Original Research

Patient Satisfaction With Outpatient Psychiatric Treatment: The Role of Diagnosis, Pharmacotherapy, and Perceived Therapeutic Change

Gregor Hasler, MD[1], Hanspeter Moergeli, PhD[2], Rosilla Bachmann, MD[3], Evelina Lambreva, MD[4], Claus Buddeberg, MD[5], Ulrich Schnyder, MD[6]

Objective: To investigate the influence of diagnosis, type of treatment, and perceived therapeutic change on patient satisfaction following psychiatric treatment for nonpsychotic, nonsubstance-related disorders.

Method: We mailed questionnaires, including Larsen's Client Satisfaction Questionnaire and Grawe's Bern Inventory of Treatment Goals, to outpatients who had undergone 8 or more therapy sessions 1 year following treatment.

Results: Patients with somatoform, eating, and personality disorders were less satisfied than patients with affective, anxiety, and adjustment disorders. Symptom reduction and changes in the interpersonal domain were important outcomes associated with patient satisfaction. Although pharmacotherapy itself was not related to patient satisfaction, patients who perceived improvements in pharmacotherapy as one of the most important treatment outcomes were less satisfied than others. Preliminary evidence shows that coping with specific problems and symptoms is associated with satisfaction among male patients, whereas changes in the interpersonal domain seem to produce satisfaction among female patients.

Conclusion: Patient-reported change and diagnostic category appear to play a relevant role in generating patient satisfaction. Further research is needed to clarify the interactions between sex, perceived outcome, and satisfaction.

(Can J Psychiatry 2004;49:315–321)

Information on author affiliations appears at the end of the article.

Clinical Implications

- Chronic psychiatric conditions, such as somatoform and eating disorders, must be considered when measuring and interpreting patient satisfaction.
- Patient satisfaction is primarily associated with patients' perceived improvements in 2 distinct outcome domains: coping with specific problems and symptoms and the interpersonal domain.
- This study encourages investigation of the role of sex-sensitive aspects in generating patient satisfaction.

Limitations

- The response rate was 60%.
- The sample was relatively small.
- Patients and treatments were heterogeneous.

Key Words: *consumer satisfaction, outcome assessment, drug therapy, psychotherapy*

In the last decade, there has been a growing interest in patient satisfaction as a measure of outcome and quality of care in psychiatry (1). Patient perspective in service evaluation is needed because objective outcome indicators in psychiatry are controversial (2). In addition, patient satisfaction is a factor in the care process (3), influencing intervention efficacy and consumer behaviour such as compliance and service utilization (4,5). Patient satisfaction is influenced by many factors, including patients' clinical and socioeconomic characteristics (6,7), expectations (8), living conditions (9), and previous service experiences (10). In addition, satisfaction appears to depend on the quality of care, as indicated by waiting time for appointments (11); support and service organization (12); and the outcome of care (that is, problem improvement as identified by patients; 9).

In a metaanalysis of literature on satisfaction with mental health services between 1955 and 1983, chronically ill patients were found to be less satisfied with treatment than were nonchronically ill patients (13). Further studies in the last 10 years have begun to investigate the relation between patient satisfaction and type of psychiatric diagnosis. Researchers in Denmark found patients diagnosed as suffering from affective and adjustment disorders or from reactive psychoses to be more satisfied than patients with schizophrenia or personality disorders. Patients receiving antidepressant treatment were particularly satisfied (7). Similarly, Canadian researchers found the greatest level of patient dissatisfaction and the lowest level of patient–therapist agreement in patients suffering from schizophrenia and other psychotic disorders. They linked their findings to therapists' underestimation of nonbiological treatment aspects, such as social support (8). Both research groups recommended comparisons of treatment needs and quality among diagnostic groups. To our knowledge, no study comparing levels of patient satisfaction in nonpsychotic, nonsubstance-related, specific diagnostic categories, such as eating disorders and somatoform disorders, has been published.

