satisfaction with treatment received from a medical doctor did not differ among racial/ethnic groups. Those with lower educations and higher social support reported greater satisfaction with treatment from a medical doctor. Results also reported that racial/ethnic minority subjects were more likely to be satisfied and had greater perceptions of helpfulness about the services received from specialty mental health providers, compared with services by generalists. Cooper-Patrick et al. also identified race relationships as they relate to the primary care setting (1999). Patients in race compatible relationships with their PCP noted higher levels of participation in the decision making.

Additionally, when examining the perceptions and attitudes of a sample of primary care patients receiving psychological care from their PCP, it is necessary to assess how elements such as interpersonal style, accessibility/convenience, finances, efficacy/outcomes, continuity of care, office environment, and availability are measured. Ware, Davis-Avery and Stewart (1978) reported eight elements that, in combination,

make up patient satisfaction. Specifically: the amount of caring a physician shows to the patient, the competency of the provider to diagnosis and treat, the convenience and accessibility of the physician's office, financial flexibility as it pertains to payment plans, the physical environment of the office, availability of the physician to schedule appointments, continuity of care and last, efficacy or usefulness of care provided to the patient.

Ware et al. (1983) described patient satisfaction as the individual's assessment of health care providers and services. Satisfied patients are more likely to seek, comply with, and continue treatment, (DiMatteo, 1979; Murphy-Cullen and Larsen, 1984; Stamps and Finkelstein, 1981; Nice, Butler & Dutton, 1983; DiTomasso and Willard, 1991). DiTomasso and Willard (1991) conducted a study to "develop and evaluate the psychometric properties of a patient satisfaction questionnaire developed within a family practice center and to overcome common methodological issues evident in some previous works" (p127). After utilization of the DiTomasso-Willard Patient Satisfaction Questionnaire (DWPSQ), it was determined that patient satisfaction consists of five areas. These are, specifically, "patient perceptions about physician interpersonal skills and knowledge, practice management, availability, wait time, and receptionist behavior toward patients "(p130).

Perceived effectiveness of psychological care for problems being treated.

The research of Wang & Patten (2007) sought to determine the effectiveness of mental health treatment when administered by a family doctor or general practitioner rather than by a mental health specialist to distinguish components related to the

effectiveness of mental health services. Mental health treatment administered by a family doctor or general practitioner resembled the care provided by mental health specialists. Because patients seeking mental health treatment often visit their family doctor or general practitioner, demographic information was also researched. Individuals who were more likely to seek care only from their family doctor or general practitioner were women, older, married, and with 13 years of education (Wang & Patten, 2007). Subjects that were treated by a family doctor or general practitioner noted less comorbid mental disorders, less severe symptoms, and less functional impairment than those who visited a mental health specialist.

Therefore, based on a thorough review of the literature, the purpose of the present study was to examine the perceptions and attitudes of a sample of primary care patients receiving psychological care from their PCP. More specifically, this study was designed to gauge: 1) the perceptions and beliefs that PCP patients hold about seeking care for psychological problems from their PCP; 2) the rated quality of care that is being received; 3) the quality of the physician-patient relationship and empathy; 4) the perceived satisfaction with this care; and 5) the perceived effectiveness of psychological care for problems being treated.

Chapter 3

Research Questions

1) What are the perceptions and beliefs that PCP patients hold about seeking care for psychological problems from their PCPs?

2) For those currently being treated by their PCP for a mental health problem, what is the rated quality of the physician-patient relationship regarding interpersonal treatment, communication, trust, and access?

3) For those currently being treated by their PCP for a mental health problem, what is the rated quality of empathic understanding?

4) For those currently being treated by their PCP for a mental health problem, what is the perceived satisfaction with this care?

5) For those currently being treated by their PCP for a mental health problem, what is the perceived effectiveness of psychological care for problems being treated?

Hypotheses:

1. The greater the quality of the physician-patient relationship, the greater the degree to which patients will perceive their PCP as a resource for mental health treatment

2. The greater the perceived empathy provided by a PCP, the greater the degree to which patients will perceive their PCP as a resource for mental health treatment.

3. The greater the perceived level of empathy provided by a PCP, the greater the perceived quality of the physician-patient relationship

4. The greater the perceived level of empathy provided by a PCP, the greater the perceived satisfaction with medical care.

5. The quality of the physician-patient relationship, belief in the PCP as a mental health resource, and rated quality of empathy will significantly predict perceived satisfaction with medical care.

6. The quality of the physician-patient relationship, belief in the PCP as a mental health resource, and rated quality of empathy will significantly predict perceived effectiveness of treatment for a mental health problem.

7. Female PCP's will be perceived as significantly more empathic than male PCPs.

Chapter 4

Methodology

Subjects.

The subjects were males and females who were 18 years of age and older and were recruited through internet websites. Inclusion criteria included male and females who were able to read and write in English and who reported that they were diagnosed with a mental health problem, excluding psychotic disorder and schizophrenia, and who are not being treated by mental health professional. Exclusion criteria included those subjects with psychotic disorder and or schizophrenia. Subjects who treat individuals with mental illness such as psychologists, psychiatrists, social workers, and counselors, and patients who were being treated by a mental health professional were also excluded.

Materials.

The present researcher developed the Survey of Perceptions and Attitudes of Primary Care Patients Receiving Psychological Care from Their PCP, based on an adaptation of items from of the following surveys: the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), by Fischer and Turner (1970); the Jefferson Scale of Patient's Perceptions of Physician Empathy (JSPPPE), by Hojat (2010); DiTomasso Willard Patient Satisfaction Questionnaire (DWPSQ), by DiTomasso and Willard (1991); the Patient Satisfaction Questionnaire (PSQ-III), by Ware (1994); and the Consumer Reports Effectiveness Study, by Seligman (1994).

The ATSPPHS was developed by Fischer and Turner (1970) as a way of measuring people's attitudes concerning the idea of seeking professional help. The scale has 29 items, with 11 positive and 18 negative listed. The specific items are organized

into four subscales: Factor I—Need (eight items); Factor II—Stigma (five items); Factor III—Openness (seven items); and Factor IV—Confidence (nine items). Survey participants choose the answer that most closely reflects their responses using a 4-point Likert scale, with 87 being the highest possible score. Scores are computed for the entire assessment and for each subscale. Positive attitudes on the ATSPPHS are indicated by a high score.

Concerning reliability, the ATSPPHS has a verified internal consistency, as reported by both Fischer and Farina (1995) and Fischer and Turner (1970)—Factor I, r = .67; Factor II, r = .70; Factor III, r = .62; and Factor IV, r = .74. Both Fischer and Farina (1995) and Fischer and Turner (1970) found the ATSPPHS to be reliable in differentiating those who have positive attitudes from those who have negative attitudes about seeking professional psychological help. The construct validity of the ATSPPHS was affirmed when the total scores were shown to correlate positively and significantly (r = 0.49) with the Help-Seeking Attitude Scale (Poltkin, 1983). Items in the current study were adapted and modified for use.

