Regular Article

Consultation frequency and perceived consultation time in a Japanese psychiatric clinic: Their relationship with patient consultation satisfaction and depression and anxiety

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Aim: To examine the relationship of the consultation frequency and the perceived consultation time of psychiatric clinic attenders with their satisfaction towards the consultation and depression and anxiety (measured by the Hospital Anxiety and Depression Scale).

Methods: Questionnaires were distributed to 186 outpatients attending a psychiatric clinic.

Results: In a path analytic model, a longer session with shorter interval ('dense' session) predicted lowered depression and anxiety level of the patients through the perceived satisfaction of the patients, and it was also predicted by the higher anxiety level. The dense session was also influenced by shorter duration of clinic attendance.

Conclusion: Dense psychiatric sessions in busy Japanese outpatient clinics may benefit patients.

Key words: anxiety, depression, patient satisfaction, psychiatric consultation, psychotherapy.

DESPITE NUMEROUS EMPIRIC studies on the effectiveness of different psychotherapy methods in mental disorders, few studies have investigated whether everyday clinical practices in busy psychiatric clinics have therapeutic effects upon the patients' psychiatric symptoms. This is a desperately needed area of research because busy psychiatric clinics rarely practice a structured psychotherapy with a specified methodology. Most clinicians in busy clinics use eclectic methods, which are tailored to each patient. Vigorously designed research is difficult due to the heavy caseloads of the psychiatric sessions.

The frequency of patient attendance and the time spent in a session vary from patient to patient and from practitioner to practitioner. Factors that determine the frequency and the length per session may include practitioner workload, patient psychopathology, and patient session objectives. Some patients are busy and wish to have longer intervals between sessions, whereas others are anxious and desire more frequent sessions. There are also differences regarding the time spent in a single session. Many psychiatrists working for outpatient clinics do not have fixed appointment times. Consequently, they may have shorter sessions with patients with fewer needs and may have longer sessions with patients with more needs.

Regardless of the reason, longer sessions with shorter intervals may induce a higher patient satisfaction that he/she is heard. Being heard may elicit a sense of satisfaction and acceptance by the practitioner and may create a good relationship between the patients and the practitioner. Japanese clinics are often caricaturized as 'an hour waiting for a 3-minute consultation'. Sufficiently long consultation sessions are the basis of better physician–patient communication.

Herein, the findings from a questionnaire study on the frequency and time spent in psychiatric sessions at busy Japanese outpatient clinics are presented. The aim is to examine whether 'dense' consultation sessions (longer sessions with shorter intervals) lead to an increase in patient satisfaction, which in turn, leads to lower level of depression and anxiety.

METHODS

Participants

Participants consisted of 258 outpatients attending a psychiatric clinic over a 2-month period. Of these 186 questionnaires were used. These 186 patients consisted of 72 men and 114 women. The mean age ± SD was 44.8 ± 13.4 years for men and 38.8 ± 13.8 years for women. Men were significantly older than women (t = 2.9, $P < 0.01$). A single psychiatrist conducted the clinical sessions. Patients visited the clinic as they desired, but typically the patients and psychiatrist agreed upon the date of the next consultation, but not the time. The duration of each consultation was not predetermined. Thus, the consultation time depended on various factors such as the extent of the waiting list, the topic the patient would like to discuss with the psychiatrist, and the aims that the psychiatrist had for the patient (e.g. detailed mental status examination, disclosure of necessary medical information etc.).

Measurement

Frequency of and perceived time spent in the current psychiatric session

Each participant was asked about the frequency of their clinic attendance on a 4-point scale: 1, two or more times a week; 2, once a week; 3, biweekly; and 4, once every several weeks. Higher scores indicate a longer span between sessions. The participant was also asked about the time (in minutes) spent during the current session. A composite variable Session Concentration Index (SCI) was created to examine the interaction of these two variables. The SCI was derived from the perceived time spent in the current session (in minutes) divided by the session frequency score (described above). A higher SCI scores indicate denser psychiatric sessions.