The correlation between patient satisfaction and objective treatment outcome, as assessed by the Symptom Checklist-90-Revised (SCL-90-R), has been found to be low (14). This finding may be explained by the difference between actual and perceived change (2,9): a small change could make a great difference to the individual patient, while a significant change may be irrelevant in the patient's perception. Sex differences have attracted particular interest regarding the determinants of health and the need for health care (15,16). Some authors urge using a typology of problems, goals, or foci for assessing the most relevant change domains (2,17). To our knowledge, the relation between patient satisfaction and outcome across different change domains has not been studied systematically.

This study investigates the influence of diagnosis on patient satisfaction with psychiatric psychotherapeutic care provided by the psychiatric outpatient department of a university general hospital in a consecutive sample of patients with nonpsychotic, nonsubstance-related disorders. We further investigate the relation between type of treatment and perceived types of change on patient satisfaction. We address 3 questions. First, does patient satisfaction depend on psychiatric diagnosis? Second, with regard to satisfaction levels, do patients treated with psychotherapy alone differ from patients treated with a combination of psychotherapy and pharmacotherapy? Third, is there a relation between perceived type of therapeutic change and patient satisfaction?

Methods and Materials

This study includes all outpatients who received 8 or more sessions of individual psychiatric–psychotherapeutic treatment at the psychiatric department of the University Hospital of Zurich, Switzerland, during the years 1999 and 2000. Patients were considered eligible if they were diagnosed with 1 of the following ICD-10 (18) diagnostic categories: F3 (mood or affective disorders), F4 (neurotic, stress-related, and somatoform disorders), F5 (behavioural syndromes associated with physiological disturbances and physical factors, mainly eating disorders), or F6 (disorders of adult personality and behaviour).

We based our sample size estimation on the metaanalysis by Lehman and Zastowny (13), which found a mean difference of 0.49 standard deviations (SDs) in the satisfaction level of chronic and nonchronic patients for all analyzed studies. In outpatient health care programs, the mean difference was 1.19 SDs. We assumed an effect size (that is, mean difference divided by SD) of 1 as clinically significant for group comparisons. For a power of 80% in a *t* test ($\alpha = 0.05$, 2-tailed), 17 patients per group were required. Informed by data regarding the quantity and characteristics of treatments provided by our clinic and assuming a response rate of 50%, we felt that a sample recruited from a 2-year intake of patients would suffice to address our research questions.

Between 9 and 21 months following treatment, we contacted 161 patients by mail (that is, 65 patients in 1999 and 96 patients in 2000) and requested their study participation (that is, we asked patients to complete a self-report questionnaire). We sent a reminder to patients who did not respond after 3 weeks. Following this procedure, a total of 97 patients returned the questionnaire, for a response rate of 60.2%. We interviewed 41 of the 64 nonrespondents by telephone and asked all subjects for written informed consent to participate in the study.

Table 1 Diagnostic categories of respondent and nonrespondent patients

ICD-10 diagnosis	Respondents *n* (%)	Nonrespondents *n* (%)	Pearson χ^{2a}	df	*P*
Affective disorders	18 (18.6)	14 (21.9)	0.27	1	0.61
Anxiety disorders	33 (34.0)	8 (12.5)	9.41	1	< 0.01
Adjustment disorders	19 (19.6)	13 (20.3)	0.01	1	0.91
Somatoform disorders	5 (5.2)	7 (10.9)	1.87	1	0.17
Eating disorders	13 (13.4)	16 (25.0)	3.51	1	0.06
Personality disorders	9 (9.3)	6 (9.4)	0.00	1	0.98
Total	97 (100)	64 (100)			

[a]One diagnostic category compared with all other diagnostic categories.

Measures

We registered patients' demographic and administrative data and diagnoses at the beginning and at the end of treatment. Diagnoses were based on the first clinical interview, using ICD-10 diagnostic criteria (18).

We assessed patient satisfaction using the 3-item short form of Larsen's Client Satisfaction Questionnaire (CSQ) (19). The CSQ is one of the most widely used satisfaction measures in German-speaking countries (14). We chose the short form because research by Larsen and colleagues has shown there is only 1 underlying factor in their 8-item scale with a high degree of internal consistency (Cronbach's alpha = 0.94 in a large follow-up assessment) (19). In our sample, Cronbach's alpha = 0.89. The global satisfaction score (GSS) of the 3-item CSQ ranges from 3 to 12.