The Jefferson Scale of Patients Perception of Physician Empathy (JSPPPE) was developed by Hojat (2010) after he created the JSPE. The objective of the JSPPPE was to create a short measure to assess patients' perceptions of their physicians' abilities to empathize. Empathy can improve physician-patient relationships and increase patient compliance, which can result in improved outcomes overall. The JSPPPE was combined with nine questions from the American Board of Internal Medicine, four from the physician's Humanistic Behavior Questionnaire (Weaver et al., 1993), and one item from the Matthews and Feinstein (1989) questionnaire, which is designed to measure a

patient's appraisal of physician performance (1989). Last, Kane et al. (2007) used results from the JSPE to examine the similarity between the patient's perception of physician empathy and the physician's self-reported empathy. In all, 225 patients, who were cared for by 166 residents at the Jefferson Hospital Ambulatory Clinic, were requested to answer three demographic questions and 19 items. The responses were reported on a 5-point Likert scale. Currently, there is no available information concerning the reliability or validity of the instrument. The JSPPPE is used in its entirety in the present study.

DiTomasso and Willard (1991) created the DWPSQ, the purpose of which is to measure patient satisfaction with the health services they received in a family practice residency setting. In developing the DWPSQ, the authors compiled a 100-item questionnaire that was analyzed by an expert panel. The final version of the questionnaire contains 80 items to be answered, using a 4-point Likert scale. Two hundred, sixty-eight subjects over the age of 18 were chosen at random to participate in the study. The receptionist at the Tatem-Brown Family Practice Center in Southern New Jersey approached patients, at random, to inquire about their interest in participating in the study. The survey was shown to possess five factors: Factor 1—Satisfaction with the physician (29 items); Factor 2—Dissatisfaction with practice management (18 items); Factor 3—Availability (six items); Factor 4—Receptionist behavior (three items); and Factor 5—Wait time (four items). The DWPSQ can be used in the evaluation of residencies and primary care settings. Its subscales also make it useful for evaluating patient satisfaction in such areas as educational programs and medical treatment facilities. In the present study, several items from the Satisfaction with Physician subscale were used.

Ware et al. (1994) developed the Patient Satisfaction Questionnaire III, succeeding previous versions. The first Patient Satisfaction Scale had 80 items and was later reduced to 50, addressing six aspects of satisfaction in regard to medical care: interpersonal manner (seven items), communication (five items), technical competence (ten items), time spent with doctor (two items), financial aspects (eight items), and access to care (12 items). An index of broad satisfaction with care (six items) is also included. The instrument contains both positively and negatively worded items. In 1974 and 1975, 1,280 adults from California and Illinois were asked to indicate how they felt about their general medical care, through the use of a 5-point Likert scale. No information is currently available concerning the reliability or validity of the survey. In the present study, several items from the PSQ-III were adopted and used.

The Consumer Reports annual survey of 1994 included an accompanying survey about psychotherapy and drugs developed by Seligman. Readers of Consumer Reports were requested to complete the mental health section if they had sought help for emotional problems during 1991 to 1993. Of the 22,000 readers who responded to the annual questionnaire, 7,000 responded to the mental health portion of questions (Seligman, 1994). Seligman (1994) reported that of the 7,000 responders, 1,073 saw a psychologist and approximately 1,000 met with a family physician.

The mental health portion of the questionnaire consisted of 26 questions focusing on physicians, medications, self-help groups, mental health problems, emotional states, types, ffrequencies and durations of therapy, coverage, outcomes of therapy; patient satisfaction; and terminations. This portion of the survey contained three subscales: specific improvement, satisfaction, and global improvement. The Consumer Reports

(CR) study provides the most comprehensive results on the effectiveness of psychotherapy. According to Seligman, the reason lies in the fact that it is "representative of the middle class and educated population who make up the bulk of psychotherapy patients" and "informs us about treatment effectiveness under the duration constraints of actual therapy" (Seligman, 1994, p 969).

The CR study adds to the knowledge of how treatment goes beyond the mere elimination of symptoms….the main methodological virtue of the CR study is its realism: It assessed the effectiveness of psychotherapy as it is actually performed in the field with the population that actually seeks it, and it is the most extensive, carefully done study to do this. This virtue is akin to the virtues of naturalistic studies using sophisticated correlational methods, in contrast to well-controlled, experimental studies. (Seligman, 1994, p. 971).

Items were developed for the present study based on important areas measured in the Seligman (1994). The survey is included in Appendix A.

Design

The researcher used a survey design to examine perceptions and attitudes of a sample of primary care patients receiving psychological care from their PCP. The survey methodology also allowed the researcher to utilize a cost effective way of examining participants' attitudes and opinions.

Procedure

Subjects were recruited through websites using Survey Monkey during a 12 month period. Subjects read the solicitation letter, completed the inclusionary/exclusionary items and then agreed to participate or not participate if

deemed eligible. Subjects who agreed to participate completed the survey through a link provided to them and submitted their responses electronically. Subjects were provided with an explanation about the purpose of the study through Survey Monkey. Estimated time of completion was 30 minutes. The survey included questions pertaining to perceptions of primary care patients about seeking care for mental health problems from PCP's; questions related to quality of care being received and the characteristics of the physician-patient relationship and empathy; questions to specify the types of problems for which care is typically being sought; the perceived quality of psychosocial care being received; perceived satisfaction with this care and perceived effectiveness of psychological care for problems being treated. The final section of the questionnaire included demographic information. The questionnaire surveyed participants' knowledge and expectations of and attitudes towards practitioners in the treatment of mental health disorders. The Statistical Package for the Social Sciences (SPSS) version 23 was utilized to provide an analysis of the data.

Chapter 5

Results

In this section, descriptive statistics including means standard deviation for each of the demographic variables are described. Coefficient alpha reliabilities are also reported for each of the subscales. Finally, the results of hypothesis testing for each hypothesis are reported in the form of correlation coefficients and independent sample t-tests.

Demographic characteristics

A total of 118 individuals entered the link to participate in the study; only 40 met the inclusion criteria. Of those who met the inclusion criteria, only38 provided usable data by completing all parts of the questionnaires.

The sample for this study compromised 26 females (68.4%) and 8 males (21.1%), ranging in age from 24 to 75 years old. The mean age was 42.97 years old (s = 13.53). The racial ethnic composition of the group is shown in Table 1. The educational levels of the subjects are shown in Table 2. More than half of the participants were being treated by a Caucasian PCP. As shown in Table 3, more than 71% were being prescribed medication for a psychological disorder by their PCP. A similar percentage of participants had insurance to cover visits to a mental health professional.

Table 1.

Racial Ethnic Composition of the group

	Frequency	Percent
Missing Values	4	10.5
African Americans	3	7.9
American Indian	1	2.6
Caucasian	29	76.3
Hispanic	1	2.6
Total	38	100.00

Table 2.

Highest Degree or level of education completed

	Frequency	Percent
Missing Valid	4	10.5
Associates Degree	5	13.2
Bachelor's Degree	9	23.7
High School Diploma	2	5.3
Master's Degree	13	34.2
Vocational Certificate	5	13.2
Total	38	100.00

Table 3.

