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Differences in the Level of Trust in Mental Health Providers among Individuals with Severe Mental Illnesses

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Abstract

Background: The study examines trust among patients with Severe Mental Illness (SMI) in mental health services providers. Study's hypothesis suggests higher level of patients' trust inthe biosocial model advocated by social workers in comparison with the biomedical model advocated by psychiatrists. **Method:** The study includes 60 participants (*N*=60), living in the community, with a history of psychiatric hospitalization. All Participants were in constant contact with psychiatrist (9 psychiatrists) and social worker (11 social workers) for a minimum period of six months.**Findings:** Study findings indicates that, in accordance with the hypothesis, the level of trust toward social workers was significantly higher compared to psychiatrists.In the context of the biomedical model,asignificant correlation was found between duration of contact with a psychiatrist and betweenpatient's level of trust. Moreover,frequency of therapy sessionsfound to be the only variable predicting level of trust felt towards psychiatrists.In the context of thepsychosocial model,duration of contact, frequency of therapy sessions and number of readmissions since first hospitalization, were found to predict the level of trust felt toward social workers. **Conclusions:** Increasing frequency of sessions between a psychiatrist and his patient will create the essential conditions that shall allow a professionals to create a higher levels of trust among patients. In the other hand, reduced number of readmissions may retain the trust level felt toward social workers.

Keywords: trust, mental health,psychosocial model, social workers,biomedical model, psychiatrists

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Literature Review

Trust, Quality and Accessibility of Mental Health Services

Patients' level of trust in providers of mental health services is essential to a variety of aspects pertaining to the service quality: service accessibility, diagnostic ability, effective treatment and ongoing collaboration with patients' treatment plan (Brown,Calnan, Scrivener, & Szmukler, 2009). These services are only part of the aspects affected by the level of trust between patients and service providers. Therefore, regarding to the issue of services' accessibility, the patients' perceived level of trust may decide whether to contact and receive services or not.

In cases ofpatients' negative previous utilization of service and negative experience of previous interventions, avoiding repetition of service is reasonable. Furthermore, in cases of inexperience or insufficient experience with mental health services, patients usually make use of knowledgeable previous social interaction (Appleby, 2008). Previous knowledge and close social relationships constitute trust between patients and service providers; especially during insecure experiences and lack of confidence (National Institute for Clinical Excellence, 2003). In the absence of other knowledge resources available forthe assessment of mental health servicescredibility, patients' decision-making is influenced via trust levelof a referral authority, and thus overcome the uncertainty (Brown et al., 2009).

Even though general perceptions about mental health services regarding to trust are important, effective communication between service providers and patientsis vital (Brown, 2008; Calnan & Sanford, 2004).In addition, experiencing support, combined with positive intervention affected by quality interaction of patient-service provider, is even more essential for creating trust.

According to the biomedical model, psychiatric diagnosis; unlike diagnosis in general medicine; rely largely on the interaction between service provider and patient. Effective therapeutic interaction in which the patient 'feels safe' to trust a service provider, may lead the patient to expose his precise and explicit 'history', and thus help the service provider to facilitate accurate diagnosis, evaluation, and determine further intervention program (Dew et al., 2007). In this context, trust becomes extremely vital to the process of diagnosis and treatment bygranting the patient an opportunity of openself-disclosure (Seale, Chaplin, Lelliott, & Quirk, 2006).

Trust as a Communicative Process in Therapeutic Sessions

Trust is a process of knowledge structuring that serves one person to overcome the possibility of vulnerability in situations of uncertainty (Mollering, 2006).

It is based on using the 'known'in order to evaluate the 'unknown' and develop positive expectations. According to the psychosocial model, one way that people tend to categorize others, is by the extent to which you can trust, as a part of a preliminary judgmental process (Schutz, 1972).

Trust may be perceived as irrational because of the fact that the decision to trust someone puts a person in a state of vulnerability, since he does not have full knowledge about the consequences. Trust, by definition, occurs in circumstances of uncertainty regarding the motives and ability of the trustee. In this sense, trust is an ambivalent construct, since it is based on previous experience used to build assumptions about the future (Brown et al., 2009).

Williams (2007) consider trust as an expression of the person's inner faith, that the trusteeshares a common motive. In the opposite way, mistrust is a lack of believe that both sides share the same interests: "I feel mistrust when I suspect that someone else's agenda and purpose are not in line with my agenda or what the other person claims" (Williams, 2007, p. 4).