We assessed therapeutic change as perceived by the patients, using a modified form of the Bern Inventory of Treatment Goals (BIT-C) (17). The 67 items of the inventory are preceded by the statement, "My therapy at the psychiatric outpatient clinic helped me to . . . . " These 67 items can be subsumed under 21 change categories and 6 change types: P = coping with specific problems and symptoms (categories 1 to 10), M = medication issues (category 11), I = interpersonal changes (categories 12 to 16), W = well-being and functioning (category 17), E = existential issues (category 18), and G = personal growth (categories 19 to 21). Following the item list, we asked patients to record 3 most important changes. Further details of this modified form are available (20,21).

Statistical Analyses

We used SPSS for Windows for statistical analyses (22). In our sample, the GSS was negatively skewed (GSS = –0.87) and nonnormally distributed (Kolmogorov–Smirnov $z = 1.89$, $P < 0.01$). Thus, for bivariate analyses we used nonparametric tests (that is, the Kruskal–Wallis test, the Mann–Whitney *U* test, Spearman's correlation coefficient, and the Pearson chi-square). We used linear multiple regression analysis for the multivariate prediction of patient satisfaction, and we found no violation of the normality assumption after performing a logarithmic data transformation (1 – log [13 – x]: reflect, logarithm and reflect again (23, p 85) of the GSS (Kolmogorov–Smirnoff $z = 1.22$, $P > 0.10$). We chose predictor variables with respect to our main hypotheses (that is, diagnostic category, pharmacotherapy, and domains of perceived change), which were all conceptualized as indicator variables. Regarding the domains of perceived change, we selected the change types yielding significant results in the bivariate analyses (such as coping with specific problems and symptoms, interpersonal goals, and medication issues). To avoid multicollinearity, we omitted the category "no change." No perceived change is a residual category and is, therefore, negatively related to perceived changes in the other categories. In addition, we entered sex, age, number of sessions, and the time between treatment end and assessment into the regression analysis, because it is well known that these factors may influence patient satisfaction (6).

Results

The average age of the 62 (63.9%) female patients and 35 (36.1%) male patients was 39.1 years (SD 14.1 years). Of the total patients, 32 (33.0%) were married, 55 (56.7%) were unmarried, 7 (7.2%) were separated, 1 (1.0%) was widowed, and 2 (2.1%) had missing data. Of these patients, 21 (21.6%) lived alone; 64 (66.0%) lived with parents, partners, or other persons; and the remaining 12 (12.4%) provided no data on their living arrangements. A total of 44 patients (45.4%) had full-time paid work, 15 (15.5%) had part-time paid work, 33 (34.0%) had no paid work or were unemployed, and 5 (5.1%) had missing data. Table 1 shows the diagnostic characteristics. Respondents and nonrespondents differed significantly among diagnostic categories ($\chi^2 = 11.8$, df 5; $P < 0.05$), with more anxiety disorders and fewer eating disorders among respondents (see Table 1). Moreover, Swiss nationality was more prevalent in respondents, compared with nonrespondents ($\chi^2 = 14.8$, df 1; $P < 0.001$). There were no

Table 2 Global satisfaction score of patients with different psychiatric diagnoses

ICD-10 diagnosis	*n*	Mean	SD	Median	IQR
Affective disorders	18	9.1	2.8	10.3	4.63
Anxiety disorders	33	9.8	2.4	11.0	2.75
Adjustment disorders	19	10.4	2.4	11.0	2.00
Somatoform disorders	5	8.0	2.4	9.0	4.50
Eating disorders	13	7.9	2.2	7.5	3.25
Personality disorders	9	7.7	3.7	6.5	7.50
Total	97	9.3	2.7	10.5	4.25

SD = Standard Deviation; IQR = Interquartile Range

Table 3 Correlation of most important changes with global satisfaction in the total sample and in male and female patients separately

Most important changes	Satisfaction		
	Total sample (*n* = 97)	Male patients (*n* = 35)	Female patients (*n* = 62)
Coping with specific problems and symptoms	0.33**	0.52**	0.13
Interpersonal goals	0.28**	0.22	0.27*
Well-being and functioning	–0.01	0.25	–0.17
Existential issues	0.04	0.09	–0.02
Personal growth	0.07	–0.09	0.14
Medication issues	–0.29**	–0.41*	—[a]
No change	–0.41**	–0.48**	–0.33**

*Spearman correlation is significant at the 0.05 level (2-tailed).
**Spearman correlation is significant at the 0.01 level (2-tailed).
[a]Female patients did not perceive medical issues as the most important change

significant differences regarding sex, age, education, and psychotropic medication.

