Patients' treatment requests, psychiatrists' understanding of patient requests, and adherence to treatment.

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ABSTRACT

This study aimed to determine the treatment requests of patients in the initial psychiatric interview and to compare the relative preference of these requests to those of other patient samples. It also aimed to determine psychiatrists accuracy in estimating the importance their patients placed on their requests, and to explore the relationship between psychiatrist understanding of patient requests to patient adherence to treatment.

The study was carried out on 269 consecutive new patients to a psychiatric unit attached to a public hospital of whom 85 completed a 14 item Patient Request Form before their initial interview, and their psychiatrists completed an equivalent form at the conclusion of the interview. Patients adhered if they returned for their next appointment. Generally it was found that patients wanted psychologically based treatments most and medical oriented treatment least, and that the rank orders of the requests provided significant positive correlations with all other samples.

It was found that psychiatrists significantly underestimated six request categories and overestimated one, supporting nine of the 14 differences hypothesised. No significant relationship was found between adherence and psychiatrists understanding of patients requests. Results are discussed in terms of their implications for helping therapists understand their patients requests.

PREFACE

This research was originally designed to study patient satisfaction with the initial interview, as well as other outcome measures. A four item outcome questionnaire (see Appendix IX) was to be given to patients who agreed to participate in the research. This was considered an important measure especially as positive patient outcome, such as patient satisfaction, has previously been associated with variables of the negotiated approach. However this measure was disallowed by the authorities of the setting because it was considered that it " ... would make a difficult time for the patient more difficult. This was especially so as the patient could well be already confused as to what his demands were." (Scrimgeour, G. Personal communication, May 28, 1981.)

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TABLE OF CONTENTS

		Page
ABSTRACT		ii
PREFACE		iii
ACKNOWLEDGEMENTS		iv
OVERVIEW		1
INTRODUCTION		3
The Negotiated Approach		3
Patient Requests		8
Patient Request Preferences		12
Clinicians Estimates of Patients Requests		14
Adherence to Treatment		16
Adherence, requests and the Negotiated Approach		18
HYPOTHESES		21
METHOD		22
The Setting		22
Subjects		23
Instruments		26
Procedure		30
Adherence Measures		30
RESULTS		33
Hypothesis one		33
Hypothesis two		35
Hypothesis three		41
DISCUSSION		42
Patient Request Form Development		52
Conclusions		54
REFERENCES		57
APPENDICES		62
Appendix I	Description of Request Categories	62
Appendix II	Patient Identification Form	65
	Patient File Card	66
Appendix III	Patient Request Form	67
	Patient Request Form (Psychiatrist Version)	69
Appendix IV	Procedure for receptionists	71
Appendix V	Three-way ANOVA	73
Appendix VI	Two-way ANOVA for psychiatrists ratings only	74
Appendix VII	Means of psychiatrists ratings by requests	75
	Total means of psychiatrists ratings	75
Appendix VIII	Factor Analysis : Varimax Rotated Factor Matrix	76
Appendix IX	Patient Outcome Questionnaire	77

LIST OF TABLES AND FIGURES

		Page
Table 1	Rank order of preference of patient requests	13
Table 2	Pearson product moment correlation co-efficients of patient request ratings between New Zealand sample and three other samples.	33
Table 3	Rank order of preference of patient requests for N.Z. sample.	34
Table 4	Hypothesised estimation versus obtained means and F-values for psychiatrist and patient ratings of requests	36
Figure 1	Mean ratings of raters by psychiatrists	38

OVERVIEW

The thesis deals with three main areas; an approach to the initial psychiatric interview called the negotiated approach; the central component of this approach, patient requests; and the relationship between psychiatrists' ability to understand patient requests in the initial interview, and patient adherence to treatment.

The Oxford English Dictionary (1970) defines "request" as "The act, on the part of a specified person, of asking for some favour, service etc; the expression of one's desire or wish directly addressed to the person or persons able to gratify it." In this study the "specified person" was the psychiatric patient, the "desire or wish" for "some favour or service" was the patient's desire or wish for a type of treatment, and the "person or persons" to whom it was addressed, and who were able to gratify it was the clinician, in this case a psychiatrist.

Since clinicians, after learning the patient's complaint (chief complaint) or the patient's goals, often believe they know the patient's request, it is worth distinguishing the three to help clarify our definition of "request." The complaint is the patient's initial statement as to what is bothering him; for instance, "I am depressed." The goal is what the patient would like to accomplish or how he would like to feel; for instance, "I would like to feel well enough to return to work." The request is how the patient would like the clinician to respond to help him achieve the desired goal (Lazare, Eisenthal and Wasserman, 1975a).

The relationship of patient requests to the negotiated approach is briefly as follows.

The negotiated approach requires the clinician to:-

(a) help the patient to verbalise the request for help;

(b) indicate an understanding of the request for help

to the patient; and

(c) to include the patient in the decision making about the treatment plan.

Thus the study of the patients' requests in the negotiated approach to the initial psychiatric interview is a major subset of the overall process.

This thesis aims to determine the rank order of importance of requests made by new patients to a psychiatric clinic, and compare patients request endorsement with similar research conducted in other settings.

It also aims to determine psychiatrists ability to estimate the importance their patients place on their requests, and from this to explore whether such estimates have any effect on patients adherence to treatment.

INTRODUCTION

The Negotiated Approach

The negotiated approach to the initial psychiatric interview is based on the negotiated concensus model of Levinson, Merrifield and Berg, (1967).

Levinson et al (1967) present four different models of how the initial psychiatric interview is conducted:

(a) the diagnostic model, in which the clinician's task is to find the diagnosis by a descriptive - objective methodology. Treatment then follows from this process;

(b) the suitability model in which the patients are evaluated, like candidates, as to their suitability (e.g., motivation - insight, verbal facility etc), for the ideal treatment procedure, often psychodynamic psychotherapy;

(c) the help-seeking model in which the clinician's task is to accommodate to the patient's preferences regarding help, with the patient playing the major determining role regarding treatment; and

(d) the negotiated concensus model which attempts an integration of the patient's intentions and the clinician's evaluation. Open ended negotiation between the clinician and the patient is seen as essential for productive planning, decision-making, and treatment disposition.

It is this negotiated consensus model which had a major influence on the development and application of a "Negotiated Approach" to the initial interview (Eisenthal & Lazare, 1977a), originally called the customer approach to patienthood. (Lazare et al, 1975a).

The negotiated approach was initially developed to provide a meaningful training experience for beginning psychiatric residents in walk-in psychiatric clinics, so that patient care and staff morale would be improved (Lazare, Cohen, Jacobson, Williams, Mignone & Zisook, 1972; Lazare et al, 1975a).

Using the negotiated approach the clinician shares with the patient in the definition of the problem and the treatment plan, negotiating differences when necessary (Eisenthal & Lazare, 1977a). The patients request is considered the starting point for this negotiation.

One basic proposition in the negotiated approach is that patients have a distinct perspective regarding their problems and treatment. They come with ideas about the nature, causes and severity of their problems and they have preferences regarding the kind, conditions and goals of treatment. Patients arrive with a variety of requests as to how they hope the clinician will intervene in their behalf to achieve the desired goals (Grad & Lindenmayer, 1977; Zisook, De Vaul, Jaffe & Click, 1979a; Lazare, Eisenthal, Wasserman & Hartford, 1975b; Eisenthal & Lazare, 1976b; Burgoyne, Staples, Yamamoto, Wolkon & Kline, 1979. etc).

Another proposition of the negotiated approach is that the clinician should strive to understand the patient's perspective, recognise the legitimacy of conflicts when they occur, and negotiate their resolution (Eisenthal et al, 1979).

Proponents of the negotiated approach feel it renders several positive effects on the conduct and outcome of the initial interview. By stating the request the patient provides clinical material on goals, expectations, and motivations, otherwise frequently over-looked in the initial interview. Knowing the request, the clinician is better able to shape and direct the interview toward planning treatment. A benefit of hearing and exploring requests is the opportunity to evaluate the patients preferred working style. As a result of these

interactions and experiences of mutual influence both parties will feel more knowledgeable, satisfied, respected, and confident in the treatment plan.

An evaluation study (Eisenthal & Lazare, 1976a) of negotiation in the initial interview found patients ratings of satisfaction and being helped correlated with their ratings of the utilisation of the negotiated approach (r = ·626). In fact it was shown that a patients satisfaction with the initial interview was more highly correlated with his belief that the clinician helped him verbalise his request (r = ·568) than it was with feelings of being understood (r = ·406 Eisenthal & Lazare, 1976a).

The negotiated approach regards requests by patients as both legitimate and informative. Patient requests vary in their appropriateness and feasibility, but clinicians tend to underestimate, if not over-look the patients judgement. Evidence for this is provided by Hornstra, Lubin, Lewis and Willis (1972) who found little credence was placed upon the initial statement of many patients, that they wish only to "talk as needed", or that they seek other supportive short-term services. Clinicians in the Hornstra et al (1972) study saw more frequent need to use hospitalization than did the patients, or their relatives.

Lipsius (1973) also found evidence that indicated patients judgement was overlooked or underestimated. Except for patients diagnosed as affective psychotic, the questionnaire responses of staff and patients indicated agreement that hospitalization could be avoided through alternative treatment. Lipsius (1973) concluded that patient judgement, even of the acutely disturbed was much more valid than expected.

As patients are able to make valid judgements and requests then the negotiated approach is suited to identify them.

Criticisms which could be leveled at the negotiated approach are that it takes too much power away from the clinician and inappropriately gives it to the patient. Critics believe that patients do not have requests, that the requests are irrelevant, that eliciting requests places the patient in the role of a shopper in a medical supermarket and thereby dilutes the physician's ability to influence the patient through his sanctioned authority - the feared outcome of which is clinical helplessness in the face of ceaseless patient demands (Kanton & Kleinman, 1981).

Lazare, his co-workers, and others have convincingly demonstrated that patients do have requests, the expression of which does not bind the clinician to fulfill them. In fact, eliciting them makes the clinician more knowledgeable and empathetic, and this in turn enables him to exert a more sensitive and sensible therapeutic influence. Lazare et al have not found that negotiation lowers professional standards nor leads to therapeutic surrender, but they have discovered that patient requests are usually more realistic statements of perceived needs than the clinician had anticipated.

Another possible criticisim is that negotiation may give the clinician even greater control than he already possesses over his patient, and that this will eventuate in further abuses of the clinicians power (Lazare et al, 1975; Kanton & Kleinman, 1981). Lazare and his colleagues point out, the elements in negotiation have core clinical tasks; developing trust, establishing expertise, explaining to patients why one therapeutic approach is preferable to another, arguing against actions that from the clinical perspective appear dangerous and the like. They argue that negotiation between patient and clinician strengthens and improves the participation of both parties in the clinical transaction (Lazare et al cited in Kanton & Kleinman, 1981).

As a large body of research shows that clinician-patient communication is poor and often leads to patient drop-out or dissatisfaction (Polak, 1970; Bloom and Wilson, 1979; Hurwitz, Zander and Hymotovitch 1960; Francis, Korsch and Morris, 1969), negotiation could also help improve this aspect of the clinical transaction.

One of few studies conducted at an acute psychiatric unit in New Zealand, found that over-all patients were satisfied with the service provided, but the area of greatest dissatisfaction was that 32% of the patients felt they were not involved enough in the planning of their own treatment, and 35% felt that they were unable to discuss changes in their treatment with staff (Snelling and Walker, 1978), indicating some barrier to communication.

This study suggests that problems in clinician patient interaction may lead to patient dissatisfaction. Although patient satisfaction does not ensure success in treatment (Edwards, Yarvis, Mueller and Langsley, 1978) patient dissatisfaction is thought to be related to premature termination of treatment (Heilbrum, 1972, 1974; Masur, 1981). Masur (1981) in reviewing adherence to health care regimens felt that the patient-provider interaction system was " ... the most reasonable and promising intervention point in attempts to improve compliance." (p.451). This interaction system is only accessible in the interview situation.

