Improving Therapeutic Communication in a Psychiatric Mental Health Clinic

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Improving Therapeutic Communication

Abstract

Title: Improving Therapeutic Communication in a Psychiatric Mental Health Outpatient Clinic.

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Purpose: The purpose of this project is to demonstrate the benefits of therapeutic communication in a mental health clinic with an outcome to increase patient satisfaction of their care and improve patient-caregiver communication and relationship.

Background: The consequences of poor communication or non-therapeutic communication cannot be overemphasized; these can include non-adherence to treatment plan, reduced treatment compliance, higher psychological morbidity, dissatisfaction with care and poor patient-caregiver relationship. Patients' perception of how they are being treated affects how they respond to treatment plans and medication regimens

Method: The project consisted of providing education on the principles of therapeutic communication to healthcare workers in an outpatient psychiatric clinic. Follow up materials on therapeutic communication principles were provided on a weekly basis for one month. A pre-survey questionnaire was given to patients before intervention and a post-survey questionnaire after intervention to determine patient satisfaction with care and degree of communication with healthcare workers**.** The Short Assessment of Patient Satisfaction (SAPS) and the Communication Assessment Tool-Team (CAT-T) were the instruments utilized in this project.

Finding: Patient satisfaction and communication with staff were statistically and significantly improved after education on therapeutic communication was given to staff.

Conclusion: Education on therapeutic communication is an effective intervention tool in improving patient's satisfaction and communication with staff and health care team members in a psychiatric outpatient clinic.

Keywords: *therapeutic communication, non-therapeutic communication, patient satisfaction, poor communication, principles of therapeutic communication, patient-caregiver relationship*

Improving Therapeutic Communication in a Psychiatric Mental Health Clinic

Effective communication and strong therapeutic relationships are critical to successful mental health interventions (Doyle & Doherty, 2013). The purpose of this project was to implement the principles of therapeutic communication (TC) in a mental health agency with an outcome to improve patient satisfaction with care, and improve caregiver-patient relationship through education provided to providers and healthcare workers.

Background and Significance

Communication in the field of mental health nursing is one of the most vital tools that could be utilized to promote positive patient outcomes. A study conducted by Bhui et al. (2013) established that black and minority ethnic groups who are receiving mental health specialist care were more likely to be detained under the Mental Health Act, experience less use of effective therapies and are more likely to be dissatisfied with their care. The researchers concluded that the disengagement from services and poor satisfaction was as a result of lack of Therapeutic Communication (TC). It is therefore imperative that for clients to receive premium care in the mental health unit, caregivers must understand the rudiments involved in effective TC. According to Thompson and McCabe (2012), TC is the foundational tool that establishes the platform that promotes patient-caregiver relationship and creates a therapeutic alliance (TA) that may determine the success of treatment. Patients' perceptions of how they are being treated by caregivers may also affect how they respond to treatment plans and medication regimens. Haron and Tran (2007), conducted a study in a mental health hospital in Israel that amongst other things considered important to patient, mental health clients desired to be respected by staff and not be treated like just another psychiatric case.

Misdrahi, Verdoux, Lancon and Bayle (2009), stated that the style of communication adopted by clinicians was also a determining factor in patient's adherence to the treatment plan. One of the greatest challenges in treating a mentally ill patient is the high rate of probability of non-adherence. Approximately 50% of patients who suffer from diverse chronic diseases do not take their medication as prescribed (Ahmed, Gandhi & Baruah, 2015). In their research, Ahmed et al. (2015) suggested that the use of TC as an intervention may be used to better the outcome of treatment for mental illness. The conscious use and application of TC is a specific intervention that can improve adherence. When patients are not compliant with the treatment plan, the overall negative outcome could be overwhelming. The consequences of poor communication or non-therapeutic communication (NTC) cannot be overemphasized; these are seen with far reaching costs including non-adherence to treatment plan, reduced treatment compliance, higher psychological morbidity, incorrect or delayed diagnosis, patient's dissatisfaction with care and increased complaints (Jack et al., 2013).