Race/ethnicity of PCP's

	Frequency	Percent
Missing Values	7	18.4
African Americans	3	7.9
American Indian	3	7.9
Asian	4	10.5
Caucasian	21	55.3
Total	38	100.00

The length of time that participants reported being patients of their PCPs ranged from 6 months to 35 yrs. The average length mean was 8.7 years (s = 9.7). The majority of participants were being treated by PCP with specialties in Family Medicine and Internal Medicine. More than three- fourths of these participants indicated having seen a psychologist or psychiatrist in the past. Self-reported diagnoses revealed that 57.9% were diagnosed with depression, and 65.8% with an anxiety disorder. Participants reported that the primary problems that led them to seek help from their PCP included: relationship (21.1%), productivity (15.8%), stress (39.5%), a desire to enjoy life more (23.7%), growth and insight (5.3%), self-esteem (15.8%) and mood (28.9%). Of the participants who reported stopping treatment with their PCP, the following reasons was cited: problem resolved or it was more manageable (15.8 %); the belief that further treatment would not help (7.9%); termination recommended by PCP (2.6%); concerns

about the PCP competence (2.6%), problems with insurance coverage (5.3%), and sought treatment from a mental health provided (2.6%).

Participants were asked to report as many diagnoses as applied to them and the results were as follows: anxiety (55.3 %), panic (7.9%), phobia (5.3%), depression (52.6%), low mood (10.5%), alcohol or substance abuse (7.9%), grief (5.3%), and weight control (7.9%).

In Table 4, descriptive statistics including means and standard deviations for items comprising each of the dependent variables are reported.

Table 4

Descriptive Statistics

	N	Minimum	Maximum	Mean	Std. Deviation
When I am undergoing psychological distress I would seek help from my primary care physician (PCP) as opposed to a mental health professional.	38	1	6	4.24	1.515
If someone important to me was experiencing psychological distress, I would recommend that he/she see a psychiatrist immediately as opposed to his/her PCP easily.	38	1	6	3.37	1.651
I would confide in my PCP about personal matters that were upsetting me.	38	1	6	4.82	1.486
In the face of overwhelming distress, I would not hesitate to seek out my PCP for help.	38	1	6	4.58	1.588
PCPs are skilled in handling patients with mental health problems.	37	1	6	3.73	1.805

For emotional and mental health problems, I would prefer to be helped by my PCP than by a psychologist or psychiatrist.	38	1	6	3.39	1.685
Talking about emotional problems with my PCP primary care physician seems to be a reasonable way to solve problems.	38	1	6	3.74	1.589
I would feel completely comfortably sharing personal problems with my PCP.	38	1	6	4.42	1.588
If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in talking with my PCP.	37	1	6	3.95	1.715
PCPs are a valuable resource for handling personal problems.	38	1	6	3.95	1.692
PCPs are knowledgeable about how to help patients with social, personal and mental health problems.	38	1	6	4.03	1.479
PCPs are an important part of mental health workforce in this country.	37	1	6	4.49	1.407
PCPs know a great deal about problems such as depression and anxiety.	38	1	6	3.89	1.657
PCPs know a great deal about problems such as substance abuse.	38	1	6	4.18	1.291
PCPs are skilled at evaluating psychosocial problems.	38	1	6	3.63	1.460
PCPs are committed to treating	38	1	6	4.74	1.446

the whole person.					
PCPs are skilled at identifying mental health and emotional problems in their patients.	37	1	6	4.00	1.434
I am comfortable with my PCP asking questions about my mental health.	38	1	6	4.97	1.325
PCPs are competent at administering medications for mental health problems.	38	1	6	4.42	1.388
If I had a psychiatric crisis the first person I would seek out would be my PCP	37	1	6	4.14	1.653
PCPs know their patients very well.	37	1	6	4.41	1.462
PCPs can be helpful in assisting patients to change health threatening habits.	38	3	6	4.92	1.024
PCPs can handle the majority of problems a patient can experience.	38	1	6	4.32	1.472
PCPs are an important source of health and mental health education for patients.	38	1	6	4.58	1.426
PCPs address the connection between the mind and the body.	38	1	6	4.03	1.585
My PCP is an expert	37	1	6	4.41	1.404
My PCP truly understands me as a person	38	1	6	4.24	1.567
My PCP gives me the best quality of care	37	2	6	4.84	1.068
I would recommend my PCP to my friends	37	1	6	4.89	1.350

I can trust what my PCP tells me	37	2	6	5.16	1.118
My PCP confuses me with technical terms	38	1	6	5.08	1.440
My PCP is available when I need him or her	38	1	6	4.47	1.350
My PCP is warm and friendly	38	3	6	5.21	.991
My PCP really follows through	38	1	6	4.68	1.509
My PCP accepts me as an individual	38	3	6	5.21	.905
My PCP is well-trained and knowledgeable	35	3	6	5.29	.893
My PCP encourages me to ask questions	35	2	6	4.97	1.200
I can depend on my PCP	36	1	6	5.00	1.219
I can talk to my PCP about important personal matters	36	1	6	4.89	1.260
If you want to meet someone nice, talk to my PCP	36	3	6	5.00	.986
My needs are met by my PCP	35	1	6	4.51	1.560
My PCP wastes time talking about things that really don’t matter to me	36	1	6	5.06	1.372
My PCP treats the “whole” person	36	1	6	4.75	1.556
If something was bothering me emotionally, I could speak to my PCP about it	35	1	6	4.63	1.416
My PCP conveys a true sense of understanding to me	35	1	6	4.57	1.357

My PCP listens carefully to what I have to say	36	1	6	5.00	1.242
My PCP understands my emotions, feelings and concerns	36	1	6	5.14	1.334
My PCP is an understanding doctor.	36	3	6	5.58	.732
My PCP seems concerned about me and my family	36	3	6	5.44	.877
My PCP asks about what is happening in my daily life	36	1	6	5.06	1.433
My PCP can view things from my perspective (see things as I see them)	36	1	6	4.94	1.393
I am very satisfied with the medical care I receive.	36	2	6	4.78	1.198
There are some things about the medical care I receive that could be better.	36	1	6	3.17	1.715
All things considered, the medical care I receive is excellent.	36	2	6	4.89	1.190
There are things about the medical system I receive my care from that need to be improved.	36	1	6	2.53	1.665
The medical care I have been receiving is just about perfect.	36	1	6	3.92	1.592
I am dissatisfied with some things about the medical care I receive.	36	1	6	3.44	1.594
Before beginning treatment for my emotional problem with my PCP, my emotional state was	34	2	6	4.41	1.328

very problematic.					
After receiving help from my PCP, I am convinced he/she is competent to treat my mental health problems	34	1	6	4.06	1.594
Meeting with my PCP has made my mental health problem(s) a lot better.	34	2	6	4.26	1.442
I attribute the improvement in my emotional state to the help I received from my PCP.	34	1	6	4.29	1.567
My emotional state has clearly improved from the help my PCP has given me.	34	1	6	4.35	1.433
Overall, I am satisfied with the mental health treatment I receive from my PCP.	34	1	6	4.53	1.542
I would recommend my PCP to others in need of mental health treatment	33	1	6	4.03	1.895
I no longer have the symptoms or they are much less in intensity, compared with those when I first sought treatment with my PCP.	34	1	6	4.32	1.628
After working with my PCP, my symptoms have clearly improved	34	2	6	4.56	1.375
After receiving help from my PCP, I would be comfortable recommending him or her to others in need of help.	33	1	6	4.03	1.667
Lint (PCPs are skilled handling patients with mental health problems)	38	1	6	3.71	1.784

LINT (My treatment needs are met by my PCP)	38	1	6	4.55	1.515
LINT (My PCP is well trained and knowledgeable)	38	3	6	5.30	.866
Valid N (listwise)	27				

Five dependent variables were computed. These variables included perceiving the PCP as a resource for mental health treatment which included 25 items; the quality of physician patient relationship, which included 21 items; perceived level of empathy which contained 5 items; perceived satisfaction which included 6 items and perceived effectiveness which included 10 items.

