Medical Patients' Attitudes Toward Emotional Problems and Their Treatment

What Do They Really Want?

Bernd Löwe, MD, PhD,¹ Ute Schulz, MD,¹ Kerstin Gräfe, MS,¹ Stefanie Wilke, PhD¹

¹Department of Psychosomatic and General Internal Medicine, University of Heidelberg Medical Center, Heidelberg, Germany.

BACKGROUND: Understanding medical patients' attitudes toward emotional problems and their management is crucial to overcoming obstacles to efficient depression treatment.

OBJECTIVE: To investigate attitudes toward emotional problems, psychotherapy, antidepressants, alternative treatment approaches, and self-management techniques in depressed and nondepressed medical outpatients.

DESIGN: Cross-sectional interview study, including quantitative and qualitative methods.

PATIENTS: Eighty-seven depressed subjects (mean age, 41.0 years; 66% female) and 91 nondepressed subjects (mean age, 41.4 years; 67% female) from 7 internal medicine outpatient clinics and 12 family practices (participation rate, 91%).

MEASUREMENTS: Depression diagnoses were established using a structured diagnostic interview, and patient attitudes were investigated with open-ended interview questions regarding treatment preferences, factors improving and impairing emotional well-being, and patients' self-management to improve well-being.

RESULTS: Among the depressed patients, psychotherapy was the most frequently preferred treatment (29%) and the most common factor reported to improve emotional well-being (36%). Twenty-two percent of the depressed patients desired depression treatment within their current medical system, but requested substantially more time to communicate with their physician. Antidepressants were rarely mentioned as a preferred treatment (6%) or factor improving well-being (11%). Thirty-eight percent of the depressed patients attributed their impaired mood to health problems. Compared with the depressed patients, the nondepressed controls preferred significantly less frequent depression-specific therapies.

CONCLUSIONS: The vast majority of medical outpatients prefer treatment approaches for emotional problems that go beyond antidepressant medication therapy. Health care providers should consider providing sufficient time to communicate with their patients, the strong preference for psychotherapy, and an appropriate treatment of comorbid physical conditions.

KEY WORDS: depression; patient preferences; antidepressants; psychotherapy; primary care.

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In spite of a series of studies aimed at improving provider detection and treatment of depression over the past 20 years, only 1 out of 5 patients with a major depressive disorder receives adequate treatment.^{1–5} Nevertheless, 83% of depressed patients desire treatment⁶ and 84% are at least somewhat interested in receiving help for their emotional distress from their primary care physician.⁷ In order to bridge

the gap between the availability of efficient depression treatment^{8–11} and the low number of depressed patients actually receiving treatment,¹ in-depth investigations of patients' attitudes toward emotional problems are necessary. Existing studies are focused on patient acceptance of psychotherapy or antidepressant medication,^{6,7,12–16} as opposed to considering alternative treatment approaches and self-management techniques that patients with depression might consider helpful in improving their well-being. To our knowledge, our study is the first to investigate subjective treatment preferences that include alternative approaches and self-management techniques.

Despite our fragmentary knowledge on depressed patients' alternative treatment approaches and self-management techniques, their preferences for traditional treatment approaches are relatively clear: in studies from the United States, Europe, and Australia, most patients prefer counseling or psychotherapy compared to antidepressants.^{6,7,12–17} A German general population survey suggests that the preference for psychotherapy is based on the idea that this treatment provides an opportunity for personal exchange and problem solving.¹³ Many patients, who want their physician to help them with emotional problems, do not meet standard criteria for depressive disorders.^{7,17,18} Nevertheless, patients with major or minor depression are significantly more likely to desire treatment for emotional distress than patients with no depression.⁷ In addition, because of potential prior experience with depression treatment and the cognitive features of depressive disorders, e.g., diminished interest in activities or negative view of the world,^{19–21} it is necessary to investigate these questions in depressed and nondepressed patients separately.

Structured interviews or questionnaires are limited in adequately reflecting patients' attitudes, beliefs, and preferences as these methods do not account for reactions beyond the given response format. In order to address these questions in the patients' everyday context, we used a qualitative approach including open-ended questions.^{22–26} With the long-term goal to better match depression care with patients' beliefs, this study aimed to investigate treatment preferences for emotional problems and factors affecting emotional well-being among depressed and nondepressed medical outpatients.

