Depressed patients' perceptions of depression treatment decision-making

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Abstract

Objective Little is known about the feasibility and effects of patient-clinician shared decision-making (SDM) for depression treatment. Within a goal of informing the design of a SDM intervention, the objective of this study was to investigate depressed patients' perceptions of the treatment decision-making process with general practitioners (GPs).

Setting and participants Data were gathered from a convenience sample of 40 depressed patients to understand key aspects of treatment decision-making from the patient perspective. The sample varied in depression severity and type of setting in which treatment was sought.

Main variables studied Semi-structured interview questions focused on patients' prior experiences with depression and treatment, perceptions of the treatment decision-making process, and needs and expectations about treatment. Current depression severity was also assessed.

Results Patient lack of insight regarding depression severity substantially delayed patient engagement in treatment seeking and decision-making. Patients expected their GPs to be a first and main source of objective information and discussion about depression and treatment and to provide emotional support for decision-making. Patients also identified needs for additional information about depression and its treatment, as well as concerns about certain aspects of treatment.

Conclusions The depression treatment context has some aspects that differ from treatment decision-making for other types of health conditions. SDM approaches for depression treatment should be adapted based on depression severity and patient-identified needs.

Introduction and study objective

Depression is one of the most common and significant public health problems worldwide.¹ Despite its public health significance, depression often goes inadequately detected and treated, including in primary care settings in which most people receive health care.² Amongst other factors, inadequate information, unfavourable health-care provider-patient communication, and patient acceptance of treatment have been shown to be associated with patients not receiving adequate evidence-based depression treatment.^{3,4} As a response to these issues, in recent years there has been an enhanced focus on the patient in the form of patient-centred interventions to improve depression care, such as Stepped Collaborative Care models for primary care depression treatment.⁵⁻⁷ The patient-provider aspects of these interventions that more centrally involve the patient are gaining attention, in part due to the shared treatment decision-making (SDM) initiatives underway in western Europe and North America. However, little is known about the feasibility and effects of patient-clinician shared decision-making (SDM) for depression treatment. SDM does not advocate that patients are to be convinced to choose one treatment option or another. It rather implies that an increased involvement of patients in decisions about their care could allow them to express their preferences and make a health-related decision which is acceptable for them and to which they can adhere.⁸ Within a goal of informing the design of a SDM intervention, the objective of the study reported in this paper was to investigate depressed patients' perceptions of the treatment decision-making process with general practitioners (GPs).

Background

Theoretical perspectives on SDM

In SDM at least two individuals are involved in partnership to share the process of making a treatment decision. Both parties exchange key information about treatment options before they agree on a preferred treatment option.⁹ Ideally

patients and clinicians also share information about what is valued in relation to the treatment options. For example, a patient may value the benefit of feeling and functioning better, and a clinician can share current knowledge with the patient about the effectiveness rates of the various treatment options.

In terms of autonomy, SDM is located between the paternalistic approach, in which the clinician decides what is best for the patient, and the model of informed choice, in which the patient is regarded as the expert for his condition and makes decisions after being informed about different options by the clinician.¹⁰ SDM has been noted to be especially useful in situations where more than one treatment alternative exists and there are significant trade-offs between treatment benefits and risks.¹¹ Patient-centred interventions to improve engagement in SDM can result in improved patient satisfaction and treatment adherence for a chosen treatment plan, by addressing barriers such as information, communication and treatment engagement issues.¹²⁻¹⁵ Necessary steps and skills for SDM can be impacted by these barriers, such as developing a partnership with the patient, and ascertaining and responding to patient's ideas, concerns and expectations, or mutually negotiating a decision.¹⁶

Knowledge about SDM in mental health

With regard to decision-making involvement, patients have been shown to differ in the amount of involvement that is preferred. Not all patients are necessarily willing or able to engage in SDM.¹⁷ SDM research is expanding rapidly, but limited data are available thus far about how patients and professionals perceive SDM in actual practice.¹⁸ For SDM in the mental health-care context very few published studies are available. For the purposes of this paper, four published studies were located that included some elements of SDM.¹⁹ Three of them were intervention studies focusing on depressed patients and the fourth investigated a sample of patients with the diagnosis of schizophrenia. In these studies patients were given free choice of

therapy. No significant effects of free choice were found for patient satisfaction or outcomes. In the study on treatment of schizophrenia the important factors for continuance or discontinuance of medication were the patients' psychopathology and current side-effects.²⁰ However, the SDM model was not appropriately applied in any of the study designs according to an integrative model of SDM.²¹

