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Treatment Goals of Depressed Outpatients: A Qualitative Investigation of Goals Identified by Participants in a Depression Treatment Trial

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Abstract

Treatment goals and preferences of depressed patients are important, but they are rarely empirically studied. Although clinicians are likely to discuss goals with individual patients, research that clarifies overall patterns in the treatment goals of depressed patients could be useful in informing new interventions for depression. Such research could also potentially help address problems such as poor adherence and psychotherapy drop-out. In this preliminary qualitative investigation, we examined treatment goals established by depressed outpatients in the context of a trial of behaviorally oriented psychotherapy. The treatment goals that were most commonly articulated included improving social and family relationships, increasing physical health behaviors, finding a job, and organizing one's home. These results underscore the fact that, in addition to improvement in the symptoms of depression, functional improvements are viewed as key treatment goals by depressed individuals.

Keywords

depression; treatment; goals; psychotherapy

INTRODUCTION

Major depressive disorder (MDD) is one of the most prevalent and costly psychiatric disorders, with lifetime prevalence rates of approximately 20% of women and 10% of men in the United States.^{1,2} In addition to the distress associated with MDD itself, patients often struggle with substantial functional impairments at home, work, and school, and in social

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relationships,³ contributing to the fact that depression has been ranked as the leading psychiatric disorder causing disability.⁴ Fortunately, effective psychosocial and pharmacologic treatments have been developed, including cognitive-behavioral therapies, interpersonal psychotherapy, and a wide range of antidepressant medications. However, in spite of this, persistent problems exist in engaging and retaining individuals in treatment. A meta-analysis of studies concerning treatment seeking found that only 27.6%--60.7% of people with MDD engage in care.⁵ Certain sub-populations (racial/ethnic minority patients, uninsured individuals) are at particularly high risk for poor treatment engagement. Moreover, even when depressed individuals seek help, attrition is a significant issue that prevents many from obtaining an adequate amount of treatment.⁶ For those who stay engaged in treatment, research suggests that only 40%--50% fully respond to an initial treatment trial, whether the approach involves psychotherapy or medications.⁷⁻⁹ Thus, untreated and undertreated depression is a major public health concern.

In light of the serious consequences of untreated depression, it is important for researchers, clinicians, and mental health policy makers to better understand the range of issues that contribute to a pattern of poor engagement and retention in depression care. Some contributing factors are likely to be broad, systemic issues (e.g., lack of adequate insurance coverage). However, other factors that limit treatment retention may be related to individuals' beliefs and preferences regarding whether staying in mental health treatment would be useful, and a potential "mismatch" between what patients *hope* to receive from a course of treatment and what they *actually* receive. While existing treatments are efficacious for some individuals, they may not always address the specific issues that patients want to address---and this mismatch could lead some depressed individuals to become less committed to staying in treatment, or to have less success even if they do stay in treatment. A greater emphasis on providing patient-centered care, and understanding what patients want out of treatment, may help address this problem.¹⁰

A major aspect of providing patient-centered care is being responsive to patient preferences, needs, and values when making treatment decisions.^{11,12} Emerging evidence suggests that attending to patient preferences may improve treatment quality and outcomes.^{13,14} The literature on patient preferences for depression treatment has mainly focused to date on a few specific areas: preferences for treatment type^{15,16} or provider type,¹⁷ and how preferences influence service use.¹⁸ Another important area that has been given little attention is patients' goals for treatment. While practicing clinicians may frequently engage individual patients in discussions of goals for treatment, empirical research that can identify broader patterns of treatment goals across individual patients is also important.

Understanding patients' treatment goals is important for practitioners, as well as for program administrators and treatment developers. Typically, individual clinicians will seek out and have a good understanding of patients' goals and will attempt to incorporate them into their work with the patient. However, a better understanding of goals may direct researchers and clinicians to investigate novel ways to augment traditional treatments. Experts have suggested that, when patients receive treatment that is perceived to be truly relevant to their needs, they are likely to exhibit greater commitment to and engagement in treatment, which may, in turn, significantly decrease patient drop-out, increase satisfaction, and improve

outcomes.^{19,20} For example, in a recent study examining drop-out among 273 patients receiving community-based mental health care in Italy, researchers found that the primary reason for drop-out was dissatisfaction with treatment.²¹ Results from the NIMH Treatment of Depression Collaborative Research Program^{22–24} suggested that psychotherapy patients were more likely to remain in therapy when the treatment they received was congruent with their explanations of their problems and was perceived to be helpful in addressing those problems.