Treatments comprised individual short-term therapies with supportive and interpersonal elements, with or without medication. All treatments were conducted by residents in their last years of specialization as psychiatrists, and in most cases, they were assisted by an external supervisor. The average number of therapy sessions was 17.5 (SD 12.3 sessions, range 8 to 70 sessions). Of these patients, a total of 53 (54.6%) received psychotherapy combined with psychopharmacological medication, and 44 (45.4%) received psychotherapy only. Of the patients treated with medication, antidepressants were prescribed for 73.6%, tranquilizers for 26.4%, and neuroleptics for 11.3%.

Table 2 shows the GSS of patients with different psychiatric diagnoses. We found a statistically significant relation between satisfaction scores and diagnostic categories (Kruskal–Wallis test, $\chi^2 = 14.7$, df 5; $P < 0.05$). The 70 patients with disorders following an episodic course (that is, affective, anxiety, or adjustment disorders) were significantly more satisfied (mean 9.8, SD 2.5) with treatments than the 27 patients with chronic disorders, such as somatoform, eating, and personality disorders (mean 7.9, SD 2.7 patients; Mann–Whitney *U* test = 533.5, $P < 0.001$).

Patients treated with a combination of psychotherapy and pharmacotherapy ($n = 53$, mean 9.7, SD 2.4) were numerically but not statistically more satisfied than patients treated with psychotherapy alone ($n = 44$, mean 8.8, SD 3.0; Mann–Whitney *U* test = 985.0, $P = 0.19$). The treatment with antidepressants in particular was also not associated with satisfaction.

Table 3 shows the correlation between global satisfaction and most important types of change. In all patients, changes in coping with specific problems and symptoms and changes in the interpersonal domain were positively correlated with satisfaction. The experience of no change and changes in the handling of and confidence in medication were negatively linked to satisfaction. Sex appeared to have an influence on the relation between perceived changes and satisfaction. The positive correlation between changes in coping with specific problems and symptoms was significant in male patients but nonsignificant in female patients. However, in female

Table 4 Results of multiple regression predicting global satisfaction[a]

Predictor variable	β	*P*
Sex (female)	0.06	ns[b]
Age (years)	0.13	ns
Diagnosis: chronic vs episodic disorders	–0.27	0.01
Pharmacotherapy	0.07	ns
Number of treatment sessions	–0.09	ns
Days between treatment end and assessment	–0.12	ns
Perception of most important outcome		
Coping with specific problems and symptoms	0.31	0.01
Interpersonal domain	0.25	0.05
Medication issues	–0.26	0.01

[a] $n = 84$, $R = 0.63$, adjusted $R^2 = 0.33$ ($P < 0.001$)

[b] ns = not significant ($P > 0.05$)

patients, interpersonal changes were significantly correlated with satisfaction, whereas in male patients, this relation did not reach statistical significance. Further, the correlation coefficients for changes in well-being were markedly different, with opposed signs for female and male patients.

Table 4 shows the results of the multiple regression predicting global satisfaction. The factors sex, age, pharmacotherapy, number of treatment sessions, and days between treatment end and assessment did not have a significant effect on patient satisfaction. However, the presence of a chronic disorder was a significant predictor for dissatisfaction. Concerning the perception of most important outcomes, changes in coping with specific problems and symptoms and changes in the interpersonal domain were positive predictors of patient satisfaction. However, improvements in pharmacotherapy reported as one of the most important outcomes predicted dissatisfaction. The predictive model accounted for 33% of the variance in patient satisfaction.

