A Qualitative Exploration of Individuals Preferences, Expectations, Lived

Experiences and Satisfaction with Treatment for Depression

Sarah Funnell

This thesis is submitted in partial fulfilment of the degree of Masters of Psychology (Clinical)

School of Psychology

University of Adelaide

November 2019

Word Count: 4981 (Literature Review), 7008 (Research Article)

Declaration

This thesis contains no material which has been accepted for the award of any other degree or diploma in any University, and, to the best of my knowledge, this report contains no materials previously published except where due reference is made.

I give permission for the digital version of my thesis to be made available on the web, via the University of Adelaide's digital research repository, the Library Search, and also through web search engines, unless permission has been granted by the School to restrict access for a period of time.

Sarah Funnell

November, 2019

Acknowledgments

First and foremost, I would like to express my sincere thanks and gratitude to my supervisor Dr Melissa Oxlad for the patience, dedication, valuable support, assistance and encouragement that she has provided to me over the last two years.

I want to extend my thanks and appreciation to my beautiful family, and in particular my mother, whose support and encouragement has never wavered. I also want to thank my friends who have had to endure me during this time, your support has truly meant so much. Many thanks also to the Murdochs, who made me feel like part of their family while I was in Sydney and supported me through the latter part of my write-up.

Finally, I would like to thank each of the participants who were willing to share their experiences with me. Thank you for so honestly and openly sharing your mental health journeys with me. Without you, this research would not have been possible. My heartfelt thanks.

Table of Contents

List of Tables

A Qualitative Exploration of Individuals Preferences, Expectations, Lived

Experiences and Satisfaction with Treatment for Depression

Literature Review

Word count: 4981

Abstract

Depression is one of the most commonly occurring disorders that can significantly impact an individual's quality of life and often leads to increased morbidity and mortality. This paper reviews the existing literature on the prevalence and impact of major depressive disorder. It explores the ongoing issues associated with help-seeking and examines factors that influence or impede individuals accessing help. Research about patient preferences, expectations and satisfaction with treatment for depression are reviewed in the context of both pharmacotherapy and psychotherapy. Limitations of current research, including ongoing discrepancies across the literature, are presented, and recommendations for future research are discussed. In particular, the work concludes that there should be a greater focus on understanding individual perspectives and experiences in more naturalistic community settings, with less emphasis on the use of clinical trial data.

Introduction

Major Depressive Disorder (MDD) is now one of the most common mental health disorders in adults across the globe (Cipriani et al., 2018), and is identified as the main contributor to the global burden of disease (Gariepy, Honkaniemi, & Quesnel-Vallee, 2016). The World Health Organisation (WHO) has reported that globally, approximately 300 million people suffer from depression (WHO, 2017). This commonly occurring, recurrent disorder has a substantial impact on an individual's quality of life and is linked to a diminished and debilitating level of functioning (Gerhards et al., 2011; Kessler & Bromet, 2013). Given the recurrent nature of depression, it is now more appropriately viewed as a chronic disorder rather than an acute illness (Saver, Van-Nguyen, Keppel, & Doescher, 2007). WHO has now ranked depression as the fourth leading cause of disability worldwide and asserts that by 2020, it will be the second leading cause of disability (Kessler & Bromet, 2013). Depression is also the main contributor to suicide, with approximately 800,000 suicide deaths per year, equating to one person every 40 seconds (WHO, 2017). The increasingly high rates of depression have resulted in substantial medical, economic and societal costs (Anderson & Roy, 2013).

MDD: Definition and Diagnostic Criteria

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association [APA], 2013) categorises MDD as the occurrence of five or more of the (nine) following symptoms that have been present during the same 2-week period and represent a change from previous functioning: depressed mood most of the day, nearly every day; markedly reduced pleasure and/or interest in all, or almost all activities; significant weight loss or weight gain (without dieting), or a decrease or increase in appetite; insomnia or hypersomnia; psychomotor agitation; fatigue or loss of energy; feelings of worthlessness or excessive guilt; reduced ability to think or concentrate and/or indecisiveness; and recurrent

10

thoughts of death or suicidal ideation without a specific plan or alternatively a suicide attempt, or a specific plan for committing suicide (APA, 2013). The DSM-5 specifies that at least one of the symptoms is either depressed mood or a loss of interest and/or pleasure (APA, 2013). While specific criteria must be met to receive a formal diagnosis of MDD (APA, 2013), individuals may experience a range of depressive symptoms including low self-esteem, unremitting fatigue, physical malaise, suicide attempts and self-harming behaviours, feelings of worthlessness and loss of interest in things, without satisfying criteria for a formal diagnosis (McCann, Lubman, & Clark, 2012; Wang, 2018).