Patient satisfaction

The Perceived Physician's Communication Style Scale (PPCSS)[1] is a self-report, which was designed to assess a cancer patient's perceptions of his/her physician's behavior during a medical encounter. The PPCSS includes 27 items that are each rated on a 5-point Likert scale. Takayama *et al.* interpreted the PPCSS concepts as related to 'acceptance' (e.g. 'your doctor seemed to be in a hurry' a reverse item), 'patient centred' (e.g. 'your doctor really seemed to care about you and your health problems'), 'attentiveness' (e.g. 'your doctor listened to your questions attentively'), and 'facilitativeness' (e.g. 'your doctor asked whether you had any opinions').[1] There are some reverse items. The total score ranges from 0 to 96. A higher score indicates that the patient felt that there was good communication with his/her physician and that the physician was supportive. Although this scale was developed to measure a physician's communication style with a cancer patient, it seems to assess whether a patient feels that his/her physician understands and empathizes with his/her situation regardless of the diagnosis.

Depression and anxiety

The Hospital Anxiety and Depression Scale (HADS) measures the cognitive symptoms of depression and anxiety.[2] The reliability and validity of the HADS is well established.[3,4] The HADS includes 14 items, and the Depression and Anxiety subscales each include seven items on a 4-point scale ranging from 0 (no depression/anxiety) to 3 (high depression/anxiety). The total score of the Depression and Anxiety subscales can range from 0 to 21 and a higher score indicates more severe depression and anxiety, respectively. The HADS has been translated into Japanese[5] and is becoming more common.[6,7]

Treatment history

Each participant was asked about how long he/she has been seen at the clinic (in months) and the duration since onset of the disorder (in months).

Statistical analysis

After examining the psychometric properties of the consultation frequency and the time spent in the session, the correlation coefficients of the PPCSS
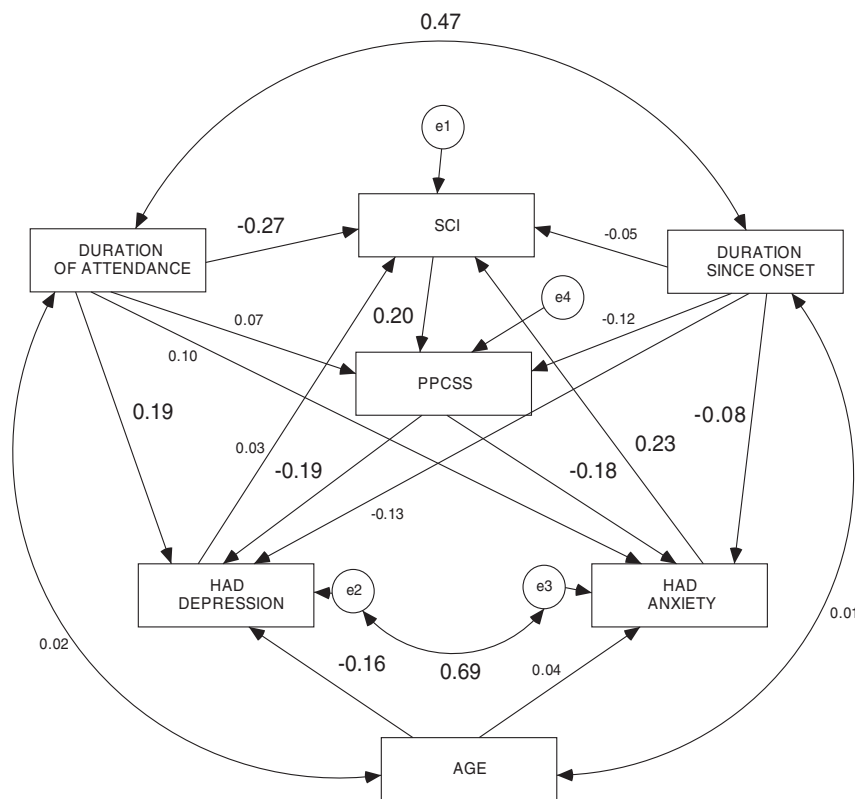
Figure 1. Path analytic model. HADS, Hospital Anxiety and Depression Scale; PPCSS, Perceived Physician's Communication Style Scale; SCI, Session Concentration Index. **Bold**, statistically significant path coefficients.

scores with (i) consultation frequency, (ii) time spent in the current session, and (iii) SCI score were calculated.