According to Olfson et al. (2009), about one-fifth of adults in mental health treatment dropped out before completing the recommended course of treatment, with 70% dropping out after the first and second visits. This is an important statistic to consider as the foundation for TC and therapeutic relationships can be laid in those early visits made by patients. In a randomized control trial (RCT), Zarea, Maghsoudi, Dashtebozorgi, Hghighizadeh and Javadi (2014) investigated the impact of Peplau's Therapeutic Communication Model in patients suffering from anxiety and depression. The Hospital Anxiety and Depression Scale (HADS) was used to assess depression and anxiety before, and two and four months after the intervention. After seven therapeutic communication sessions were held with the intervention group, the analyzed results showed the mean anxiety and depression levels were lower in the intervention group after the TC

sessions were completed ($p<0.01$). Through education, providers and other caregivers can learn the principles of TC and when applied can improve adherence to treatment plan. Cooper, Martins and Wanda (2013) felt that part of the problem with lack of use of TC may be due to inadequate training and preparation.

Patient Satisfaction and Improved Caregiver-Patient Relationship

Zendjidjian et al. (2014) found that amongst other determinants, stronger patient satisfaction was firmly established when therapeutic alliance (TA) and TC were ingrained into the day to day patient care routine. The authors concluded that therapeutic relationship (TR) was the most important feature associated with a patient's satisfaction and it is viewed as an important indicator of the quality of care received in a psychiatric setting. Using the Rome Opinion Questionnaire (ROQ), Paludetto, Camuccio, Cutrone, and Baldo (2015), acknowledged that the satisfaction gained by patients during care should be routinely measured through the use of short questionnaires.

The relationship of nurses and patients in a psychiatric inpatient unit was investigated by Seed, Torkelson, and Alnatour (2010). The study revealed that nurses spent only 2.18 minutes per shift educating patients on symptoms and almost two hours completing paper work. Due to lack of quality and therapeutic time spent with patients, nurses were less satisfied with their jobs.

Internal Evidence and Problem Statement

The identified problem is ineffective and non-therapeutic communication, patient dissatisfaction with care, non-adherence and non-compliance with care and incidences of multiple missed appointments in an outpatient psychiatric clinic. Verbal interviews with some patients revealed that they (patient) felt "insulted" or treated with "less respect" in the course of their engagement in care with healthcare team. Some health care workers felt "sometimes a few

patients could be very difficult to deal with". The resultant effect of this frosty relationship between health care team and patients culminated in some patients refusing to show up for appointments, opting out of therapeutic programs and activities, noncompliant with medication regimen and in some instances requesting "to be changed to another facility". It is therefore important that the principles of TC should be one of the core educational cornerstones for mental health caregivers so as to improve patient outcomes, improve communication between patient and staff and increase patient-caregiver satisfaction. With the prevailing issue of lack of TC in this particular mental health facility, this investigation has led to the relevant PICOT question: "In a mental health care team working in an outpatient psychiatric clinic, how does education on therapeutic communication compared to no education, affect patient satisfaction with treatment plans and affect communication with healthcare team over a 3 month period"?

Search Strategy

In order to answer the aforementioned PICOT question, an extensive search of literature was conducted within the following electronic databases: PubMed, Psychiatry Online, OvidMD, Ovid Medline, Psych INFO, CINAHL and Cochrane. Key words used included; therapeutic communication, patient satisfaction, seclusion and restraints, adherence and compliance, patient outcomes, mental health and psychiatry, disruptive behavior management, poor communication, non-therapeutic communication, patient dissatisfaction. The combination of "therapeutic communication and mental health" yielded the most results.