An interview technique such as the negotiated approach should improve problems associated with poor patient-clinician communication by promoting negotiation of treatment and requiring clinician understanding of patient requests. Further investigation is required to determine if the negotiated approach or its components do lead to better treatment outcome. The present study attempts to contribute by dealing with one crucial aspect of the approach - patient requests.

Patient Requests

Research into patient expectations preceded research into patient requests, and was considered most relevant to patient requests. A "pervasive assumption" found in the psychotherapy literature was that discrepant clinician patient expectations lead to negative outcome in psychotherapy (Duckro, Beal & George, 1979). Although much research confirms this assumption (e.g. Borghi, 1968; Heine & Trosman, 1960) critical evaluation by Duckro et al (1979) found 21 emperical studies supported the above hypothesis and 22 did not. They concluded that disconfirmed expectations between therapist and patient have not been clearly demonstrated to lead to negative therapeutic outcome. Despite this conclusion the view that patient expectations and requests be carefully explored and negotiated is still popular today (Lazare et al, 1975a; Twaddle, 1981).

In developing a request classification system Lazare et al (1972) drew primarily on the expectation literature even though expectations differ from requests as they represent the anticipation of roles, techniques, duration of treatment and outcome where-as requests represent hopes and desires (Goldstein, 1962 cited in Lazare et al, 1972).

Most of the "classifications" of patient treatment expectations were broad and unspecific. Overall and Aronson (1963) and Aronson and Overall (1966) used five categories described by Hollingshead and Redlich (1958) to determine whether the patient expected the therapist to be active in instructing the patient, medical in focusing on organic problems, supportive in bolstering the comfort of the patient, passive in leaving the direction of the discussion to the patient, or psychological in focusing on emotional or dynamic material.

Borghi (1968) also observed five categories of expectations related to an answer to the question "Am I mentally ill?", unrealistic, advice, expectations that something be done about the spouse, and vague or non-existent expectations.

Other studies used fewer categories; Goin, Yamamoto and Silverman (1965) classified patients as either expecting to talk about their feelings,medication or advice. Many studies made the medical, psychotherapy dichotomy (Garfield & Wolpin, 1963; Heine & Trosman, 1960).

Research into patient goals and aims was also considered related to request classification. Hill (1969) described seven patient intentions in therapy; insight wanting, therapist involvement seeking, wanting catharsis, gaining relief from tensions, wanting reassurance and having the therapist side with the patient, demonstrating to the therapist one's knowledge of improvement, and more personal response from the therapist.

Although these studies may have been useful in the initial construction of the patient request categories no past or present classification system related to requests has been found to be as comprehensive or well defined as that developed from Lazare et al (1972), (e.g. Dimsdale, Klerman & Shershow,1979). This is to be expected as the research rarely looked at requests specifically.

Lazare et al, (1972) first postulated 14 supposedly independant and exhaustive request categories called; Control, Reality contact, Succorance, Institutional contact, Confession, Ventilation, Advice Clarification, Intrapsychic psychotherapy, Medical, Administrative request, Social intervention, Community triage and Nothing (Fuller description of these are given in Appendix I).

These categories were based on 200 interviews with psychiatric patients from a walk-in clinic of an urban general hospital. The

patients were asked; why they came to the clinic, why they decided to come the day they did instead of another week, what they thought the clinic could do for them (what they wanted),what they thought caused their difficulties, and what they thought would have happened to them if they had not gone for help.

Another study by Lazare et al (1975b) had trained observers record patients verbatim first visit requests from 100 clinical interviews and "careful examination" of these lead to a modified list of 15 categories. Institutional contact was deleted, Intrapsychic psychotherapy was modified to Psychodynamic insight, and Limit setting and Psychological expertise were added. A 75-item self-rating questionnaire developed from patients verbatim requests, attempted to measure the degree to which patients wanted each of the 15 requests. The scores of 201 patients who completed the Patient Request Form were factor-analysed and yeilded 19 factors. Nine of the 15 hypothesised factor categories were clearly confirmed, three were partially confirmed and three were not confirmed. Continuing from this Lazare and Eisenthal (1977) did a second factor-analytical study on a different sample of 296 patients using a revised 84 item Patient Request Form with modified patient request categories. Factor-analysis yeilded 18 factors. Thirteen of the 14 hypothesised categories were clearly confirmed according to the criteria that at least three of the hypothesised defining items loaded on the factor. These categories were: Clarification, Administrative request, Control , Confession, Reality contact, Succorance, Ventilation, Advice, Medical, Social intervention, Community triage, Psychological expertise and Psychodynamic insight.

Only the "Nothing" factor was not clearly confirmed, it had two hypothesised items which loaded on the factor. There was an absence of any major non-hypothesised factor dimension suggesting congruence between hypotheses and the way patients report their requests.

The final state of the request categories forming the basis of the present study are as Lazare and Eisenthal (1977) define them in Appendix I.

Only two studies could be found related to patient requests, which did not use the same categorisation of requests as postulated by Lazare and his fellow researchers. Mackey, Taschan and Kisielewski (1969) analysed 365 requests for help from persons who telephonedor came to a mental health study centre on their own initiative. Most were seeking help for themselves or for family members. The authors classified problems as:

(a) Intrapersonal conflict - specific somatic complaints such as headaches, irrational or bizarre thoughts, nervous habits, and negative or hostile feelings.

(b) Intrafamilial conflicts - marital tension, parent-child conflict, and conflicts with other relatives such as aunts and uncles.

(c) Extrafamilial conflicts - under achievement at school, inability to work adequately, and delinquent behaviour in the community, and

(d) Other - requests for technical and financial information, and requests for information on community resources and on hospitalisation of persons with psychiatric problems.

Mackey et al's (1969) four groupings are broad and probably cover the full range of possible patient requests, but the unspecific nature of the categories makes them less useful for formulating a treatment plan. As this is one aim of the negotiated approach these request categories are less practical than those formulated by Lazare and Eisenthal (1977).

Grad and Lindenmayer (1977) conducted their study to determine treatment requests of 334 patients in a 24 hour walk-in clinic. They

used a psychiatric interview questionnaire, rating scale, and previous records. Requests were broken down into eight categories; No further help, Social help, Psychological help, Psychological help and medication, Psychiatric admission, Treatment for addiction (through admission), Medication for somatic complaints and Medical admission. No further elaboration of the categories was provided.

Although more specific than Mackey et al's (1969) classification they do not include certain request categories in Lazare et al's (1977) classification (e.g. Community triage, Administrative request). Some requests such as "Psychiatric admission" give little information related to the treatment plan, and with no definition are unspecific. The request categories used by Grad and Lindenmayer (1977) are all accommodated by Lazare's classification.

The fact that Lazare et al's (1977) classification is precise, comprehensive, and adequately defined makes it the best available framework for studying patient requests.

Patient Request Preferences

Using Lazare and co-worker's framework, five studies, conducted by three research teams, have determined the relative preference among the 14 request categories for separate patient populations (Lazare et al, 1975b; Lazare & Eisenthal 1977; Zisook et al, 1979a, 1979b; Burgoyne et al, 1979). Patient Request Forms ranging from 84 to 14 items were used.

All five studies provided very similar request preferences, for this reason only the three most recent rank orderings from each research team are compared in the present study. The rank order of requests for these three studies is given in Table 1.

Table 1 - Rank order of preference of patient requests

Request Category	Researchers		
	Lazare (1977)	Zisook (1979a)	Burgoyne (1979)
Clarification	1	1	1
Psychodynamic insight	2	5	2
Psychological expertise	3	2	-
Medical	4	4	12
Ventilation	5	6	7
Control	6	3	3
Succorance	7	9	8
Reality Contact	8	7	10
Advice	9	8	5
Community Triage	10	10	6
Confession	11	11	9
Social Intervention	12	13	11
Administrative request	13	14	14
Nothing	14	12	13
Institutional Contact	-	-	4
Number of items in Patient Request Form	84	54	14
Setting	Acute Psychiatric service walk-in clinic of General Hospital	Psychiatric outpatient attached to University	Psychiatric outpatient clinic of University Medical Centre
Sample size	296	250	325

It can be seen from table 1 that Burgoyne et al (1979) used Lazare et al's (1972) original request classification, while the other two studies used the Lazare and Eisenthal (1977) classification.

These rank orders allow comparison of request endorsement and appear quite similar. There seems to be a common preference across patient samples for particular treatment requests. The only extreme exception is the "Medical" request made by the Burgoyne et al (1979) sample.

If a common request preference exists, where appropriate, clinics may be able to enhance their treatment programmes by ensuring that the treatment is easily available to patients. Clinic resources could be saved by awareness of patient treatment requests; for instance clinicians aware of common treatment requests would have greater insight into patient expectations of treatment and be better prepared to negotiate if inappropriate treatment requests were made, thus saving time.

Using the 14 request categories postulated by Lazare et al this research aims to determine the rank order of request endorsement made by psychiatric patients.

Secondly, this New Zealand sample will be compared with the three American studies to see of request endorsement is similar across psychiatric settings and patient samples.

Clinicians Estimates of Patients Requests

Clinicians estimates of patients requests have been shown to be inaccurate. Zisook et al (1979b) studied the requests of 82 new psychiatric outpatients and found "very low correlations" (p.345) between what the patient requested on the Patient Request Form and what the therapist felt was offered or dealt with.

A study by Burgoyne et al (1979) attempted to "Compare the relative importance of the patients' requests and their therapist's perception

of those requests after the initial interview. Do therapists accurately identify their patients' requests, and if so, do they appreciate the importance the patient attaches to these requests?" (p. 400, Burgoyne et al, 1979). To answer this, 325 consecutive new patients at an Adult Psychiatric Outpatient Clinic completed a 14 item Patient Request Form, based on the 14 request categories postulated by Lazare et al (1972), before their inital interview. Their therapist completed an equivalent form after the interview.

Results indicated that therapists clearly considered their patients' requests to be less important than did the patients themselves. Therapists significantly underestimated the importance their patients attached to requests for, Clarification, Administrative request, Control, Confession, Reality contact, Advice, Institutional contact, Intrapsychic psychotherapy and Community triage (all $p < .001$). There were no significant differences between therapists and patients ratings for requests of Ventilation, Succorance, Medical and Social intervention. The final request category of "Nothing" was found to be perceived significantly more important by the therapists than the patients ($p < .01$).

From these results Burgoyne et al (1979) concluded that increased attention to patients' requests was required, and through increased attention, a need for some changes in most outpatient programmes would probably be indicated.

The present research aims to determine the ability of clinicians to estimate the importance their patient population places on their requests. It is predicted that as Burgoyne et al (1979) found, clinicians will consider the patients' requests to be less important than did the patients themselves.

The study is a replication of Burgoyne et al (1979) with modifications to overcome limitations described in the method and results.

Adherence to Treatment

Two studies have researched the relationship of the negotiated approach and adherence to treatment (Zisook et al, 1979b; Eisenthal et al, 1979). Eisenthal et al (1979) found that patients who felt the clinician understood their request were significantly more likely to adhere.

Zisook et al (1979b) found no relationship between patient requests and adherence.

We aim to clarify this disparity by investigating the relationship between psychiatrists understanding of patients requests, and patients adherence to treatment.

Research related to adherence, continuance, compliance, attrition, drop-out or premature termination of treatment, although all having slightly different meaning, are usually studying much the same phenomena - how well patients follow through with their treatment plan. The present research uses the term "adherence" because it suggests a more egalitarian interactive patient-clinician system than terms such as compliance.