In the therapeutic context, perceived trust is a function of the service provider's professionalism, focusing on his patient andgiving him attention and making use of professional expertise (Calnan & Sanford, 2004). Nowadays, where patients have more knowledge than before and are aware of professionals' ability of making mistakes, there must be effective, mutual and bi-directional communication between patients and service providers (Alaszewski & Brown, 2007).This type of communication means that service providers are able to listen, encourage, and to communicate clearly with their patients (Allsop & Jones, 2008).Where professional capabilities were taken for granted in the past, modern service providers must prove their capabilities.Consumers must be convinced of conveyed communication messages, motivation and level of expertise. Thus, trust creation, according to researchers requires a certain degree of closeness in order to reduce the reliance on tentative conclusion, and thus overcome vulnerability and uncertainty in the future (Dunn, 1993).

According to literature reviewed previously,patient-therapist good communication and sense of closeness are necessary for creating trust. In mental health, we argue that trust has implications, not only on the quality of thepatient-therapist dyadic relationship, but also on patients' perceptions of mental health services quality. It is worthy to examine patients' level of trust in professionals from two main approaches: psychosocial and medical which are advocated accordingly by social workers and psychiatrists. Therefore,we hypothesize to find a higher level of trust among patients toward the psychosocial model than the biomedical one.

Method

Participants

The current study included 60 subjects (*N*=60) living in the community while data were collected (four community housing services and rehabilitation institutes) in the North of Israel. All subjects were hospitalized in a psychiatric hospital at least once and were diagnosed during their first admission as suffering of severe mental disorders. All subjects maintained continuous contact (for at least six months) with a psychiatrist and a social worker as an integral part of their rehabilitation program. The study included 9 psychiatrists, 8 of them males (*N=8; 87.5%*), at mid-forties (*M=44.78; S.D= 5.44*), alongside with 11 social workers, 10 Females (*N=10; 90.9%*), at their late-thirties (*M=37.33; S.D=2.96*). Table 1 below presents research sample:

Table 1: Sample's Description

		%	N
Patient's gender	Women	43.33%	26
	Men	56.67%	34
Patient's Age	37.7 (10.3)		
Number of readmissions	3.8 (3.5)		
Patient's education (in years)	11.1 (1.9)		
Years of education	Psychiatrist 24.08 (.92)		
	Social worker 15.66 (.79)		
Patient's marital status	Single	53.33%	32
	Married	26.67%	16
	Divorced	20%	12
Patient's religion	Jews	100%	60
First inpatient psychiatric diagnosis	Schizophrenia	50%	30
	Major depression	26.67%	16
	Bipolar disorder	16.67%	10
	Personality disorder	6.67%	4

Study Tools

Study tool encompassed two parts: (1) a background characteristics questionnaire of patients and professionals; and (2) a questionnaire examining level of trust in professionals among patients. Both questionnaires were submitted to the patients in Hebrew.

Background Characteristics Questionnaire

The questionnaire examined background characteristics of patients and included: demographic information and psychiatric history including follow-up and monitoring in the community.

This part included the following variables: Age; gender; marital status; number of children; years of education; date of first psychiatric hospitalization; first inpatient psychiatric diagnosis; medications; date of release from first psychiatric hospitalization; maintaining contact with a psychiatrist in the community; duration of contact; frequency and duration of the session;maintaining contact with a social worker in the community;duration of contact; frequency and duration of the sessionand the number of psychiatric hospitalization that the patient gained since his first release from hospital.The questionnaire that examined the background data of caregivers included the variables: age;gender and years of education.

The Level of Trust in Professionals among Patients Questionnaire

The measure was developed by Egede and Elisse (2008), in order to assess the level of trust in three dimensions: (1) level of trust in service providers(10 items); (2) level of trust in medical insurance (4 items); and (3) level of trust in medical institutions (3 items). All 17 items constitute disclaimer sentences rated by the subjects according to five point Likert scale: (1) I always feel so; (2) I often feel so; (3) I sometimes feel so; (4) I rarely feel so; and (5) I never feel so.

For conducting the current study, we utilized the first dimension to examine patient's level of trust in service providers. Questionnaire relevant dimension reported reliability by theauthors was sufficient for research needs (α=.89). Reliability value of current study is similar (α=.86). The questionnaire was validated using criterion validity procedure. Medium to high significant correlations were found in all 10 items. Index's maximum score is 50 and minimum score is 10.