In the Cochrane library database there were 22 trial results showing "therapeutic communication" and 6823 results using the same combination for Psych Online. PubMed provided 2828 results when "therapeutic communication and adherence" were combined. Ovid provided just one result when "therapeutic communication and restraints" were combined. A

combination of therapeutic communication, patient satisfaction and mental health on CINAHL produced 91 results. The articles selected in total was 10

Critical Appraisal and Synthesis

The level of evidence ranged from one to five, indicating strong to moderate strength of the evidence. A few of the articles had instruments to measure patient satisfaction, staff satisfaction, patient's perception of provider's knowledge in TC amongst other important research markers. The studies were mainly descriptive with samples of narrowly defined populations to illustrate the important relationship between TC and positive patient outcomes. The level of statistical significance was high for a majority of the studies with a p value set at <0.005. Intervention methods ranging from education on TC, cultural influence on communication, self-assessment of TC knowledge and patient education on treatment options were used in the studies. All the studies agreed that TC was an integral part of psychiatry and nursing in general.

All of the studies included physicians, nurses and patients, while eight out of ten included social workers and therapists. There was homogeneity in all of the studies reviewed, with TC as an intervention and an integral part of patient care. Two of the studies used instruments that were developed to specifically measure therapeutic relationships between caregiver and patients. A modified version of the instrument (N-STAR) was used in one study and included other parameters that were omitted in the original version of the instrument. One study used the Short Assessment of Patient Satisfaction (SAPS) tool while another used the Communication Assessment Tool-Team (CAT-T) tool.

A majority of the studies were conducted in the United States, one each in China, Norway and Israel. All of the subjects were psychiatric patients, with only one study done

specifically with patients suffering from depression and schizophrenia. All the articles chosen for inclusion included the subject of TC between caregivers and mental health patients. The completion rate for all participants in the studies was greater than 90%, mostly due the convenience of the sample population and the research methods. One study specifically included the use of TC in nursing schools after determining that student nurses in psychiatry rotations were not well versed in the principles and applications of TC. All the studies suggested educating caregivers to improve their relationships with patients through the use of TC. The validity of the data collected in all articles shows TC as a positive measure required in the treatment of mental health disorders. Variables of interest were males and females between the ages of 32 years to 46 years for both patients and clinicians.

Evidence Based Practice Model/Conceptual Framework

Hildegard Peplau's model of Therapeutic-Nurse Client Relationship/Interpersonal Theory was the evidence based practice model and conceptual framework that guide this project. This model is based on the conceptual framework of interpersonal relationship between caregivers and clients. It is the first significant psychiatric nursing theory that views nursing as an interpersonal and ongoing process, in which interventions and positive outcomes are the results of nurse-client relationship (Peplau, 1991). This conceptual framework divides a therapeutic nurse-client relationship into three phases: (1) introduction and orientation, (2) Working, identification and exploitation and (3) Termination and resolution phase (Keltner, Schwecke & Bostrom, 2007).

The first psychiatric interview of a client by the provider is considered very important, the introduction and orientation phase should be used meticulously to create a trusting environment that will be viewed as therapeutic by the client. The working, identification, and

exploitation phase allows the caregiver to clarify client expectations, implement treatment plans, involve the client in decision making processes and evaluate outcomes of care. In the termination phase, the progress made by clients will be reviewed while therapeutically disengaging from relationships that were earlier established. The implementation of these concepts will help build a therapeutic nurse-client relation that is fueled by TC.

Application of Evidence to Practice

The agency for Healthcare Research and Quality (AHRQ) Model of Knowledge Transfer was used as the cornerstone for the application of evidence. The Steps of knowledge transfer in the AHRQ model is divided into three groups: (1) knowledge creation and distillation, (2) diffusion and dissemination, and (3) organizational adoption and implementation (Hughes, 2008). Knowledge creation and distillation is undertaking research with hopes that the findings will be relevant with enough evidence for use in practice. Diffusion and dissemination involves working with professional opinion leaders and health care organizations to disseminate knowledge that can form the basis of action (e.g., facilitating the application of therapeutic communication principles in an inpatient psychiatric unit). End user adoption, implementation, and institutionalization are the last step of the knowledge transfer process.