In Table 5, the coefficient alpha reliabilities for each of the subscales are reported.

Table 5

Coefficient alpha reliabilities for each of the subscales

Variable	Coefficient Alpha	Number of items	Item Number
PCP as a mental health resource	.97	25	1. When I am undergoing psychological distress I would seek help from my primary care physician (PCP) as opposed to a mental health professional. 2. If someone important to me was experiencing

			psychological distress, I would recommend that he/she see a psychiatrist immediately as opposed to his/her PCP easily. 3. I would confide in my PCP about personal matters that were upsetting me. 4. In the face of overwhelming distress, I would not hesitate to seek out my PCP for help. 5. PCPs are skilled in handling patients with mental health problems. 6. For emotional and mental health problems, I would prefer to be helped by my PCP than by a psychologist or psychiatrist. 7. Talking about emotional problems with my PCP primary care physician seems to be a reasonable way to solve problems. 8. I would feel completely comfortably sharing personal problems with my PCP. 9. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in talking with my PCP. 10. PCPs are a valuable resource for handling personal problems. 11. PCPs are knowledgeable about how to help patients with social, personal and mental health problems.

			12. PCPs are an important part of mental health workforce in this country. 13. PCPs know a great deal about problems such as depression and anxiety. 14. PCPs know a great deal about problems such as substance abuse. 15. PCPs are skilled at evaluating psychosocial problems. 16. PCPs are committed to treating the whole person. 17. PCPs are skilled at identifying mental health and emotional problems in their patients. 18. I am comfortable with my PCP asking questions about my mental health. 19. PCPs are competent at administering medications for mental health problems. 20. If I had a psychiatric crisis the first person I would seek out would be my PCP. 21. PCPs know their patients very well. 22. PCPs can be helpful in assisting patients to change health threatening habits. 23. PCPs can handle the majority of problems a patient

			can experience. 24. PCPs are an important source of health and mental health education for patients. 25. PCPs address the connection between the mind and the body.
Quality of physician patient relationship	.97	21	26. My PCP is an expert. 27. My PCP truly understands me as a person. 28. My PCP gives me the best quality of care. 29. I would recommend my PCP to my friends. 30. I can trust what my PCP tells me. 31. My PCP confuses me with technical terms. 32. My PCP is available when I need him or her. 33. My PCP is warm and friendly. 34. My PCP really follows through. 35. My PCP accepts me as an individual. 36. My PCP is well-trained and knowledgeable. 37. My PCP encourages me to ask questions. 38. I can depend on my PCP. 39. I can talk to my PCP about

			important personal matters. 40. If you want to meet someone nice, talk to my PCP. 41. My needs are met by my PCP. 42. My PCP wastes time talking about things that really don't matter to me. 43. My PCP treats the "whole" person. 44. If something was bothering me emotionally, I could speak to my PCP about it. 45. My PCP conveys a true sense of understanding to me. 46. My PCP listens carefully to what I have to say.
Perceived level of empathy	.88	5	47. My PCP understands my emotions, feelings and concerns 48. My PCP is an understanding doctor. 49. My PCP seems concerned about me and my family 50. My PCP asks about what is happening in my daily life 51. My PCP can view things from my perspective (see things as I see them)
Perceived satisfaction	.93	6	52. I am very satisfied with the medical care I receive. 53. There are some things about the medical care I receive that could be better.

			54. All things considered, the medical care I receive is excellent. 55. There are things about the medical system I receive my care from that need to be improved. 56. The medical care I have been receiving is just about perfect. 57. I am dissatisfied with some things about the medical care I receive.
Perceived effectiveness	.96	10	58. Before beginning treatment for my emotional problem with my PCP, my emotional state was very problematic. 59. After receiving help from my PCP, I am convinced he/she is competent to treat my mental health problems. 60. Meeting with my PCP has made my mental health problem(s) a lot better. 61. I attribute the improvement in my emotional state to the help I received from my PCP. 62. My emotional state has clearly improved from the help my PCP has given me. 63. Overall, I am satisfied with the mental health treatment I receive from my PCP.

			64. I would recommend my PCP to others in need of mental health treatment. 65. I no longer have the symptoms or they are much less in intensity compared with those I had when I first sought treatment with my PCP. 66. After working with my PCP, my symptoms have clearly improved. 67. After receiving help from my PCP, I would be comfortable recommending him or her to others in need of help.

Hypothesis 1

Hypothesis 1 predicted that the greater the perceived quality of the physician patient relationship, the more the patient would perceive his/her PCP as a resource for mental health treatment. A Pearson product correlation coefficient was calculated to assess the degree of relation between these 2 variables and was found to be significant ($r(38) = .71$, $p=.001$) supporting Hypothesis 1. The coefficient of determination revealed that 50% of the variability in perception of PCP's as a resource for mental health treatment is attributable to differences in quality in the physician patient relationship.

Hypothesis 2

Hypothesis 2 predicted that the greater the perceived empathy reported by a patient, the greater will the patient perceive his or her PCP as a resource for mental health care. A Pearson product correlation coefficient was calculated to assess the degree of

relationship between these 2 variables and was found to be significant (r (38) = .71, p=.001). Hypothesis 2 was therefore supported. The coefficient of determination revealed that 50% of the variability in perception of PCPs as a resource for mental health treatment is attributable to differences in perceived empathy in the PCP by the patient.

Hypothesis 3

Hypothesis 3 predicted that the greater the perceived level of empathy by the PCP, the greater is perceived quality of the physician patient relationship. A Pearson product correlation coefficient was calculated to assess the degree of relationship between these 2 variables and was found to be significant (r (38) =.77, p=.001), supporting Hypothesis 3. The coefficient of determination revealed that 58.8 % of the variability in perceived quality in the patient PCP relationship is attributable to perceptions of empathy of the physician.

Hypothesis 4

Hypothesis 4 predicted that the greater the perceived empathy of the PCP by the patient, the greater the level of satisfaction with medical care. The obtained correlation coefficient was significant (r (38) =.61, p=.001), supporting Hypothesis 4. The coefficient of determination revealed that 38% of the variability in perceived satisfaction with medical care was attributed to differences in perceived empathy of the healthcare provider.

Hypothesis 5

Hypothesis 5 stated that the quality of the physician, patient relationship, belief in the PCP as a mental health resource, and rated quality of empathy will predict satisfaction with medical care.

A multiple linear regression analysis using the Enter method was conducted using perceived empathy, perception of PCP as a resource, and perceived quality of PCP relationship as predictor variables, and perceived satisfaction with care as the criterion variable. All assumptions of multiple regression were met because the relationships between the predictors and the criterion variables were linear. Second, collinearity diagnostics including tolerance and variance inflation factor were acceptable. Finally, the Durbin-Watson statistic (1.84) was also acceptable, revealing that error variances were uncorrelated. This statistic tests the assumptions that residuals are not serially correlated, essentially indicating that the size of the residual for one case does not affect the residual size for the next case. For this analysis, there is no indication that the residuals are correlated. Fields (2009) suggest that Durbin-Watson values less than 1 or larger than 3 indicate cause for concern.