Psychiatric patient adherence to treatment has been reviewed from several perspectives. Blackwell (1976) found 55 out of 320 articles dealt directly with adherence problems in psychiatry. Almost half of the 55 studies were related to drug treatment adherence. Blackwell's review found many and varied factors which contributed to non-adherence. Factors implied were; the patient, his attitudes, illness behaviour, demographic and personality factors; the patient's illness, especially type of disturbance; the physician, his attitudes and communication with the patient; the treatment setting, environmental and administrative factors; and treatment, such as the therapeutic regime, labelling, delivery systems, side effects and type of medication.

Blackwell (1976) concluded "There is scant concensus of features

that consistently influence adherence, despite the study of more than two hundred variables. A complex interaction of risk factors is involved between the patient, illness, physician, treatment setting and medication" (p.527).

This statement reflects some of the difficulties which are encountered in studying adherence.

Baekeland and Lundwall (1975) critically reviewed dropping out of treatment in six areas, one being general psychiatric patients. They concluded by conceptualizing dropping-out as a result of three vectors:

(1) a set of intrapsychic factors favourably or unfavourably disposing the patient to the treatment setting and its change agents (e.g. demographic, clinical and personality factors);

(2) a set of variables related to the therapists personality, attitudes toward patients and therapeutic style and;

(3) a set of variables related to environmental factors.

Reder and Tyson (1980) reviewed 47 research articles on dropout of individual psychotherapy, which closely relates to our study with respect to the definition of adherence.

Again dropout was associated with several factors; severity of psychopathology, problems in motivation, treatment type, selection procedures, experience and skill of therapists, and differences in treatment setting. No single factor consistently determined dropout.

"A consistent finding among these reports was that patient dropout is initially high, falling off after a few sessions or weeks of treatment." "In light of the high patient dropout rates reported at the beginning of treatment, it might be advantageous for therapists, especially those beginning long-term psychotherapy, to view the early stages of treatment as quite tentative - as a trial not only of the treatments suitability and specificity for the patient, but also of

the match of therapist and patient." (Reder and Tyson, 1980, p.246).

The initially high dropout rate suggests the initial interview may be an important variable in adherence. Viewing the early treatment stages as tentative and a trial period, suggests future negotiation would be fruitful in determining the final treatment plan.

These two factors imply that the negotiated approach to the initial interview is a method which could improve adherence to treatment.

This argument is supported by Baekeland and Lundwall (1975) whose guidelines to cut down the dropout problem appear inherent in the negotiated approach.

The best evidence supporting the negotiated approach as a method for increasing adherence comes from research which directly investigates adherence and the negotiated approach.

Adherence, requests and the Negotiated Approach

In a walk-in psychiatric clinic of a general hospital Eisenthal et al (1979) administered 130 new patients the Patient Request Form before their intake interview, and a Post-Interview Questionnaire measuring negotiation, outcome, and diagnostic understanding. Forty-one percent of the patients adhered by keeping at least one referral appointment. The results supported their hypothesis that patients who gave higher ratings on measures of the negotiated approach would be more likely to follow through with treatment recommendation. An item that measured the extent to which the patient felt the clinician understood their request significantly differentiated between patients who did and did not adhere ($p = .031$), and also significantly correlated with adherence ($r = .245$ $p < .05$). Adherence was not found to be related to the type of requests patients made but was significantly related to patients getting the plan they wanted.

The only other research which studies patient requests and adherence was conducted by Zisook et al (1979b) at a psychiatric out patient department. Before the initial interview patients completed the Demographic Form, and 54 item Patient Request Form. Immediately after the initial session patients completed the Post-Interview Questionnaire, as in Eisenthal et al's (1979) study. Of 82 consecutive new patients 65% showed up for a second appointment while 35% failed to return.

Zisook et al (1979b) did not substantiate any significant differences between continuers and non-continuers based on patient requests, nor did they show any associations between identifying, negotiating or fulfilling requests and treatment adherence. Only three factors significantly influenced whether a patient returned for a second appointment: having one's feelings understood, being satisfied with the initial session,and planning to keep the next appointment.

Neither Eisenthal et al (1979) or Zisook et al's (1979b) studies found any significant differences between continuers or non-continuers on any demographic variables (social class, age, sex, marital status, ethnicity, income, education, work history, religious preference), symptom measures (diagnostic, presenting complaint, or self-rating of upset), referral variables (referral source, discussing problems with others, or disposition), or treatment history variables (entry into mental health system, length of treatment history, previous psychiatric contact or number of hospitalizations).

The two studies have produced almost opposite results in terms of the relationship between the negotiated approach and patient requests to treatment adherence. This difference may be a result of several variables. The most likely variable is the differing settings and patient populations. Eisenthal et al's (1979) walk-in clinic dealt with acute patients in crisis more than did the university outpatient

psychiatric clinic of Zisook et al (1979), which is reflected in the greater proportion of psychotic diagnoses in Eisenthal et al's (1979) patient description compared to Zisook et al's (1979b). Both studies varied in the experience of their therapists in using the negotiated approach and both used slightly different adherence criteria. Any one of these three variables may have been enough to produce the different relationships between adherence and the negotiated approach.

A major problem described in reviews of patient adherence was the "lack of definition" (Blackwell, 1976), and limited ability to make comparisons between studies due to inconsistences in definition (Baekeland & Lundwall, 1975; Reder & Tyson, 1980).

Zisook et al (1979b) and Eisenthal et al (1979) provide another example of limited ability to make comparisons due to slightly differing definitions of adherence.

This thesis aims to alleviate these problems by providing a clear description of the clinical setting and patient sample, assessing the effects of individual therapists, and providing an explicit, precise, and comparable definition of adherence.

The third aim of the present study is to determine the relationship between clinician's ability to estimate the importance patients place on their requests and patients adherence to treatment.

This differs from Zisook et al (1979b) and Eisenthal et al (1979) as we look directly at clinicians understanding of patients requests, as opposed to patients perceptions of clinicians understanding of their requests.

The research also addresses itself more directly to patient requests as opposed to the negotiated approach in general.

HYPOTHESES

Hypothesis one

There will be a significant positive correlation between ratings of request categories for the New Zealand sample and the

(i) Burgoyne et al (1979) sample

(ii) Zisook et al (1979a) sample

(iii) Lazare and Eisenthal (1977) sample

Hypothesis two

(i) On average psychiatrists will significantly underestimate the extent patients in general want requests for Clarification, Administrative request, Control, Confession Reality contact, Advice, Community triage, Psychodynamic insight, and Psychological expertise.

(ii) On average psychiatrists will significantly overestimate the extent patients in general want the request for Nothing.

(iii) On average psychiatrists will not significantly under or overestimate the extent patients in general want the requests for Ventilation, Social intervention, Succorance, and Medical.

Hypothesis three

Average difference scores between psychiatrist estimate of patients requests, and patients requests will be significantly different for non-adherers and adherers.

METHOD

The Setting

The research was conducted at a psychiatric unit attached to a city public hospital. The unit caters for an average of 50 people per day, who attend voluntarily. It has 20 beds to cater for inpatients. The ward is mixed bed, for all ages, and staffed by medical specialists, nurses, psychologists, child and occupational therapists, social workers, administrative and domestic staff.

All treatment is paid by the State as part of the state welfare system.

Subjects

Subjects comprised 269 consecutive new patients or reassessments who came to the psychiatric clinic from the 15/6/81 to the 1/11/81, and who met the criteria for inclusion.

New patients had no previous assessment and had not received treatment from the clinic before. They first came as patients to the clinic for their initial assessment interview. Reassessments were patients who had previous assessment, and had been discharged. They came for their first reassessment interview since their discharge.

The criteria for inclusion were:

(1) Patients must have been 16 years of age or over on the date of their initial interview. Sixteen was considered to be an age where patients could understand the questionnaire, and task. Patients under 16 years of age entered the Children's Unit of the clinic which used a different reception area.

(2) Patients should not have been assessed or involved in any treatment based at the clinic within three months prior to the day of their initial interview (all subjects had been discharged, for at least three months). This was to avoid a sampling bias which would favour returning patients.

(3) Patients should not have been "Acute". This criterion was required and defined by the clinic. It was introduced to avoid further upset to already disturbed patients.

Patients were considered acute if the referral source telephoned the clinic and asked that the patient be seen as soon as possible, usually the same day, (The referral letter usually accompanied the patient when he came to the clinic). The "normal" referral practice

occured when the referral letter was sent to the clinic from the referral source, and an appointment time was then made for the patient to see the psychiatrist.

The exclusion of "acute" patients was unfortunate firstly, because they were defined by the method of referral "acute" did not necessarily reflect acute disturbance or symptomatology, and was thus an over inclusive definition for research purposes, possibly creating a sample bias.

Secondly, since access to demographic and other variables was denied on grounds of confidentiality,this made it impossible to identify characteristics of the "acute" patients or to accurately determine the representativeness of the sample, possibly decreasing the generalisability of the results.

The "Patient Identification" form (see Appendix II) was used to collect patient demographic variables. The Revised Socioeconomic Index for New Zealand, (Elley & Irving, 1976) classified patients according to socioeconomic status. Referral source, diagnosis, previous contact, and dates of visits were obtained from Patient file cards (see Appendix II).

Of the 269 new patients and reassessments who came to the clinic 123 or 46% were ineligible because they were "acutes". Of the 146 (54%) patients who were eligible to participate in the research 32 (22%) refused, 19 (13%) were missed and 10 (7%) were unable to complete the form.

Eighty-five (58%) of the eligible patients completed the Patient Request Form. These patients had the following characteristics - Sixty-seven percent were female, 94% European, and 5% Maori. Age ranged from 16 to 67 years, the mean being 33.8 years with 72% within the 16 to 40 year age group. Fifty-one percent were married, 28% single, 18% defacto or separated with the rest widowed or divorced.

Thirty-two percent indicated no religious preference, 31% were Anglican, 13% Roman Catholic, 12% Presbyterian, 4% Methodist and 9% were other religions. Sixty-six percent of the patients were uncodable on the Socio-economic index, due to the large number of housewives and beneficiaries.

Twenty-five percent of the sample had been patients at the clinic before. Thirty-one percent were diagnosed as having a neurotic disorder, 15% had a psychotic disorder, 24% personality disorders, 12% transient situational reactions, 6% other diagnoses, 9% had "no psychiatric diagnosis" and data was not available on 2 (3%) patients. Ninety-four percent were referred by medical doctors.

The patient sample sizes ranged from 35 to 9 patients for each psychiatrist. For reasons of confidentiality patient sample sizes are not given for individual psychiatrists.

Instruments

A fourteen item Patient Request Form based on that used by Burgoyne et al, (1979), see Appendix III), was used to obtain data on patient requests.

The request categories were the same as those developed by Lazare et al (1975).

Construct validity of the 75 and 85 item Patient Request Forms were indicated from factor-analyses (Lazare et al, 1975b; Lazare & Eisenthal, 1977) which found that 13 of the 14 postulated request categories were confirmed as being independent.

Factor-analysis of the Burgoyne et al (1979) 14 item Patient Request Form produced two factors one of which was similar to one of three higher order factors found by Lazare and Eisenthal (1977).

Content validity is demonstrated in several ways. The request items and categories were based on verbatim requests made by patients in their initial interviews (Lazare et al, 1975b). These items were selected to cover the content of definitions provided for each postulated request category.

Four judges oriented to the meaning of the request categories were able to sort each of 75 items into its proper category. The judges agreed with the researchers category designation of the items, 98%, 95%, 95% and 89% of the time (Lazare et al, 1975b). This and the fact that no non-hypothesised factors were found in factor-analysis (Lazare & Eisenthal, 1977), provides strong evidence for content validity of the request categories used.

No measure of criterion-related validity has been made, and this is probably due to the nature of patient requests. It is difficult to make a meaningful comparison of a patient's request to an external variable which would provide a direct measure of the requests.