Study Procedure

Study proposal was submitted to the Ethics Committee at the academic institution where the research was conducted. After receiving an initial consent by the supervisors in the four services; an informed consent form was drawn up. The application was transferred to theparticipantsby thestaff that was in direct contact with them. The application included a brief explanation of the study and its purposes andsubjects were asked to express their written consent to participate in the research while receiving a commitment by the researchers to maintain anonymity and data use only for the current study. 60 out of 68 participants who have agreed to be interviewed appeared to a pre-determined meeting. 8 participants that didn't appear were not included in the study. Data were collected through interviews with the participants by third yearsocial work studentsas a part of a research methods seminar.

Findings

The purpose of this study was to examine the difference in the level of trust among two approaches: the biomedical model that is advocated by psychiatrists and is comparedwithsocial workers that advocates the psychosocial model within severe mental illness patients. To test the hypothesis; a T-test exam was conducted to comparethe level of trust in both groups; the results are presented in table 2. Subsequently, a correlation analysis was conducted to examine the effect of the independent variables (background variables) on the level of trust - (table 3). And finally, a multiple regression analysis was conducted to examine the contribution of each independent variable for explaining the variance in the dependent variable, When the effects of other independent variables are controlled – (table 4). Table 2 below shows the results of aT-test exam comparing the average level of trust inpsychiatrists compared with social workers.

Table 2: Comparison between the Average Levels of Trust in Psychiatrists Compared with the Average Level of trust in Social Workers

	Psychiatrist (Biomedical model) (N=9)	**Social worker (psychosocial model) (N=11)**	
Average level of trust (N=60)	27.78 (3.32)	35.26 (6.27)	*t = 43.54 ; df=59 ; p<.001*
Minimum	26.92	33.64	
Maximum	28.64	36.88	

Table 2 shows that the difference in patient's average level of trust in psychiatrists compared with social workers; is statistically significant in favor of social workers. The average level of trusts in psychiatrist is according to data is 27.78 (*SE= 3.32*), compared with 35.26 (*SE=6.27*) in social worker.

Table 3 below shows results of a correlation analysis that examines the independent variables' effect (Age; gender; marital status; number of children; number of readmissions; patient's education (years); duration of contact with a psychiatrist (months); duration of contact with a social worker (months); session's frequency with a psychiatrist (weeks); session's frequency with a social worker (weeks); duration of session with a psychiatrist (minutes); duration of session with a social worker (minutes); psychiatrist's age; social worker's age; psychiatrist's education (years); social worker's education (years)) on the level of trust.

Table 3: Correlations among Study Variables

Independent variables	Average (SE)	Level of trust in psychiatrist	Level of trust in social worker
Patient's age	37.7 (10.3)	-.10	.11
Patient's gender		.09	.07
Marital status		-.21	.02
Number of children	1.2 (.93)	-.03	-.14
Number of readmissions	3.8 (3.5)	.16	**-.74****
Patient's education (years)	11.1 (1.9)	.01	-.22
Duration of contact with a psychiatrist (months)	8.97 (3.17)	**24*.**	
Duration of contact with a social worker (months)	10.7 (6.02)		**.77****
Ssession's frequency with a psychiatrist (weeks)	12.57 (7.6)	-.01	
Session's frequency with a social worker (weeks)	2 (.8)		**.81****
Duration of session with a psychiatrist (minutes)	13.50(4.14)	-.10	
Duration of session with a social worker (minutes)	33.66 (8.72)		.02
Psychiatrist's age	44.78 (5.44)	-.03	
Social worker's age	37.33 (2.96)		.09
Psychiatrist's gender		18.99	
Social worker's gender			10.34
Psychiatrist's education (years)	24.08 (.92)	-.13	
Social worker's education (years)	15.66 (.79)		-.11

** p<.05 ; ** p<.001*

Table 3 indicates positive significant correlation between patient's level of trust in psychiatrists and duration of contact; the higher score of duration of contact with psychiatrist is, the higher patient's level of trust is (r_p *=.24; p<.05; df=1*). No significant correlations were found in the other independent variables: age; gender; years of education; marital status; number of children; number of psychiatric hospitalization; frequency and duration of sessions.Table 3 also shows a negative significant correlation between patient's level of trust in social workers and number of readmissions; the higher number of readmissions is, the lower level of trust in the social workers is (r_p *=-.74; p<.001; df=1*). Also found as shown in Table 3, apositive significant correlation between patient's level of trust in social workers and duration of contact with; the higher scores of duration of contact is, the higher level of trust in social workers is (r_p *=.77; p<.001; df=1*).