A normal P-P plot revealed no evidence that the assumption of random errors and homoscedasticity were violated.

As shown in the model summary, Table 6, the predictors account for approximately 65% of the variability on the criterion, with a multiple correlation of .804. The adjusted R squared value of .616 revealed how well the regression model in this instance generalizes to the population, indicating that shrinkage is small (.647-.616=.031). Overall, about 65% of the variability in patient satisfaction is attributable to the linear combination of the set of predictors.

Table 6

Model Summaryb

Model	R	R Square	Adjusted R^2	Std. Error of the Estimate	Durbin-Watson
1	.804[a]	.647	.616	.79150	1.843

As shown in the ANOVA summary table (see Table 7) the regression model is significantly better at predicting perceived satisfaction than using the mean as a best guess (Field 2000). According to Field, this F ratio indicates the ratio of improvement in prediction that results from fitting the model that is the regression, relative to the residual that represents inaccuracy that exists. In this instance, the improvement from fitting the regression model far exceeds the inaccuracy in the model, meaning that the final model significantly improves the ability to predict satisfaction.

Table 7

ANOVA[a]

Model	Sum of Squares	df	Mean Square	F	Sig.
1					
Regression	39.077	3	13.026	20.792	.000[b]
Residual	21.300	34	.626		
Total	60.377	37			

Table 8 contains the unstandardized and standardized beta coefficients and results of the t-test for each variable. This table reveals that two of the predictors make a

significant contribution to the prediction of satisfaction, including quality of physician patient relationship and perceived physician as a mental health resource.

Table 8

Coefficients[a]

Model	*Unstandardized Coefficients*		*Standardized Coefficients*	*t*	*Sig.*
	B	*Std. Error*	*Beta*		
1(Constant)	-.960	.746		1.287	.207
(PHYSPTRELATIONSHIP)	.744	.224	.565	3.318	.002
(RESOURCEMENTALHEALTH)	.428	.178	.372	2.400	.022
(PERCEIVEDEMPATHY)	-.110	.228	-.083	-.485	.631

Hypothesis 6

Hypothesis 6 predicted that the quality of physician patient relationship, belief in the PCP as a mental health resource, and rated quality of empathy will predict perceived effectiveness of treatment for mental health problem.

A multiple linear regression analysis using the Enter method was conducted, using perceived empathy, perception of PCP as a resource and perceived quality of PCP relationship as predictor variables and perceived effectiveness with care as the criterion variable. All assumptions of multiple regressions were met because the relationships between the predictors and the criterion variables were linear, Second, collinearity diagnostics including tolerance and variance inflation factor were acceptable. Finally, the Durbin-Watson statistic (1.5) was also acceptable, revealing that error variances were uncorrelated. This statistic tests the assumptions that residuals are not serially correlated,

essentially indicating that the size of the residual for one case does not affect the residual size for the next case. For this analysis there is no indication that the residuals are correlated. Fields suggest that Durbin-Watson values less than 1 or larger than 3 indicate cause for concern.

A normal P-P plot revealed no evidence that the assumption of random errors and homoscedasticity have been violated.

As shown in the Model Summary Table 9, the set of predictors account for approximately 58% of the variability on the criterion. The adjusted R squared of .54 revealed that shrinkage is small (.576-.539=.037), meaning that if our regression model were derived from the population rather than from the sample in this instance, it would account for .04 % less variance than the criterion.

Table 9

Model Summaryb

Model	R	R^2	Adjusted R^2	Std. Error of the Estimate	Durbin-Watson
1	.759[a]	.576	.539	.87642	1.500

As shown in the ANOVA Table 10, the regression model is significantly better at predicting perceived satisfaction than in using the mean as a best guess (Field, 2000). According to Field, this F ratio indicates the ratio of improvement in prediction that results from fitting the model that is regression, relative to the residual that represents inaccuracy that exists. In this instance, the improvement from fitting the regression model far exceeds the inaccuracy in the model, meaning that the final model significantly improves our ability to predict effectiveness.

Table 10

ANOVA Summary

Model	Sum of Squares	df	Mean Square	F	Sig.
1					
Regression	35.540	3	11.847	15.423	.000[b]
Residual	26.116	34	.768		
Total	61.656	37			

Table 11 contains the unstandardized and standardized beta coefficients and results of the t-test for each variable. This table reveals that only one of the predictors make a significant contribution to the prediction of effectiveness which perceives the PCP as a mental health resource.

Table 11

Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
1(Constant)	-.481	.826		-.582	.565
(PHYSPTRELATIONSHIP)	.190	.248	.143	.765	.450
(RESOURCEMENTALHEALTH)	.503	.198	.432	2.546	.016
(PERCEIVEDEMPATHY)	.349	.252	.259	1.385	.175

A-test for independent groups was conducted to test the significance of the mean difference in satisfaction for patients being treated by a male physician versus a female physician. The Levene's test for equality of variances was not significant (F.432, p=515), supporting homogeneity of variances in each group. The independent samples test was not significant.

Table 12

Independent Samples Test

	Levene's Test for Equality of Variances		t-test for Equality of Means	
	F	Sig.	t	df
LINT satisfaction Equal variances assumed	.432	.515	.121	36
Equal variances not assumed			.121	35.576

Table 13

Independent Samples Test

	t-test for Equality of Means		
	Sig. (2-tailed)	Mean Difference	Std. Error Difference
satisfaction Equal variances assumed	.904	.05093	.42067
Equal variances not assumed	.904	.05093	.42069

Hypothesis 7

Hypothesis 7 predicted that female PCP's will be perceived as significantly more empathic than male PCPs. A test to evaluate the significant difference of the mean on empathy between patients being seen by a male physician versus patients being seen by a

female physician was calculated. The Levene's test for equality of variances in the comparison groups was not significant (as shown in Table 14, F=.424, p=519). The t-test was also not significant.

Table 14

Independent Samples Test

	Levene's Test for Equality of Variances		t-test for Equality of Means
	F	Sig.	t
(perceived empathy) Equal variances assumed	.424	.519	.469
Equal variances not assumed			.463

Table 15

Independent Samples Test

	t-test for Equality of Means		
	df	Sig. (2-tailed)	Mean Difference
perceived empathy Equal variances assumed	36	.642	.14722
Equal variances not assumed	32.005	.647	.14722

Table 16

T-Test

Physician Gender 1=male 2=female	N	Mean	Std. Deviation
PERCEIVIEDEMPATHY			
1	18	5.3222	1.08712
2	20	5.1750	.84347

Chapter 6

Discussion

Summary of Findings.

This study found a significant relationship between the physician-patient relationship and the physician being perceived as a resource for mental health. Specifically, the variability in perception of PCPs as a resource for mental health treatment is attributable to differences in quality in the physician patient relationship. In essence, the better the quality of the physician-patient relationship, the more significantly does the patient perceive the physician as a resource for mental health treatment.

