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Attitudes and Confidence in the Integration of Psychiatry Scale

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Abstract

Objective—There is growing consensus in medical education regarding the importance of integrating training in behavioral health and psychiatry with other fields of medicine, given broad applicability, inter-relatedness, and clinical relevance. The authors developed a scale to measure attitudes and confidence in the integration of psychiatry into other fields of medicine.

Methods—The Attitudes and Confidence in Integration of Psychiatry in Medicine (ACIP) scale was developed through discussion with content experts across disciplines and pilot testing of items. This scale was administered to third- and fourth-year medical students at three United States medical schools (University of Iowa, University of Michigan, Rush University) for validation, focused on assessment of variability, internal consistency, factor structure, and test-retest reliability.

Results—A total of 310 medical students completed the survey (35% participation rate). The scale had a high internal consistency (Cronbach's $\alpha=0.88$) and was without ceiling or floor effects. Survey items loaded on the two factors of interest: attitudes and confidence. Students rated the integration of psychiatry into the practice of surgery and its subspecialties as less relevant than its integration into other specialties; however, scores were not biased by students' interest in procedural vs. non-procedural specialties. Test-retest reliability was high (Cronbach's $\alpha=0.90$).

Conclusions—The ACIP may serve a useful role in determining the outcome of educational efforts toward integrated care.

Keywords

Medical Education; Medical Students; Attitudes; Psychiatry; Questionnaires

There is growing consensus in medical education regarding the importance of integrating training across major domains and fields of medicine [1]. Behavioral health and psychiatry are particular targets of integration due to the applicability and importance of their principles

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across disciplines [2–5]. Behaviors such as diet, physical activity, smoking, and alcohol/drug use play an important role in development and progression of human disease [6]. Psychiatric disorders are common [7] and disabling [8–10], worsen the prognosis of other medical conditions [11], and shorten life expectancy [12]. The ability to engage patients empathically and effectively toward developing more adaptive health behaviors and to identify, address, and assuage psychological suffering promotes a more humanistic, patient-centered approach to medical practice [13].

Attitudes toward psychiatry improve during the psychiatry clerkship but later deteriorate [14–16]. Medical educators are therefore challenged to extend the teaching of skills and concepts relevant to the integration of psychiatry and behavioral health into other medical specialties beyond the psychiatry clerkship into other clerkships. Educational interventions can impact both attitudes and confidence [17, 18], which are often correlated. Although there are several measures related to attitudes toward psychiatry [19–23], we found no measures assessing attitudes or confidence in specifically integrating psychiatric and behavioral principles into general medical practice. We thus developed and validated a scale: Attitudes and Confidence in Integration of Psychiatry in Medicine (ACIP) as a tool to measure students' attitudes and confidence related to such integration.

Methods

After a systematic review of the literature revealed no specific surveys that address attitudes toward integration of psychiatry, we reviewed broader measures of attitudes toward psychiatry. We used or modified key items from these scales for comparison to our draft metric, which students and content experts across disciplines reviewed for revision. The ACIP scale includes 14 items that assess attitudes toward the integration of teaching in psychiatry and behavioral health into various medical specialties as well as self-reported capability in performing relevant skills. The survey was piloted in small groups of students for feedback and to study response process. Institutional Review Board approval was obtained at the University of Iowa, University of Michigan, and Rush University to survey students using REDCap electronic data capture tools [24, 25] with an exempt information sheet because no personal identifiers were collected. In the event of <50% participation, a second e-mail was sent. No incentives for participation were provided at Iowa and Michigan. Rush provided an incentive with gift cards ranging in value from \$10–50 to a random sample of five participants who completed follow-up tests for test-retest reliability. We administered this scale to all third- and fourth-year medical students in 2013 at Iowa and Michigan and in 2014 at Rush. To assess the validity of the scale, we evaluated variability, internal consistency, and factor structure. At Iowa and Michigan, the survey included the ACIP and eight additional questions; some borrowed or adapted from existing scales, capturing opinions on the role of psychiatry in the medical curriculum, the relevance to other medical fields, and self-reported intention of screening for common conditions. At Rush, we assessed test-retest reliability at a 1-week interval in 105 of the 122 initial respondents (86% retest response rate). The curriculum at Iowa and Rush involved a 4-week psychiatry clerkship and at Michigan a 6-week clerkship. The required clerkship could be taken in the third or fourth year at Iowa and only during the third year at the other sites.