There is also little research on patient perspectives about SDM for depression treatment. In the United States, stepped collaborative care models for depression treatment has emerged as a 'gold standard' for optimal care of depression. Collaborative care models have more recently begun to explicitly incorporate considerations of how decision-making is shared amongst providers and patients. For example, in an intervention programme for prevention of depression relapse SDM was included.⁷ In this study, improvement was found in medication adherence over a 1-year follow-up period. This more recent finding regarding the impact of SDM highlights the potential for the positive effects of SDM in depressed patient populations.

Other studies have examined patient decision involvement, preferences for aspects or types of depression treatment, information needs when starting antidepressant medication, and psychometric properties of decision-making measures. For example, in a study of doctors and patients about the amount of control that both parties should have in decision-making, patients wished to be equal partners for treatment decision-making, but the resident doctors preferred to have more decision control.²² In another study, a high preference for receiving information regarding depression and treatment options was found amongst depressive patients (regardless of their symptom severity).²³ In a recent study on patients' information needs when starting antidepressant medication and their preferences for involvement in treatment decision-making, the most common unmet information need was in relation to adverse drug reactions that had a high impact on decision-making about continuing or discontinuing medication.²⁴ In addition, the patients expressed a high need for information

and discussion at the beginning and later on in treatment. The level of involvement in decision-making varied across patients and for the same patients at different points of time. As symptoms improved, patients showed more participation. An important finding of this study is that depressed patients' preferences for participation were shown to be dynamic, varying on the basis of time point in treatment.²⁴

In summary, SDM in mental health treatment contexts, including depression, has been investigated to a limited extent. While SDM has been related to positive outcomes for other health treatment contexts, its potential benefits for mental health treatment contexts such as depression are in need of additional research. While the concept of patient-centeredness has always played a role in mental health treatment, SDM involves a more active role for patients.²⁵

Patients' experiences with depression and their attitudes towards depression treatment

Studies on patients' experiences with depression show that this condition is still associated with substantial social stigma.²⁶ If professional help is sought at all, many patients view their family doctor as the most appropriate person to contact.²⁶ In a study of young adults' non-acceptance of the diagnosis of depression, Van Vorhees *et al.* found that non-acceptance was associated with personal attitudes, social norms and low symptom severity.²⁷ While the favoured treatment for many people is counselling,²⁸ it has been found that people try a wide range of coping strategies before seeking professional medical attention.²⁹ People often perceive that taking antidepressant medication is more harmful than helpful and that antidepressant medication is addictive.^{30,31} A recent study by Thacher *et al.* found three types of treatment preferences in depression.³² One group of patients focuses on treatment effectiveness whereas another one puts more emphasis on costs and side-effects. The third group was found to consider both sides. This finding has also been documented in experimental studies to model people's likelihood of antidepressant medication

acceptance.³³ Factors associated with depression treatment preferences have been found to include ethnicity, gender, income and knowledge about treatment options.²⁸

Study objective and questions

Within a goal of informing the design of a SDM intervention, the objective of this study was to investigate depressed patients' perceptions of the treatment decision-making process with GPs. This study was conducted as pre-clinical trial research study within one of a series of 10 projects implementing SDM in various medical conditions (e.g. schizophrenia, chronic pain, multiple sclerosis) funded by the German Ministry of Health and Social Security (<http://www.shared-decision-making.org>). The results reported in this study focus on the patient-specific component of the broader research project. The main project addressed the implementation of SDM in primary care treatment of depressive disorders via the training of GPs. To better inform the design of SDM interventions, additional investigation was needed of patient factors within the clinician–patient interaction that function as barriers to decision-making in depression care.

The following research questions were examined in this qualitative study of patient perceptions.

- 1 Whom did patients contact first for their health concerns?
- 2 Which sources of information on depression were available to patients?
- 3 What types of decisions did patients consider in their depression treatment decision-making?
- 4 How was the decision-making process characterized in terms of duration, participation, communication, ambivalence and barriers?