It was also hypothesized that the greater the perceived empathy reported by a patient, the greater does the patient perceive his or her PCP as a resource for mental health care. Half of the variability in the perception of PCPs as a resource for mental health treatment is attributable to differences in perceived empathy in the PCP by the patient. The next hypothesis analyzed involved whether or not the greater perceived level of empathy of the PCP by the patient correlated with the perceived quality of the physician-patient relationship. When the degree of relationship between these 2 variables (empathy and physician-patient relationship) was assessed, it was found to be significant, with a majority of the variability in perceived quality in the patient PCP relationship being attributable to perceptions of empathy of the physician. Therefore, the relation between the quality of the physician-patient relationship and perceiving the medical doctor as empathic was statistically significant. Whether or not the greater the perceived empathy of the PCP by the patient influences the greater the level of satisfaction with the physician-patient relationship was also investigated. The analysis of the degree of

relationship between these 2 variables (empathy and satisfaction) was also found to be significant. More than a third of the variability in perceived satisfaction with medical care was attributed to differences in perceived empathy of the healthcare provider. Accordingly, findings from this study support this hypothesis.

The next hypothesis is whether or not the quality of the physician-patient relationship, belief in the PCP as a mental health resource and the rated quality of empathy predicted satisfaction with medical care. The two predictors which made a significant contribution to the prediction of satisfaction include the quality of physician patient relationship and perceiving physician as a mental health resource. Rated quality of empathy, however, did not significantly predict perceived satisfaction with care. The sixth hypothesis stated that the quality of a physician-patient relationship, belief in the PCP as a mental health resource, and the rated quality of empathy would predict the effectiveness of treatment for mental health problems. Results of this study revealed that one of the three possible predictors made a significant contribution to the prediction of effectiveness which perceived the PCP as a mental health resource. The quality of a physician-patient relationship and the quality of empathy did not predict the effectiveness of treatment for mental health problems by the PCP.

Last, whether or not female PCP's are perceived to be significantly more empathic than male PCPs was investigated. The difference of the mean on empathy between patients being seen by a male physician versus patients being seen by a female physician was calculated. The t-test was not found to be significant and failed to confirm this hypothesis.

Practical Significance of Findings.

Although this study attempted to identify a specific factor that correlates with satisfaction and effectiveness of PCP providing care, the study found that there are a multitude of factors that influence the relationship between patients receiving mental health care from their PCP. Specifically, the study found that if a patient believes that he or she has a good relationship with the PCP, he or she is more likely to view the physician as a resource and, therefore, it is probable that the patient will seek guidance and treatment through his or her PCP. Conversely, it is assumed that if a patient does not have a satisfactory relationship with his or her PCP, he or she will not seek services from or access mental health from that PCP.

This study also found a correlation between the perceived relationship between a patient and his or her PCP and viewing that physician as a mental health resource. These results highlight the idea that patients are more likely to seek services and, more importantly, discuss mental health concerns with their PCP. Empathy showed a significant correlation with satisfaction, perceived positive relationship and viewing the PCP as a mental health resource. Each of the factors can contribute to discussion and disclosure of mental health issues. In addition, patients who perceived their PCP as empathic and as a resource for mental health may be more likely to continue with mental health services as well as have better treatment results. A patient who holds these perceptions and beliefs about his or her PCP, may be more likely to seek treatment, less likely to drop out of services and have overall better clinical outcomes.

Findings from this study are increasingly important in light of the move to Person Centered Medical Home (PCMH). This transition allows services to be focused on

providing continuous, comprehensive and coordinated patient-centered healthcare to increase clinical outcomes and lowering costs (Starfield, Shi, & Macinko, 2005, Miller & Druss, 2013). Increasing primary care through strengthening patient experience is an important goal of PCMH (Reddy, Canamucio, & Werner, 2015). Through the implementation of PCMH, primary care is being recreated with an objective to improve delivery that patients receive for comorbid mental health illnesses. There is a push, based on current research to incorporate mental health providers into the PCMH care teams. However, because the model is presently in the infant stages, weaknesses exist. One weakness in particular is the lack of referral management, lack of follow up and negative clinical outcomes due to the barriers that insurances place on the process. Therefore, it falls into the hands of family physicians and PCPs to promote access to mental health care (Miller & Druss, 2013). Results from this study may allow for further areas of study with regard to improving patient experiences, resulting in a successful PCMH model.

Findings from this study are similar to Hojat's (2011) study which examined the correlation of patients' empathy and clinical outcomes with patients' diagnoses of diabetes. The study stressed the importance of empathy when a positive relationship with physician empathy and patients outcomes was reported. Pollak et al's. (2011) research also indicates that physicians who were rated as more empathetic had higher rates of satisfaction and conversely, physicians rated as less empathic had lower rates of patient satisfaction. Therefore, in supporting findings from the present study, physicians perceived as being empathic result in patients who report satisfaction with the physician.

Also supporting the findings from the present study, Kim et al. (2004) reported that emotional aspects of the physicians' communicative behaviors played the most

important roles in increased satisfaction and compliance. A physician's empathic communication skills significantly and substantially influenced patient satisfaction and patient compliance.

Additionally, Derksen, Bensing, and Lagro-Janssen (2013) studied the effectiveness of empathy in general practice. Their results also support the training physicians in the use of empathy through communication. Specifically, increases were reported in patient satisfaction, enablement, and adherence as well with clinical outcomes. Decreases were identified in anxiety and distress as reported by patients. . The importance that empathy plays in medicine is unquestionable.

The results yielded in the present study regarding the importance that effectiveness plays is similar to the results yielded from Wang & Patten's study (2007). When treating with a family doctor or general practitioner for mental health issues, subjects noted fewer comorbid mental disorders, less severe symptoms, and less functional impairment than those who visited a mental health specialist.

As noted previously, satisfied patients are more likely to seek, comply with and continue treatment; the converse is also true for those dissatisfied with care. (DiMatteo, 1979; Murphy-Cullen and Larsen, 1984; Stamps and Finkelstein, 1981; Nice, Butler & Dutton, 1983; DiTomasso and Willard, 1991). Satisfaction, therefore, plays a significant role in patients receiving mental health care from their PCPs.

Relationship to previous works.

Although no studies were identified as having compared patients' perceptions and beliefs about seeking care for psychological problems from their PCP, research has been conducted on different factors affecting mental health treatment and PCPs. Often,

patients who are more hesitant to receive mental health treatment select general medical providers because they do not believe they are receiving "psychiatric care" (Young, Klap, Sherbourne, & Wells, 2001; Leaf, Bruce, Tischler, Freeman Jr, Weissman, & Myers, 1988; Greenly & Mechanic, 1976). Being treated by a primary care physician and not receiving psychiatric care may be reassuring to many patients because it does not threaten their sense of autonomy (Wood, 2000; Kessler et al., 1999; Krosnick & Petty, 1995). Patients diagnosed with emotional problems who were treated by their general medical physician reported reluctance to see mental health specialists and fear the label of the psychiatric patient and related stigma (Gonzalez et.al, 2011).

Relevance to the Theory and Practice of Psychology

Findings obtained from this study reinforce the importance of collaboration between psychology and the medical field. The importance of PCPs receiving training in psychology, especially as it pertains to empathy and to understanding the inner experiences and perspectives of the patient, support the need to build the bridge between medicine and psychology. Coordinating the collaborative and interactive pieces of medicine and psychology allow the professions to approach issues as a team rather than independent entities. With the biopsychosocial model being front and center, the field of psychology is given the opportunity to make a stronger presence in primary care.

Implications

The findings of this study highlight the need for additional education regarding factors that contribute to positive clinical outcomes when treating patients with mental health concerns.