In this project, knowledge creation involved gathering information on the usefulness of TC and how its application will improve patient satisfaction and improve patient-health care worker relationship. This knowledge will be diffused and disseminated to providers, managers and other healthcare professionals to enhance the proposed change. The last step will involve bringing organizations, teams, and individuals to adopt, implement and use the evidence-based research findings and innovations in everyday practice. At the end of the project, stage three

should be fully implemented to bring about the desired change in the clinical site and improvement in patient-caregiver relationship.

Conclusions about Evidence

It is evident that TC is an important aspect of patient care in psychiatry. Evidence from the studies shows a correlation amongst patient satisfaction, adherence, reduced use of seclusion and restraints, nurses' job satisfaction and improved communication between staff and patients. When there is therapeutic alliance, communication is much improved and care is patient centered making recovery and wellness possible due to the likelihood of patients completing their treatments. If TC is practiced, an alliance can be built between caregiver and patient that will foster a stronger relationship, build trust and promote patient-centered care. Since the goal of every provider is to see the improvement in health status of their patients, TC provides one of the most viable tools to establish a good rapport, build a therapeutic relationship and gain the trust of their patients

Project Method

Design

A quasi-experimental pre and post- test design using quantitative methods was used to conduct this EBP project. A convenience sample was used as a sampling method for healthcare members and patients participating in the study.

Recruitment and Participants

The administrator was approached by DNP student and project explained in detail. Flyers advertising the project were printed and distributed to staff with a set date for the intervention to be delivered. Potential participants (patients) were identified at the clinic site during daily morning meetings held by staff and during appointment hours. The participants were given the

consent document at the time if interested in participating in the study. In addition, patients were recruited to fill out a patient satisfaction survey and also patient's perception of provider/ healthcare worker understanding of effective communication.

The recruitment was based on the following inclusion and exclusion criteria. Inclusion criteria recommended for the training included the following: participants must be providers, nurses, social workers, case managers, counselors, therapists, front desk or any staff that comes in direct contact with patients working in the psychiatric/mental environment who speak English. The inclusion criteria for patients participating in the project were: patients had to be 18 years or older, patients that are able to read the consent form and questionnaires and those who were receiving psychiatric treatment at the facility. The exclusion criteria included participants suffering from Neuro-cognitive deficits and those that may not be able to sit for a period of up to 1hr. None of the recruits fell into this category and no one who consented to partake in this project was excluded.

Practice Site/Setting

This practice setting was an outpatient clinic that offers psychiatric services, case management, free transportation, interpreter services and health & wellness groups facilitated mostly by clinic registered nurses. The facility seeks to view its relationship with patients as a partnership. The facility is associated with the Maricopa Crisis Response Center for emergency cases, where immediate help can be rendered to patient in danger of causing harm to themselves or others. There are psychiatrists and nurse practitioners who serve as providers at this site. Support staff includes case managers, social workers, nurses, therapists, activities director and coordinators.

The facility offers therapies such as cognitive behavioral therapy (CBT), trauma therapy, dialectical behavioral therapy (DBT), individual therapy, group therapy and nutritional therapy.

Intervention/Procedure

Education on the principles of therapeutic communication was provided to the Healthcare Team Members (HcTMs) for an hour with follow up materials termed "nuggets" provided weekly for a month to update learning and maintain communication therapeutic skills. HcTMs were reminded of the original lecture and advised that "nuggets" was a follow-up on the learning process. Team meetings in the mornings were ideal to distribute "nuggets" with a brief summary provided. HcTMs were also located on individual basis and handed the "nuggets" followed by a brief explanation of the targeted section of the original lecture for clarity.

Organizational Culture

The organizations' culture is hierarchal and the organization is well structured and maintains a focus on efficiency, stability and promotes innovation and evidence based programs. The organization encouraged the project and provided a letter of support from the chief medical officer. Together with staff support, logistics and other resources were provided to assist with project design and subsequent implementation.