No formal measures of reliability have been applied to the

Patient Request Form.

The use of Burgoyne et al (1979) 14 item questionnaire as opposed to a larger, but potentially more valid questionnaire such as Eisenthal et al (1979) 84 item Patient Request Form, was due to the time factor. Eisenthal and co-workers were conducting structured research interviews with all new patients routinely, and were thus able to obtain permission to conduct a far lengthier interview including the questionnaire. In the current setting there were strong limitations on the accessibility of patients, and on staff time. The research would not have been permitted to proceed if a questionnaire of 84 items were to be used.

A pilot study indicated that it took patients approximately 10 minutes to complete the 14 item form and psychiatrists approximately 5 minutes. A longer questionnaire would have been impractical.

The Patient Request Form used in this study differed from Burgoyne et al (1979) in minor ways, having one new category, two modified categories and one category deleted, with the other eleven categories identical to those used by Burgoyne et al (1979),(see Appendix III).

The category of "Nothing" was modified on the recommendation of Burgoyne et al (1979) who felt that their "I came because some-one sent me" was not a very good item. Patients referred from other facilities may have endorsed this item when it was supposed to identify those patients who have no clear requests. To correct this, the "Nothing" item with the highest factor loading in Lazare and Eisenthal's (1977) factor analysis replaced Burgoyne et al's (1979) "Nothing" category item. The new item of "I do not want help from the clinic" appears to fit the description of this category provided by Lazare and Eisenthal (1977).

The category of Intrapsychic psychotherapy has been modified since Burgoyne et al's (1979) study, and the name changed to Psychodynamic insight, (Lazare et al, 1975b). At the same time a new request category was developed, that of Psychological expertise. Again the items for Psychodynamic insight and Psychological expertise were developed using Lazare and Eisenthal's (1977) factor analysis.

Items with factor loadings of at least ·70 were given the most attention and items with factor loadings of less than ·40 were not considered to be of great significance. Reference to the descriptions of the categories was important in constructing the items, as Burgoyne et al's (1979) single item for each request category were quite general, covering the whole breadth of meaning of each category, while Lazare et al's request categories were made up of more than one item per category. Referring to the overall description of each request category allowed adjustment to single items making them broad enough to include all elements of the whole category.

The following changes were made to the Likert type scale and instructions given at the beginning of the Patient Request Form. Burgoyne et al (1979) used a four point scale ranging from 1, "not important" to 4, "very important," where-as Lazare et al (1975b) originally used a five point scale of 1, "not at all" to 5 "this is exactly what I want, " later changing to a three point scale using the above two points as anchors at 1 and 3, (Lazare et al, 1977).

The current research used Lazare et al (1975b) five point scale for several reasons; the five point scale allows a wider range of responses for an item, requiring more accurate discrimination between points than in a four or three point scale, while still being within subjects discrimination capabilities. The anchors of 1, "not at all" and 5 "this is exactly what I want" appear to be more terminal than Burgoyne et al's (1979), "Not important" and "Very important." That

is, the word "exactly" excludes any other meaning, where-as the subjective meaning of "very" appears more variable. This view is consistent with Summers (1977) who recommends the use of less evaluative scales, and who demonstrated that subjects being offered five alternatives from which to choose yielded a near-normal distribution.

Numerical values were attached to each of the scale headings. Thus, if subjects did not construe the scale headings as being equal intervals apart, (as is required for the statistical analysis), the attached figures would indicate this to be the case (Dawes, 1972).

Instructions on the Patient Request Form were the same as those used on Lazare and fellow researcher's forms. Burgoyne et al (1979) instructions were not considered complete enough to provide patients with adequate information to undertake the task with ease.

An open ended question "What other requests do you have?" was placed at the end of the Patient Request Form to allow patients to express other requests which they may have had, but felt were not included in the previous fourteen items.

The Patient Request Form was modified for the psychiatrists' use by changing the pronouns, as was done by Burgoyne et al (1979) (see Appendix III).

Procedure

Before their initial interview eligible patients able to complete the Patient Identification Form (see Appendix II), were informed of the research, and asked if they would participate by the researcher or one of four receptionists. Standardised instructions on the procedure were given verbally and in written form to the receptionists (see Appendix IV). Patients who did not complete the Patient Request Form were recorded as being "Ineligible", "Unable", or "Refused." "Ineligibles" did not meet the criteria for inclusion, "Unables" were too disturbed, and the others refused to participate, or were missed, in that they had their initial interview before obtaining a form.

It was stressed that neither receptionists nor any other third party were to influence the patients responses on the Patient Request Form, although they could explain what was required.

Psychiatrists were informed verbally and in the following written form as to what they were to indicate on their form after the initial interview. "Complete the Patient Request Form (Psychiatrist Version) within 30 minutes of seeing the patient. Indicate on the Patient Request Form what you think the patient's original requests were at the start of the interview.

NOTE: We are not asking for your assessment of the patients' needs nor the patients' requests following the interview, as these may change."

No forms included in the data were known to have been completed later than 30 minutes after the interview.

All data was coded to ensure confidentiality for both patients and psychiatrists.

Adherence Measures

Review of the adherence literature produced a wide range of

definitions which could be placed into five broad categories. Non adherers were those patients who either: Missed scheduled appointments, (e.g. Arvey, Gordon, Messengill & Mussio, 1975; Fiester, Mahrer, Gambra & Ormiston, 1974; Fiester & Rudestain, 1975; Gottesfeld & Martinez, 1972; Heilbrum, 1972; Ungerer, Hartford & Coloni, 1975; Zisook et al 1979b; Eisenthal et al, 1979); did not take medication (Roth & Caron, 1978; Blackwell, 1976); missed a number of "sessions" (Stern, Moore & Gross, 1975; Gundlach & Geller, 1958; Borghi, 1968; Garfield, Affleck & Muffly, 1963; Hiler, 1959); did not remain in treatment for a specified time period (Garfield, 1977; Fink & Heckerman, 1981; Lorr, Katz & Rubinstein, 1958); or failed to continue treatment when staff felt continuance was needed, (Hoppe, 1977; Kline & King, 1973; Raynes & Patch, 1971).

There were many combinations within and between these categories.

The following adherence measure was used for this study:

A patient was considered to adhere to treatment if he kept his first appointment after the initial interview. Patients must have had an appointment made within one month of their initial interview to be included in the adherence measure.

This definition was considered most appropriate because it is consistent with previous related research allowing close comparison and, because it has been considered "demanding" by other researchers (Heilbrum, 1974) its strength as a valid measure of adherence behaviour is recognised.

The present definition makes statistical analysis simpler by having an all or nothing criteria, other definitions could have allowed differing degrees of adherence, depending on the number of appointments missed. A measure which included more appointments than the first referral appointment only, would introduce extraneous variables.

As access to clinical files was not permitted, appointment books and file cards were used to determine if patients adhered. By obtaining information on one appointment per patient as opposed to many, the error rate is theoretically reduced and the reliability of the adherence measure increased.

Adherence measures were obtained by psychiatrists indicating whether "Follow-up recommended" was for inpatient treatment, consultation only (no further treatment) or outpatient treatment. Inpatients, consultations only, and outpatients assigned to daypatient care were ineligible for the adherence measure as no specific "appointments" were made. Outpatients referred to various departments within the clinic (e.g. social work, psychology) or given another appointment to see the psychiatrist were eligible for the adherence measure. Adherence data was obtained from appointment books, where the return appointment time was obtained, and the patient file card, where patient visits were recorded.

RESULTS

Hypothesis One

Patients' averaged ratings for each request category were used to compare results from the New Zealand sample with those from Burgoyne et al (1979) and Zisook et al (1979a).

For comparison between the New Zealand sample and Lazare and Eisenthal (1977) sample, percentages of patients who rated each category "This is exactly what I want" were used because averaged ratings were not available.

Pearson product moment correlations determined the similarity of request endorsement between the New Zealand sample and each of the other three samples (Table 2).

Table 2 Pearson product moment correlation co-efficients of patient request ratings between New Zealand sample and three other samples

Sample	New Zealand
Lazare and Eisenthal (1977)	r = ·544 *
Zisook et al (1979 a)	r = ·581 *
Burgoyne et al (1979)	r = ·847 **

* $p < ·05$ $df = (n-2) = 12$ ** $p < ·01$ $df = (n-2) = 11$

From table 2 it can be seen that all three other patient samples show a significant correlation with the New Zealand sample; the Burgoyne et al (1979) sample correlation being notably greater than the other two, which are quite similar. A low range of scores reduced the likelihood of artificially inflated co-efficients.

For easy comparison of all four samples the rank order of preference of patients requests for the New Zealand sample based on averaged ratings is presented in table 3.

Comparison of table 3 with table 1 (see p.13) suggests similarity between rank order of requests.

Rank one represents the highest average endorsement or greatest patient preference.

Table 3 Rank order of preference of patient requests for N.Z. sample

Request Category	Rank
Clarification	1
Psychodynamic Insight	5
Psychological Expertise	2
Medical	14
Ventilation	6
Control	4
Succorance	8
Reality Contact	10
Advice	3
Community Triage	7
Confession	12
Social Intervention	9
Administrative Request	13
Nothing	11
Number of items in Patient Request Form	14
Setting	Psychiatric clinic of general hospital
Sample Size	85

NOTE: Request category descriptions can be obtained from Appendix I.

The results support hypothesis one, all three other patient samples ratings of request categories were significantly and positively correlated with the New Zealand sample.

Hypothesis two

A three way analysis of variance was calculated between Psychiatrists (4), Raters (Psychiatrist and Patients, 2) and Requests (14) with repeated measures on raters and requests. This ANOVA was completed primarily to test for significant differences between raters on the different request categories, (see Appendix V for full ANOVA).

No significant main effects were found for psychiatrists, F (3, 71) = 0·5956, $p > .05$, or raters, F = (1, 71) = 1·7219, $p > .05$. As expected a significant effect for requests was found, F = (13,923) = 26·458, $p < .0000$. There was a significant interaction between raters and psychiatrists, F = (3, 71) = 3·6458, p = ·0164, indicating that for some psychiatrists, patients and psychiatrists differed in their overall ratings, (discussed in more detail on p.37). As expected there was also a significant interaction between psychiatrists and requests, F = (39, 923) = 1·9763, p = ·0006, showing that psychiatrists rated request categories in different ways. There was no significant interaction found for psychiatrists by raters by requests, F = (39, 923) = 1·2527, $p > .05$.

Finally there was a significant interaction between raters and requests, F = (13, 923) = 4·4045, $p < .0000$, indicating psychiatrists and patients significantly differed in their ratings of requests. F - tests were used to test the planned comparisons between mean psychiatrist and patient ratings on requests.

There is controversy surrounding the use of methods to correct for the number of comparisons being made. Keppel (1973, p. 89-94) argues that for planned non-redundant comparisons a per comparison error rate, as used in a standard F - test is acceptable. In redundant or post-hoc comparisons a corrected error-rate is required to avoid Type I errors (e.g. Dunn test d). Table 4 shows the F - values

obtained for the raters by requests comparisons.

