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Research report

Treatment preferences in patients with first episode depression

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ABSTRACT

Background: Treatment preferences of patients suffering from depression may affect adherence and clinical outcomes. This study examines associations between patients' treatment preferences, their characteristics and illness representations of depression.
Methods: Illness representations of depression (IPQ-R), treatment acceptability and preferences were assessed in 88 newly diagnosed patients with first episode depression. Other measures recorded: gender, age, education level, income, psychiatric comorbidity, depressive symptomatology (PHQ-9), a family history of depression, and current treatment of depression. Multiple logistic regression was used to identify factors associated with a preference for psychotherapy.
Results: Psychotherapy was preferred by 41% of participants, while 31% favored antidepressants. Acceptability was strongly associated with preference. Patients preferring psychotherapy perceived that their depression has more serious consequences than those preferring medication and were more likely to attribute their depression to social causes than psychological or physical causes. Participants who preferred psychotherapy were more likely to be female, have a university degree and have a family history of depression.
Limitations: The cross-sectional design precludes causal interpretations.
Conclusions: Preferences vary according to gender, level of education, family history and illness representations. It may be important to provide accurate information on both treatments and discuss patients' preferences before prescribing treatment.

1. Introduction

In Canada, over one out of ten people (12%) will suffer from depression at one point in their lives (Patten et al., 2006). This mental disorder is characterized by a strong recurrence rate. During the first year following recovery, between 21% and 37% of patients experience a second episode of depression and this rate can reach 85% after 15 years (Hardeveld et al., 2010). Psychotherapy and antidepressants are the two main treatments for depression (Canadian Network for Mood and Anxiety Treatments (CANMAT), 2009). In order to avoid relapses, people suffering from depression must properly adhere to their prescribed treatment. In the case of antidepressants, the recommended minimum duration of treatment is 6 to 12 months, yet 30% of patients stop taking their medication in the first 30 days and over 40% stop in the first three months (Olfson et al., 2006). As for psychotherapy, according to Canadian recommendations a minimum of 12 visits are needed, but only 60% of patients having begun psychotherapy receive this much treatment (Duhoux et al., 2012).

Under current guidelines, health professionals and, in particular, physicians need to take patient preferences into account in order to encourage adherence and effective treatment of depression (Trivedi et al., 2007; American Psychiatric Association, 2000; National Institute for Health and Clinical Excellence (NICE), 2009). Patients obtaining their preferred treatment (whether psychotherapy or pharmacotherapy) is associated with the best clinical results, particularly in terms of better remission rates but also in terms of a more significant reduction in depressive symptomatology (Clever et al., 2006; Gelhorn et al., 2011; Kocsis et al., 2009; Loh et al., 2007; Lin et al., 2005; Mergl et al., 2011). Persons suffering from depression often have very clear preferences (Churchill et al., 2000; Dwight-Johnson et al., 2000) and want to play an active role in treatment selection (Stacey et al., 2008; Arora and McHorney, 2000).

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While physicians generally prefer antidepressants, patients often prefer psychotherapy (Van Schaik et al., 2004; Löwe et al., 2006; Khalsa et al., 2011; Churchill et al., 2000; Dwight-Johnson et al., 2000; Iacoviello et al., 2007; Mergl et al., 2011).

The rare studies that have examined the predictors of preferences in treatment of depression indicate that women are more likely than men to prefer psychotherapy (Churchill et al., 2000; Dwight-Johnson et al., 2000; Garcia et al., 2011; Givens et al., 2007; Khalsa et al., 2011), but few studies have examined the influence of education and income level (Morey et al., 2007). People who prefer antidepressants to psychotherapy tend to subscribe more to biomedical explanations of illness (Khalsa et al., 2011; Garcia et al., 2011), but representations concerning the illness's chronic nature, seriousness and consequences have not been associated with treatment preferences. Prior studies dealt with samples that were very heterogeneous in terms of treatment history. We know nothing of the preferences of individuals with a newly diagnosed first episode of depression when they are offered treatment for the first time. Primary care physicians rarely consider the treatment preferences of their depressed patients (Young et al., 2008). Better knowledge of the factors associated with the preferences expressed by patients could prove useful to physicians. It could help them tailor their discussions with patients to treatment preferences and provide appropriate information that supports shared decision making.

This study examines treatment preferences among individuals treated in primary care for a first episode of a major depression. It has two objectives: (1) to describe perceptions of psychotherapy and antidepressants among individuals with a newly diagnosed first episode of depression; (2) to identify the main correlates of treatment preferences, including patient characteristics (sex, age, level of education, income and psychiatric comorbidity), illness representations and perceived social stigma.