Statistical Analyses

Analyses were performed using SAS 9.4 (SAS Institute, Inc., Cary, NC). We assessed the variance of individual items using descriptive statistics to avoid items with intra-item floor or ceiling effects. Item-to-total correlations ensured individual items were in line with the overall construct. We assessed internal consistency using Cronbach's alpha in aggregate and with each item individually removed. We performed a factor analysis using Proc Factor with promax rotation, which provides both orthogonal and oblique rotations. We determined the optimal solution to the underlying factor structure through visual inspection of a scree plot and restriction to those factors with an eigenvalue > 1 in accord with the Kaiser-Guttman rule. For our *a priori* power analysis, assuming 150 students would participate across sites and a Cronbach's alpha of 0.7, the precision of our 95% confidence intervals would be 0.63 to 0.76 for the ACIP sub-scales.

We contrasted individual attitudes items to compare the perceived relevance of psychiatry across rotations. We report means for these 7-level ordinal measures to facilitate comparison, notwithstanding limitations for using mean as a measure of central tendency in ordinal data. We compared ACIP scores to responses to 8 additional questions to assess the relationship to other variables.

Results

A total of 310 students completed the survey. The participation rate was 30% at Iowa, 31% at Michigan, and 47% at Rush. Most respondents were female (56%) and between the ages of 26 and 30 years (57%). Only 7 (2%) students had less than 6 months' experience on clinical rotations, whereas 26% had 6–12 months, 38% had 13–18 months, and 34% had >18 months of experience. There were no site differences in the age or gender of respondents. Students at Rush had more experience on clinical rotations ($\chi^2=96.5$, $df=6$, $p<0.0001$). The age of respondents was representative of the student body, and females were slightly, but not significantly, more likely to respond (55% of respondents vs. 52% of student population, $p=0.35$). Figure 1 illustrates the individual survey items and the percent of respondents who provided a particular response for each item. Relative to other rotations surveyed, students reported teaching in psychiatry and behavioral medicine was significantly more important for emergency medicine (mean 5.8, range 1 [not important at all] to 7 [extremely important] point ordinal scale), adult ambulatory medicine (5.7), neurology (5.7), pediatrics (5.4), and inpatient medicine (5.6); significantly less important for general surgery (4.2) and specialty surgery (4.1); and not significantly different for obstetrics and gynecology (5.2).

We did not observe site differences in ACIP score (mean [SD]: Iowa 58.1[11.2]; Michigan 59.9[10.0]; Rush 59.9[11.4]) and pooled data for analyses. We did not impute scores for missing data, and 292 provided complete data for calculation of the total ACIP score. The mean (SD) total ACIP score was 73.4 (10.9). The ACIP total score had a slight negative (left) skew (skewness -0.32 , Kolmogorov-Smirnov test $p=0.01$) and was without ceiling effects. The scale showed considerable variability across respondents (as illustrated in Figure 1) and a high internal consistency (Cronbach's alpha=0.88). Removal of individual items did not increase the alpha, and all variables were at least modestly correlated with the ACIP total score, with the correlation of individual items with the total score ranging from

$r=0.39$ to $r=0.68$. From the 105 participants who repeated the instrument 7–10 days later at Rush, test-retest reliability was high ($r=0.82$, $p<0.0001$, Cronbach's $\alpha=0.90$).

On factor analysis, two factors demonstrated eigenvalues > 1 . All attitudes items most closely aligned with a factor interpreted as *Attitudes* and confidence items most closely aligned with a factor interpreted as *Confidence* (Table 1) with modest correlations between items capturing attitudes and those capturing confidence. The mean (SD) score on the attitudes subscale was 41.8 (8.5) and 31.6 (5.1) on the confidence subscale. The attitude and confidence subscales were correlated ($\rho=0.26$, $p<0.0001$).

The ACIP total score and subscales, which were explored only to pursue significant associations to total score, were associated with responses to an additional eight questions, which were asked on a 5-point, ordinal, Likert scale (strongly agree, agree, neutral, disagree, strongly disagree; Table 2). Those with higher ACIP scores were more likely to believe that medical schools should devote more of their curriculum to psychiatry ($\rho=0.22$, $p=0.003$, significant for only attitude sub-scale, $p<0.0001$) and that increased detection of psychiatric and substance use disorders would improve medical outcomes ($\rho=0.38$, $p=0.0001$, significant for only attitude sub-scale, $p<0.0001$). Those with higher ACIP scores were less likely to view students who go into psychiatry as wasting a portion of their medical school training ($\rho=-0.22$, $p=0.004$, significant for only attitude sub-scale, $p=0.0009$). Those who scored higher on the ACIP were also more likely to report intent to screen for drug use, mood disorders, or delirium and more likely to report having discovered the presence of an undetected psychiatric disorder while rotating on non-psychiatry clerkships. These items were significantly related to both attitude and confidence sub-scales.