Table 4 Hypothesised estimation versus obtained means and F-values for psychiatrist and patient ratings of requests

		Means		F-values
Request Category	Hypothesised	Patient	Psychiatrist	F=(1,923)
Clarification	↓	3.78	3.27	8.84 **
Advice	↓	3.46	3.11	5.06 *
Community Triage	↓	2.68	2.32	5.15 *
Psychodynamic Insight	↓	3.06	2.47	13.92 ***
Psycholocial Expertise	↓	3.42	2.89	11.77 ***
Administrative	↓	1.96	1.74	2.06
Control	↓	3.35	3.38	0.05
Reality Contact	↓	2.33	2.58	2.47
Confession	↓	1.97	2.71	22.23 ***
Nothing	↑	2.10	1.45	16.99 ***
Ventilation	-	2.86	2.67	1.14
Social Intervention	-	2.39	2.32	0.01
Succorance	-	2.68	2.84	1.20
Medical	-	1.76	1.85	0.49

Key ↓ psychiatrists underestimated ↑ psychiatrists overestimated
- No difference

* $p<.025$ ** $p<.01$ *** $p<.001$

F - tests indicated that on average psychiatrists significantly underestimated the extent that patients wanted requests for Nothing, Psychodynamic insight, Clarification, Advice, Psychological expertise and Community triage. On average psychiatrists significantly overestimated the extent that patients wanted the request for Confession, and there were no significant differences between psychiatrists estimates and patients actual ratings of requests for

Reality Contact, Administrative request , Ventilation, Succorance, Medical, Social intervention and Control.

The results generally support hypothesis two with nine of the 14 requests being estimated as predicted. The exceptions were Administrative request, Control and Reality contact with no significant difference between psychiatrist estimation and patient ratings obtained, when it was hypothesised all three would be underestimated. "Confession" was predicted to be underestimated, but was overestimated and "Nothing" was predicted to be overestimated, but was underestimated by psychiatrists.

As stated earlier a significant interaction between psychiatrists and raters was found, F (3,71) = 3.6458, p = ·0164. The means are presented graphically in Figure 1. To determine which psychiatrists rated differently to their patients, and how this would affect the overall under or overestimation of patient requests by psychiatrists as a group the Dunn test for multiple comparisons between means was used (Keppel, 1973). This test was appropriate asthis was a post-hoc analysis with a limited number of comparisons (Keppel, 1973).

The results indicated that there was a significant difference between patients mean request ratings and psychiatrist ratings, for psychiatrist B, d (2,71) = 0·3945, $p <$ ·01. No other significant differences were found.

Figure 1 shows that psychiatrist B's mean ratings collapsed across all request categories was significantly lower than the patients mean ratings. This significant difference probably occured because psychiatrist B had the lowest mean rating of all the psychiatrists, and psychiatrist B's patients had the highest mean rating of all patients.

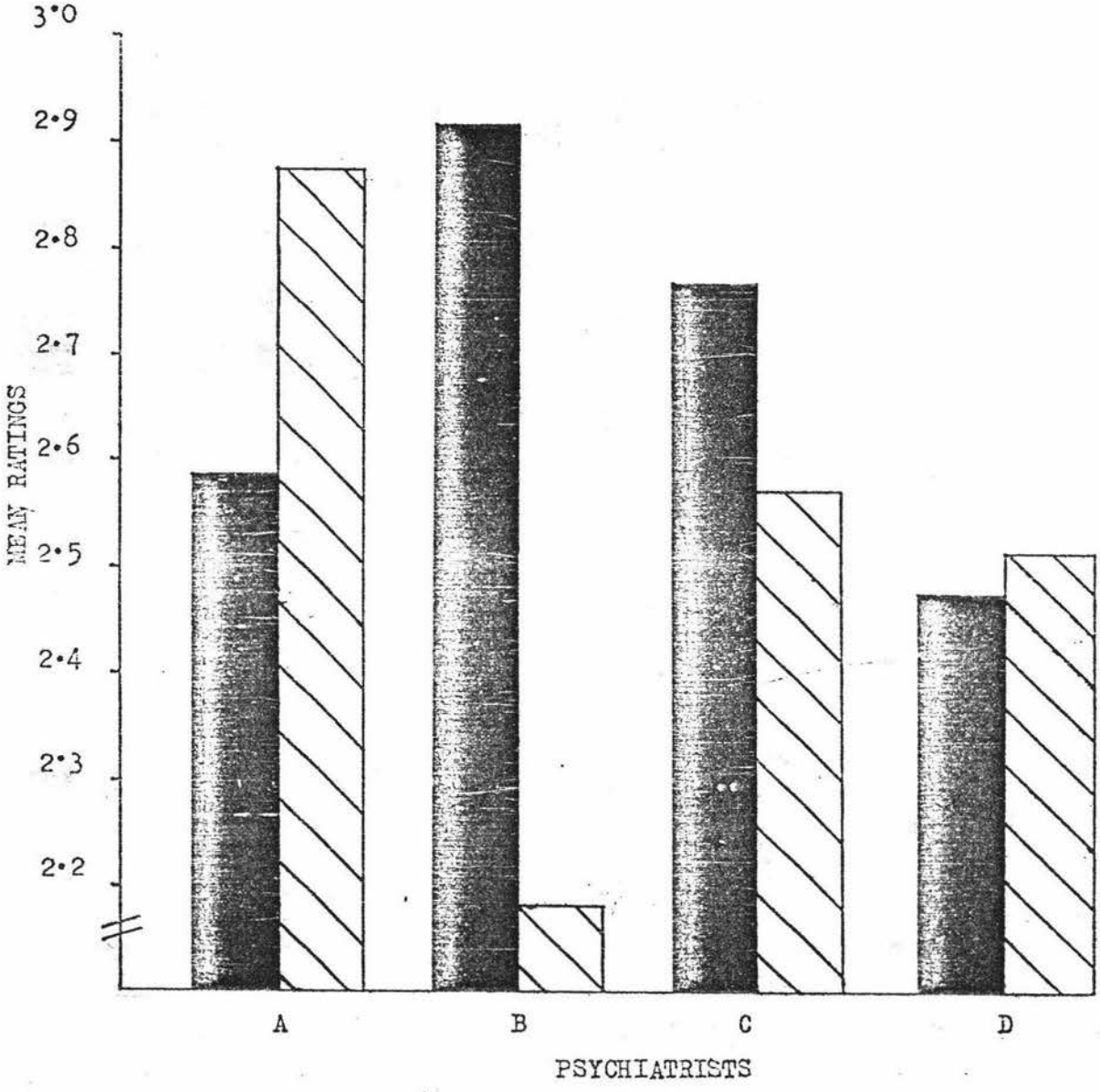

Figure 1 Mean ratings of raters by psychiatrists.

Key Patients Psychiatrists

In order to determine whether under or overestimation of patient requests was effected significantly by individual psychiatrists a supplimentary two way analysis of variance was performed for psychiatrists(4), by requests (14), with repeated measures on requests. This analysis used psychiatrist ratings only, patient ratings were excluded (see Appendix VI for the complete analysis). The analysis indicates whether estimation of patient requests was due to systematic bias in only one or two of the psychiatrists, a variable Burgoyne et al (1979) did not consider. As expected there was a main effect for requests, $\underline{F}$ (13,923) = 17.5351, $\underline{p} < .0000$. There was also a main effect for psychiatrists, F (3,71) = 13.4006, $\underline{p}$ = ·0026, indicating psychiatrists differed significantly in their overall mean ratings. The Dunns test indicated that this difference existed only for psychiatrist B who rated lower than psychiatrist A, $\underline{d}$ (14,923) = 0·7050, $\underline{p} < ·05$, (See Appendix VII for means).

Most importantly a significant interaction between psychiatrists and requests was found $\underline{F}$ (13,923) = 2·2239, $\underline{p} < ·0001$. The Dunns test indicated that psychiatrist B rated the request category of Psychological expertise significantly lower than psychiatrists A and C, and also rated Clarification and Reality Contact significantly lower than psychiatrist A, (all at $\underline{d}$ (14,923) = 0·9973, $\underline{p} < ·05$). Psychiatrist C rated Social intervention significantly lower than psychiatrists A and D, and psychiatrist D rated Community triage significantly lower than psychiatrist A, (all at $\underline{d}$ (14,923) = 0·9973, $\underline{p} < ·05$, see Appendix VII for means and Dunns test $\underline{d}$). No other significant differences were found.

This indicates that some psychiatrists rated some request categories significantly differently to other psychiatrists. Although psychiatrist B underestimated four of the seven differences other psychiatrists also underestimated the requests. It is unlikely that these individual

biases in rating would have significantly added to the overall underestimation of patient requests by psychiatrists as a group, because only a small number of differences were found and these were not consistent across request categories or for any one psychiatrist. We can thus reasonably attribute psychiatrists over or underestimation of patient requests to psychiatrists as a group, while being aware of the rating bias of some psychiatrists to rate lower than others on a few request categories.

Although psychiatrists significantly under or overestimated 7 of 14 patient requests, the Pearson product moment correlation coefficient between psychiatrists and patients ratings of request categories, $r = \cdot 804$, $p < \cdot 005$, indicates a high degree of agreement on the average relative order of importance of each request.

Hypothesis three

For the 75 patient-psychiatrist matches 41 patients adhered to treatment, three did not adhere, 29 were ineligible for the adherence measure, and data was not available for two patients. There were only three subjects in the non-adherent group and these were all patients of the same psychiatrist. Only the patients of this psychiatrist were included in the analysis (Adherers n = 19 Non-adherers n = 3).

Absolute difference scores between psychiatrist and patients were used as the measure of psychiatrist understanding, or estimate of patient requests. The 14 difference scores for each request category were added to give each subject a total difference score. The direction of the difference scores was disregarded as the effect of psychiatrist understanding on adherence is obtained regardless of over or underestimation of patient requests. The difference squared was not used as a measure of similarity, as larger differences are much exaggerated by squaring (Cronbach & Gleser, 1953). Correlation co-efficients were not used because a high correlation can be obtained when the profiles are actually very dissimilar in both level and pattern (Cronbach & Gleser, 1953).

To test the hypothesised relationship between psychiatrist understanding of patient requests to adherence a weighted means t-test for independent samples was performed between absolute difference scores for adherers and non-adherers (Meyers & Grossen, 1978, P.276-277). There was no significant difference between adherers ($\bar{x}$ = 15·9) and non-adherers ($\bar{x}$ = 14·0) based on absolute difference scores of patients and psychiatrists ratings on the Patient Request Form, t (20) = 1·19, $p > ·05$.

DISCUSSION

From the results it can be seen that Hypothesis one is confirmed. There was a significant positive correlation between ratings of request categories for the New Zealand sample and (i) Burgoyne et al (1979) sample (ii) Zisook et al (1979a) sample and (iii) Lazare and Eisenthal (1977) sample.

This indicates a degree of agreement for the relative order of importance of each request category across treatment settings. As noted in the introduction this ordering provides a useful platform from which to assess whether clinics provide treatment which their patient population request. Knowledge of request preferences also gives clinicians insight into patient requests which could be used at the interview level.

Agreement on relative order of importance of requests using different Patient Request Forms is also an important finding. Although ranks of the two larger request forms (84 and 54 items) appear more closely related to each other than to the 14 item forms (see tables 1 and 2) there are still significant correlations between New Zealand and the two larger samples. This provides some evidence that all the forms are measuring the same variables - patient requests as validated by Lazare et al (1975b) and Lazare and Eisenthal (1977).

The request for Clarification was ranked first in all four studies. It seems sensible for most therapists to help their patients put their feelings, thoughts or behaviour in some perspective so they can see their choices for making some decision. The patient wants to understand. This is a logical first choice request, as for most patients the first visit to a psychiatric clinic is a new experience, and they would naturally want their situation clarified, and their options made clear so as to make an informed decision on how to proceed.

Psychological expertise and Psychodynamic insight were both consistently ranked high. This means almost all patients wanted some form of psychological therapy, and they saw their problems as being psychological rather than physical or situational. They either want an expert to explain why they think, feel or act the way they do, and/or they believe their problem evolves from early development, has a relative quality and they want to talk it out in order to understand the roots of the problem.

Patients desire for psychologically based therapy may be due to this being viewed as the most common or popular method of care for psychiatric problems. Media like film and television typically portray psychiatrists and other clinicians in the psychoanalytic mode, or at least in some form of in-depth "talk " therapy. However the wording of the Psychological expertise item does not indicate a clearly psychological therapy, but more of an educative treatment.