Methods

Sample and setting

A convenience sample of 40 depressed patients was selected who were already engaged in out-patient, inpatient and self-help group treatment

for depression. As consistent with the overall aim of the study, the possibility of generalizing the study findings was secondary to obtaining preliminary information about the overall perceptions and needs of a somewhat broad range of patients. Therefore, to maximally inform the interview results, the patients were selected to ideally represent a range of illness and depression treatment experiences. For qualitative research a sample size between 30 and 50 respondents is recommended.³⁴ In order to document a variety of results and yet keep the effort of the study within a feasible time frame an approximate sample size of 40 was estimated to be sufficient for data saturation purposes.

The patients were recruited for the study via their GPs, psychiatric department doctors and contacts with self-help groups. Inclusion criteria were patient age ≥ 18 years, an agreement of patient and doctor that a treatment decision had been made in the last consultation and the presence of depression. International Classification of Diseases (ICD-10)³⁵ diagnoses from F.31 through F.39 were accepted as evidence for the presence of a depression diagnosis. Patients with a diagnosis of schizophrenia (ICD-10 codes F.21 through F.29), acute suicidal tendencies or psychotic episodes by medical history were excluded from the study. Following informed consent for participation, the place and time of the interview were set in accordance with the needs of the patients.

Design

Semi-structured interview

The design for the present study was an exploratory qualitative approach using an audiotaped semi-structured interview protocol. As this was a pre-clinical trial study to inform the design of a SDM intervention, a qualitative approach was suitable. The aim of the interviews was to gain more insight into the treatment decision-making process between doctor and patient and to reveal as many different perceived aspects as possible from patients who were currently in treatment. It was not intended to judge the adequacy of treatment. Instead the focus was

on depressed patients' experiences with deciding on options to improve their symptoms. The results, especially patients' views on how barriers in this process could be overcome, were used to maximally inform the implementation of the SDM intervention in the broader research project.^{36–38}

An interview guide was developed according to the method of focused interviewing.³⁶ This guide included topics that were considered as necessary aspects of decision-making to be explored before designing an SDM intervention. Topics such as patients' experiences with depression, initial access to treatment, information about illness and treatment, treatment decisions, decision-making process, needs, and expectations were included in the interview guide. The interview was structured such that the questions were asked in the same order and standard structured probes used as needed to clarify or promote elaboration on a given topic. For example, probes for the question, 'How was the conversation with your GP before the decision was made?' included standard probes regarding the number and duration of conversations, whether or not the patient perceived provider-to-patient unidirectional or bidirectional communication, and the patient's perception of whether or not sufficient time was allowed for conversation. The first author, a psychologist, carried out all interviews after doing training sessions conducted by two experienced members of the research team. Three supervised pilot interviews were completed for training purposes and to assess the feasibility of the interview protocol. The length of interviews ranged from 45 min to 1.5 h. Approval of the project was given by the local Ethics Review Board of the University of Freiburg, Germany.

Data transcription and coding

Audiotapes were subsequently transcribed and analysed via binary content coding analysis.^{36–38} This approach to coding enables an analysis of global content themes. Responses for each global theme category are coded as to whether or not study participants gave responses consistent

with a given thematic category (0 = not mentioned; 1 = mentioned). The labels for thematic categories that emerged in the research team initial review and discussion of transcripts were defined on the basis of topics in the interview guide and extended by additional themes that occurred during the interviews. Once an initial set of coding category labels was developed, the categories were discussed and further refined by the research team to eliminate substantive redundancies and categories into which little content was codable. At this stage of the analysis, specific coding rules were well defined by the team in order to fully differentiate between categories. The initial coding was carried out by two members of the research team (D.S., A.L.) who did three interviews together for pilot testing and coding. The first author then independently coded the interviews, followed by a group discussion of the coding results. Initial concordance between the first author and the research team was found for more than 75% of the refined coding categories. For the remaining 25% of coding for which there was a discrepancy between the research team, the discrepancies were resolved by discussion and group consensus.