Outcome Measures and Instruments

The outcomes measured in this project was patient satisfaction with care and patient's perception of provider/ healthcare worker understanding of effective communication after completion of the educational intervention on therapeutic communication. The Short Assessment of Patient Satisfaction (SAPS) was the instrument that was used to measure patient satisfaction outcomes. It is a brief, valid and reliable instrument that can be used to assess patient satisfaction with their treatment. The SAPS is a the product of scientific evaluation of a lists of patients

satisfaction surveys with only seven items eventually considered as having the best measurement properties and the most comprehensive coverage of the domains of patient satisfaction. Reliability is Cronbach's alpha $\alpha = 0.85$; it correlates highly with other measures of patient satisfaction, and correlates well with other indicators of treatment outcomes (Hawthorne, Sansoni, Hayes, Marosszeky & Sansoni, 2014). The validity and reliability were tested by Hawthorne et al., (2014) in a hospital project sponsored by the Australian government. The domains of patient satisfaction covered by SAPS include: treatment satisfaction, explanation of treatment results, clinician care, participation in medical decision-making, respect by the clinician, time with the clinician, and satisfaction with hospital/clinic care on a 5-point response scale. SAPS scale has answers ranging from 0 to 4. Very dissatisfied, strongly disagree, none of the time =0, Dissatisfied, some of the time=1, neither satisfied nor dissatisfied, about half the time, not sure, neither satisfied nor satisfied=2, satisfied, agree, most of the time=3, very satisfied, strongly agree, all of the time=4.

Patient perception of communication with the HcTMs was measured using an adaptation of the Communication Assessment Tool (CAT), which is a previously validated instrument that was made to assess communication across different specialties especially physicians (See Appendix B). The CAT was adapted to include questions specific to the communication of physicians otherwise all questions in the original CAT and CAT-T remained the same. It contains 15 items on a 5-point response scale that evaluates the quality of communication (1 = "poor," 5 = "excellent") between patient and HcTMs, with a Communication Assessment Tool Cronbach's alpha score of 0.98 (Mercer et al., 2008).

Data Collection

The project was approved by the Arizona State University Institutional Review Board (IRB). After IRB approval, data collection began and data collection spanned over five weeks, with actual collection done intermittently at least 2-3 times per week. Patients were met at the outpatient psychiatric clinic and tool administered by Co-PI. A consent form and project overview was given to would be participant. The pretest and posttest questionnaires consist of 7 questions from SAPS and 15 questions from CAT-T (a total of 22 questions) and administration time was approximately 10 minutes per patient.

Data Analysis

Data analysis was conducted using SPSS® Version 23. The SPSS® version 23 statistical package was used to analyze the data. Descriptive statistics were used to describe the sample and outcome variables. The independent t-test was used to compare the mean scores of the SAP and CAT-T of two independent groups (Cronk, 2014)**.** The critical value was set at $p<0.05$.

Results

Patients (n=61) attending an outpatient psychiatric clinic completed the project; with 32 participants completing the pretest and 29 different patients completed the posttest. In the pretest, 23 (72%) participants were female, 9 (28%) were male whereas in the posttest, 15 (52%) were male while 14 (48%) were female. The education of the patients completing the pretest and posttest were similar. In the pretest, people with less than a high school education were 4 (6.3%), 15 (25%) had some college, 13 (21.9%) had college degrees and 29 (46.9%) had high school diplomas. In the posttest, 23 people (37.9%) had high school diplomas, 21 (34.5%) had some college,, 8 (13.8%) had college degrees and 8 (13.8%) had less than high school diplomas. Lastly, the majority of the patients were Caucasians, followed by African American, Hispanics and Asians in both pretest and posttest. (See Figures 1-3 in Appendix C).