Discussion

In this explorative study, we assessed a consecutive sample of patients with nonpsychotic, nonsubstance-related disorders after psychiatric–psychotherapeutic treatment. Using self-report questionnaires, we investigated the relation between patient satisfaction and 1) diagnosis, 2) use of psychopharmacological medication, 3) important outcomes as reported retrospectively by patients.

Several methodological shortcomings need to be addressed. Recruiting all patients after 8 or more treatment sessions provided a heterogeneous sample with regard to psychopathology and treatments. However, this methodology allowed us to make comparisons between diagnostic categories and between treatment modalities; the results may be generalized to similar clinical settings. Also, the response rate of 60% and the significant differences between respondents and nonrespondents reduced the external and internal validity of the investigation. We did not include data assessed by interview because satisfaction scores assessed by questionnaire and direct interview are not comparable (6). In fact, the satisfaction scores assessed by telephone interview in our study were higher than those assessed by questionnaire. Because of this study's cross-sectional design, no inferences can be made about the direction of causality between our measures of change and patient satisfaction. We applied no standardized instruments for assessing health status before and after treatment; thus, patient satisfaction and patients' reported change could not be compared with quantitative health measures.

An analysis of variance revealed a relation between diagnostic categories and patient satisfaction. This result was confirmed by the final multiple regression showing a significant negative relation between the presence of a chronic psychiatric condition and patient satisfaction. The rather high level of satisfaction in subjects with affective and anxiety disorders and the rather low level of satisfaction in subjects with personality disorders confirms the results of previous studies (7,8); it supports the findings that patients with chronic psychosomatic conditions, such as eating and somatoform disorders, tend to have low levels of satisfaction and that patients with adjustment disorders (that is, time-limited mild conditions) tend to have high levels of satisfaction. In summary, our results support the generalizability of the association between dissatisfaction and the course (13) and severity (10) of mental health conditions.

Regarding different treatment aspects, we could not find a significant relation between the use of psychotropic medication and patient satisfaction, either by bivariate or by multivariate analyses. Therefore, we could not confirm the finding of the Danish researchers that "treatment with antidepressants is the most sensitive indicator of patient satisfaction" (7). However, our results are in line with studies showing that nonbiological

aspects of treatment, such as social support, contribute significantly to patient satisfaction (8) and that potential effects of psychotropic medication, such as reduction of psychiatric symptoms, may not be related to patient satisfaction (9,14).

Patient satisfaction was associated with the perception of important improvements in 2 specific outcome domains: coping with specific problems and symptoms and the interpersonal domain. This result consistently emerged both in bivariate and multivariate analyses. Although objective positive treatment outcome, measured as the difference in health status before and after treatment, does not necessarily produce patient satisfaction (24), our finding is in line with previous studies that found a strong relation between satisfaction and patients' global reports of outcome (10).

Moreover, we found a sex difference in the relation between satisfaction and perception of change. Among male patients, coping with specific problems and symptoms was associated with satisfaction, whereas among female patients, changes in the interpersonal domain were associated with satisfaction. These results must be interpreted with caution, because the sample was too small for more sophisticated statistics testing interactions among sex, patient-reported outcome, and satisfaction. This preliminary finding is intriguing, given that genetic and environmental factors causing psychiatric disorders may differ between the sexes (25,26). For example, male subjects were more sensitive to the depressogenic effects of work problems, while female subjects were more sensitive to problems socializing with individuals in their proximal network (26). Significant sex differences have also been shown in physiological responses to stress: male subjects showed significantly greater cortisol responses to achievement stress, while female subjects showed greater cortisol responses to social rejection challenges (27). Taken together, further research is warranted to test the hypothesis that treatment processes associated with positive outcome, including patient satisfaction, differ between the sexes.

As expected, the perception of no therapeutic change was associated with dissatisfaction. Unexpected, however, was the finding that only dissatisfied male patients reported improvement in the handling of and confidence in medication as important outcomes. Multivariate statistics confirmed the association between medication issues perceived as an important change and dissatisfaction. According to our data, interpreting this finding was not easy, because pharmacotherapy was not related to dissatisfaction, and improvements in pharmacotherapy perceived as one of the most important outcomes were not associated with lack of important outcomes in other change domains.