Prevalence of Depression

Research indicates that specific information about the prevalence and correlates of depression does not exist for most countries. However, while the available data indicates that there is immense variability in prevalence estimates, other components of depression's epidemiology, such as the age of onset and persistence, are relatively consistent across countries (Kessler & Bromet, 2013). A recent Global Burden of Disease study reported that the number of Disability Adjusted Life Years attributed to mental disorders increased by over 37% between 1990 and 2010 (Harvey et al., 2016). During this time, mental health disorders replaced musculoskeletal disorders/conditions as the primary reason for absences and inability to work (Harvey et al., 2016). Depression is now one of the most commonly encountered conditions in primary health care (Saver et al., 2007).

In 2017, the prevalence of depression among those aged 18 years and older within the United States of America (USA) was an estimated 7.1% (National Institute of Mental Health, 2019). In Australia, 1 in 6 women, and 1 in 8 men will reportedly experience some level of depression during their lifetime (BeyondBlue, 2019). Across the globe, depression is commonly comorbid with many other psychiatric disorders, including but not limited to various anxiety disorders, Substance Use Disorder, Post-Traumatic Stress Disorder and

11

Borderline Personality Disorder (Hasin et al., 2018). Research indicates that 85% of Australians with depression also experience significant symptoms of anxiety (Tiller, 2013). Unsurprisingly, comorbid depression can further reduce levels of functioning, and increase impairment and health care use (Tiller, 2013).

Many people identified as having mental health disorders do not receive treatment. In response to the identified 'treatment gap', the 2001 World Health Report made ten recommendations, including increasing the training of mental health practitioners, making treatment for mental health more accessible and making pharmacological drugs more readily available (Jorm, Patten, Brugha, & Mojtabai, 2017). It has been suggested that closing the 'treatment gap' should reduce the prevalence of mental health disorders. In a recent review of four developed countries (Australia, Canada, England, USA), researchers examined whether an increase in treatment provision has led to a decrease in the prevalence of mental health disorders (Jorm et al., 2017). The results indicated that despite significant increases in treatment delivery, in particular, the prescription of antidepressants, none of the countries have observed a reduction in prevalence. More specifically, it was reported that in Australia, antidepressant use increased by 352% from 1990 to 2002 (Jorm et al., 2017). This trend has steadily continued, with a 95% increase from 2000 to 2011 (Jorm et al., 2017). There has also been considerable growth in the resources allocated to mental health care in Australia. For example, there has been an increase in the mental health workforce, increased use of antidepressants and increased provision of psychological therapies. In turn, this has led to an increase in expenses associated with mental illness, with Australian government expenditure rising by 178% between 1992 and 2011 (Jorm et al., 2017). In Australia, the annual cost of depression is currently estimated to be around $12.6 billion (Harvey et al., 2016).

Help-Seeking for Depression

Unfortunately, a high proportion of individuals who require psychological help do not seek it (Prins, Verhaak, Bensing, & van der Meer, 2008). Studies examining the rates of service utilisation for depression report that the difference between the number of individuals who needed treatment and the number of individuals who sought professional help ranged between 15.9% and 83.9% (Magaard, Seeralan, Schulz, & Brutt, 2017). Furthermore, it is estimated that the median untreated rate for depression is 56.3% worldwide (Magaard et al., 2017). Attempts to understand the patterns of low help-seeking behaviour have consistently found reduced service utilisation among males compared to females (Harris et al., 2015). For example, in Australia, only 1 in 4 men who experience depression access treatment (BeyondBlue, 2019). Despite the above, there is increasing evidence that Australians are becoming more open about mental health. For example, between 1995 and 2011, there was a significant increase in the number of individuals who reported having, or having had, an issue similar to that of a depressed person described in a vignette (Jorm et al., 2017). Similarly, Australians also recorded a reduction in the belief that depression is a character weakness (Jorm et al., 2017).

Several factors influence help-seeking behaviours, including individuals not recognising themselves as experiencing psychological difficulties, not believing they will see substantive change in their problems and general stigma (Prins et al., 2008). Numerous psychological models have been developed to explain variations in help-seeking behaviour among populations across the globe. These include the Health Belief Model and the Self-Regulation Model, with the Behavioural Model of Health Services Use explicitly developed to explain help-seeking behaviours (Magaard et al., 2017). This model suggests that health behaviours are influenced by a range of considerations including an individuals' predisposition to use services, factors that enable or inhibit the use of services, and the degree

to which they require care (Magaard et al., 2017). In the most recent version of the model, individual and contextual characteristics that influence service utilisation and health-related outcomes have been distinguished. More specifically, the model asserts that individual and contextual factors involve predisposing factors such as age, gender, ethnicity, education and family status; enabling factors such as finances; and needs factors such as depression severity and/or comorbidity (Anderson, 2008; Magaard et al., 2017).