An independent t-test comparing the mean scores of the pre and post- test groups on the outcome variables. The mean score of the two groups on the SAPS ($t(59) = -4.987$, $p < 0.001$) was significantly different. The mean score of the two groups on the CAT_T scores of two different groups were, also significantly different ($t(59) = -2.31$, $p = 0.02$). The average patient satisfaction score was significantly different in the two groups. The mean of the post-test group ($M=3.43$, $SD=0.43$) was significantly higher than the pre-test group ($M = 2.7$, $SD=0.67$). The average communication score was significantly different in the two groups. The mean of post-test group ($M =4.19$, $SD= 0.72$) was significantly higher than the pre-test group ($M==3.7$, $SD=0.94$). Levene's test give values $p_{saps}=0.065>0.05$, and $p_{cat\text{-}t}$ $p=0.142>0.05$ for the SAPS and CAT-T, respectively. Therefore; there are equal variances so the results are significant for both outcome variables (See Tables 1& 2 in Appendix D).

Discussion

In comparing the results to the evidence, it shows that therapeutic communication is a very useful technique in improving patient outcomes in psychiatric settings. Different authors all agree that effective communication is a necessary tool that promotes patient outcomes. According to Benedetti, 2011, "communication by clinicians has the power to turn diagnoses and prognoses into parts of the treatment, to influence treatment effectiveness, and to modulate the way in which patients cope with their conditions" (Benedetti 2011;

Strengths and Limitations

Random sampling of patient participants and ease of administration of the instruments are major strengths. The small sample size of participants is one weakness. More so by not providing the intervention group with the same pretest and posttest survey, one is not able to measure a

self-administered satisfaction scale and level of communication of the HcTMs. Conclusively, this project can be easily replicated.

Recommendation

As seen from the demographic data, there is a significant difference between percentage of males in pre and post samples. This could mean the difference in answers between males and females in SAPS and CAT-T posttest and pretest questionnaires may depend on gender of patients. Further research of this potential threat of results should be investigated. There was no cost incurred in this project and its application in similar setting may be of benefits to patients and HcTMs.

Conclusions

The significance of this project is the recognition of the role of therapeutic communication in a psychiatric outpatient clinic. With overwhelming evidence supporting the influence of HcTMs communication pattern on patient outcomes, education on the principles of therapeutic communication will provide a foundation upon which patient-HcTMs relationship can be built. A major outcome of this project is adoption of the lecture materials used during intervention by the administration of this facility as part of its continuing education program. The relevance of patient outcomes may be seen in reduced cancellations of appointments at the clinic, reduced dissatisfaction rate with care and improved compliance. In healthcare delivery in general, because patient satisfaction is improved, facility rating will also improve and this will positively affect funding.

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Appendix A

The Short Assessment of Patient Satisfaction (SAPS)

(Please mark an "X" where applicable)

DEMOGRAPHICS:

AGE_____

GENDER: MALE____ FEMALE____

EDUCATION: Less than high school_____ High school_____ some college_____, College degree_____ Graduate Degree_____

Ethnicity: Caucasian_____, African American/Black_____, Asian_____, Hispanic _____Pacific Islander_____, Other_____

Instructions: After reading each question, circle the answer that best describes you. The order of the answers varies between the questions, so take a moment to read each question carefully.
We know that sometimes answers may not describe you exactly, so please pick the answer that *most closely describes you*.
When you have finished, please check that you have answered all questions.

1. How satisfied are you with the effect of your {treatment/care}?

___ *Very dissatisfied =0*

___ *Dissatisfied=1*

___ *Neither satisfied nor dissatisfied=2*

___ *Satisfied=3*

___ *Very satisfied=4*

2. How satisfied are you with the explanations the {doctor/other health professional} has given you about the results of your {treatment/care}?

____*Very dissatisfied=0*

____*Dissatisfied=1*

____*Neither satisfied nor dissatisfied=2*

____*Satisfied=3*

____*Very satisfied=4*

The Short Assessment of Patient Satisfaction (SAPS)

Instructions: After reading each question, circle the answer that best describes you. The order of the answers varies between the questions, so take a moment to read each question carefully.
We know that sometimes answers may not describe you exactly, so please pick the answer that *most closely describes you*.
When you have finished, please check that you have answered all questions.