After correlating all the variables studied in this investigation, we set up the path analytic model (Fig. 1) in that both HADS Depression and Anxiety scores would be predicted by the lower PPCSS score as well as longer duration since the start of attendance and duration since onset of the disorder. In addition, it was expected that the SCI score would be predicted by the demand of psychologically unadjusted patients, while the SCI would predict the PPCSS score. Finally, we expected covariance between the treatment history variables, age, and the two HADS subscale scores. It is of note that because depression and anxiety share a fair amount of covariance in this and other studies, we intended to set covariance between HADS Depression and Anxiety scores directly. But the software package AMOS does not allow such a covariance between two endogenous variables. Therefore we set a covariance between the error variables of the HADS Depression and Anxiety scores. The fit of the model was evaluated using various fit indices. It is recognized that we should

avoid reporting all fit indices developed but have not reached a conclusion as to which indices should be used.[8] Thus we limited the goodness-of-fit indices to goodness-of-fit index (GFI), and comparative fit index (CFI). According to conventional criteria, a good fit is indicated by GFI > 0.95 and CFI > 0.97, and an acceptable fit by GFI > 0.90 and CFI > 0.95.

All the statistical analyses were performed using SPSS 14 (SPSS, Chicago, IL, USA) and AMOS 6 (XXX).

This project was approved by the Ethical Committee of Kumamoto University Graduate School of Medical Sciences.

RESULTS

Characteristics of consultation frequency and perceived consultation time

The consultation frequencies of the 186 outpatients at the clinic were as follows: three (2%) attended the clinic two or more times a week; 39 (21%) attended once a week; 89 (48%) attended biweekly; and 55 (30%) attended once every several weeks. There was

Table 1. Variables and correlations (Pearson product moment correlation coefficients)

	2	3	4	5	6	7	8	9	10	Mean	SD
[1] Age	−0.21**	−0.06	−0.15*	0.05	0.04	−0.01	0.02	0.01	−0.01	41.1	14.0
[2] Sex	–	0.11	0.09	−0.04	−0.06	0.04	−0.02	0.04	0.05		
[3] PPCSS		–	−0.14	−0.13	−0.14	0.11	−0.04	−0.12	0.16*	87.5	13.9
[4] HADS Depression			–	−0.69***	0.01	0.15*	−0.14	−0.02	0.12	9.7	4.4
[5] HADS Anxiety				–	−0.13	0.16	−0.07	−0.01	0.20**	9.6	4.7
[6] Frequency of consultation score					–	−0.05	0.19**	0.08	−0.51***	3.1	0.08
[7] Perceived time spent for consultation						–	−0.21**	−0.15	0.85***	13.6	6.6
[8] Duration since the start of attendance (months)							–	0.47***	−0.28***	23.1	28.5
[9] Duration since the onset of the current disorder (months)								–	−0.18*	59.3	71.0
[10] SCI									–	4.8	2.9

*P < 0.05; **P < 0.01; ***P < 0.001.
HADS, Hospital Anxiety and Depression Scale; PPCSS, Perceived Physician's Communication Style Scale; SCI, Session Concentration Index.

no gender difference in the consultation frequency. There was no correlation between age and consultation frequency.

The mean ± SD time spent for the current session was 13.6 ± 6.6 min. The range of the time spent was 3–60 min, but approximately 83% spent between 10 and 15 min. There was no gender difference for the time spent in the current session. There was no correlation between age and time spent.

The SCI scores vary from 0.8 to 20.0 with a mean ± SD of 4.8 ± 2.9.

Consultation frequency, time spent and patient satisfaction

The PPCSS scores were higher, although they were not statistically significant, for patients who attended the clinic in shorter intervals and for those with longer perceived consultation times. The PPCSS scores were significantly higher (r = 0.17, P < 0.05) among those with greater SCI scores (Table 1).

Session Concentration Index and patient depression and anxiety

Whereas there was no significant correlation between the SCI score and the HADS Depression score, the

HADS Anxiety score was positively correlated with the SCI score (Table 1). Thus, anxious patients were more likely to have a longer current session. Patients who had been receiving treatment at the clinic for a long time and who had had a disorder for a long time were more likely to have a lower SCI score (Table 1).