METHODS

Subjects

This study was performed in patients from 7 internal medicine outpatient clinics of the University of Heidelberg, Medical Center, and 12 family practices in Heidelberg, Germany. The participants of this study were recruited among a patient sample

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Address correspondence and requests for reprints to Dr. Löwe: Department of Psychosomatic and General Internal Medicine, University of Heidelberg, Medical Center, Im Neuenheimer Feld 410, D-69120 Heidelberg, Germany (e-mail: bernd.loewe@med.uni-heidelberg.de).

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from a prior study.²⁷ In the prior study, depression status was investigated in 501 patients using the Structured Clinical Interview for DSM-IV (SCID)²⁸ in order to validate the German version of the Patient Health Questionnaire (PHQ).^{27,29,30} For the present study, we aimed to interview subgroups of depressed and nondepressed patients, approximately equal in size and comparable in terms of patient characteristics. Among the 126 patients with the diagnosis of any depressive disorder in the prior study, we invited all available subjects who had agreed to be re-interviewed at the time of the prior study. To recruit a similar number of patients with no current depression diagnosis, we approached a sub-sample of subjects with no previous depression diagnosis from the same study. As the patient group with no depression diagnosis in the prior study ($n=375$) was 3 times larger than the patient group with a depressive disorder, we selected the potential participants for our present study by matching them with respect to age, gender, and study site using the depressed patient group as a reference. The present study was performed 12.3 ± 3.0 months after the previous study, and the interviewers were blinded to the patients' individual results from the previous study. The patients were approached and individually interviewed by telephone. The telephone interview was independent of visits at the outpatient clinics or practices.

Attitudes toward emotional problems and their treatment were compared between currently depressed and nondepressed patients. Additionally, as the patients' individual course of depression and actual treatment experience are expected to influence their attitudes, we specifically investigated preferences for psychotherapy or antidepressant medication in the 4 possible subgroups: (a) prior depression, current depression; (b) prior depression, no current depression; (c) no prior depression, current depression; and (d) no prior depression, no current depression. We expected the most valid information to come from group (b), as this patient subgroup had improved depression status. All subjects provided informed consent. The study was approved by the Institutional Review Board of the Medical Faculty, University of Heidelberg.

Measures

The telephone interview included the SCID,²⁸ open-ended questions to investigate patients' views of emotional problems and their management, sociodemographic variables, treatment variables, and an assessment of depression severity. Depression severity was measured using the German version of the 9-item depression module from the PHQ-9.^{27,29,31,32} The validated German version of the PHQ was compiled using several steps of translation and blind back-translation following state-of-the art procedures for test translation.^{27,33} Medical records were reviewed to obtain primary physical diagnoses according to the International Classification of Disease, 10th edn.

The SCID²⁸ was used as the criterion standard for diagnosing depressive disorders according to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR).²⁰ Panic disorder was also diagnosed with the SCID, because this condition is highly prevalent in medical patients^{30,34} and might influence the patients' attitudes toward psychotherapeutic or psychopharmacological treatment. Patients with panic disorder alone were excluded from analyses to prevent confounding by this frequent condition in the comparison group. The SCID

was administered by 2 trained raters. In our previous study, interrater reliability for the SCID was excellent (e.g., major depressive disorder, $\kappa=0.88$).^{27,35}

A semi-structured interview, including 4 open-ended questions, was used to investigate patients' attitudes toward emotional problems and their treatment. The patients were informed that our aim was to identify factors that would help to improve clinical care. Earlier versions of these questions have been tested in another study.³⁶ The wording of these questions was:

1. "What kind of treatment would you prefer for your emotional problems?"
2. "Was there something that impaired your emotional well-being?"
3. "In your opinion, what factor helped most to improve your emotional well-being?"
4. "What could you do, yourself, to improve your emotional well-being?"

The questions were asked literally, but were explained further if the patient asked. Notes of patients' responses were taken during the telephone interview, and then verified for completeness and accuracy immediately after the telephone call.