3. The {doctor/other health professional} was very careful to check everything when examining you.

____*Strongly disagree=0*

____*Disagree=1*

____*Not sure=2*

____*Agree=3*

____*Strongly agree=4*

4. How satisfied were you with the choices you had in decisions affecting your health care?

____*Very dissatisfied=0*

____*Dissatisfied=1*

____*Neither satisfied nor dissatisfied=2*

____*Satisfied=3*

____*Very satisfied=4*

5. How much of the time did you feel respected by the {doctor/other health professional}?

____ *None of the time=0*

____ *Some of the time=1*

____ *About half the time=2*

____ *Most of the time=3*

____ *All of the time=4*

The Short Assessment of Patient Satisfaction (SAPS)

Instructions: After reading each question, circle the answer that best describes you.
The order of the answers varies between the questions, so take a moment to read each question carefully.
We know that sometimes answers may not describe you exactly, so please pick the answer that *most closely describes you*.
When you have finished, please check that you have answered all questions.

6. The time you had with the {doctor/other health professional} was too short.

____ *Strongly disagree=0*

____*Disagree=1*

____*Not sure 2*

____ *Agree=3*

____*Strongly agree=4*

7. Are you satisfied with the care you received in the {hospital/clinic}?

____*Very dissatisfied=0*

____*Dissatisfied=1*

____*Neither satisfied nor dissatisfied=2*

____*Satisfied=3*

____ *Very satisfied=4*

Appendix B

COMMUNICATION ASSESSMENT TOOL -TEAM (CAT-T)

Communication with patients is a very important part of quality medical care. We would like to know how you feel about the way your medical team communicated with you. Your answers are completely confidential, so please be as open and honest as you can. Thank you very much.

Please use this scale to rate communication during this visit. *Circle* your answer for each item below.

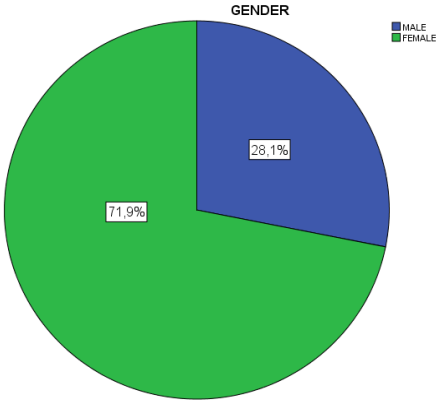
The medical team:	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
1. Greeted me in a way that made me feel comfortable	1	2	3	4	5
2. Treated me with respect	1	2	3	4	5
3. Showed interest in my ideas about my health	1	2	3	4	5
4. Understood my main health concerns	1	2	3	4	5
5. Paid attention to me (looked at me, listened carefully)	1	2	3	4	5
6. Let me talk without interruptions	1	2	3	4	5
7. Gave me as much information as I wanted.	1	2	3	4	5
8. Talked in terms I could understand	1	2	3	4	5
9. Checked to be sure I understood everything	1	2	3	4	5
10. Encouraged me to ask questions	1	2	3	4	5
11. Involved me in decisions as much as I wanted	1	2	3	4	5
12. Discussed next steps, including any follow-up plans	1	2	3	4	5
13. Showed care and concern	1	2	3	4	5
14. Spent the right amount of time with me	1	2	3	4	5
The front-desk staff	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**

The medical team:	**Poor**	**Fair**	**Good**	**Very Good**	**Excellent**
15. Treated me with respect	1	2	3	4	5