Under-Recognition of Depression and Treatment Options

The increased prevalence of depression and its subsequent implications emphasise the importance of early detection and treatment of depression. However, depression often remains substantially under-diagnosed and under-treated (Saver et al., 2007). While research indicates that early detection and treatment programs can be cost-effective, dissemination of such programs has been impeded by a general reluctance on the part of primary care practitioners to implement them (Kessler et al., 2003). Research also indicates that the ability of non-psychiatric physicians to recognise and diagnose depression can significantly influence outcomes, as unrecognised and undiagnosed individuals are often not offered or provided treatment for their depression (Cepoiu et al., 2008). Data suggests that the precision with which non-psychiatrists successfully recognise depression is low (Tiller, 2013). One study reported that amongst those with depression, less than half had their condition recognised by their primary care practitioners, even after five years of follow-up (Cepoiu et al., 2008). Similarly, in a qualitative study examining the missed opportunity for diagnosis of depression, some participants reported frequently missed diagnosis by their practitioner, despite experiencing recurrent depression (Saver et al., 2007). There are numerous reasons for under-recognition, under-diagnosis and under-treatment of depression, including but not limited to inadequate knowledge about diagnostic criteria, insufficient insight into the various

presentations of mental health disorders, time pressures and thus an inability to detect and manage patients with such presentations (Cepoiu et al., 2008).

Even when successfully diagnosed and evidence-based guideline treatments are provided, many individuals do not commence treatment, fully participate in it or complete an adequate treatment course (Saver et al., 2007). An individuals' decision to not initiate or complete treatment may result from a myriad of factors, including inadequate health literacy and disappointment or dissatisfaction with the treatment offered (Raue, Schulberg, Heo, Klimstra, & Bruce, 2009). Research indicates that patients often report that they do not receive sufficient information about mental health. For example, Saver and colleagues (2007) found that participants who accessed care in both mental health and primary health care settings stated that they received limited information from their health care practitioner about depression and potential treatment options. These findings are consistent with previous literature relating to the shortcomings and deficits in diagnosing and treating depression (Saver et al., 2007).

In some instances, treatments are not offered or used effectively. Australian data from one study indicate that of individuals who commenced treatment, only 45% were offered a treatment that could be beneficial (Tiller, 2013). Numerous treatments have been developed to manage and treat depression. Choosing and recommending the initial treatment type is the most fundamental decision health practitioners face in caring for clients with depression (Dunlop et al., 2017). In Australia, there is some evidence that practitioners are advocating for and providing treatments that are not consistent with clinical practice guidelines (Jorm et al., 2017). Clinical guidelines recommend that individuals with depression should initially be treated by either evidence-based psychotherapy or pharmacotherapy (Dunlop et al., 2017).

Pharmacotherapy: Antidepressant Medications

Antidepressants, categorised into various classes of drugs with differing mechanisms of action, are widely used as a treatment for depression (Cipriani et al., 2018). Pharmacotherapeutic treatment (i.e. selective serotonin reuptake inhibitors [SSRIs]) predominately affect the serotonin network of the limbic system, such as the amygdala and hippocampus (Quidé, Witteveen, El-Hage, Veltman, & Olff, 2012). Antidepressants are now the most commonly used medications across the globe. Approximately 10% of Australian adults take them each day, at a rate that has more than doubled since 2000 (Davey & Chanen, 2016). In 2011, Australia had the second-highest (of 23 countries) consumption of antidepressants, yet an increase in the prevalence of mental health disorders has continued (Jorm et al., 2017). Similarly, within the USA, antidepressants remain the primary treatment for individuals experiencing depression, with 81.9% of individuals in 2007 receiving this treatment type (Jorm et al., 2017). Moreover, despite international guidelines recommending discontinuation of antidepressants 4 - 12 months after remission, antidepressant use is often long-term; only about 10% of individuals discontinue antidepressants each year (Bosman et al., 2016). It is now recognised that unnecessary continuation of antidepressants can result in long-term side-effects for the individual as well as high healthcare costs (Bosman et al., 2016).