For all samples "Nothing" and "Administrative requests" were ranked low. This indicates patients usually have requests, and come to the clinic with definite ideas on what they want, which is consistent with previous research (e.g. Eisenthal & Lazare, 1976b). Administrative requests such as legal assistance, disability evaluation, medical excuse to leave work, testimony in court or admission to a hospital were generally not requested often. The other request categories fell between these high and low priority requests with some variation between the four samples.

For the New Zealand sample the request for Advice was relatively high compared to the other samples. Patients wanted professional guidance on the "best" or wisest" thing to do, often to make some decision. This may have been high in the New Zealand sample because patients had thought their problem through to a decision point, or because they place more faith in the advice of experts than do

patients in the overseas samples.

The "Medical" request is the only category where there is a consistent and large difference between its order on the large item questionnaires, to that of the shorter forms, (approximately rank 4 to 13). This difference may occur because "Medical" items measure different variables for the long versus short form, and the "Medical" request of the 14 item Patient Request Form may require modification in the future. An alternative explanation may be that different patient samples make different requests, but insufficient data on patient variables makes it difficult to determine if this is what caused the difference. Although the settings do not clearly differ, variables related to referral source or patient problem may account for the difference in the "Medical" request rank order.

Burgoyne et al (1979) also obtained a low rank for the Medical request and felt it was most likely related to the more temporarily pressing needs of walk-in patients, as compared to patients who have usually been referred and have had to wait for an appointment before being seen. In the present study patients with more "pressing needs" were further screened out by the exclusion of the "Acute" population, which may tend to lower the preference for the Medical request.

"Medical" being the least preferred treatment request is consistent with psychological requests being ranked high. Patients who participated in this study did not see their problem as being physical in origin and consequently did not want medical treatment such as tranquilizers, nerve pills, or hospitalization. As noted earlier this may be due to a sample bias where participating patients were less acute. The request for Social intervention was also ranked relatively low (9) again consistent with psychological requests being high in that patients felt their problems were not often situational. Psychological

requests being high, with physical and situational type requests low, indicates internal consistency in the way that patients reponded to the request categories.

As expected, because of the greater similarity between questionnaires, the correlation between Burgoyne et al (1979) and the New Zealand sample was considerably higher than the other two samples.

Hypothesis two was partially supported (see Table 4, p.36) with nine of the 14 hypothesised relationships being confirmed. Those not confirmed were Control, Reality Contact, and Administrative request which were hypothesised to be underestimated by psychiatrists, but no significant differences between psychiatrist estimation of patients' requests, and patients' ratings of requests was obtained. We also predicted that Confession would be underestimated, but it was over-estimated by psychiatrists. Finally, based on previous research, we hypothesised "Nothing" would be overestimated by psychiatrists, but it was underestimated.

Before exploring the alternatives to explain these discrepancies we need to clarify whether over or underestimation of patients requests was due to psychiatrists equally as a group, or whether one or two psychiatrists contributed more to the obtained findings than others, because of a bias in the way they rated the form.

The results indicate that psychiatrists significantly differed in their ratings of requests in seven instances out of a possible 84 (14 x 6 see p. 39). This indicated that the number of discrepancies were relatively low. Also out of a possible six differences for each category the highest number was two for the categories of Social intervention and Psychological expertise. The other three categories had only one difference each, (Clarification, Reality contact, and Community triage). This indicates a lack of consistancy in the differences. Although psychiatrist B accounted for

four of the seven differences these were not consistent across psychiatrists or request categories. As Social intervention and Psychological expertise had two differences each they are most likely to be affected by bias in psychiatrist ratings. Any biasing effect on these two request categories was unlikely because psychiatrists underestimated patients requests for Psychological expertise significantly at $p < .001$ and the F-value for Social intervention was extremely low (the lowest, see Table 4) making any significant result improbable.

The small number and inconsistency of the differences in psychiatrists ratings of request categories make it unlikely that only one or two of the psychiatrists significantly effected the over or underestimation of patient requests. Thus we reasonably attribute the over or underestimation of patient requests to psychiatrists as a group.

There are several possible alternatives to account for the discrepancies between the hypotheses and obtained results, such as different psychiatrist and patient samples, or changed items. One viable explanation lies in the results of the statistical analysis. All hypothesised relationships were based on Burgoyne et al (1979) sample where multiple t - tests were performed to indicate whether psychiatrists under or overestimate patient requests. In the present analysis F-tests were performed using a pooled error term and thus minimizing Type I error (Spatz & Johnston, 1976). If Burgoyne et al (1979) had used the same statistic they may not have found as many statistically significant differences between psychiatrist estimation of patient requests and patients actual requests. Inspection of Burgoyne et al's (1979) analysis shows the five smallest significant t-values were for the same five request categories in

the present study for which hypotheses were disconfirmed. This means our original hypotheses may have been based on incorrect inclusions by Burgoyne et al (1979), when the differences for the categories were actually originally insignificant, and this contributed to the differences in hypotheses and obtained results found in the present study. However as most significant differences from Burgoyne et al's (1979) t-tests were at $p < .001$ this explanation could still be questionable.

A plausible alternative explanation could account for the five unconfirmed hypostheses; the request categories of Reality contact, Control and Administrative request were not underestimated as hypothesised, (there were no significant differences), because psychiatrists in New Zealand sample were better able to estimate their patients requests than those in the Burgoyne et al (1979) sample. This explanation is supported in that the New Zealand sample of psychiatrists obtained a higher correlation co-efficient, ($r = .804$, $p<.005$), than Burgoyne et al's (1979) sample, ($r = .585$, $p < .05$) between psychiatrist estimates and patient requests. This finding is also consistent with the training of clinicians in both samples. Burgoyne et al's (1979) clinicians were second year residents in psychiatry while those used in the present study were all fully qualified experienced psychiatrists. It would be probable that more experienced clinicians would estimate patients requests more accurately. The most valid explanation for these three disconfirmed hypotheses is that the New Zealand psychiatrist sample were better able to estimate their patients requests than Burgoyne et al's (1979) psychiatrists.

It was predicted that the "Nothing" request would be overestimated by psychiatrists, but it was underestimated. This is most likely due to the item change from Burgoyne et al's (1979) "I came because someone sent me" to "I do not want help from the clinic" used in this

study.

The "Confession" item is the same as used by Burgoyne et al (1979), but instead of being underestimated as hypothesised it was over-estimated by the New Zealand psychiatrist sample. If Burgoyne et al (1979) were correct and "Confession" was significantly underestimated by psychiatrists, then the only explanation for overestimation obtained in this study is that the psychiatrist sample differed in their estimations compared to Burgoyne et al (1979). It is the "Confession" request category which provides the most discrepant finding compared to Burgoyne et al (1979). Psychiatrists in this study overestimated the degree that their patients felt guilty about their thoughts or deeds, and how much the patient wanted to discuss these in order to feel better or be forgiven.

Generally, psychiatrists tended to underestimate the degree to which patients wanted certain requests. This supports previous research which indicates clinicians tend to think patients do not have clear ideas of what they want, and do not place much credence in what patients say they need (e.g. Hornstra et al, 1972). The general underestimation of patient requests was also found by Burgoyne et al (1979).

The over all pattern of estimation of patient requests is very similar between the Burgoyne et al (1979) and New Zealand samples. The same request categories tended to be under estimated or estimated accurately, perhaps because common background and training of psychiatrists leads to a common bias of what patients do or do not want in terms of treatment, a phenomenon which also seems to occur across samples of psychiatrists. Evidence for such bias has been found in the Attribution research which indicates that professional helpers might be under strong role-related pressure to attribute client's problems a certain way (Batson, 1975; Sherrard & Batson, 1979, Batson & Marz, 1979; Batson, Jones & Cochran, 1979). This

attributional research concludes a "systematic perceptual predisposition" creates bias in how therapists see the patients problem. It is probably this predisposition which has lead to a common pattern of psychiatrists estimation of patient requests, but this still does not explain why psychiatrists are unable to accurately estimate the extent that patients want certain requests. The most probable explanation is that patients do not communicate their requests to psychiatrists, or psychiatrists are unable to elicit the requests from the patients, and understand them.

Eisenthal and Lazare (1976b, 1977b) have found about 35% of patients fail to express a specific request during the intake interview while 65% express a specific request. Of the 35% who do not express a request some would not have requests and would thus rate on the "Nothing" category, and some would have requests, but fail to express them. It was also found that while a majority of patients (69.5%) verbalized a specific request it was significantly less than the percentage (93%) who endorsed at least one request on the Patient Request Form (Eisenthal & Lazare, 1976b). It was concluded that personal and normative constraints in the interview situation played a significant role in such a result. Again this reflects barriers to communication. The breaching of such barriers is the responsibility of both clinician and patient, but it is the clinician who has the power to sanction the patient to make requests. Eisenthal and Lazare (1977b) were able to increase the number of patients who expressed requests by 25% using a verbal probe, indicating clinicians are able to improve communication of patient requests.

The negotiated approach purports to improve patient-clinician communication, and provides specific steps in order to accurately determine patient requests. Some knowledge or training in this approach should improve psychiatrist understanding of patient requests

and also communication, patient satisfaction, and possibly adherence to treatment (Eisenthal et al, 1979).

The third hypothesis of this thesis aimed to investigate psychiatrists understanding of patient requests and its effect on adherence. Hypothesis three was disconfirmed, the results showed no significant difference between patients who adhered to treatment and those who did not based on psychiatrists estimation of patients requests. This result must be regarded in relation to the limits of using a statistic with the extremely low sample size of three for the non-adherent group. This considered, the finding supports Zisook et al (1979b) who also found no significant differences between adherers and non-adherers based on identifying, negotiating, or fulfilling requests. Eisenthal et al (1979) found patients were significantly more likely to adhere if they felt their clinicians understood their requests.

Our results do no refute Eisenthal et al (1979), as did Zisook et al's(1979b) because we did not relate adherence to the extent patients felt the clinician understood their requests, but to an actual measure of clinicians understanding, (i.e. clinicians estimations compared to patients ratings of requests). Eisenthal et al's (1979) findings may be valid, but our results tend to lend more support to those of Zisook et al (1979b). If understanding patients requests does not improve adherence then it may be the patient's belief that their requests are understood, or some other component of the negotiated approach which improves it. Before pursuing this line of thought we need to assess the variables of the present study, which may have affected the outcome.

One factor was, the overall adherence rate was high compared to other studies. Of the 44 patients who were eligible for the adherence measure 41 or 93% of these patients adhered while only 7% did not. Eisenthal et al (1979) found 41% of their patients adhered while Zisook et al (1979b) had 65% who adhered. Both these adherence rates

are considerably lower than the 93% found in this research. Adherence rates below 45% have been generally associated with walk-in clinics. (Craig, Huffine & Brooks, 1974; Chafetz, 1965; Wilder, Plutchnik & Conte, 1977 all cited in Eisenthal et al 1979; Chomeides & Yamamoto, 1973) while rates above 55% have been consistently associated with traditional outpatient psychiatry clinics (Raynes & Warren, 1971; Whyte, 1975; Zisook et al, 1979b). Adherence rates reportedly vary from a low rate of 25% (Craig et al 1974, cited in Eisenthal et al, 1979) to a high rate of 94% (Lief, Lief & Warren, 1961 cited in Eisenthal et al, 1979). Our adherence rate of 93% is very close to the highest rate obtained.