A positive significant correlation also applies to the session's frequency with social workers; the higher scores of session's frequency is, the higher level of trust in social workers is (r_p *=.81; p<.001; df=1*). No significant correlations were found in other independent variables: age; gender; years of education; marital status; number of children and duration ofsessions.

To examine the contribution of each independent variable in explaining the variance in the dependent variable; when controlling the effects of other independent variables; a multiple regression analysis was performed on the dependent variable separately with psychiatrists and social workers. Table 4 below shows the multiple regression analysis results: the effect of eight independent variables on the level of trust.

Table 4: Multiple Regression Analysis on the Level of Trust InpsychiatristsandSocial Workers (N=60)

Independent variables	Level of trust in social workers			Level of trust in psychiatrists		
	B	SE	B	B	SE	B
Duration of contact	.13	.04	**.23****	.05	.07	.05
Session's frequency	3.99	.64	**.56*****	.36	.03	**.83*****
Duration of session	.02	.04	.04	.01	.05	.01
Number of readmissions	.40	.14	**.23****	.09	.06	.09
Number of children	.27	.31	.27	.19	.19	.07
Gender: Male=0	.03	.72	.00	.63	.45	.09
Female=1	.06	.19	.01	.10	.12	.06
Years of education	.02	.03	.02	.02	.02	.07
Age	.04	.02	.03	.03	.02	.06
	R^2 (adjusted)= .82			R^2 (adjusted)= .75		

**p<.05 ; **p<.01 ; ***p<.001*

The finding in table 4 indicates; that the best predictor of patient's level of trust in psychiatrists is session's frequency (β*=.83;*R^2*=.75*).Other predictors are inconsistent. Regarding to the level of trust in social workers; the best predictor of patient's level of trust in social workers is session's frequency (β=.56; *R^2=.82*). Other predictors are inconsistent.

In summary, the findings support our research hypothesis. Patient's average level of trust in a social worker is significantly higher than patient's average level of trust in a psychiatrist. In a bivariate analysis; a positive significant correlation was found between duration of contact and patient's level of trust in psychiatrists and social workers; a negative significant correlation was found between number of readmissions and patient's level of trust in social workers; a positive significant correlation between session's frequency and level of trust insocial workers. In a multivariate analysis; we found that the best predictor of patient's level of trust in psychiatrists and in social workersis the session's frequency.

Discussion

The study findings support the hypothesis that patient's level of trust inpsychosocial model advocated by social workers is significantly higher than the level of trust inbiomedical model advocated by psychiatrists. We found that the variables: duration of contact; session's frequency and number of readmissions, were helpful in predicting patient's level of trust in thepsychosocial model. On the other hand; we found that only session's frequency predicts patient's level of trust in the biomedical model.

Another possible explanation for the significant difference in patient's level of trust between psychiatrists and social workers may be related to the differences in professional's work model (Akechi et al., 2001). While psychiatrists rely on the biomedical model(Engel; 1977), social workers tend mostly to rely on the psychosocial model (Aviram;2002). The one-dimensional focus on the medical model of diagnosing illness and identifying symptoms; especially in mental health symptoms; may 'miss' the patient standing behind the disease. Likewise, patients may perceive psychiatrists as charged with handling the symptoms of the disease; and hence; on a particular aspect of the disease, while patients perceive social workers as a figure that can assist on wider aspects. The attempt to find solutions for a variety of problems;combined with accompanimentand support; probably represent fertile ground for creating trust.

An explanation for the findings may be referred to the difference in the nature of these two approaches. The fact that social workers; unlike psychiatrists; devotes their meetings with the patient for providing support, assessing abilities and skills, identifying and satisfying needs, detecting existing resources in patient's natural environment, and therefore, draw attention to improvethe patient's quality of life (Aviram; 2002; Foster; 2005). On the other hand, a psychiatrist; ex officio; is busy on assessing and diagnosing illnesses (Rose; 2002). Due to this responsibility, psychiatristsare required tospend time and effort in diagnosing, assessing and interventions (often combines forced use of drugs and/or involuntary hospitalization and restrictions of freedom). More than once as indicated in the findings during the process of evaluation and measurement;trust is damaged because of a lack in creating closeness.