The efficacy and effectiveness of antidepressants is a longstanding and controversial issue, with varying perspectives across the literature. Some researchers postulate that antidepressants are the cornerstone of depression treatment and have been proven to effectively reduce the severity and impact of depressive symptoms (Ho, Jacob, & Tangiisuran, 2017). There is also strong evidence to suggest that antidepressants are effective in preventing relapse (Davey & Chanen, 2016). When comparing the effectiveness of

different antidepressant medications, research reports similar effectiveness; however, the side-effects often differ (Winter & Barber, 2013).

Conversely, other researchers have concluded that the short-term benefits are modest and that long-term sustainability and balance of benefits versus harm are under-researched (Cipriani et al., 2018). Approximately 30-40% of individuals with depression do not respond sufficiently to an adequately performed first-line drug treatment (Oestergaard & Møldrup, 2011). Furthermore, individuals who do not successfully respond to the first pharmacological treatment also have a lower probability of responding to subsequent antidepressant treatment (Oestergaard & Møldrup, 2011). The use and consumption of antidepressants has continued to rise despite accumulating evidence that they are not as effective as previously thought (Davey & Chanen, 2016). Earlier studies reported substantial effect sizes for antidepressants. However, recent meta-analyses have reported modest overall effect sizes, albeit higher for severe compared with mild depression (Davey & Chanen, 2016). Interestingly, some studies even report a significant placebo effect (Rutherford, Wager, & Roose, 2010).

Considerable work has been undertaken to elucidate why antidepressants appear to be failing. The myriad of putative factors includes selective publishing of positive results, the identification of unpublished negative trial results and the increasing rate of positive response to placebo (Davey & Chanen, 2016). Furthermore, many studies found that depressed individuals have concerns about their antidepressant medication or believe that they can become addicted. Brown et al. (2005) found that individuals commonly believe their current or future health depends on antidepressant medication, but also believe that doctors prescribe too many medications (Prins et al., 2008).

Psychotherapies

Psychotherapies such as Cognitive Behavioural Therapy (CBT) and Interpersonal Psychotherapy have shown to be at least as effective as pharmacotherapy for mild to

17

moderate depression (as defined by cut-off scores on depressive symptom inventories; Davey & Chanen, 2016; Weitz et al., 2015). Psychotherapies are structured, time-limited therapies that primarily aim to directly address and rectify the core features of depression (Davey & Chanen, 2016). While psychotherapies are effective, some meta-analyses have shown that earlier studies reported inflated effect sizes (Davey & Chanen, 2016). This may have occurred as many early therapy trials only analysed participants who completed treatment, often only included non-clinical participants, and used non-active control conditions (Davey & Chanen, 2016).

The APA and British Association for Psychopharmacology guidelines for treating depression advise that while psychotherapy may be sufficient for treating mild depression, severe depression (i.e., MDD) is best treated with antidepressants (Weitz et al., 2015). This recommendation comes from the National Institute of Mental Health Treatment of Depression Collaborative Research Program, which found CBT to be less effective than medication in the treatment of severe depression (Weitz et al., 2015). Unfortunately, there is an increasing propensity to prescribe medications as the sole treatment for depression, irrespective of severity. For example, in the USA, psychotherapy is currently being offered less often than previously. From 1998 to 2007, the number of individuals with depression treated with psychotherapy decreased from 54% to 43% (Davey & Chanen, 2016).

The continued declining emphasis on psychotherapy training in psychiatry has coincided with the expanding and escalating use of pharmacological treatments (Parker, Bylett, & Leggett, 2013). For example, general practitioners (GP), the primary prescribers, invariably use antidepressants to treat mild depression, while the evidence and clinical guidelines recommend that psychological therapy be the first line of treatment (Jorm et al., 2017). Research also indicates that individuals are less likely to be advised of psychotherapies as an option for depression. In their study, Saver and colleagues (2007)

18

reported that fewer than half of participants were advised of, or provided with, information about psychotherapies as a treatment for depression. Furthermore, no participants recalled being advised what psychotherapy treatment options (including CBT) entail (Saver et al., 2007). The same study reported that only a minority of participants felt they had a say in decision-making about treatment options and even when they did, not all felt they had sufficient information to make a good choice (Saver et al., 2007).