Qualitative and Statistical Methods

To better understand patients' attitudes toward emotional problems and their treatment, we used qualitative content analysis^{23,25,37} of patients' responses to the 4 open-ended questions. First, the information most pertinent to the posed question was identified. Second, names were given to each unit of information identified. Third, these content units were compared, ordered, and grouped into categories. The categories were initially generated by 1 author (U.S.) and subsequently reviewed by the other authors. This procedure was repeated in cyclic processes until all authors agreed upon the final categories. The validity of the final categories was assessed by intersubjective consensus, plausibility, and discriminatory power.^{38,39} Finally, the prevalence of each response category was measured.

To compare response category frequencies for each question between depressed and nondepressed patients, we performed χ^2 tests or Fisher's exact tests if cell counts were <5 . Because these comparisons were considered exploratory and hypotheses-generating in nature, statistical significance was based on 2-sided tests evaluated at the .05 level of significance. However, comparisons that remained significant after Bonferroni's adjustment for multiple testing were identified in the results tables.

Because of the number of depressed subjects in our previous study,²⁷ our sample size was limited to approximately 90 subjects per group. Given this sample size, an α -level of 5% (2-sided), and a β -level of 20%, power analyses for comparing proportions between 2 groups showed sufficient power to detect a group difference of 20% for a lower base rate of 20%, or a group difference of 15% for a lower base rate of 5%, respectively.

Table 1. Patient Characteristics

Categorical Variables	Depressed Patients (N=87), n (%)	Nondepressed Patients (N=91), n (%)
Sex, female	57 (66)	61 (67)
Married or living with a partner	62 (71)	68 (75)
At least 10 y of schooling	46 (53)	52 (58)
Self-employed	6 (7)	6 (7)
Primary physical diagnosis, ICD-10		
Musculoskeletal system and connective tissue	15 (17)	23 (25)
Endocrine, nutritional, and metabolic	11 (13)	13 (14)
Cardiovascular and circulatory	11 (13)	9 (10)
Gastrointestinal system	8 (9)	10 (11)
Respiratory system	10 (12)	4 (4)
Other	32 (37)	32 (35)
Current treatment for emotional problems		
Psychotherapy*	33 (38)	15 (17)
Antidepressant medication*	29 (33)	12 (13)
Psychotherapy or antidepressants*	51 (59)	22 (24)
Continuous Variables	M (SD)	M (SD)
Age (y)	41.0 (13.6)	41.4 (13.3)
Days impaired, past 3 mo*	28.0 (36.6)	11.0 (24.8)
Days hospitalized, past 3 mo*	3.1 (9.6)	0.6 (3.0)
Number of doctor's visits, past 3 mo*	9.3 (9.7)	4.1 (5.7)
Depression severity, PHQ-9 (range 0 to 27)*	14.1 (4.8)	3.6 (3.3)

*P-value $\leq .05$, using χ^2 test for categorical data, and t-test for continuous data, respectively.

ICD-10, International Classification of Disease, 10th edn; PHQ-9, 9-item depression severity scale of Patient Health Questionnaire.

RESULTS

Patient Characteristics

Two hundred and twenty-six patients were eligible for the present study. For 21 of these patients, current telephone numbers were not available. All of the remaining 205 patients were approached, and 186 completed the interview (participation rate, 186/226, 82.3%). Participation rate did not differ significantly between currently depressed and nondepressed patients, and participants and nonparticipants did not differ significantly by gender, age, and prior psychiatric diagnosis.

Current depressive disorders were diagnosed in 87 patients: major depression in 41 (47%) patients, major depression in partial remission in 16 (18%), and minor depression in 30 (34%). Thirty-seven (42%) patients had comorbid panic disorder. Eight patients with panic disorder alone were excluded from the analyses. The 91 patients with no diagnosis of depressive or panic disorder constituted our control group. With respect to the prior study, the numbers of patients assigned to the 4 possible subgroups were as follows: (a) prior depression,

current depression, $n=73$; (b) prior depression, no current depression, $n=32$; (c) no prior depression, current depression, $n=14$; and (d) no prior depression, no current depression, $n=59$.