Thus, it is important to develop a better understanding of the treatment goals valued by depressed patients in order to ensure that treatment is meaningful and responsive to their needs. To begin to identify the types of goals that patients have for outpatient depression treatment, we conducted a preliminary, qualitative investigation that included patients enrolled in a small clinical trial of outpatient psychotherapy for depression. The overall treatment program being evaluated in the trial was named GIFT (Group, Individual, Family Treatment of Depression) and has been described previously.²⁵ As part of the GIFT program, patients worked with a therapist to set treatment goals at the beginning of treatment. Through careful analysis of the clinical records of all study patients enrolled, we developed a coding system to categorize and describe the treatment goals that patients articulated. The aim of this report is to describe the types of goals that depressed outpatients hope to address in the context of psychotherapy.

METHOD

The methods and procedures of the GIFT depression treatment program have been described in greater detail elsewhere.^{25,26} This section presents an overview of the methods relevant to the current study on patients' treatment goals.

Participants

Participants were recruited through advertisements in the newspaper and referrals from local clinicians. All participants were between the 18 and 70 years of age, met criteria for MDD based on the Structured Clinical Interview for DSM-IV,²⁷ and scored 14 or higher on the Modified Hamilton Rating Scale for Depression-17 item version (MHRSD).²⁸ Participants were excluded if they met criteria for schizophrenia, MDD with psychotic features, bipolar disorder, substance dependence, anorexia nervosa, bulimia, or schizoid, schizotypal, borderline, or antisocial personality disorder, or if they were at high risk of suicide. Twenty-six patients who were consecutively enrolled in the GIFT program are included in this report, 65% of whom ($n = 17$) were women and 35% of whom ($n = 9$) were men. The average age was 46.8 years ($SD = 11.1$ years). Of the 26 patients in the sample, 19% ($n = 5$) reported income below \$10,000; 46% ($n = 12$) reported income between \$10,000 and \$50,000; 27% ($n = 7$) reported income between \$50,000 and \$100,000; and 8% ($n = 2$) reported income over \$100,000. Thirty-five percent ($n = 9$) were married. The majority (96%) were Caucasians, while 1 patient (4%) was African American.

The GIFT Program

This research was approved by local Institutional Review Boards and all participants provided written informed consent. GIFT is a 10 to 14 week, cognitive-behavioral program for individuals with MDD. Those enrolled participated in weekly group therapy sessions, three individual sessions, and two family sessions. Although GIFT included several components, we describe only the goal-setting component in this report. In the first individual session, a patient and a GIFT therapist worked together to help the patient set long-term goals. Patients were encouraged to set realistic, meaningful goals that they believed would, if achieved, help improve their depression. Patients were asked to set three long-term goals in key life areas; a fourth long-term goal for all patients was to increase pleasant activities. Therapists would not set goals for patients; rather, their job was to help patients translate vague goals (e.g., “feel better about myself”) to more concrete goals by asking relevant questions (“What would you need to do to feel better about yourself?”) Throughout the course of treatment, patients also set concrete weekly goals that would help them achieve their long-term goal. Long-term and weekly goals were reviewed in each group therapy session. Although patients did not typically change long-term goals during the course of treatment, they were encouraged to do so if a new goal became more relevant. Four therapists were trained to administer the GIFT intervention.

Data Abstraction and Analysis

At each therapy session, therapists recorded each patient’s long-term and weekly goals on the GIFT Goals Tracking Form. To abstract data for this investigation, goals were recorded verbatim from each patient’s Goal Tracking Forms. Next, we developed a coding manual using an “editing organizing style” for the analysis of qualitative data.²⁹ To do this, one author and a trained research assistant developed a list of general categories by reading all the long-term goals of participants and independently developed comprehensive categorization systems. These two systems were very similar; the few differences that existed were resolved in a collaborative fashion. A codebook was developed that described categories (Table 1) and provided hypothetical examples. After training and discussion, a second research assistant coded each of the three long-term goals that a GIFT patient set each week on the GIFT Goal Tracking Form. A third research assistant coded a subset (25%) of these goals; agreement was calculated to be very good ($\kappa = 0.86$).