The previously well-established, long tradition of medical psychotherapy appears to be in decline (Davey & Chanen, 2016). At present, very few doctors have the expertise to deliver psychotherapy. This lack of expertise appears to have resulted in GPs and psychiatrists advocating for antidepressants rather than psychotherapy as the first-line of treatment for depression (Davey & Chanen, 2016). Some researchers contend that psychotherapies are the preferred treatment for all patients. They further suggest that medication should only be considered in cases of moderate or greater severity, or when psychotherapy has been refused or is deemed ineffective (Davey & Chanen, 2016). Factors associated with preference for psychotherapy over medication have included female gender, greater knowledge of psychotherapy or prior psychotherapy experience, and no recent antidepressant treatment (Prims et al., 2008).

Combination of Pharmacotherapy and Psychotherapy Treatment

Given that the effects of psychotherapy and medication appear to operate independently of one another, research indicates there is an opportunity to concurrently administer treatments (Cuijpers et al., 2014). The National Institute for Health and Clinical Excellence (NICE) stipulates that individuals with treatment-resistant, high severity or recurrent depression should receive a combination of both pharmacological treatment and individual CBT (Oestergaard & Møldrup, 2011).

The combination of medication and psychotherapy is reportedly more effective than either treatment alone (Davey & Chanen, 2016). The effect of a combined treatment approach compared with placebo is approximately twice that of medication only compared with placebo (Davey & Chanen, 2016). Recent research has emphasised the importance of combining the two treatment options in more individuals than is done in current clinical practice (Cuijpers et al., 2014).

Preferred Treatment for Depression

Evidence for the types of treatments individuals with depression prefer varies across the literature. However, some studies indicate that an individual's belief about mental health difficulties and the best treatment option vary markedly from the beliefs of health professionals (Prins et al., 2008). Thus, individuals with depression may have different perceptions about what factors may influence their help-seeking behaviours, what treatments will be helpful for them and acceptability and adherence to treatment (Prins et al., 2008). The APA guidelines now stipulate that when appropriate and feasible, practitioners should follow patient preferences when recommending treatment for depression (Winter & Barber, 2013).

Individuals who are offered treatments they show a preference for tend to be more likely to initiate, engage in and adhere to treatment and develop a better alliance with their practitioner (Dunlop et al., 2017). In studies specific to depression, the relationship between treatment preference and treatment outcome shows significant variation (Dunlop et al., 2012). For example, some studies indicate that individuals who receive their preferred treatment have more optimal treatment outcomes than individuals who do not (Dunlop et al., 2012). However, other studies have found no evidence to support treatment preference as a predictor in depression treatment outcomes (Dunlop et al., 2012). Regardless, treatment preference has been identified as an important contributing factor to treatment adherence and attrition. For example, meta-analyses have indicated that individuals who do not receive their preferred

20

treatment are more likely to cease treatment prematurely (Dunlop et al., 2017). Furthermore, some research postulates the importance of using patient preferences for initial treatments (Dunlop et al., 2017). Individual preferences are deemed valuable as studies have found that those who receive their preferred treatment invest more fully in their treatment (Dunlop et al., 2017).

An important potential confounding factor of the impact of preference on outcomes is an individuals' prior treatment exposure (Dunlop et al., 2017). Prior treatment may influence an individuals' willingness to trial particular treatments (Dunlop et al., 2017). Furthermore, previous experience with depression treatment, either personally or through a friend or family member, has been associated with treatment preference (Winter & Barber, 2013).

Expectations and Their Role in Mental Health

Expectations comprise an individual's beliefs or cognitions that are future-orientated and focused on the occurrence or non-occurrence of an event or experience (Rief & Glombiewski, 2017). In the context of treatment for mental health disorders, expectations are considered as a "central mechanism of change" (Rief & Glombiewski, 2017, p. 210). Within the field of mental health, expectations have previously been divided into either "prognostic expectations" or "participant role expectations" (Rutherford et al., 2010, p. 2). Prognostic or outcome-oriented expectations relate to anticipated positive and/or adverse effects of treatment, and the associated probabilities of various outcomes (Rutherford et al., 2010). Role expectations refer to anticipated behaviours on the part of the treating practitioner and individual during treatment (Rutherford et al., 2010).

It is now well established that expectations can have positive or negative impacts on treatment outcomes, depending on many factors, including whether or not an individual believes that treatment will be beneficial or harmful. Moreover, the impacts can vary in strength depending on the rationale for the individual's expectations (Rutherford et al., 2010).