The findingwhich indicated that session's frequency with psychiatrists is a predictor of patient's level of trust, consistent with previous findingsconsidering the development of trust in relationshipsthatrequire time (Langley &Klopper; 2005).The reason for this,is basedon the connotation of trust as a process of knowledge construction,that servesa person as a resource to overcome problems of vulnerability in situations of uncertainty (Mollering; 2006).This process of Knowledge construction requires time to become deeply acquainted, create and establish therapeutic relationship and creating closeness. It is likely that lackson community mental health services, especially in the periphery and lack of psychiatrists number (Ministry of Health, 2012) is the reason to the data that indicated a low session's frequency between patients and psychiatrists (once in 12.56 weeks in average compared to once in two weeks among social workers). Lack of psychiatrists and services imposes unusual load on psychiatrists. This load, might harm the quality of the therapeutic interaction,and reduce the session's frequency dedicated to patients. Perhaps this explains the main finding of the present study; that patients tend to give less trust in psychiatrists; and why increased session's frequency with the psychiatrist improvepatient's level of trust; given that it requires time to development trust (Langley &Klopper; 2005). Furthermore, increasedsessions' frequency with psychiatrists may enable them in-depth acquaintance with patients. These kinds of acquaintances may allow psychiatrists; eventually;to attribute enough importance to anxiety experienced by patients, and integrate effective support and care, that shall strengthen the level of trust.

The finding that patient's level of trust in social workers decreases with an increase number of readmissions probably indicates the damagecaused to patients due to their multiple readmissions. Repetition to hospitalization; is probably experienced by patients; not only asa failure in coping with life's demands in the community, but also as a system failure in preparing them to do so. Hence, patient's level of trust in the system; including in social workers; decreases with recurrence failure experience that accompanies readmissions.

Another possible explanation of that may be related to the characteristics of patients with frequent readmissions thatare probably suffering originally from very serious mental disorder. These patients are characterizedwith difficultiesin trusting other persons (e.g. paranoia), combined with lack of insight or limited insight,that contributes the difficulties in trustingthe system include social workers. Therefore; given the fact that it requires time for developing trust; the reason thatsession's duration and frequency raisepatient's level of trust in social worker is apparentlyrelated to the fact that they have more opportunities to create closeness with patients (Langley &Klopper; 2005). Hence, increasing sessions is perceived as an express of concerning, that eventually increases patient's level of trust in service providers in both models.

Conclusions and Recommendations

The fact that there are gaps in patients' level of trust in psychiatrists compared with social workers should be a warning light in front of policy makers' eyes. This is probably due to the central role played by psychiatrists inthe diagnostic process, treatment and rehabilitation of mental health according to the biomedical model. Additionally,trust process has a critical meaning oninformation's disclosure for the diagnostic process, determining treatment and rehabilitation program,cooperation, persistence of treatment and rehabilitation program.

Due to the finding that the only variable found to predictpatient's level of trust in psychiatrists is session's frequency; exploring ways for increasing session's frequency is worthy. Because it is a necessity in creating minimal conditions that eventually shallhelp psychiatristscreating trust with their patients.

Duration of contact and session's frequency with social workers were found to contribute to predicting patient's level of trust. These findings indicate the importance of the time element in creating and establishing an adequate level of trust.Due to trust's vitality in rehabilitation process and recovery; which are long processesby nature; these kinds of processes should exist without limiting them previously in time.

The fact that the number of readmissions in psychiatric hospitalswas found to contribute to predicting lower levels of trust, requires efforts to reduce these numbers; not only because readmissions might harm prospects of patient's rehabilitation andintegrating in the community life; but also might reduce patient's ability to trust the systemwith all the negative consequences of this.

Limitations of the Study

The main limitation of this study is related to the gender variable's distribution in both groups of service providers,were patient's trust level was compared. The fact that the sample included only one female psychiatrist out of nine, and one male social worker out of 11, makes it difficult to determine whether the difference in patient's level of trust is associated with the gender of the service providers or withtheir profession.This limitation also exists with respect to the age variable in both groups of service providers. The fact that social workers' average age is smaller that psychiatrists' average age, makes it difficult to determine whether the difference in patient's level of trust is associated with the age of the service providers or with their profession.

In addition, this study did not include random allocations of patients topsychiatrists and social workers. Therefore the internal validity is not perfect and the control criterion doesn't fully exists. Such research design,may indicate a correlation but not causation;despite the fact that as a partial solution to the problem; a multivariate analysis was performed.Since the four rehalibitatioservices that were conducted in the study serve a geographically defined population and not a general population, and since the sample is relatively small, there is no justification to generalize the findings to all patients who have contact professionalsin community mental health services.

Another limitation that should be pointed-out, is that the study was conducted through the lenses of social work. However, findings may draw attention among professionals and policy makers to the trust issue that was neglected so far, and is so essential for providing quality services in mental health.

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