RESULTS

The categorization of patients’ treatment goals resulted in the emergence of three major goal areas: social/family goals, occupational/financial goals, and other goals. A number of more specific goal categories fell under each of these three broad areas. We found that the majority of goals identified by depressed patients in this study were coded into five specific categories. As can be seen from Table 1, outpatients in the GIFT program most frequently articulated goals that fit in the category of “Improve or increase number of non-family social relationships” (73% of participants). Examples of specific goals in this category included making new friends or re-contacting old friends. “Improve family relationships” was another frequently articulated social/family goal, endorsed by 65% of participants. “Improve physical health” was endorsed as a goal by 50% of participants; examples included changing

one's diet or exercising more frequently. Finally, a significant portion of patients also chose goals that fit into the categories of "Find a job" (35% of participants) and "Organize/clean my home (35% of participants)." The category "Organize/clean my home" included tasks such as cleaning the house, eliminating clutter, repairing things, and finishing home improvement projects.

DISCUSSION

Key Findings

Our aim in this brief report was to identify common treatment goals of individuals seeking outpatient treatment for depression. We examined the treatment goals set by patients who were participating in behaviorally oriented psychotherapy for depression.^{25,26} Patients with MDD most often articulated goals related to improving family or other social relationships, increasing positive health behaviors, finding a job, or organizing their home. Although findings regarding the relative importance of each treatment goal cannot necessarily be generalized to all depressed populations, we believe these results provide useful information about what types of goals may be generally important to depressed outpatients, and how existing psychosocial treatment for depression may be improved.

The finding that depressed outpatients are likely to set treatment goals directly related to their day-to-day functioning is not surprising, given that distress due to functional impairments, such as relationship or employment problems, may often prompt entry into care. The importance of interpersonal and other functional goals was also observed in a recent study of inpatients seeking treatment for depression.³⁰ These findings are also consistent with a recent study that compared the goals of anxious and depressed patients; that study found that depressed patients in particular tend to voice a wide range of functional goals---in contrast to anxious patients who express goals primarily geared toward symptom relief.³¹ Although improvement in functional domains is commonly viewed as very important by psychiatrists, psychotherapists, and other care providers, it is notable that efficacy trials designed to evaluate MDD treatments tend to focus mostly---or in some cases, exclusively---on symptom reduction, not functional improvement. Evaluation of depression treatments, for both clinical and research purposes, would therefore be improved and made more relevant to patients' needs if greater attention was placed on change in functional domains rather than just symptom reduction.

Although it is critical for psychotherapists to focus attention on assessing and addressing patients' treatment goals, making progress in certain goal areas may require input from other allied professionals. Some goals that were frequently expressed by depressed patients tap into areas of life functioning that may, understandably, reach beyond the expertise of clinicians who are providing care. For example, goals were frequently raised that related to improving one's financial skills, such as learning to balance a checkbook or improving skills in long-term financial planning. Losing weight and improving one's physical health were also commonly endorsed, as was finding a new job and changing careers. Providers will need to assess whether their patient is having difficulty with motivation in making changes in these areas, or whether he or she has a skills or knowledge deficit that is contributing to the problem---or both. If there is a skills deficit, the clinician may find it useful to develop

relationships with other professionals in the field who can provide competent training and consultation in these areas (i.e., financial consultants, career counselors, occupational therapists, physical trainers) to either the patient or the clinician.

Coordinating care with other mental health professionals may also be necessary. As noted earlier, more than half of patients with MDD endorsed goals related to improving family relationships, and nearly all endorsed some type of goal relating to social functioning. Given that it can be difficult to adequately address certain types of relationship issues in individual treatment, it may be worthwhile to refer patients for adjunctive family or marital treatment. Alternatively, it could be useful to incorporate a family or marital component within a course of individual psychotherapy. Even if the primary treatment modality is individual treatment, conjoint sessions with the patient's spouse or other family members can provide a critical adjunct to the treatment process in many cases.³²

Limitations

Several limitations of this study are worth noting. First, our sample was comprised of a small number of participants in a clinical trial of a group-based psychotherapy, and thus may not be representative of outpatients with MDD as a whole. For example, we did not include patients treated in primary care settings or mental health centers, or those seeking non-traditional forms of mental health treatment. Therefore, although the categories of goals that we report may be important to many depressed outpatients, the relative importance of these goals to patients in different settings is unknown. Second, our sample was primarily Caucasian, with few racial/ethnic minority participants. It is likely that ethnic, cultural, or racial background may influence the kinds of treatment goals one might value. Third, due to the nature and size of our sample, we are not able to draw conclusions about whether depression severity or demographic factors (i.e., age, gender, marital status) influence patient treatment goals.