Brief-PHQ survey

Following the semi-structured interview, patients completed the Brief Patient Health Questionnaire (Brief-PHQ³⁹), a screening instrument for assessing psychiatric disorders which is the authorized German version of the PRIME-MD Brief-PHQ.⁴⁰ Response options on 10-items assessing depression range from 1 ('not at all') to 4 ('almost every day'), and address symptoms that have occurred within the past 2-week time period per Diagnostic and Statistical Manual Fourth Edition (DSM-IV) diagnostic criteria for current major depressive episode. Other modules of the PHQ for anxiety and substance abuse disorders were not included. Sum scores up to 10 represent a sub-syndromal level of depression. Scores of 11 and more show a major depression with the categories mild (11–14), moderate (15–19) and severe (20–27). The German version of the PHQ has been developed

according to state of the art procedures for test translation including several steps of translation and blind back-translation. Cronbach's alpha (internal consistency reliability) was high at 0.88. Sensitivity (95%) and specificity (84%) are documented for detecting major depression, and are documented as 79% and 85% for any depressive disorder.⁴¹

Results

Sample characteristics

Table 1 presents the sample characteristics. Twenty-four (60%) study participants were female, ranging in age from 18 to 70 years. Twenty-six (65%) patients were in outpatient treatment, and 14 (35%) were currently hospitalized for depression. Seventeen (42.5%) study participants were single, 14 (35%) were married

and the remaining nine (22.5%) were either widowed, separated or divorced. Seventeen (42.5%) patients were employed, and nine (22.5%) were retired due to their illness. Four patients (10%) reported symptoms, which did not reach the syndrome (clinically significant) level according to the PHQ, but mentioned a prior history of more severe depression. Nine (22.5%) participants scored as mildly depressive, another nine (22.5%) were moderately depressive and 18 (45%) patients were severely depressive.

Interview results

Key categories coded from the transcripts included first professional contact for mental health concerns, information regarding illness and treatment, decision topics, decision-making process and future expectations.

First contact for mental health concerns

The initial topic of the interview was the patients' efforts to seek professional support for their depression-related health problems. Thirty (75%) patients went to see their GP as the first contact, and they perceived their symptoms as mainly 'physical' as opposed to psychological. Three (7.5%) patients, however, did consult a psychotherapist because they viewed their depression symptoms as primarily psychological in origin, whereas five (12.5%) patients who had depression symptoms for a while without treatment were so severely ill that they had to be brought to the hospital by relatives or friends. The remaining two (5%) patients of the sample reported consulting their gynaecologist. These patients interpreted symptoms such as mood changes associated with a gynaecological problem after giving birth or due to menopause.

In general, patients reported that the perception and classification of their problems as symptoms of a serious illness determined whom they consulted. In many cases, patients reported that it took them a long time before they fully understood the necessity of treatment and sought care in the health-care system, as the following quote illustrates:

Table 1 Sample characteristics

Age	
Mean (SD)	43.2 (12.2)
Range	18–70
Sex	
Female	24 (60.0%)
Male	16 (40.0%)
Treatment	
Inpatient	14 (35.0%)
Outpatient	26 (65.0%)
Marital status	
Single	17 (42.5%)
Married	14 (35.0%)
Widowed	3 (7.5%)
Divorced	3 (7.5%)
Separated	3 (7.5%)
Occupational status	
Working	17 (42.5%)
Retired due to illness	9 (22.5%)
Retired	3 (7.5%)
Other (e.g. maternity leave)	3 (7.5%)
Looking after home and family	3 (7.5%)
Job training	2 (5.0%)
Unemployed	3 (7.5%)
Severity of depression	
Symptoms below clinically significant level	4 (10.0%)
Mildly depressive	9 (22.5%)
Moderately depressive	9 (22.5%)
Severely depressive	18 (45.0%)

'For a long time I used every occasion as a reason and excuse for my problems and tried to live with it before I finally realized that I needed to look for some kind of treatment (male, age 33)'.

Sources of information about illness and treatment options

For 26 (65%) patients, their GPs played an essential information role, as the only source of information the patients obtained from a health-care professional. Many patients also informed themselves by use of books or other media such as television, newspapers and the Internet. Almost one in four (22.5%) patients reported that they benefited from knowledge about personal experiences from affected relatives or friends. Five (12.5%) patients received only a diagnosis from their GPs and were told that inpatient treatment was necessary. For these patients it was not until their inpatient treatment experience started that they were given additional information about depression, as the following example illustrates:

'I would have liked to know more about how to cope with a severe depression and how to continue with my life, but all my GP said was that I have to accept the fact that I am depressive. It took several weeks until I received more information in the hospital (female, age 48)'.