Mediation of patient satisfaction between SCI and patient depression and anxiety

A path analytic model was created (Fig. 1). The final model demonstrated that both the HADS Depression and Anxiety scores were predicted by the low PPCSS score and that the PPCSS was predicted by the SCI score.

In contrast, the SCI score was predicted by a higher HADS Anxiety score and a shorter duration since the start of clinic attendance. Younger age predicted the HADS Depression score. The goodness of fit of this model with the data was excellent: GFI = 0.999, CFI = 1.000, AIC = 31.086.

It was plausible that the density of the psychiatric session (SCI) would directly predict a lower level of depression and anxiety. Therefore, the same path analytic model was repeated, except for the directions of the paths from the two HADS subscale scores to the SCI score (data not shown). It was found that in

this revised model the SCI score predicted higher scores for the HADS depression (standardized estimate, 0.212) and anxiety (standardized estimate, 0.365). The goodness of fit of this model was GFI = 0.986, CFI = 0.995. Its AIC (35.772) was, however, higher than the original model. Therefore this model was rejected. The original model seemed to fit the data the best.

DISCUSSION

This study indicates that in everyday clinical situations dense psychiatric sessions are linked to patient satisfaction with the communication with their practitioner, which in turn predicts lower levels of negative affectivity (depression and anxiety). This study has also found that anxious patients induce more dense sessions. The present study is unique because it probes typical clinical practices rather than carefully designed research settings. A recent systematic review on randomized controlled trials, controlled clinical trials, and controlled patient preference trials of counseling interventions in primary care patients with psychological and psychosocial problems documented that such counseling is associated with modest short-term improvement compared to the usual care, but does not provide additional long-term advantages and that it is associated with patient satisfaction.[9] The results of the present study have suggested that the patients' mental state is better following sessions which are longer and occur more often.

Another unique feature of the present study is the mediation of the effects of the dense session on the negative affectivity by increased patient satisfaction in regards to communication with the clinician. This suggests that a better mental state is obtained not simply by dense sessions, but also by the patient's perception that the session is satisfactory. The communication satisfaction reflects good treatment relationship.

In contrast, clinicians seem pressed to dispense dense sessions to patients with severer anxiety symptoms. Anxious patients may have more things they wish to report to their clinician, whereas depressed patients are reluctant to do so. It is the clinicians' responsibility to respond to patient need even when the patients are reluctant to talk or too depressed to do so. Also, the present study indicated that as a patient continues to attend a clinic, the sessions become less dense.

The observed link between dense sessions and patient satisfaction both in bivariate analysis and path analytic modeling indicates that sufficiently perceived long sessions with regular short intervals at busy psychiatric outpatient clinics benefit the patients in both satisfaction and therapeutic effects. What remains to be clarified is the optimal time for a single session to achieve this.

The present study has shown that the longer the patient has been attending the clinic the less dense the psychiatric session becomes. Thus patients who have been attending the clinic for a long time may feel less satisfied with the session being mediated by the less dense session. Due to the cross-sectional nature of the present study we are unable to make any comments on this issue, but this should be further studied in a prospective study.

A limitation of the present study was that it was not designed to examine the effectiveness of psychological intervention for patients with specified mental disorders. The present study used a patient population with mixed diagnoses. Second, this was a cross-sectional study and, as such, causative interpretation should be made with caution. Third, the present study did not separately examine the model for patients with a given diagnosis. In addition, all the variables including the time spent for the current session were rated by the patients. Thus their measurement of time may be biased by their psychological state. It may also be possible that the patient's perception of the time spent in the session may be influenced by the degree of satisfaction he/she has obtained from the session. This should be examined by a more objective measure of time such as by an observer. The magnitude of path coefficients was not robust. Modest magnitude of path coefficients suggests that there are other variables unobserved here but strong in influencing the model.

Despite these shortcomings, this preliminary study suggests that dense psychiatric sessions in busy Japanese outpatient clinics benefit patients and that this issue merits further investigation with more refined research methodology.

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