2. Methods

2.1. Sample

The participants were recruited in three regions of Quebec, Canada (the Montreal, Outaouais and Capitale nationale regions) through advertisements in newspapers, posters in medical clinics and pharmacies, and information pamphlets distributed by primary care physicians and mental health caregivers. The study's inclusion criteria were: (1) being 18 years of age or older; (2) being English or French-speaking; (3) having a first episode depression as diagnosed by a physician in the previous eight weeks; (4) having received a medical prescription for an antidepressant or psychotherapy; (5) having a PHQ-9 result (Spitzer et al., 1999) equal to or greater than 10 on entry into the study. Individuals with psychotic disorders and women who were pregnant or who had given birth in the previous six months were excluded. A total of 480 persons contacted the research coordinator to participate to the study, 337 were excluded for not meeting our inclusion criteria, and 55 refused to participate after being informed of the participation expected from them. Participants were recruited from September 2010 to April 2012. A financial compensation of $20 was offered for completing the questionnaire. A total of 88 persons participated in the study (61% participation rate). All patients gave informed written consent and the study was approved by the Ethics Board of the Research Centre of the University of Montreal Hospital Centre (CRCHUM).

2.2. Measures

2.2.1. Treatment acceptability and preferences

We adapted the treatment acceptability and preferences measure (Sidani et al., 2009) – a generic measure that assesses the acceptability of different treatments – to depression. Participants were provided with information on psychotherapy and antidepressant treatment in clearly labeled sections: treatment name, description, benefits, and disadvantages. Perceptions of treatment acceptability were measured using specific attributes: (a) *effectiveness* in treating depression; (b) *appropriateness*, i.e., the treatment seems to be a logical way to address depression; (c) *suitability* to the individual's life style; (d) *ease* of adherence; and (e) *convenience*, i.e., willingness to apply and adhere to the treatment. A total score was calculated for each treatment by averaging the scores on all the questions. Final scores could vary from 1 to 5, with higher scores indicating higher acceptability. The two scales (psychotherapy and antidepressants) demonstrated good internal consistency (Cronbach's alphas:.77 and.91, respectively). For treatment with antidepressants, a supplementary question examined perceptions of the severity of side effects. Preference was measured by asking "Do you prefer one of these two types of treatment?" The respondent could answer yes or no. If the answer was yes, the respondent needed to specify whether he or she preferred antidepressants or psychotherapy.

2.2.2. Illness representations

The illness perceptions questionnaire-revised (IPQ-R; Moss-Morris et al., 2002) was used to assess cognitive and emotional representations of depression. We replaced the word "illness" with "depression" throughout the questionnaire, following a recommendation by Moss-Morris et al. (2002). The first part of the IPQ-R, which asks participants to rate a number of symptoms perceived as part of the illness, was not administered. Seven subscales from the second part were used: *acute/chronic timeline*, depression will last a long time (6 items); *cyclical timeline*, symptoms come and go in an unpredictable way (4 items); *consequences*, depression will have serious consequences in various aspects of life (6 items); *personal control*, power to control depression is in the hands of the depressed person (6 items); *treatment control*, medical treatment is effective in controlling depression (5 items); *illness coherence*, depression is understandable (5 items); and *emotional representations*, depression affects emotions negatively (6 items). The internal consistencies of the subscales were satisfactory (Cronbach's alphas:.51–.84). The third part of the IPQ-R assesses causal attributions with 27 items. As recommended by Moss-Morris et al. (2002), we performed a factor analysis in order to identify groups of causal belief. Three subscales with 18 items were created: *psychological attributions*, such as my personality or my attitude (7 items); *physical attributions*, like hereditary or medical illness (6 items); and *social attributions*, such as family problems or the loss of a significant relationship (5 items). The subscales proved sufficiently reliable (Cronbach's alphas:.62–.75).

2.2.3. Patient characteristics

Data were collected on sex, age, ethnicity, level of education, employment status and family income. Family income was compared to the number of persons in the household in order to determine if each participant was above or below the poverty line for his or her area. Psychiatric comorbidity was examined for anxiety disorder (with one item of the functional comorbidity index; Groll et al., 2005) and for substance abuse or dependence disorder (with the MINI; Sheehan et al., 1997). Participants were asked if they were taking an antidepressant at the time of the interview and if they were currently in psychotherapy. Current or past depression in the family was also investigated.