As Reiss et al. (2012) reported, a brief intervention grounded in the neurobiology of empathy significantly improved physician empathy as rated by patients, suggesting that the quality of care in medicine could be improved by integrating empathy into medical education. Yet, Hojat (2012) reported a significant statistical decrease in patient-rated empathy by 3rd-year medical students. This is crucial because it is typically in the medical students' 3rd year when training becomes more clinical and more interactive with patients. Providing medical students who are specializing in primary care with in-depth training in empathy as a resource for mental health treatment, and for effectiveness and satisfaction may provide more effective treatment resulting in increase in clinical outcomes

Requirements that courses in continuing education include training in elements of empathy, knowledge about how one can be a resource for mental health treatment, and information about elements of effectiveness and satisfaction in primary care may provide more effective treatment that results in an increase in clinical outcomes.

Advocacy Implications

Current findings support the need for medical training facilities to provide education in areas identified within this study to improve medical adherence and clinical outcomes. The importance to advocate for all individuals to receive appropriate mental health treatment is imperative. Due to insurance and financial issues, some people can treat only with their PCPs so it is important for PCPs to be well versed in treating mental health. It is also important for the PCPs to know when the illness is beyond their scope and therefore, find it necessary to "refer out".

Explanations for Unexpected Findings

It was hypothesized that female PCP's will be perceived as significantly more empathic than male PCP's. Yet, results yielded did not significantly support this hypothesis. In contrast to results obtained from this study, research has shown gender distinctions with regard to empathy (Davis 1983 and Hogan, 1969). Women are more receptive than men to emotional signals (Trivers, 1972), a characteristic that can lead to a better understanding and an increased empathic communication (Hatcher et al., 1994). Zinn (1993), reports that women are more likely to provide emotional support and understanding, resulting in more satisfied empathic relationships than that provided by males. This highlights the concept that women physicians who are more empathic may be viewed as displaying expected female behavior rather than being credited for their skills. (Hall, Roter, Blanch-Hartigan, Schmid Mast, and Pitegoff, 2015).

Empathy was identified as not being a predictor for perceived satisfaction in the multiple regression, when analyzed with quality of physician patient relationship and belief in the PCP as a mental health resource. It is considered that the items included in the quality of the physician patient relationship section may have overlapped with the items in the empathy section.

Limitations

The study utilized survey data to analyze perceptions and attitudes of a sample of primary care patients receiving mental health care from their PCPs. Although the study reported significant findings, it is important to note the power was less than ideal. Having a larger sample size would perhaps have allowed for better generalization. Yet, despite the small sample size, significant associations were observed. Also, ResearchMatch.org

was used to obtain subjects; this may also be considered a limitation due to the fact only individuals registered with the site had access to the survey. Social desirability bias is another limitation. Participants may tend to portray themselves in a more favorable light rather than answering the questions truthfully. Subjects may have difficulty with exact recall because the survey was completed at one point in time, and there may be a lack of honesty in answering the questions because the participants are anonymous. Last, generalizability is a limitation. The demographics of this study included predominantly white, better educated females.

Future Directions

Future studies may examine the PCPs' perceptions of these factors in treating patients with mental health problems in their practices. Also, analyzing PCPs' training on these factors, both when in medical school and when in practice through continuing education, is an area of future research. Specifically, the utilization of pre and post-tests at different intervals in medical school would be beneficial. Taking a closer look at how doctors would rate their perceived levels of empathy and obtain feedback from PCPs to the responses measured (i.e. do they view themselves as a good resource for mental health treatment) could also be useful.

Summary and Conclusions

More than 43.6 million individuals in the United States and 450 million individuals, globally, suffer at this time from a mental disorder (SAMHSA, 2015, NIMH, 2011). Of those affected, 58.7% receive treatment (NIMH, 2011). Many patients do not seek traditional psychological care for many reasons. As a result, PCPs are often sought out by these patients who are experiencing psychological distress. The findings of this

study identify factors that influence patients' perceptions and beliefs, relative to receiving mental health treatment from their PCPs. Perceived physician-patient relationship, perceived empathy, and the perceptions of the PCP as a mental health resource are reported to have an impact in the treatment of mental health problems by PCPs. The findings of this study should highlight the importance of educational programs that regard empathy as an important element in being an effective PCP and also as a resource for mental health treatment. Furthermore, the results of this study may be useful in understanding factors that relate to perceived effectiveness of care being received as well as in educating both patients and PCPs about how these factors interact in predicting perceived helpfulness of services being offered. The findings may also prove useful in training primary-care physicians to meet the needs of their patients in the most effective, possible manner.

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Appendix A

Survey of perceptions and attitudes of a sample of primary care patients receiving psychological care from their PCP

This survey was adapted from Fischer and Turner (1970), Hojat (2010) Di Tomasso and Willard (1991), Ware (1994) and Seligman (1994).

1. If you are a psychologist, psychiatrist, social worker, or counselor who treats individuals with mental illness please proceed directly to question number 5 and chose the first option “I do not meet the criteria to be in this study and accept your thanks for my interest.” Otherwise, please proceed to question number 2.

2. Are you currently age 18 or older?

_____Yes

_____No

3. Are you currently diagnosed with a mental illness but do not have a mental health problem?

_____Yes

_____No

4. Do you only treat with your primary care physician for this mental health problem?

_____Yes

_____No

5. If you have answered "no" to any of the above questions, please select the first option below. If you have answered "yes" to all the above questions, please choose the second option below.

_____I do not meet the criteria to be in this study and accept your thanks for my interest.

_____I do meet the criteria to be part of this study. I agree to participate and complete the entire questionnaire. I understand that my responses are anonymous and confidential and will be reported only as part of the larger group of those who are in the study. I agree not to include any identifying information about myself. I understand that I can discontinue being in this study at any point in time without any consequence to me. I agree to contact, Dr. DiTomasso, the principal investigator if I have any questions, concerns, or negative reactions.

This section includes items related to perceptions and beliefs a person may hold about his or her primary care physician. Read each item carefully and chose the response that most closely indicates your agreement or disagreement with each statement.

Section 1. Perceptions and beliefs	**Strongly Disagree**	**Moderately Disagree**	**Mildly Disagree**	**Mildly Agree**	**Moderately Agree**	**Strongly Agree**
1. When I am undergoing psychological distress I would seek help from my primary care physician (PCP) as opposed to a mental health professional.						
2. If someone important to me was experiencing psychological distress, I would recommend that he/she see a psychiatrist immediately as opposed to						

his/her PCP easily.						
3. I would confide in my PCP about personal matters that were upsetting me.						
4. In the face of overwhelming distress, I would not hesitate to seek out my PCP for help.						
5. PCPs are skilled in handling patients with mental health problems.						
6. For emotional and mental health problems, I would prefer to be helped by my PCP than by a psychologist or psychiatrist.						
7. Talking about emotional problems with my PCP primary care physician seems to be a reasonable way to solve problems.						
8. I would feel completely comfortably sharing personal problems with my PCP.						
9.If I were experiencing a						

serious emotional crisis at this point in my life, I would be confident that I could find relief in talking with my PCP						
10. PCPs are a valuable resource for handling personal problems.						
11. PCPs are knowledgeable about how to help patients with social, personal and mental health problems.						
12. PCPs are an important part of mental health workforce in this country.						
13. PCPs know a great deal about problems such as depression and anxiety.						
14. PCPs know a great deal about problems such as substance abuse.						
15. PCPs are skilled at evaluating psychosocial problems.						
16. PCPs are committed to						

treating the whole person.						
17. PCPs are skilled at identifying mental health and emotional problems in their patients.						
18. I am comfortable with my PCP asking questions about my mental health.						
19.PCPs are competent At administering medications for mental health problems.						
20.If I had a psychiatric crisis the first person I would seek out would be my PCP						
21. PCPs know their patients very well.						
22. PCPs can be helpful in assisting patients to change health threatening habits.						
23. PCPs can handle the majority of problems a patient can experience.						