Finally, multiple regression analysis controlling for variables such as sex, age, and time between treatment end and assessment, which had shown weak effects on patient satisfaction in previous studies (10), did not change the primary results of this study. The direction of association between patient satisfaction and patient age, and between patient satisfaction and the interval between treatment end and assessment, was consistent with previous reports (6).

We conclude that chronic psychiatric conditions, such as somatoform and eating disorders, must be considered when measuring and interpreting patient satisfaction. Future research is needed to clarify the relation between medication issues reported as important outcomes and dissatisfaction. Moreover, this study encourages investigations of the role of sex in generating patient satisfaction.

References

1. Svensson B, Hansson L. Patient satisfaction with inpatient psychiatric care. The influence of personality traits, diagnosis and perceived coercion. Acta Psychiatr Scand 1994;90:379–84.
2. Kazdin AE. The meanings and measurement of clinical significance. J Consult Clin Psychol 1999;67:332–9.
3. Ruggeri M. Patients' and relatives' satisfaction with psychiatric services: the state of the art of its measurement. Soc Psychiatry Psychiatr Epidemiol 1994;29:212–27.
4. Ware JE Jr, Davies AR. Behavioral consequences of consumer dissatisfaction with medical care. Eval Program Plann 1983;6:291–7.
5. Tehrani E, Krussel J, Borg L, Munk-Jorgensen P. Dropping out of psychiatric treatment: a prospective study of a first-admission cohort. Acta Psychiatr Scand 1996;94:266–71.
6. Berger M. Toward maximizing the utility of consumer satisfaction as an outcome. In: Lambert M, Christensen ER, DeJulio SS, editors. The assessment of psychotherapy outcome. New York: John Wiley and Sons; 1983. p 56–80.
7. Kelstrup A, Lund K, Lauritsen B, Bech P. Satisfaction with care reported by psychiatric inpatients. Acta Psychiatr Scand 1993;87:374–9.
8. Perreault M, Rogers WL, Leichner P, Sabourin S. Patients' requests and satisfaction with services in an outpatient psychiatric setting. Psychiatr Serv 1996;47:287–92.
9. Marriage K, Petrie J, Worling D. Consumer satisfaction with an adolescent inpatient psychiatric unit. Can J Psychiatry 2001;46:969–75.
10. Lebow JL. Research assessing consumer satisfaction with mental health treatment: a review of findings. Eval Program Plann 1983;6:211–36.
11. Shipley K, Hilborn B, Hansell A, Tyrer J, Tyrer P. Patient satisfaction: a valid index of quality of care in a psychiatric service. Acta Psychiatr Scand 2000;101:330–3.
12. Middelboe T, Schjodt T, Byrsting K, Gjerris A. Ward atmosphere in acute psychiatric in-patient care: patients' perceptions, ideals and satisfaction. Acta Psychiatr Scand 2001;103:212–9.
13. Lehman AF, Zastowny TR. Patient satisfaction with mental health services: a meta-analysis to establish norms. Eval Program Plann 1983;6:265–74.
14. Hannöver W, Dogs CP, Kordy H. Patientenzufriedenheit–ein Mass für Behandlungserfolg? Psychotherapeut 2000;45:292–300.
15. Cohen M. Towards a framework for women's health. Patient Educ Couns 1998;33:187–96.
16. Riecher-Rössler A. Mental diseases in women—some arguments for a gender-sensitive psychiatry and psychotherapy. Z Psychosom Med Psychother 2000;46:129–39.
17. Grosse Holtforth M, Grawe K. Bern Inventory of Treatment Goals: Part 1. Development and first application of a taxonomy of treatment goal themes. Psychother Res 2002;12:79–99.
18. Dilling H, Mombour W, Schmidt MH. Internationale Klassifikation psychischer Störungen. ICD-10 Kapitel V (F). Klinisch-diagnostische Leitlinien. Bern: Verlag Hans Huber; 2000.
19. Larsen DL, Attkisson O, Hargreaves WA, Nguyen TD. Assessment of client/patient satisfaction: development of a general scale. Evaluation Program Planning 1980;2:197–207.
20. Hasler G, Mörgeli HP, Grosse Holtforth M, Buddeberg C. Erfassung von Veränderungen in psychiatrisch-psychotherapeutischen Kurztherapien aus Sicht der Patienten. Zeitschrift für Klinische Psychologie, Psychiatrie und Psychotherapie 2002;50:91–100.
21. Hasler G, Mörgeli HP, Schnyder U. Outcome of psychiatric treatment: what is relevant for our patients? Compr Psychiatry 2003. Forthcoming.
22. SPSS for Windows User's Guide. Release 10.0. Chicago (IL): SPSS Inc; 1999.