CONCLUSION

In this qualitative investigation, we examined the treatment goals that outpatients in a psychotherapy research trial articulated during the course of treatment. Findings based on a systematic process of coding these treatment goals suggest that depressed outpatients hope that psychotherapy will address a number of important areas of psychosocial functioning, including family relationships, social relationships, employment problems, and other areas of functioning. While psychotherapy researchers, clinicians, and other mental health specialists may understandably focus upon symptom reduction when planning or designing treatments for patients with MDD, it is important to carefully assess, understand, and prioritize the goals that depressed patients themselves set over the course of treatment. Increased attention to patients' goals for treatment may play a critical role in making treatment more relevant and meaningful to patients, ultimately helping to reduce problems of poor engagement in care and psychotherapy attrition.

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References

1. Hasin DS, Goodwin RD, Stinson FS, et al. Epidemiology of major depressive disorder: Results from the National Epidemiologic Survey on Alcoholism and Related Conditions. *Arch Gen Psychiatry*. 2005; 62:1097–1106. [PubMed: 16203955]
2. Kessler RC, McGonagle KA, Nelson CB, et al. Sex and depression in the National Comorbidity Survey. II: Cohort effects. *J Affect Disord*. 1994; 30:15–26. [PubMed: 8151045]
3. Judd LL, Akiskal HS, Maser JD, et al. Major depressive disorder: A prospective study of residual subthreshold depressive symptoms as predictor of rapid relapse. *J Affect Disord*. 1998; 50:97–108. [PubMed: 9858069]
4. Murray CJ, Lopez AD. Alternative projections of mortality and disability by cause 1990–2020: Global Burden of Disease Study. *Lancet*. 1997; 349:1498–1504. [PubMed: 9167458]
5. Bristow K, Patten S. Treatment-seeking rates and associated mediating factors among individuals with depression. *Can J Psychiatry*. 2002; 47:660–665. [PubMed: 12355678]
6. McFarland BR, Klein DN. Mental health service use by patients with dysthymic disorder: Treatment use and dropout in a 7 1/2 year naturalistic follow up study. *Compr Psychiatry*. 2005; 46:246–253. [PubMed: 16175754]
7. DeRubeis RJ, Hollon SD, Amsterdam JD, et al. Cognitive therapy vs medications in the treatment of moderate to severe depression. *Arch Gen Psychiatry*. 2005; 62:409–416. [PubMed: 15809408]
8. Thase ME, Haight BR, Richard N. Remission rates following antidepressant therapy with bupropion or selective serotonin reuptake inhibitors: A meta-analysis of original data from 7 randomized controlled trials. *J Clin Psychiatry*. 2005; 66:974–981. [PubMed: 16086611]
9. Papakostas GI, Fava M. A meta-analysis of clinical trials comparing milnacipran, a serotonin-norepinephrine reuptake inhibitor, with a selective serotonin reuptake inhibitor for the treatment of major depressive disorder. *Eur Neuropsychopharmacol*. 2007; 17:32–36. [PubMed: 16762534]
10. Laine C, Davidoff F. Patient-centered medicine. A professional evolution. *JAMA*. 1996; 275:152–156. [PubMed: 8531314]
11. Institute of Medicine. [accessed July 22, 2010] Crossing the quality chasm: A new health care system for the 21st century. 2001 Mar 1. available at www.iom.edu/Reports/2001/Crossing-the-Quality-Chasm-A-New-Health-System-for-the-21st-Century.aspx
12. Stewart M, Brown JB, Donner A, et al. The impact of patient-centered care on outcomes. *J Fam Pract*. 2000; 49:796–804. [PubMed: 11032203]
13. Clever SL, Ford DE, Rubenstein LV, et al. Primary care patients' involvement in decision-making is associated with improvement in depression. *Med Care*. 2006; 44:398–405. [PubMed: 16641657]
14. Lin P, Campbell DG, Chaney EF, et al. The influence of patient preference on depression treatment in primary care. *Ann Behav Med*. 2005; 15:75–83.
15. Alvidrez J, Azocar F. Distressed women's clinic patients: Preferences for mental health treatments and perceived obstacles. *Gen Hosp Psychiatry*. 1999; 21:340–347. [PubMed: 10572775]
16. Van Schaik DJ, Klijn AF, Van Hout HP, et al. Patients' preferences in the treatment of depressive disorder in primary care. *Gen Hosp Psychiatry*. 2004; 26:184–189.
17. Lewis CL, Wickstrom GC, Kolar MM, et al. Patient preferences for care by general internists and specialists in the ambulatory setting. *J Gen Intern Med*. 2000; 15:75–83. [PubMed: 10672109]
18. Cooper LA, Brown C, Vu HT, et al. Primary care patients' opinions regarding the importance of various aspects of care for depression. *Gen Hosp Psychiatry*. 2000; 22:163–173. [PubMed: 10880709]
19. Dwight-Johnson M, Sherbourne CD, Liao D, et al. Treatment preferences among depressed primary care patients. *J Gen Intern Med*. 2000; 15:527–534. [PubMed: 10940143]
20. Glass CR, Arnkoff DB, Shapiro SJ. Expectations and preferences. *Psychotherapy*. 2001; 38:455–461.
21. Ruggeri M, Salvi G, Bonetto C, et al. Outcomes of patients dropping out from community-based mental health care: A 6-year multiwave follow-up study. *Acta Psychiatr Scand*. 2007; 116:42–52.