Students at Iowa were asked how likely they were considering a career in psychiatry on a Likert scale, and this did not predict ACIP total score ($\rho=0.11$, $p=0.31$) or either subscale. Students at Michigan and Rush were asked which specialty they were most interested in pursuing. Students interested in psychiatry ($N=16$) had higher ACIP scores (psychiatry mean (SD) 80.6 (7.6) vs. comparison mean (SD) 73.4 (10.8), Wilcoxon Rank Sum $Z=-2.8$, $p<0.005$), which was significant only for the confidence subscale. Students selecting a procedural specialty ($N=62$) did not differ from those selecting a non-procedural specialty on the ACIP or its subscales. ACIP scores were not significantly higher for those with more clinical experience, but students with more than 1 year of clinical experience scored higher on the confidence subscale (mean (SD) 32.3 (4.6) vs. 29.6 (5.8), Wilcoxon Rank Sum $Z=-3.93$, $p<0.0001$), but not the attitude subscale.

Discussion

The ACIP scale provides a valid measure of attitudes and confidence in the integration of psychiatry and other areas of medicine. The items neatly fit into two subscales, attitudes and confidence. For specific applications, one subscale may be more relevant than the other because some educational interventions may be more interested in changing attitudes and others, self-perceptions of clinical skills.

Similar to general attitudes towards psychiatry [26, 27], students rated psychiatric teaching as highly relevant to patient care. We did not identify any substantive differences in attitudes or confidence by self-reported specialty of interest beyond psychiatry. This finding may challenge stereotypes regarding the attitudes toward psychiatry of students interested in particular specialties, such as procedural specialties. Career interests do not appear to reflect attitudes about the relevance of psychiatry to other specialties despite the perception that psychiatry is less relevant to surgical specialties. Surgeons have been noted to have poorer attitudes toward collaborative mental health care than other physicians [28]. In light of our findings, this may reflect perceived relevance to their specialty of practice rather than simply negative attitudes toward an entire class of providers. Surgical specialties may be one area where attitudes toward integration could be better targeted.

Attitudes toward psychiatry improve during the psychiatry clerkship [29], though decay over time [14–16]. A focus on the integration of psychiatry into other areas of medicine following the clerkship may counter this decay. Students who believed that increased detection of psychiatric and substance use disorders improves other medical outcomes or had personally discovered an unrecognized behavioral disorder in other medical settings had better attitudes toward the integration of psychiatry in other areas of medicine. This finding suggests that integration of such training into the very settings wherein these skills could be used might be effective for improving attitudes. Future study of interventions targeting such educational integration is warranted; the ACIP may serve as a useful outcome measure.

There are several limitations in the development of this ACIP survey. Confidence measures self-perceptions of competence, and our study cannot determine whether these self-perceptions reflect actual skill or implementation in practice. Validation focused on content, response process, and relationships to other variables. Future study is needed to provide external validation of this measure to the actual practice of medicine. The survey was conducted with medical students across three medical schools of varying urbanicity in the US. Testing in other countries would demonstrate whether it would perform similarly. It would be of interest to see how these measures evolve into postgraduate medical training. It is not established whether these results would generalize to trainees in other health care fields. Our participation rate was modest and this likely reflects the lack of compensation for survey completion at two sites. Differences in outcome were not observed in the site with greater participation. The total score weighs the attitudes items more heavily than confidence items, the appropriateness of which may vary by the needs of a given program. The combination of attitudes and confidence may be of interest to some, but not all, users, and individual sub-scores can subsequently be derived.

Our results have important implications for medical educators. Emphasis is needed on the applicability of behavioral medicine to surgical specialties. Learning exercises in psychiatric clerkships can utilize cases in which a psychiatric issue is addressed in a general medical or surgical setting. In 2015, only 4.6% of US senior medical students matched into psychiatry through the National Residency Matching Program [30]. Thus, for the vast majority of medical students, the application of training in psychiatry and behavioral medicine relates to the integration of such training and skills into their non-psychiatry practice, where these skills are clearly relevant. The ACIP may also be useful to examine other correlates, such as

personal experience (including experience on clinical rotations), familial experience, and stigma, which were not assessed in this study.

This is the first questionnaire developed to assess the attitudes and confidence of medical students with regard to the integration of psychiatry and behavioral medicine into other medical settings. The content captured here extends beyond attitudes toward psychiatry, which have been measured elsewhere [29]. The ACIP deals with the perceived relevance of psychiatric skills to the practice of medicine and is therefore applicable to the general training of physicians in the integration of psychiatric skills into their practice. The ACIP is useful to assess attitudes and confidence and can serve as an outcome for educational efforts and interventions targeting integration. Future study is necessary to determine whether any such changes in attitudes and confidence are correlated with improvements in the actual practice of medicine.