Patient characteristics are summarized in Table 1. The depressed and nondepressed patient groups were well matched by age, gender, marital status, educational level, self-employment, and primary physical diagnosis. As expected, depression severity, treatment rates for emotional problems, the numbers of days impaired or hospitalized, and the number of doctor's visits were significantly higher in the depressed compared with the nondepressed patients.

Treatment Preferences

Among the depressed patients, psychotherapy was the most preferred treatment (29%) (Table 2). Twenty-five percent of the depressed patients were convinced that they needed no treatment at all. Twenty-two percent criticized the medical care they actually received and thought that its improvement, e.g., having more time to talk with the treating physician, would be the best treatment for their emotional problems. In addition, 13% of the patients considered the treatment of their physical illness as crucial for their emotional problems. Only 6% of the depressed patient sample regarded medication treatment as appropriate therapy for their emotional problems. Depression-specific treatment, such as psychotherapy, relaxation techniques, and medication, were more frequently mentioned by the depressed compared to the nondepressed patients. In contrast, no specific treatment was more frequently named by the nondepressed patients.

Table 2. Treatment Preferences for Emotional Problems*

	Depressed Patients (N=85) [†] , n (%)	Nondepressed Patients (N=91), n (%)
Psychotherapy [‡]	25 (29)	13 (14)
No treatment ^{‡§}	21 (25)	45 (50)
Improvement of medical care (e.g., more time to communicate with physician)	19 (22)	12 (13)
Physical treatment: physiotherapy, sports, massage, weight reduction	15 (18)	16 (18)
Treatment of physical illness	11 (13)	10 (11)
Relaxation techniques [‡]	10 (12)	2 (2)
Alternative medicine or acupuncture	8 (9)	8 (9)
Medication [‡]	5 (6)	0 (0)
Regular consultations by primary care physician [‡]	4 (5)	0 (0)
Other preferences (each mentioned by ≤ 2 patients)	6 (7)	8 (9)

*Assessed with open-ended question: "What kind of treatment would you prefer for your emotional problems?"

[†]Two depressed patients did not respond to this question.

[‡]P-value $\leq .05$, using χ^2 test or Fisher's exact test (if cell counts < 5).

[§]Group differences are significant after Bonferroni's adjustment for multiple testing ($P < .0012$).

Table 3. Factors Impairing and Factors Improving Emotional Well-Being

	Depressed Patients, n (%)	Nondepressed Patients, n (%)
Factors impairing emotional well-being*	(N=87)	(N=91)
Interpersonal problems ^{‡§}	36 (41)	16 (18)
Work-related problems [‡]	33 (38)	17 (19)
Health problems	33 (38)	23 (25)
Psychological problems: anxiety, worries, depression, lack of self-confidence	12 (14)	8 (9)
Non-satisfactory medical care	9 (10)	3 (3)
Nothing/don't know ^{‡§}	7 (8)	28 (31)
Excessive demands	7 (8)	11 (12)
Dealing with significant others' problems:	4 (5)	9 (10)
illness, unemployment, etc.		
Housing conditions	4 (5)	7 (8)
Death of family member/close friend	3 (3)	8 (9)
Financial situation	1 (1)	4 (4)
Other factors (each mentioned by ≤ 2 patients)	3 (3)	1 (1)
Factors improving emotional well-being[‡]	(N=84)	(N=89)
Psychotherapy [‡]	30 (36)	17 (19)
Partner [‡]	19 (23)	8 (9)
Family	14 (17)	16 (18)
Talking with close friends	14 (17)	11 (12)
Activity/exercise	11 (13)	18 (20)
Relaxation/rest	10 (12)	7 (8)
Medication	9 (11)	9 (10)
Actively addressing problems	8 (10)	12 (14)
Medical care/improvement of physical illness	8 (10)	5 (6)
Success in one's career	6 (7)	7 (8)
Suppressing problems	4 (5)	2 (2)
Nothing/don't know [‡]	3 (4)	12 (14)
Positive thinking	1 (1)	5 (6)
Other factors (each mentioned by ≤ 2 patients)	3 (4)	1 (1)

*Assessed with open-ended question: "Was there something that impaired your emotional well-being?"