Topics of recent treatment decisions

This coding category included sub-categories of 'treatment in general', 'decisions regarding pharmacotherapy' and 'other decisions'. The dominant themes that emerged from the overall analysis of decision topics concerned insight regarding the existence of a mental illness, the necessity of treatment and social stigma concerns. In addition, the patients' overall attitudes towards treatment (especially their beliefs in treatment effectiveness) played a central role.

Decisions about treatment in general. Decisions about treatment in general contained several topics. The first concerned the question of GP vs. specialist treatment. This decision was stated as the most recent treatment decision by nine (22.5%) participants. When treated by their

GPs, patients mentioned that they could avoid stigmatization associated with obtaining specialty treatment, but at the same time they were aware of the limited treatment options available from their GPs. On the other hand, patients indicated that a specialist treatment would result in more adequate treatment and knowledge, leading in turn to a more stable health status. However, the patients who had made this decision viewed psychiatrists mainly as medication prescribers and as less interested in the other aspects of individuals. The aspect of stigmatization and the view of psychiatrists were most dominant in the trade-off for this decision.

The decision regarding inpatient vs. outpatient treatment was made as the most recent decision by 15 (37.5%) patients. All patients reporting this decision indicated that their reasons for considering inpatient treatment included being in a secure environment, feeling safe and relieved from everyday pressures, and an improvement in symptoms that could not be achieved via outpatient treatment. However, these patients also feared being completely shut away from the world outside and the stigmatization of being mentally ill that was marked by going to a psychiatric hospital, as illustrated in this quote:

'When I was told that in-patient treatment would be necessary all that came to my mind was that I would be completely isolated from the world outside. I could not think of anything positive a psychiatric hospital could have to offer (female, age 56)'.

Patients favouring outpatient treatment mentioned the familiar everyday environment, the possibility to go on fulfilling their social roles and their responsibilities for their families and jobs. On the other hand, they were also concerned about receiving insufficient treatment. The effort to maintain everyday life and the fear of stigmatization had the highest influence on patients' preferences for outpatient treatment until symptoms became too severe.

Psychotherapeutic treatment as the most recent decision occurred only for three (7.5%) study participants. They expected a psychotherapist to be understanding and warm-hearted,

but also mentioned difficulties coming to accept that they needed professional help and wondering if psychotherapy would add to rather than alleviate their stress.

Decisions about pharmacotherapy. Eight (20%) patients reported a decision which dealt either with pharmacotherapy as a treatment option in general, such as tapering off of medications or with changing medications. All of these patients indicated that the main reason for use of pharmacotherapy was an improvement in their symptoms. Reasons to hesitate deciding in favour of pharmacotherapy were the fear of adverse side-effects, perceptions of medications as influencing consciousness and personality, and possible addiction. They kept patients from making a decision for a long time. In cases of tapering off or changing medication these fears were not reported as being highly relevant anymore. Instead patients were rather reluctant to do so because of the possibility of a relapse. Some of them also did not believe in the likelihood of an enhanced benefit of a new medication.

Other decisions related to depression treatment. Only five (12.5%) patients made recent decisions that were classifiable into this coding category. Decisions regarding efforts to go back to work or the decreased frequency of consultations meant for patients a chance to gain more independence and continue their everyday lives. At the same time, these patients expressed concerns about the instability of their current health status and its potential to interfere with gaining more autonomy.

Attributes of the decision-making process

Time until treatment decision was made. Thirteen (32.5%) patients made a treatment decision during the first consultation. The other 27 (67.5%) participants reported a process that lasted over several weeks or months. Decisions were made more quickly when necessity and urgency due to symptom severity were clear for both the patients and the doctors. In addition, most experiences with supportive doctors and an intensive concentration on the

patients' perspective were reported in this category. The decision-making process took longer when difficult topics arose and when patients were significantly uncertain about the pros of a decision exceeding the cons. In these situations the decisions dealt with the topics of referral to inpatient treatment as well as a change in medication or tapering off of medication while patients were moderately to severely depressed. Patients' suffering over time did often produce a shift in the willingness to move forward with making a decision about what to do. During the decision-making process, a patient's fear about implementing the decision loomed as the largest concern, and most often resulted from a lack of information about the pros and cons of a treatment option. Especially for decision-making processes occurring over months, it was the patient's on-going suffering or the influence of family members and friends that finally led to a decision in all cases.