24. PCPs are an important source of health and mental health education for patients.						
25. PCPs address the connection between the mind and the body.						

This section includes items related to the relationship you may have with your current PCP. Please read each item carefully and chose your level of agreement or disagreement with each statement.

Section 2. Rated quality of physician-patient relationship	**Strongly Disagree**	**Moderately Disagree**	**Mildly Disagree**	**Mildly Agree**	**Moderately Agree**	**Strongly Agree**
1. My PCP is an expert						
2.My PCP truly understands me as a person						
3.My PCP gives me the best quality of care						
4.I would recommend my PCP to my friends						
5.I can trust what my PCP tells me						
6.My PCP confuses me with technical terms						
7.My PCP is available when I need him or her						

8.My PCP is warm and friendly						
9.My PCP really follows through						
10.My PCP accepts me as an individual						
11.My PCP is well-trained and knowledgeable						
12.My PCP encourages me to ask questions						
13.I can depend on my PCP						
14.I can talk to my PCP about important personal matters						
15. If you want to meet someone nice, talk to my PCP						
16. My needs are met by my PCP						
17.My PCP wastes time talking about things that really don't matter to me						
18.My PCP treats the "whole" person						
19.If something was bothering me emotionally, I could speak to my PCP about it						
20.My PCP conveys a true sense of understanding to me						

21.My PCP listens carefully to what I have to say						

The items in this section relate to how well you believe your current PCP is able to emphasize with you. Please read each item carefully and check the response to which you most closely agree or disagree to each statement.

Section 3. Rated quality of empathy (Hojat's)	**Strongly Disagree**	**Disagree**	**Disagree Somewhat**	**Undecided**	**Agree Somewhat**	**Agree**	**Strongly Agree**
1.My PCP understands my emotions, feelings and concerns							
2. My PCP is an understanding doctor.							
3.My PCP seems concerned about me and my family							
4.My PCP asks about what is happening in my daily life							
5.My PCP can view things from my perspective (see things as I see them)							

The items in this section address how satisfied you are with the medical care you receive. Please read each item carefully and select the item that most closely indicates your level of agreement or disagreement.

Section 4. Perceived satisfaction (Ware)	**Strongly Disagree**	**Moderately Disagree**	**Mildly Disagree**	**Mildly Agree**	**Moderately Agree**	**Strongly Agree**
1. I am very satisfied with the medical care I receive.						
2. There are some things about the medical care I receive that could be better.						
3. All things considered, the medical care I receive is excellent.						
4. There are things about the medical system I receive my care from that need to be improved.						
5. The medical care I have been receiving is just about perfect.						
6. I am dissatisfied with some things about the medical care I receive.						

The items in this section address the extent to which the care for mental health problems you are experiencing is effective. Please complete this section only if you are exclusively being treated by your PCP for a mental health problem.

Section 5. Perceived effectiveness (Seligman's):	**Strongly Disagree**	**Moderately Disagree**	**Mildly Disagree**	**Mildly Agree**	**Moderately Agree**	**Strongly Agree**
1. Before beginning treatment for my emotional problem with my PCP, my emotional state was very problematic.						
2.After receiving help from my PCP, I am convinced he/she is competent to treat my mental health problems						
3. Meeting with my PCP has made my mental health problem(s) a lot better.						
4. I attribute the improvement in my emotional state to the help I received from my PCP.						
5. My emotional state has						

clearly improved from the help my PCP has given me.						
6. Overall, I am satisfied with the mental health treatment I receive from my PCP.						
7.I would recommend my PCP to others in need of mental health treatment						
8. I no longer have the symptoms or they are much less in intensity I had compared to when I first sought treatment with my PCP.						
9.After working with my PCP, my symptoms have clearly improved						
10.After receiving help from my PCP, I would be comfortable recommending him or her to others in need of help.						

Section 6. Demographic Information

1. What is your gender?

Male

Female

2. What is your age? _____

3. Please specify your race/ ethnicity.

American Indian

Asian

African American

Caucasian

Hispanic

Other_____

4. What is the highest degree or level of school you have completed? If currently enrolled, mark the highest degree completed.

Less than high school diploma

High School Diploma

Vocational Certificate

Associates Degree

Bachelor's degree (for example: B.A., B.S.)

Master's degree (for example: M.A., M.S., M.Ed, M.S.W, M.B.A)

Doctorate degree (for example: Ph.D., Ed.D, PsyD)

Professional degree (for example: M.D., D.D.S., D.V.M., J.D.)

5. What is the gender of your primary care physician?

Male

Female

6. Please specify your PCP's race/ ethnicity.

American Indian

Asian

African American

Caucasian

Hispanic

Other_____

7. Are you currently prescribed medication for you psychological disorder by your PCP?

Yes

No

8. Does your insurance cover visits to a mental health professional?

Yes

No

9. How long are you a patient with this PCP? _____

10. Are you currently being treated for a mental health problem by your PCP?

Yes

No

11. What is your PCP's specialty (i.e. internal medicine, family medicine etc)

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12. Are you currently being seen by a mental health provider other than your PCP?

Yes

No

13. Have you seen a psychologist or psychiatrist in the past for a psychological disorder?

Yes

No

14. Are you currently diagnosed with depression?

Yes

No

15. Are you currently diagnosed with an anxiety disorder?

Yes

No

16. Do you experience the following feelings: difficulty concentrating, making decisions, fatigue, decreased energy, feelings of guilt, worthlessness, and/or helplessness, problems sleeping either difficulty falling asleep or excessive sleeping, irritability, restlessness, loss of interest in activities or hobbies once pleasurable, overeating or appetite loss or physical problems that do not ease even with treatment?

Yes

No

17. Do you experience the following feelings: sudden overwhelming fear, palpitations, sweating, shortness of breath, chest pain, nausea, dizziness, a feeling of being detached from the world (de-realization), fear of dying, numbness or tingling in the limbs or entire body, chills or hot flashes, restlessness, fatigue, difficulty concentrating, irritability or explosive anger, muscle tension, sleep disturbances, personality changes, such as becoming less social?

Yes_____ No_____

18. The specific problem that led to me speaking with my PCP was:

relation to others productivity coping with stress enjoying life more

growth and insight self-esteem and confidence raising low mood,

other:_____

19. If you have stopped treating with your PCP for the mental health concern, please circle why:

problems resolved or more manageable felt further treatment wouldn't help

PCP recommended termination received a new PCP

concerns about PCP's competence cost problems with insurance coverage

sought treatment from a mental health provider

other:_____

20. What is your diagnosis (please circle one):

general anxiety, panic phobia depression low mood

alcohol or drugs grief weight eating disorders

marital or sexual problems children or family work stress

other:_____