[‡]Assessed with open-ended question: "In your opinion, what factor helped most to improve your emotional well-being?" Three depressed and 2 non-depressed patients did not respond to this question.

[§]P-value ≤ .05, using χ^2 test or Fisher's exact test (if cell counts < 5).

[§]Group differences are significant after Bonferroni's adjustment for multiple testing (P < .0012).

Factors Impairing Emotional Well-Being

Among depressed patients, interpersonal problems (41%), work-related problems (38%), and health problems (38%) were the most commonly named factors impairing their emotional well-being (Table 3). In contrast, the nondepressed patients most frequently mentioned that nothing impaired their emotional well-being or that they were not aware of a particular factor (31%). Health problems (25%), work-related problems (19%), and interpersonal problems (18%) were also frequently endorsed by the nondepressed patients. The statistical comparisons demonstrated significant group differences with respect to the frequency of interpersonal problems, work-related problems, and the knowledge of factors impairing emotional well-being.

Table 4. Patients' Self-Management to Improve Well-Being*

	Depressed Patients (N=87), n (%)	Nondepressed Patients (N=91), n (%)
Exercise	34 (39)	34 (37)
Relaxation/rest [‡]	23 (26)	41 (45)
Actively addressing problems	23 (26)	24 (26)
Activity	22 (25)	22 (24)
Talking with close friends	16 (18)	16 (18)
Living healthier (weight loss, healthy food, enough sleep)	10 (12)	7 (8)
Suppressing problems	8 (9)	5 (6)
Nothing/do not know	8 (9)	5 (6)
Positive thinking	5 (6)	7 (8)
Better job	1 (1)	0 (0)

*Assessed with open-ended question: "What could you do, yourself, to improve your emotional well-being?"

[‡]P-value ≤ .05, using χ^2 test or Fisher's exact test (if cell counts < 5). No comparison met the level of significance after Bonferroni's adjustment for multiple testing (P < .0012).

Factors Improving Emotional Well-Being

Thirty-six percent of the depressed patients named psychotherapy as the most important factor improving their emotional well-being (Table 3). Other key factors were partner (23%), family (17%), friends (17%), activity or exercise (13%), and relaxation or rest (12%). Medication treatment was named by 11% of the depressed patients. The nondepressive patients most commonly named activity or exercise (20%), psychotherapy (19%), and family (18%). Psychotherapy and partner were more frequently mentioned as improving factors by the depressed compared to the nondepressed patients. The nondepressed patients more frequently reported that they did not know or that nothing specifically improved their emotional well-being.

Patients' Self-Management

The most frequent self-management methods to improve well-being among the depressed patients were exercise (39%), relaxation or rest (26%), actively addressing problems (26%), activity (25%), and talking with close friends (18%) (Table 4). These were also the most common methods in the nondepressed patients. However, compared with the depressed patients, the nondepressed patients more frequently mentioned relaxation or rest as a means to improve emotional well-being.

Preference for Psychotherapy or Antidepressant Medication in 4 Subgroups

The percentage of patients who had current or prior experience with psychotherapy or antidepressant medication, respectively, is shown in Figure 1 (top). As expected, treatment rates differed significantly among the 4 subgroups (psychotherapy, $\chi^2=22.2$, $P<.001$; antidepressant medication, $\chi^2=26.1$, $P<.001$). Although a similar number of patients had experience with psychotherapy and antidepressants in each subgroup, psychotherapy was the preferred treatment in 3 of the 4 subgroups (Fig. 1, middle). Similarly, psychotherapy was more frequently named as a factor improving emotional well-being in all subgroups (Fig. 1, bottom). Within the subgroup of previously depressed and currently nondepressed patients, 31% preferred psychotherapy and 0% antidepressant medication ($\chi^2=11.9$, $P<.001$).

FIGURE 1. Prior or current treatment with psychotherapy or antidepressant medication, respectively (top), treatment preferences (middle), and subjective factors improving emotional well-being (bottom) in four patient subgroups with different courses of depression.