Participation in the decision-making process. Thirty-four (85%) patients indicated that both the doctor and the patient were involved in the decision-making process. They reported that their doctors considered their opinions, talked with them about different options and then mutually agreed on a decision. Exceptions occurred when the patient was too ill to take any part in the process, and felt relieved that the doctor took action, as in the following comment:

'I went to see my GP and said: I can't go on anymore. I don't know what to do. Please help me and do something (female, age 39)'.

Other key participants in the decision-making process were relatives, friends and the treating psychotherapist (in the instance the patient was obtaining psychotherapy). Those participants took over some of the doctors' duties such as having long conversations or supporting patients in difficult phases of the illness. Patients' trust in these significant others was an important factor which in many cases finally led to the step of making the decision to seek professional treatment.

Mode of communication during the decision-making process. Patients' experiences ranged from a very short consultation with limited discussion, to a lengthy in-depth discussion in which all treatment alternatives were mentioned with an opportunity provided to ask questions. Six (15%) patients had a severe depression in which they were unable to maintain a conversation with the treating doctor because of their symptoms. Apart from the consultation itself, discussion amongst the significant others involved in the decision-making process provided additional support for patient–doctor communication.

Ambivalence towards treatment options. Ambivalence in decision-making was reported by more than 75% of the patients. Ambivalence was stated to be mainly determined by a change in symptom severity from time to time, as well as by the perception that treatment negatives outweighed the benefits. Even after a treatment decision had been made, some patients felt overwhelmed or had mixed feelings, whereas others were just relieved. Another possible reaction is shown in the next quote:

'I was not in a mood to feel anything or to be satisfied. Now I would say that the decision was alright but at that time I did not really care about what had happened (male, age 51)'.

After a decision is made, doctors could help patients dealing with their situation by checking for ambivalence and providing further support if necessary.

Barriers to decision-making. Key barriers to the decision-making process that emerged from this analysis concerned patient insight issues regarding the need for treatment with regard to their symptom severity, their fears and more general attitudes towards treatment, changes in symptom severity and being confused about sorting through too many different options for treatment.

Expectations for future decision-making Suggestions for improvement were given by 25 (62.5%) patients. For future treatment decision-making, the patients reported that they would

like to receive more time in the consultation with their health-care provider (20%). They also expected more information about their illness and the treatment (32%), as well as more knowledge on the doctors' side (12%). Even if treatment preferences differ between patients and doctors, patients would like to receive emotional support from their doctors and wish for calm and objective discussions (16%). Furthermore, patients indicated that they would like their doctor to take a more active role in difficult situations, such as when they are too consumed by their symptoms and not able to take part in a decision (20%). In these situations, patients would like the doctor to 'take charge' of the decision, even though there could be social stigma consequences associated with the doctor's action, e.g. involuntary inpatient treatment.

Discussion

This study yielded rich information regarding a broad sample of depressed patients' perceptions of the depression treatment decision-making process with GPs, including specific barriers between patients and GPs. The results provide an important foundation for the implementation of SDM in primary care, and have informed the implementation of a SDM depression treatment intervention in Germany.

This study highlighted the centrally important role that GPs play as a first contact and main source of professional information for depression and its treatment. The first contact with the health-care system does depend heavily on patients' perception of their symptoms as indicators of a serious health problem. This corresponds with findings that lay people use a different taxonomic system for diseases than health professionals and typically experience symptoms for a substantial period of time prior to initiating contact with the health-care system.⁴² Interventions for improving prompt initiation of depression treatment need to specifically target people's perceptions of illness severity and strategies for approaching GPs for discussion of symptoms.

In many instances in this study, the patients reported a basic lack of information about their illness and the treatment options. Insufficient information for a variety of health treatment decision-making situations has been documented. In one study doctors failed to fully inform patients of pros and cons of treatment options, thereby leaving much room for misunderstandings, concerns and ambivalence.⁴³ This highlights the importance of assessing mutual preferences and exchanging information in every decision-making situation in which the patient is able and willing to participate.