21

Acknowledging and understanding the role and impact of expectations in both pharmacotherapeutic and psychotherapeutic treatments is imperative (Rief & Glombiewski, 2017). Irrespective of the treatment type, expectations about treatment success are the most prominent predictor of outcome and can occur at any phase of treatment (i.e. pre, during and post; Rief & Glombiewski, 2017; Rutherford et al., 2010). For example, before treatment, individuals often develop outcome expectations based on their understanding of their disorder, the treatment being offered and any previous treatment experience (Rutherford et al., 2010). During treatment, expectations can shift depending on the severity of the individual's symptoms, the therapeutic relationship with their clinician, and any initial treatment side-effects or benefits experienced (Rutherford et al., 2010). Finally, post-treatment, individuals may experience positive or negative expectations regarding the likelihood of staying well.

Previous research asserts that individuals across all clinical contexts develop expectations about whether and how much they will improve based on the information provided to them at the beginning of treatment (Rutherford et al., 2010). This notion has colossal clinical implications and is postulated as being the primary mechanism of the placebo effect (Kirsch, 2017; Rutherford et al., 2010). This has led to the response expectancy theory that postulates that subjective and physiological responses can be modified by changing expectations (Kirsch, 1997). Response expectancies are considered pertinent when recommending and administering treatment for mental health conditions, such as depression and anxiety disorders (Kirsch, 1997). For example, previous research indicates that information given to individuals about SSRIs can have a greater impact than the medication itself (Kirsch, 2017). Similarly, in the context of psychotherapy, the likelihood of producing favourable outcomes is dependent on both the health practitioners' ability to

promote positive response expectancies and establish a therapeutic alliance and the specific treatment (Kirsch, 2017).

Satisfaction with Treatment

Another vital influencer of the quality of health care in psychiatric treatment is patient satisfaction (Köhler, Unger, Hoffmann, Steinacher, & Fydrich, 2015). Treatment satisfaction can be described as an individual's perception and rating of their experience of the process and outcomes of treatment (López-Torres Hidalgo et al., 2016). Patient satisfaction is deemed an important component in the care process as it influences consumer behaviour and treatment efficacy (Hasler et al., 2004). More specifically, treatment satisfaction is associated with treatment compliance, in that a satisfied patient will better engage in psychotherapy and/or take their medication as prescribed, thus facilitating optimal therapeutic outcomes (López-Torres Hidalgo et al., 2016).

Patient satisfaction is influenced by a multitude of factors including an individuals' clinical profile, social support, socioeconomic characteristics, expectations and previous service experiences (Hasler et al., 2004). Furthermore, patient satisfaction is also dependent on the quality of care received, the alliance and support provided by health care practitioners and the outcome of care (i.e. perceived improvement as identified by the patient; Hasler et al., 2004).

Patient satisfaction is associated with the perception of valuable improvements in two specific outcome domains: changes in symptomology and the interpersonal domain (Hasler et al., 2004). Research indicates that individuals who experience no therapeutic change are consequently dissatisfied with their treatment experience (Hasler et al., 2004). Conversely, lower severity of depressive symptoms is associated with higher patient satisfaction (Köhler et al., 2015). Similarly, one study reported that individuals with depression who were in their first onset of depressive symptoms were more satisfied with treatment compared to

individuals who had experienced multiple episodes (Köhler et al., 2015). The same study found that individuals with psychiatric comorbidities showed reduced satisfaction as the number of comorbidities increased (Köhler et al., 2015).

It is also imperative to consider the type and quality of treatment individuals are receiving, although results are sometimes variable. For example, some studies report high patient satisfaction during or following inpatient treatment, while others do not (Köhler et al., 2015). In a study of 648 individuals with comorbid depression and anxiety, individuals who received high-quality psychotherapy were more likely to be satisfied with their experience of mental health care (Stein et al., 2011). Furthermore, a dose-response relationship was evident, wherein greater CBT elements during therapy correlated with higher patient satisfaction with care (Stein et al., 2011). The same study reported that the content of sessions corresponded more with satisfaction than the number of sessions (Stein et al., 2011). Similar results were yielded in a German study, where no significant correlation was found between additional sessions of psychotherapy and patient satisfaction (Köhler et al., 2015).

Interestingly, the delivery of high-quality pharmacotherapy has not been as consistently associated with patient satisfaction (Stein et al., 2011). This could potentially be explained by the fact that there tends to be less intense clinical care for those taking antidepressants, particularly when compared to clinical trials (Sugarman, 2016). In a USA-based study comprising 84, 514 individuals, only 24% of individuals had a follow-up appointment in the first 12 weeks following initiation of antidepressant treatment (Sugarman, 2016). In addition, research indicates that 73.6% of the USA population who are on antidepressants receive their prescription from a GP rather than from a psychiatrist (Mojtabai & Olfson, 2008). This finding is particularly important given that research shows that individuals who receive their antidepressant medication from a GP are more likely to take

their medication infrequently or irregularly and to cease their medication within 30 days (Mojtabai & Olfson, 2008).