22. Elkin, I. The NIMH Treatment of Depression Collaborative Research Program: Where we began and where we are. In: Bergin, AE.; Garfield, SL., editors. *Handbook of psychotherapy and behavior change*. 4th edition. New York: John Wiley; 1994. p. 114-139.
23. Elkin I, Shea MT, Watkins JT, et al. National Institute of Mental Health Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Arch Gen Psychiatry*. 1989; 46:971–982. [PubMed: 2684085]
24. Elkin I, Yamaguchi JL, Arnkoff DB, et al. Patient-treatment fit and early engagement in therapy. *Psychother Res*. 1999; 9:437–451.
25. Friedman MA, Cardemil EB, Gollan JK, et al. The GIFT program for major depression. *Cogn Behav Pract*. 2003; 10:157–168.
26. Friedman MA, Cardemil EV, Uebelacker LA, et al. The GIFT program for major depression: Integrating group, individual, and family treatment. *J Psychother Integr*. 2005; 15:147–168.
27. First, MB.; Spitzer, RL.; Williams, JBW., et al. *Structured Clinical Interview for DSM-IV--Patient Version*. New York: Biometrics Research Department, New York State Psychiatric Institute; 1995.
28. Miller IW, Bishop SB, Norman WH, et al. The Modified Hamilton Rating Scale for Depression: Reliability and validity. *Psychiatr Res*. 1985; 14:131–142.
29. Crabtree, BF.; Miller, WL. Using codes and code manuals: A template organizing style of interpretation. In: Crabtree, BF.; Miller, WL., editors. *Doing qualitative research*. 2nd edition. Thousand Oaks, CA: Sage Publications; 1999. p. 163-177.
30. Uebelacker LA, Battle CL, Friedman MA, et al. The importance of interpersonal treatment goals to depressed inpatients. *J Nerv Ment Dis*. 2008; 196:217–222. [PubMed: 18340257]
31. Gross Holtforth M, Wyss T, Schulte MT, et al. Some like it specific: The difference between treatment goals of anxious and depressed patients. *Psychol Psychother Theor Res Pract*. 2009; 82:279–290.
32. Uebelacker, LA.; Weishaar, ME.; Miller, IW. Family or relationship problems. In: Whisman, MA., editor. *Adapting cognitive therapy for depression: Managing complexity and comorbidity*. New York: Guilford Press; 2008. p. 326-347.

Table 1Treatment goals that depressed outpatients set in a psychotherapy program ($N = 26$)

Goal category	<i>n</i>	%
<u>Social/family</u>		
Improve or increase number of non-family social relationships	19	73
Improve family (non-spouse/significant other) relationships	17	65
Improve spouse/significant other relationship	7	27
Change general social behavior (e.g., be more assertive)	4	15
Cope with grief/loss of an important relationship	2	8
Meet new dating partners	1	4
<u>Occupational/financial</u>		
Find a job	9	35
Improve/increase intellectual/creative abilities (e.g., get Master's degree)	7	27
Improve existing work situation	4	15
Non-job related financial goals (e.g., balance checkbook)	2	8
<u>Other</u>		
Improve physical health (e.g., increase physical exercise)	13	50
Organize or clean home	9	35
Find new housing	6	23
Improve emotional health (e.g., increase self-esteem)	2	8
Resolve existential/spiritual issues	2	8