With such a high adherence rate there is less likelihood of finding a variable which could consistently account for non-adherence. Both this study and Zisook et al (1979b) obtained considerably higher adherence rates (65% and 93%) than Eisenthal et al, (1979) (41%). It may be that understanding patients requests improves patient adherence in settings where the adherence rates are low. Presuming this interpretation is correct, understanding patient requests probably improves adherence of a percentage of would be non-adherers and other variables are responsible for non adherence of the rest of the population. These other variables may be factors such as patient satisfaction which has been found to be significantly correlated to patients perception that the clinician assisted them in verbalising their request (Eisenthal & Lazare, 1976b) and also to patients beliefs that clincians understood their request (Eisenthal et al 1979; Eisenthal & Lazare 1976a). Patient satisfaction has in turn been related to increased adherence (Zisook et al, 1979b).

It may be that other components of the negotiated approach are able to improve adherence. The general mood and emotional tone that the negotiated approach creates may influence adherence

(Masur 1981). Mood may be dictated by the quality of communication between patient and clinician.

Our results show no relationship between understanding patient requests and adherence to treatment. This result may have been affected by an unavoidable bias in the patient sample which made acutes, and other patients ineligible for the adherence measure, possibly decreasing the number of non-adherers. With such a high adherence rate replication of this study is needed with a lower adherence rate in order to truely determine if understanding patient requests is related to adherence.

Before concluding it pays to note that non-adherence does not necessarily mean negative therapeutic outcome, and some satisfied patients may not return for their referral appointment because of their satisfaction rather than despite it. The first session may result in patients no longer needing help, or represent adaptive coping mechanisms or strategies to regain mastery (Zisook et al, 1979b). It is therefore important that adherence research also examine patient satisfaction, an aspect not allowed in the current research. Even with the possibility of non-adherence because of satisfaction rather than despite it, there are undoubtedly a large percentage of non-adherers who do become treatment failures. For this reason continued research into the causes of non-adherence and development of techniques to prevent or alleviate non-adherence are crucial to effective patient care.

Patient Request Form Development

Several positive results not directly related to the hypotheses emerged from this research.

The 14 item Patient Request Form was found to obtain similar patient request preferences to 84 and 54 item Patient Request Forms. This lends some validity to the 14 item Patient Request Form

indicating that it does in fact measure patient requests. The 14 item form is far more practical for most research purposes than an 84 item form would be.

A factor-analysis was performed on patient requests for the current sample. This indicated four factors, (see Appendix VIII), two more than were found by Burgoyne et al (1979) using the same factor-analytic technique, and a Request Form of the same length. The increased number of factors maybe the result of a change in three of Burgoyne et al's (1979) original items and possibly the different patient populations viewing the items differently.

Conclusions

This research has found a common preference of request categories across patient samples, settings and research instruments. This ordering provides useful information for psychiatric clinics about the type of treatment their patient populations want most. If clinics are concerned about patient service and satisfaction they can modify their service to cater to the desires of their patients, by knowing their request preferences, (Patient request preference for this sample is presented in Table 3) Understanding patients requests at an individual level is also important, as individual preferences will vary from the patient population request preferences.

It was found that psychiatrists significantly underestimated the degree of help patients wanted for six request categories, over-estimated patients requests for one category, and no significant differences between psychiatrist estimations, and patients requests were found for the remaining seven request categories. The categories which were accurately estimated or over and underestimated were very similar to those of previous research (Burgoyne et al, 1979), with a few exceptions. The request category of Confession was overestimated and provided the greatest discrepancy, while some request categories were not underestimated as predicted, but accurately estimated. This was attributed to psychiatrists in this sample being better at estimating patient requests than psychiatric residents in Burgoyne et al's (1979) sample. The similar patterns of patient request estimation by psychiatrists was seen as being due to psychiatrists attributional bias in the initial assessment interview, bias being common in professional helping groups. The source of such bias was unclear and it remains for future research to determine.

Psychiatrist inaccuracy at estimating certain patient requests was viewed in terms of inadequate communication between patient and clinician

about these requests. Knowledge of those request categories which psychiatrists tend to over or underestimate provides data to help alleviate any bias in request estimation at an individual level. Such information could be incorporated in the negotiated approach which is forwarded as a viable and useful method to help improve understanding of patients requests and patient-clinician communication.

Understanding patient requests was found to be unrelated to patient adherence. This may be because understanding patient requests only improves adherence in populations where there is a high non-adherence rate. The non-adherence rate was very low in this study possibly due to a sampling bias. Again it remains for future research to test the differential effects of low and high adherence rates.

Clinicians need to be able to determine patient requests to make a fully informed and appropriate treatment decision, (Burgoyne et al, 1979). Lazare et al (1975a) feel that the negotiation process for treatment is seriously impaired if the clinician does not know the patient's request. It is this negotiation which is the key to open and equal communication between patient and clinician. Without this communication an effective, therapeutic relationship is severely hampered. There is great scope for development of the negotiated approach to the initial interview, not only related to patient requests, but centering on the negotiation process itself. Research which determines stages in negotiation, and integral requirements for open communication, will broaden the development not only of an important interview technique, but of the patient-clinician interaction itself. Research such as attribution theory analysis of trained helpers is already well on the way to improving such knowledge (Batson et al, 1979). The study of the initial interview is especially important, as this is normally the first contact that patients have of the psychiatric services, and usually determines

their subsequent progress through the system.

In investigating the initial interview, negotiated approach, or patient requests we must always consider the practical application of such research. Outcome studies often provide the most useful results in this respect, however, there are few such studies of the initial psychiatric interview (Eisenthal and Lazare, 1976a), and good applied outcome research is usually difficult (Kraemer, 1981). For these reasons greater effort is required to accomplish such study to improve the psychiatric service for all involved.

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APPENDICES

Appendix I Description of Request Categories (Lazare & Eisenthal, 1977)

Administrative request . The patient is seeking administrative or legal assistance from the clinic to help him with his current dilemma. The specific request may be to provide a disability evaluation, a draft deferment, a medical excuse to leave work, medical permission to return to work, permission to drive, admission to a hospital, or testimony in court. These powers are delegated by society to particular professionals or institutions. The power may be subsequently rescinded, or as in the case of therapeutic abortions, may no longer be necessary.

Advice. The patient wants guidance about what to do in personal or social matters. He may already have formed an opinion but now wants professional advice. He wants to know the "right" thing, the "best" thing, or the "wisest" thing to do. He may want the advice in order to have the clinician share the responsibility for a decision he is about to make.

Clarification. The patient wants help to put his feelings, thoughts, or behavior in some perspective. He does not want to be told what to do but would rather take an active role in the therapeutic process. Often the patients wants the help to be able to make a decision. He wants to understand; he wants to see his choices. The patient usually sees his problem as being acute and not a part of an ongoing neurotic pattern.

Community triage. The patient is requesting information as to where in his community he can get the help he needs. He sees the clinic as an available resource which has the necessary information.

Appendix I

Confession. The patient feels guilty about what he has said, thought or done and hopes that by talking to the therapist he will feel better. Specifically, the patient wants to be forgiven. He hopes the clinician (authority figure) will see the misdeed as medical or psychological in origin and therefore not bad.

Control. The patient is feeling overwhelmed and out of control. He may fear hurting himself or someone else or going crazy. He is saying, "Please take over. I can no longer manage."

Medical. The patient sees his problem as being physical in origin, like any other medical condition, as opposed to psychological or situational in origin. He often refers to his problem as "nerves," or as a "nervous condition." The patient, accordingly, hopes for a medical kind of treatment such as pills, ECT, hospitalization, or medical advice. He expects to take a passive role in the treatment.

Psychological expertise. The patient believes that the source of his problem is psychological rather than physical or situational. He is asking the professional to provide an explanation for why he thinks, feels, or acts the way he does. The patient anticipates playing a passive role in the interaction, contributing only that information which the expert requires.

Psychodynamic insight. The patient perceives his problem as psychological in origin, as evolving from his early development, and as having a repetitive quality. As a result, he is left feeling unhappy, unfulfilled, but not overwhelmed or out of control. He expects to take an active, collaborative role in talking about the roots of his problem and hopes that a better understanding of his problem will enable him to change.

Appendix I

Reality contact. The patient feels that he is losing hold of reality. He wants to talk to someone who is psychologically stable and "safe". The request is for the clinician to help him "check out" or "keep in touch with" reality so that he will feel he is thinking straight and not losing his mind.

Social intervention. The patient sees the problem as residing primarily in the people or situations around him. Because he feels that he does not possess the resources to effect the necessary change, he is asking the clinic to intervene on his behalf. He is asking not for the legal powers of the clinic but for its social influence.

Succorance. The patient is feeling empty, alone, not cared for, deprived, or drained. He wants the clinican to care, to be involved to be comforting, to be warm and giving so that he can feel replenished and warm inside. It is not so much the content of the interchange that is requested as its affective quality of warmth and caring.

Ventilation. The patient would like to tell the clinician about various feelings and affect-laden experiences. The patient anticipates that "getting it out" or getting it off his chest will be therapeutic. He feels like he is carrying about a burden which he would like to leave with the clinician. In contrast to confession, the patient does not feel guilty and does not need or want forgiveness.

Nothing. Patients who make no request are a heterogeneous group. They may have been referred without proper preparation; they may be psychotic; they may have problems but are not seeking help at this time; they may want help but are reluctant to state the problem; they may not need help; they may be in the wrong clinic.

Appendix II

Patient Identification Form

ADF04 ACUTE ADMISSION
PATIENT IDENTIFICATION

WARD PATIENT NUMBER

PRINT CLEARLY — USE BLOCK LETTERS

Family Name (Surname)	
Given (Christian Names)	
Maiden Name	
Other Family Names	
Title Mr Mrs Miss Ms	Patient Sex M F
Marital Status S M W D P	Race E M Other
Age Date of Birth	Place of Birth
Residential Address	
Postal Address	
Phone: Home	Business
Are you ordinarily a Resident of N.Z.?	Yes No
Religion	Occupation
Domicile Code	
Is patient prime to this Hospital? P. Prime; S. Secondary	
Next of Kin's Name	Relationship
Address	Phone
Contact Name	Relationship
Address	Phone
Contact Name	Relationship
Address	Phone
Are you a Returned Serviceman?	
Have you been an Inpatient at this Hospital?	When?
Have you been an Outpatient at this Hospital?	When?
G.P's Name (Family Doctor)	
Consultant	
Do you receive other Hospital Services?	Yes No DN MOW HA SV
Is the Admission the result of an Accident?	Where?
What happened?	
Address from which admitted	
Patient Type	Admission Source
Provisional diagnosis	
Medical Alert Information	
Admission Date Time: a.m./p.m.	Discharge Date

To the best of my knowledge the above is correct.

Signed _____ *Date* _____

Appendix II

Patient File Card

NAME		AGE		SEX	
ADDRESS					
MARITAL STATUS		PHONE: HOME			
USUAL G.P.		WORK			
REFERRED BY		CONSULTATION DATE			
NEXT OF KIN		DISCHARGE DATE			
PSYCHIATRIST		TRANSFER DATE			
THERAPIST		TRANSFERRED TO			
REASON FOR REFERAL		OUTCOME			
PREVIOUS TREATMENT		RACE			

DIAGNOSIS

																		1.2m360 S110

WE ARE INTERESTED IN LEARNING HOW YOU HOPE THE CLINIC CAN BE OF HELP TO YOU AT THIS TIME. WE HAVE LISTED 14 STATEMENTS WHICH ARE REQUESTS THAT PEOPLE OFTEN MAKE OF THIS CLINIC. FOR EACH STATEMENT OR REQUEST PLEASE CIRCLE THE NUMBER WHICH BEST INDICATES HOW MUCH YOU WANT THE CLINIC TO HELP YOU WITH THE REQUEST NOW.