Therapeutic alliance and patient-practitioner interaction is another important factor that influences patient satisfaction (Köhler et al., 2015). The mere act of accessing a health practitioner does not equate to satisfaction with care (Stein et al., 2011). Genuine, personal interest and empathy demonstrated by practitioners are significant predictors of patient satisfaction (Stein et al., 2011; Swanson, Bastani, Rubenstein, Meredith, & Ford, 2007). Communication and shared decision making between an individual and their practitioner are also positively associated with increased satisfaction (Swanson et al., 2007). Individuals who are given an explanation of their mental health condition and who are actively involved in the management and treatment of their condition report being more satisfied with their care than those who are not (Swanson et al., 2007). Similarly, individuals who receive patient-centred care report higher levels of satisfaction (Rossom et al., 2016). Patient-centred care encompasses care that is compassionate, empathetic and responsive to an individuals' needs and preferences (Rossom et al., 2016). Patient-centred care not only improves the patient-practitioner relationship but also results in the individual feeling more engaged and in control of their care (Rossom et al., 2016). Individuals who are more involved in their care not only receive guideline-concordant care but also make stronger improvements, all of which subsequently contributes to increased patient satisfaction (Winter & Barber, 2013).

Directions for Future Research

The impact, expectations and experience of depression and its subsequent treatments are all important concerns, particularly as the prevalence of depression continues to escalate globally (WHO, 2017). Recognising and successfully diagnosing depression is deemed imperative given that depression is now indisputably considered one of the most prevalent disorders and a primary public health concern (Cepoiu et al., 2008). While substantive

research has focussed on help-seeking in individuals with depression, gaps in knowledge remain. Previous studies have recommended that future research on help-seeking behaviours among individuals with depression should focus specifically on individual perspectives and experiences (Magaard et al., 2017). A better understanding of help-seeking behaviours and factors that influence or impede individuals accessing help are crucial, allowing better identification of the reasons people fail to seek adequate professional help, and in turn improving access to care and patient outcomes (Magaard et al., 2017).

Research on the impact of patient preferences, expectations and satisfaction of treatment for depression has important implications for both clinical practice and future research (Gelhorn, Sexton, & Classi, 2011). Given the disparities across the literature concerning treatment preference, expectations, satisfaction with and lived experiences of pharmacotherapy and psychological treatments for depression, future research should endeavour to explore these further. Previous studies that have examined the impact of these factors are limited and have predominately used clinical trial data (Gelhorn et al., 2011). Future research should be conducted in more naturalistic community settings as opposed to clinical trials, as that will allow the opportunity to collect data that encapsulates more "real-world" depression and its treatment (Gelhorn et al., 2011).

Previous studies have also reiterated the importance of acknowledging that each individuals' experience of depression and its treatment is unique. Thus, future research should examine the potential interaction of the aforementioned areas with factors such as patient characteristics, cost constraints, symptom severity and treatment type/setting from the perspective of the patient (Winter & Barber, 2013). By gaining an in-depth and sophisticated understanding of individuals' experiences with depression and its treatment, practitioners may be better equipped to provide patient-centred care for individuals with depression

(Hirschfeld, 2012). This, in turn, offers the potential to improve engagement with and

outcomes of treatment for depression.

References

American Psychiatric Association (APA). (2013). Diagnostic and Statistical Manual of
Mental Disorders, Fifth Edition. Washington, DC, American Psychiatric Association.

Anderson, C., & Roy, T. (2013). Patient experiences of taking antidepressants for depression:
a secondary qualitative analysis. *Research in Social and Administrative Pharmacy, 9*, 884-902. doi: 10.1016/j.sapharm.2012.11.002

Anderson, R. M. (2008). National Health Surveys and the Behavioural Model of Health
Services Use. *Medical Care, 46*, 647-653. doi: 10.1097/MLR.0b013e31817a835d

Beyond Blue. (2019). Statistics. Retrieved from
https://www.beyondblue.org.au/media/statistics

Bosman, R. C., Huijbregts, K. M., Verhaak, P. F., Ruhe, H. G., van Marwijk, H. W., van
Balkom, A. J., & Batelaan, N. M. (2016). Long-term antidepressant use: a qualitative
study on perspectives of patients and GPs in primary care. *The British Journal of General
Practice: The Journal of the Royal College of General Practitioners*, 66, 708-719. doi:
10.3399/bjgp16X686641