Appendix C

Appendix C

Figure 1 *Gender distribution in pre and post test*



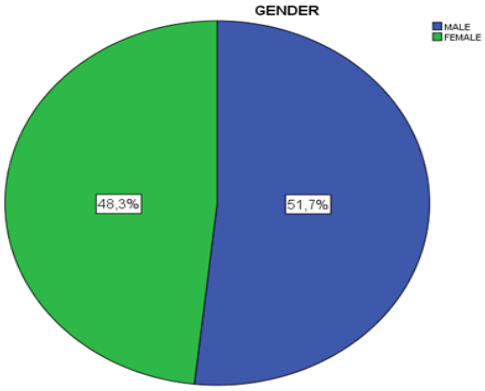
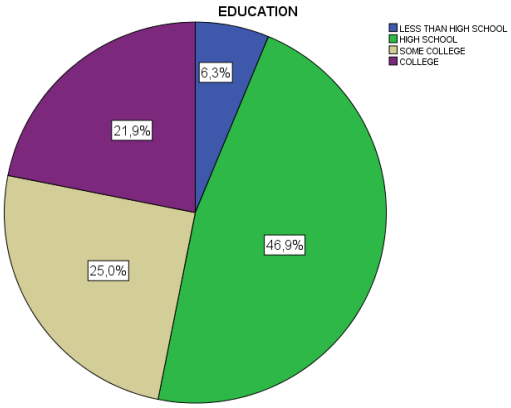


Figure 2
Education distributions in Pre and Post test



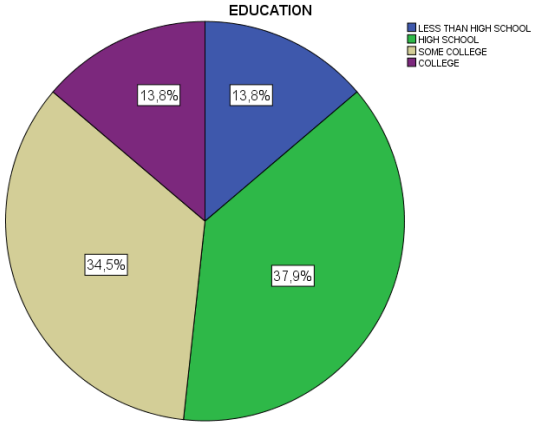
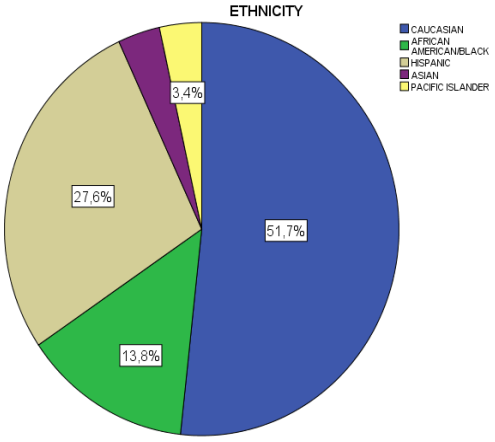
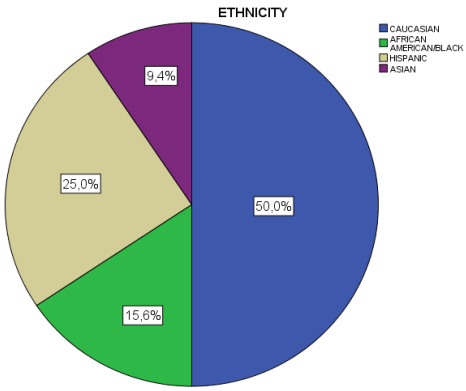


Figure 3
Ethnicity distribution in pre and post test





Appendix D

Table 1

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
SAPS2	Equal variances assumed	3.530	.065	-4.987	59	.000	-.72791	.146	-1.020	-.436
	Equal variances not assumed			-5.090	53.606	.000	-.72791	.143	-1.015	-.441
CAT-T	Equal variances assumed	2.216	.142	-2.310	59	.024	-.49914	.216	-.931	-.067
	Equal variances not assumed			-2.341	57.333	.023	-.49914	.213	-.926	-.072

Table 2

Group Statistics

	TESTSTAGE	N	Mean	Std. Deviation	Range (min, max)
SAPS	PreTest	32	2.7031	.66899	1.43
	PostTest	29	3.4310	.43305	3.57
CAT-T	PreTest	32	3.6917	.94231	2.29
	PostTest	29	4.1908	.71641	4.00