HOW MUCH DO YOU WANT THE CLINIC TO HELP YOU WITH EACH REQUEST LISTED BELOW?	DEGREE OF HELP WANTED				
	NOT AT ALL	SLIGHTLY	SOMEWHAT	STRONGLY	THIS IS EXACTLY WHAT I WANT
TO GET HELP TO PUT THINGS INTO PERSPECTIVE - TO CLARIFY THINGS	1	2	3	4	5
TO GET SOMEONE TO HELP ME WITH MY PROBLEMS WITH THE LAW, SOCIAL SERVICE AGENCIES, SCHOOL, OR OTHER AGENCY	1	2	3	4	5
TO GET HELP IN CONTROLLING MY FEELINGS AND/ OR WHAT I WISH TO DO	1	2	3	4	5
TO HAVE A PLACE WHERE I CAN DISCUSS THINGS OF WHICH I FEEL ASHAMED AND GUILTY AND CAN TELL NO-ONE ELSE	1	2	3	4	5
TO HELP ME KNOW WHETHER OR NOT I AM HAVING A NERVOUS BREAKDOWN	1	2	3	4	5
TO GAIN SOME UNDERSTANDING AND SOME CARE FROM SOMEONE	1	2	3	4	5
TO HAVE A PLACE WHERE I CAN GET IT ALL OFF MY CHEST	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	SOMEWHAT	STRONGLY	THIS IS EXACTLY WHAT I WANT
TO GET ADVICE ON WHAT I SHOULD DO	1	2	3	4	5
TO GET MEDICATION, TRANQUILIZERS, OR NERVE PILLS	1	2	3	4	5
TO GET SOMEONE TO HELP ME WITH A PARTICULAR PERSON (WIFE, HUSBAND, BOSS, FRIEND, PARENT,ETC)	1	2	3	4	5
TO FIND OUT WHERE I CAN GET THE HELP I NEED - IF YOU CAN'T PROVIDE IT, YOU CAN DIRECT ME	1	2	3	4	5
TO GET AN EXPERT TO EXPLAIN WHY I THINK, FEEL, OR ACT THE WAY I DO	1	2	3	4	5
TO TALK TO SOMEONE SO I CAN GET BENEATH THE SURFACE AND UNDERSTAND MY PROBLEMS WHICH I FEEL ARE MAINLY RELATED TO MY PAST OR CHILDHOOD.	1	2	3	4	5
I DO NOT WANT HELP FROM THE CLINIC	1	2	3	4	5
WHAT OTHER REQUESTS DO YOU HAVE?					

WE ARE INTERESTED IN LEARNING WHAT HELP YOU THOUGHT THIS PATIENT WANTED FROM THE CLINIC AT THIS TIME. WE HAVE LISTED 14 STATEMENTS WHICH ARE REQUESTS THAT PEOPLE OFTEN MAKE OF THIS CLINIC. FOR EACH STATEMENT OR REQUEST PLEASE CIRCLE THE NUMBER WHICH BEST INDICATES HOW MUCH YOU THINK THE PATIENT WANTS THE CLINIC TO HELP WITH EACH REQUEST NOW. FOR SIMPLIFICATION MALE PRONOUNS HAVE BEEN USED, PLEASE SUBSTITUTE FEMALE PRONOUNS FOR FEMALE PATIENTS.

HOW MUCH DOES THE PATIENT WANT THE CLINIC TO HELP WITH EACH REQUEST LISTED BELOW?	DEGREE OF HELP WANTED				
	NOT AT ALL	SLIGHTLY	SOMEWHAT	STRONGLY	THIS IS EXACTLY WHAT I WANT
TO GET HELP TO PUT THINGS INTO PERSPECTIVE - TO CLARIFY THINGS	1	2	3	4	5
TO GET SOMEONE TO HELP HIM WITH HIS PROBLEMS WITH THE LAW, SOCIAL SERVICE AGENCIES, SCHOOL, OR OTHER AGENCY	1	2	3	4	5
TO GET HELP IN CONTROLLING HIS FEELINGS AND/ OR WHAT HE WISHES TO DO	1	2	3	4	5
TO HAVE A PLACE WHERE HE CAN DISCUSS THINGS OF WHICH HE FEELS ASHAMED AND GUILTY AND CAN TELL NO-ONE ELSE	1	2	3	4	5
TO HELP HIM KNOW WHETHER OR NOT HE IS HAVING A NERVOUS BREAKDOWN	1	2	3	4	5
TO GAIN SOME UNDERSTANDING AND SOME CARE FROM SOMEONE	1	2	3	4	5
TO HAVE A PLACE WHERE HE CAN GET IT ALL OFF HIS CHEST	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	SOMEWHAT	STRONGLY	THIS IS EXACTLY WHAT I WANT
TO GET ADVICE ON WHAT HE SHOULD DO	1	2	3	4	5
TO GET MEDICATION, TRANQUILIZERS OR NERVE PILLS	1	2	3	4	5
TO GET SOMEONE TO HELP HIM WITH A PARTICULAR PERSON (WIFE, HUSBAND, BOSS, FRIEND, PARENT, ETC)	1	2	3	4	5
TO FIND OUT WHERE HE CAN GET THE HELP HE NEEDS— IF WE CAN'T PROVIDE IT, WE CAN DIRECT HIM	1	2	3	4	5
TO GET AN EXPERT TO EXPLAIN WHY HE THINKS, FEELS, OR ACTS THE WAY HE DOES	1	2	3	4	5
TO TALK TO SOMEONE SO HE CAN GET BENEATH THE SURFACE AND UNDERSTAND HIS PROBLEMS WHICH HE FEELS ARE MAINLY RELATED TO HIS PAST OR CHILDHOOD	1	2	3	4	5
HE DOES NOT WANT HELP FROM THE CLINIC	1	2	3	4	5
WHAT OTHER REQUESTS DO YOU THINK THE PATIENT MAY HAVE HAD?					

Follow up recommended OP _____ Referred to _____

IP _____

Appendix IV

Procedure for receptionists

A PATIENT REQUEST FORM OR YELLOW SLIP MUST BE COMPLETED FOR ALL NEW PATIENTS OR REASSESSMENTS.

If the patient is - Under 16 years of age
- Acute or
- Has been seen by the clinic in the previous 3 months

tick "INELIGIBLE" on the yellow slip, fill in the patients name, and place the slip in the box.

After the patient has given preliminary identification information approach him to give the patient request form and say:-

"This form is for research being conducted by Massey University. They are interested in what help you want from the clinic at this time. It would be appreciated if you would complete it. All information obtained will remain completely confidential to the researcher. As well he will need to look at the information you have just given on your Patient Identification Form. Again your help would be greatly appreciated and the form will only take a short time to complete. Would you mind filling it out and returning it to me ?"

If the patient refuses, tick "REFUSED" on the yellow slip, fill in the patient 's name and place the slip in the box.

If the patient is unable to complete the form either due to not being able to give identification information, being too upset, unable to read, or not being able to understand what is required etc. tick "UNABLE" on the yellow slip, fill in the

Appendix IV

patient's name and place the slip in the box.

When a patient returns the Patient Request Form to you; check that the name is entered, and all items have been answered. If an item has been missed point this out to the patient and ask if an answer could be indicated.

When the form is returned place it in the box.

Patients can be helped to understand what is required with the forms, but please do not influence the patient's responses in anyway.

The blank Patient Request Form (Psychiatrist Version). This is the blue form and should be placed in the patient's file, if the patient completed a Patient Request Form, so that the psychiatrist will receive it with the patient's file. All completed forms should go in the box.

Appendix V

Three-way ANOVA

(a) A = Psychiatrists (4) B = Raters (2) C = Requests (14)
S = Subjects

Source	df	MS	F	P
Between Subjects				
A	3	4.0217	0.5956	.6239
A/S	71	6.7521		
Within Subjects				
B	1	7.7998	1.7219	.1907
BA	3	16.5145	3.6458	.0164
BxS	71	4.5297		
C	13	35.8619	26.4518	.0000
CA	39	2.6794	1.9763	.0006
CxS	923	1.3557		
BC	13	4.0273	4.4045	.0000
BCA	39	1.1454	1.2527	.1405
BCxS	923	0.9143		

Appendix VI

(b) Two-way ANOVA for psychiatrists ratings only

A = psychiatrist B = requests S = subjects

Source	df	MS	F	P
Between Subjects				
A	3	13.4006	5.3607	.0026
A/S	71	2.4998		
Within Subjects				
B	13	17.5351	22.5721	.0000
BA	39	1.7276	2.2239	.0001
BxS	923	0.7768		

Appendix VII

Means of Psychiatrists ratings by requests

Requests Categories	Psychiatrists			
	A	B	C	D
Clarification	3.77	2.55	3.33	3.44
Administrative	1.77	1.73	2.11	1.33
Control	3.49	2.82	3.67	3.56
Confession	2.69	2.36	3.00	2.78
Reality Contact	3.26	2.27	2.33	2.44
Succorance	3.14	2.55	2.78	2.89
Ventilation	2.91	2.32	2.67	2.78
Advice	3.66	2.77	3.33	2.67
Medical	1.91	1.73	1.44	2.33
Social Intervention	2.89	2.41	1.44	2.56
Community Triage	2.89	2.18	2.56	1.67
Psychological Expertise	3.54	2.00	3.33	2.67
Psychodynamic Insight	3.00	2.23	2.33	2.33
Nothing	1.29	1.14	1.67	1.78

$$CR\ Dunn = d\,(c,\ df_{S/A})\ \sqrt{\frac{2(MS_{S/A})}{\tilde{S}}} = 0.9973$$

Total means of psychiatrists' ratings

Psychiatrist	A	B	C	D
Mean	2.8673	2.2175	2.5714	2.5159

Appendix VIII

Factor Analysis : Varimax Rotated Factor Matrix

(values under 0.3 were not included)

Request	Factor 1	Factor 2	Factor 3	Factor 4
Clarification	-	.71	-	-
Administrative	.36	-	.38	-
Control	-	.56	.43	-
Confession	.66	-	.35	-
Reality contact	.42	-	.31	.61
Succorance	.77	-	-	-
Ventilation	.71	-	-	-
Advice	-	.72	-	.41
Medical	.33	-	-	-
Social intervention	.38	.51	-	-
Community triage	-	-	-	.46
Psychological expertise	-	-	.60	-
Psychodynamic insight	-	-	.82	-
Nothing	-	-	-	.31
Percentage of variance accounted for by the Factor	60.8	18.0	11.5	9.7

NAME

YOUR ANSWERS TO THE FOLLOWING QUESTIONS WILL BE USED TO STUDY PATIENTS' SATISFACTION WITH THE CLINICS SERVICE. THEY ARE CONFIDENTIAL AND WILL NOT BE SEEN BY YOUR CLINICIAN OR ANYBODY ELSE WHO IS RELATED TO YOUR CURRENT TREATMENT. FOR EACH STATEMENT TICK THE BOX WHICH BEST INDICATES YOUR OPINION. PLEASE ANSWER THE QUESTIONS AS HONESTLY AS POSSIBLE.

ARE YOU SATISFIED WITH YOUR TALK WITH THE CLINICIAN TODAY?	VERY DISSATISFIED	DISSATISFIED	SOMEWHAT DISSATISFIED	SOMEWHAT SATISFIED	SATISFIED	VERY SATISFIED

COMPARED TO HOW YOU FELT WHEN YOU CAME IN TODAY, HOW ARE YOU FEELING NOW?	MUCH WORSE	WORSE	SOMEWHAT WORSE	SOMEWHAT BETTER	BETTER	MUCH BETTER

TO WHAT EXTENT DO YOU FEEL THAT YOU WERE HELPED TODAY?	NOT AT ALL 1	2	3	4	VERY MUCH 5

TO WHAT EXTENT DID YOU FEEL THE CLINICIAN UNDERSTOOD THE KIND OF HELP YOU WANTED FROM HIM/HER?	NOT AT ALL 1	2	3	4	VERY WELL 5