23. Tabachnick BG, Fidell LS. Using multivariate statistics. New York: HarperCollins; 1996.
24. El-Guebaly N, Toews J, Leckie A, Harper D. On evaluation patient satisfaction: methodological issues. Can J Psychiatry 1983;28:24–9.
25. Fanous A, Gardner CO, Prescott CA, Cancro R, Kendler KS. Neuroticism, major depression and gender: a population-based twin study. Psychol Med 2002;32:719–28.
26. Kendler KS, Thornton LM, Prescott CA. Gender differences in the rates of exposure to stressful life events and sensitivity to their depressogenic effects. Am J Psychiatry 2001;158:587–93.
27. Stroud LR, Salovey P, Epel ES. Sex differences in stress responses: social rejection vs achievement stress. Biol Psychiatry 2002;52:318–27.

Manuscript received February 2003, revised, and accepted February 2004.
[1]Resident Psychiatrist, Psychiatric Department, Zurich University Hospital, Zurich, Switzerland.
[2]Psychologist, Psychiatric Department, Zurich University Hospital, Zurich, Switzerland.
[3]Postdoctoral Fellow, Mood and Anxiety Disorders Program, Intramural Research Program, National Institute of Mental Health, National Institutes of Health, Bethesda, Maryland.
[4]Senior Physician, Division of Psychosocial Medicine, Zurich University Hospital, Zurich, Switzerland.
[5]Head, Division of Psychosocial Medicine, Zurich University Hospital, Zurich, Switzerland.
[6]Head, Psychiatric Department, Zurich University Hospital, Zurich, Switzerland.
Address for correspondence: Gregor Hasler, National Institutes of Health, National Institute of Mental Health, Mood, and Anxiety Disorders Program, 15K North Drive, Room 300C, MSC 2670, Bethesda, MD 20892
e-mail: g.hasler@bluewin.ch

Résumé : La satisfaction des patients quant au traitement psychiatrique externe : le rôle du diagnostic, la pharmacothérapie et le changement thérapeutique perçu

Objectif : Examiner l'influence du diagnostic, du type de traitement et du changement thérapeutique perçu sur la satisfaction des patients suite à un traitement psychiatrique pour des troubles non psychotiques, non liés à une substance.

Méthode : Nous avons posté des questionnaires, dont le questionnaire sur la satisfaction des clients de Larsen (CSQ) et l'inventaire de Berne des buts du traitement de Grawe (BIT-C), à des patients externes qui avaient eu 8 séances de thérapie ou plus, 1 an après le traitement.

Résultats : Les patients souffrant de troubles somatoformes, alimentaires et de la personnalité étaient moins satisfaits que les patients souffrant de troubles anxieux, affectifs et d'adaptation. La réduction des symptômes et les changements du domaine interpersonnel étaient des résultats importants associés à la satisfaction des patients. Bien que la pharmacothérapie en soi ne soit pas reliée à la satisfaction des patients, les patients qui percevaient les améliorations de la pharmacothérapie comme étant l'un des résultats les plus importants du traitement étaient moins satisfaits que les autres. Les preuves préliminaires indiquent que l'adaptation à des problèmes spécifiques et à des symptômes est associée à la satisfaction chez les patients masculins, tandis que les changements du domaine interpersonnel semblaient produire la satisfaction chez les patientes féminines.

Conclusion : Les patients ont déclaré que le changement et la catégorie de diagnostic semblent jouer un rôle utile dans la satisfaction des patients. Il faut plus de recherche pour clarifier les interactions entre le sexe, le résultat perçu et la satisfaction.