DISCUSSION

Our study findings suggest that traditional psychotherapy and medication are by far not the only treatment approaches that medical outpatients consider for their emotional problems. Altogether, only 35% of the depressed patients reported either psychotherapy or antidepressant medication as their preferred therapy. This low number indicates that, in most cases, the patients' subjective preferences for treatment of emotional problems are not in concordance with what their physicians

consider to be effective treatment. In addition, it suggests a lack of confidence in established depression treatment.

A substantial number of depressed patients desired treatment within their current medical system, either as efficacious treatment of their physical disease or as improved medical care. Given that 38% of the depressed medical outpatients thought that their impaired mood was caused by health problems, it is understandable that successful treatment of the physical illness and an enhanced health care system were seen as prerequisites for an improved emotional well-being.

The most important demand for an improved health care system was more time with the treating physician, allowing patient-doctor communication beyond the usual pressure of time. Specifically, the patients thought that more information and advice with respect to their physical disease would help them with their emotional problems. Relaxation techniques, alternative medicine, acupuncture, physiotherapy, sports, massage, or weight reduction were also seen as important elements of professional treatment of emotional problems.

A comparable number of depressed patients received psychotherapeutic or psychopharmacological treatment for depression at the time of the study. The finding that depressed patients strongly prefer psychotherapy compared to medication, which was even more accentuated in the subgroup of previously depressed and currently nondepressed patients, is supported by previous studies.^{6,7,12-17} Our result, that depressed patients frequently attribute improved well-being to psychotherapy, but rarely to antidepressant medication, might partially explain the preference for psychotherapy. Other study results indicate that this preference might go back to the patients' belief that emotional problems are most frequently caused by alterable factors, such as interpersonal problems, work-related problems, and health problems.

The patients' self-management to improve well-being, including exercise, relaxation, active problem solving, activity, and social support, are similar to the key elements of cognitive-behavioral depression therapy.^{19,21} This indicates that many of the depressed patients are either intuitively familiar with these key elements or that they have experienced benefit from these elements. The fact that the nondepressed patients more frequently indicated that they did not need any treatment for their emotional problems, and that "nothing" impaired their emotional well-being, reflects a realistic estimate of their nondepressed situation.

Our study included predominantly middle-aged Caucasians treated in the German health care system. Compared with most other health care systems, access to psychotherapy is somewhat easier in Germany. Patients may frequent psychotherapists without referral from primary care physicians or psychiatrists, and health insurances pay for 25 or more sessions of individual psychotherapy. It is well known that rates of specialty mental health consultations and pharmacotherapy vary worldwide.^{40,41} Nevertheless, as assessed by the World Health Organization (WHO) World Mental Health Survey Initiative, overall treatment rates of mental disorders do not vary considerably between the United States and Germany (e.g., moderate cases: U.S., 34.1%; Germany, 30.5%).⁴¹ Considering similar treatment preferences among depressed patients from Germany, the United States, the United Kingdom, and Australia,^{6,7,12-17} we assume that our study findings may also be applicable to other developed health care systems.

The aggregation of patients with major and minor depression into 1 subgroup of patients with depressive disorder might be seen as another limitation of our study. To address this limitation, we analyzed all diagnostic subgroups separately and found that the frequency of response categories did not differ significantly between groups for any response category (all $P > .05$). Similarly, the responses of depressed patients with and without comorbid panic disorder did not differ significantly (all $P > .05$).

Medical care for patients with emotional problems could be improved substantially, if primary care physicians were to make more time available to communicate information and advice to patients with emotional problems; in some cases, further treatment might not be required. In the remaining cases, it is suggested to refer depressed patients to psychotherapy or antidepressant medication depending on their decision after detailed information on treatment alternatives has been given. Both psychotherapy and psychopharmacotherapy have proven to be effective for treatment of depression,^{8-11,19} and treatment with the therapy of preference may improve treatment adherence and outcome.^{6,42} As the patients' views of emotional problems and their management remarkably differ from both physicians' perspectives and treatment guidelines, future research is necessary to better meet patients' needs for individual depression treatment.

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Thinking of applying for a K24 grant?

Check in first with those who have successfully navigated the process!

Several SGIM members who have received K24 awards have agreed to make themselves available for those who are interested in learning more about their work and about the K24 process. Go to <http://www.sgim.org/careerdevelopment.cfm> and scroll down to the bottom of the page for more information.