The broader context of the patient's life was also an important influence on where other information was sought, e.g. via books, electronic media, and experiences of relatives and friends. These more naturalistic sources for decision-making support help patients to integrate expert information into their everyday lives.⁴⁴ Interventions for improving patient knowledge of depression and treatment options should take these findings into account.

The patients in this study reported several main barriers in the process of finding a way to improve their health status. Fears of stigmatization, attitudes towards treatment for mental illness in general and fears of side-effects in the case that antidepressants were considered an option were the most prevalent barriers mentioned. These aspects have also been reported in a number of other studies as, for example, a study of young adult decision-making about medication for depression.³¹ Although the findings in the study of Wills³¹ were related to medication acceptance whereas this study focuses on depression treatment decision-making in general, the challenging issues seem to be similar. A number of researchers⁴⁵⁻⁴⁷ have previously reported upon the strong influence of stigmatization as a barrier to seeking treatment in the United States. This study documents similar concerns amongst depressed patients residing in Germany. Specific approaches for effectively managing these barriers should be incorporated in SDM interventions.

Many factors which patients in this study considered in the decision-making process cor-

respond to what is known in general about aspects of patient decision-making such as the preferred amount of information on treatment possibilities, varying preferences for participation, consideration of effectiveness of treatment and treatment side-effects.^{48,49} Beyond, the reported difficulties of accepting the diagnosis of depression and aspects of social stigma in terms of, e.g. inpatient treatment seem to be rather specific for patient decision-making in mental health.

The fact that 85% of the study participants reported that both the doctor and the patient were involved in decision-making does not seem to correspond with other results of this study such as a lack of information and a resulting fear about implementing decisions. A possible explanation could be that less positive aspects of the decision-making process were only mentioned by patients during an in-depth exploration of possible deficiencies and unmet needs.

Practice implications

Patients had several unmet expectations for their consultation time, including more time with their health-care providers, a trusting relationship and the doctor in a leader role for more difficult decisions that the patient does not feel capable of making as well as more knowledge on the doctor's side. The wish for the doctor as a leader in certain situations corresponds with the dynamics in the preferred level of participation that previously has been reported.²⁴

In relation to proposed skills and steps for SDM competencies,¹⁶ several implications emerge for decision-making in the care of depressive disorders in general practice settings. For example, exploring patients' ideas, concerns and expectations is a necessary step. For many patients this aspect of care is also likely to be a necessary condition to create patient-provider trust. However, the nature of depression is such that patients may be quite reluctant to mention their thoughts and feelings, especially in context of limited consultation times, but may be more willing to discuss them when directly invited to do so by the health-care provider.⁵⁰ A holistic

approach taking into account the roles of significant others in the SDM process such as relatives and friends is important, in order for these key individuals to be fully supportive of the patient's needs and preferences.

An SDM training programme for depression treatment for health-care providers might include strategies for knowledge transfer about diagnosis and therapy to patients and significant others, as well as a skills practice aspect in which role-playing can occur regarding communication and SDM. However, the barriers to decision-making in depression care in general practice settings are often more complex than just a lack of knowledge and skills on the part of health-care providers. Therefore, the transfer of SDM knowledge and skills into routine practice may also be fostered by developing patient-centred decision aids for use in advance and following consultations. These tools can serve as a support to the in-person consultation, to prepare patients for a more active role as an equal partner in decision-making as appropriate.¹⁶

Study limitations

There are several limitations of this study. First, conclusions from an explorative sample size of 40 can only be drawn with constraints. When patients were interviewed about the latest decision that had been made during their treatment, they could have referred to a decision that was made a few days ago or had already happened several weeks before the interview. Thus, possible bias in patient memory needs to be considered. Because of the sampling approach in this study, information about treatment decision-making was obtained only from patients who had finally decided to do professional treatment. The interview was constrained by the use of pre-structured questions, standard probes and a binary method of analysis. The standardization of the semi-structured interview improves the comparability of results, but limited the extent to which patients' views, personal meanings and emergent or unexpected topics could be explored. The study focused only on patient perceptions and did not include view-

points of the doctors or family members of patients.

The rich qualitative data about patient perceptions that were documented in this research provides essential information about what needs to be taken into account from the patients' perspective when developing a SDM training for depression in general practice. Future research should also examine results for patients with different types of depressive disorders, as well as the importance of different aspects of decision-making.

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