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Implications for Educators

- The ACIP may serve as a useful measure of attitudes and confidence toward the integration of psychiatry in other fields of medicine.
- Apart from interest in psychiatry, specialty of interest does not appear to be a reliable indicator of attitudes regarding the importance of training in psychiatry to the practice of other areas of medicine.
- Educators should avoid conflating interest with attitudes.
- Educators should focus efforts on teaching psychiatric medicine within the context of other medical specialties as a strategy to improve the attitudes, confidence, and potentially the skills necessary for successful practice across fields of medicine.

How important is teaching in psychiatry and behavioral medicine to the care of patients in:							
	1 Not Important at All	2	3	4	5	6	7 Extremely Important
A1. An inpatient medicine service?	0%	1%	4%	10%	32%	28%	25%
A2. Adult ambulatory medicine?	0%	3%	3%	11%	20%	29%	34%
A3. General surgery?	3%	12%	19%	24%	23%	11%	9%
A4. Specialty surgery settings?	5%	15%	23%	18%	24%	6%	9%
A5. Pediatrics?	0%	2%	7%	17%	23%	25%	26%
A6. Emergency medicine?	0%	1%	3%	8%	23%	26%	41%
A7. Obstetrics and Gynecology?	1%	1%	5%	17%	34%	22%	20%
A8. Neurology?	1%	0%	3%	12%	24%	31%	30%
How capable do you feel with the following:							
	1 Not Capable	2	3	4	5	6	7 Extremely Capable
C1. Interviewing an emotionally distressed patient?	1%	1%	7%	20%	32%	30%	9%
C2. Screening for delirium?	1%	5%	11%	20%	34%	20%	9%
C3. Screening for depression in outpatients?	0%	0%	1%	7%	27%	39%	25%
C4. Dealing with anxious patients and family members?	0%	2%	5%	18%	35%	32%	9%
C5. Screening for drug use in general medical settings?	1%	3%	13%	20%	27%	25%	11%
C6. Assessing a patient's risk of suicide?	0%	1%	8%	18%	38%	24%	11%

Figure 1. Attitudes and Confidence in the Integration of Psychiatry (ACIP) questionnaire

The core questions for the ACIP included 14 items rated on a 1–7 scale (range 14–98) and are shown in a tabular format analogous to that viewed by students through the electronic interface. The 8 attitudes items are denoted with the letter “A” and the 6 confidence items with the letter “C.” The modal response for each item is indicated by bold text.

Table 1**Factor Structure**

Correlations of each item with the two factors are noted above. The attitudes items (A) correlated strongly with Factor 1 and the confidence items (C) strongly with Factor 2.

Item/Correlations	Factor 1 Attitude	Factor 2 Confidence
A1. Inpatient Medicine	0.80	0.37
A2. Outpatient Medicine	0.75	0.35
A3. General Surgery	0.85	0.23
A4. Specialty Surgery	0.86	0.23
A5. Pediatrics	0.78	0.29
A6. Emergency Medicine	0.71	0.23
A7. Obstetrics and gynecology	0.75	0.21
A8. Neurology	0.76	0.25
C1. Interviewing an emotionally distressed patient	0.23	0.73
C2. Delirium screening	0.29	0.66
C3. Depression screening	0.24	0.67
C4. Dealing with anxious patients and family members	0.24	0.75
C5. Screening for Drug Use	0.15	0.70
C6. Assessment of Suicide Risk	0.31	0.74

Table 2
Items Related to Attitudes and Confidence on the Integration of Psychiatry

Non-parametric correlations (Spearman's rho) of miscellaneous items asked on a 5-point Likert scale (ranging from Strongly Disagree to Strongly Agree).

Item/Correlations	ACIP Total Score	Attitude Subscale	Confidence Subscale
Medical schools should devote more of their curriculum and/or clerkship time to psychiatry.	0.22 [‡]	0.32 [‡]	-0.12
Increased detection of psychiatric disorders and substance use disorders would result in improved medical outcomes.	0.38 [‡]	0.42 [‡]	0.09
I intend to routinely screen for drug use in patients presenting in all general medical settings.	0.26 [‡]	0.18 [‡]	0.19 [‡]
I intend to routinely screen for mood disorders in patients presenting in all general medical settings.	0.31 [‡]	0.27 [‡]	0.18 [‡]
I intend to routinely screen for delirium in hospitalized patients.	0.35 [‡]	0.24 [‡]	0.18 [‡]
I intend to routinely screen for dementia in elderly patients.	0.30 [‡]	0.23 [‡]	0.25 [‡]
During my non-psychiatry clerkships, I personally discovered the presence of an otherwise undetected psychiatric disorder.	0.35 [‡]	0.23 [‡]	0.25 [‡]
Students who go into psychiatry are wasting a portion of their medical school training.	-0.22 [‡]	-0.25 [‡]	-0.04

[‡] Signifies p<0.05.

[‡] Signifies p<0.01.