Brown, C., Battista, D. R., Bruehlman, R., Sereika, S. S., Thase, M. E., & Dunbar-Jacob, J.
(2005). Beliefs about antidepressant medications in primary care patients: Relationships to
self-reported adherence. *Medical Care, 43*, 1203-1207. doi:
10.1097/01.mlr.0000185733.30697.f6

Cepoiu, M., McCusker, J., Cole, M. G., Sewitch, M., Belzile, E., & Ciampi, A. (2008).
Recognition of Depression by Non-psychiatric Physicians – a systematic literature review
and meta-analysis. *Journal of General Internal Medicine, 23*, 25-36. doi: 10.1007/s11606-007-0428-5

Cipriani, A., Furukawa, T A., Salanti, G., Chaimani, A., Atkinson, L. Z., Yusuke, O., …
Geddes, J. R. (2018). Comparative efficacy and acceptability of 21 antidepressant drugs

for the acute treatment of adults with major depressive disorder: a systematic review and network meta-analysis. *The Lancet, 391*, 1357-1366. doi: 10.1016/S0140-6736(17)32802-7

Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F. (2014). Adding psychotherapy to antidepressant medication in depression and anxiety disorders: a meta-analysis. *World Psychiatry, 13,* 56-67. doi: 10.1002/wps.20089

Davey, C. G., & Chanen, A. M. (2016). The unfulfilled promise of the antidepressant medications. *Medical Journal of Australia, 204*, 348-350. doi: 10.5694/mja16.00194

Dunlop, B. W., Kelley, M. E., Aponte-Rivera, V., Mletzko-Crowe, T., Kinkead, B., Ritchie, J. C., … Mayberg, H. S. (2017). Effects of patient preferences on outcomes in the predictors of remission in depression to individual and combined treatments (PReDICT) study. *American Journal of Psychiatry, 174*, 546-556. doi: 10.1176/appi.ajp.2016.16050517

Dunlop, B. W., Kelley, M. E., Mletzko, T. C., Velasquez, C. M., Craighead, W. E., & Mayberg, H. S. (2012). Depression beliefs, treatment preference and outcomes in a randomized trial for major depressive disorder. *Journal of Psychiatric Research, 46*, 375-381. doi: 10.1016/j.jpsychires.2011.11.003

Gariepy, G., Honkaniemi, H., & Quesnel-Vallee, A. (2016). Social support and protection from depression: systematic review of current findings in Western countries, *The British Journal of Psychiatry: The Journal of Mental Science, 209*, 284-293. doi: 10.1192/bjp.bp.115.169094

Gelhorn, H. L., Sexton, C. C., & Classi, P. M., (2011). Patient preferences for treatment of major depressive disorder and the impact on health outcomes: a systematic review. *The primary care companion for CNS disorders, 13*. doi: 10.4088/PCC.11r01161

Gerhards, S. A., Abma, T. A., Arntz, A., de Graaf, L. E., Evers, S. M., Huibers, M. J., &
Widdershoven, G. A. (2011). Improving adherence and effectiveness of computerised
cognitive behavioural therapy without support for depression: a qualitative study on
patient preferences. *Journal of Affective Disorders, 129,* 117-125. doi:
10.1016/j.jad.2010.09.012

Harris, M. G., Diminic, S., Reavley, N., Baxter, A., Pirkis, J., Whiteford, H. A. (2015).
Males' mental health disadvantage: an estimation of gender-specific changes in service
utilisation for mental and substance use disorders in Australia. *Australian & New Zealand
Journal of Psychiatry, 49,* 821-831. doi: 10.1177/0004867415577434

Harvey, S. B., Deady, M., Wang, M., Mykletun, A., Butterworth, P., Christensen, H., &
Mitchell, P. B. (2016). Is the prevalence of mental illness increasing in Australia?
Evidence from national health surveys and administrative data, 2001-2014. *The Medical
Journal of Australia, 206*, 490-493. doi: 10.5694/mja16.00295

Hasin, D. S., Sarvet, A. L., Meyers, J. L., Saha, T. D., Ruan, W. J., Stohl, M., Grant, B. F.
(2018). Epidemiology of Adult DSM-5 major depressive disorder and its specifiers in the
United States. *JAMA Psychiatry, 75*, 336-346. doi: 10.1001/jamapsychiatry.2017.4602

Hasler, G., Moergeli, H., Bachmann, R., Lambreva, E., Buddeberg, C., & Schnyder, U.
(2004). Patient satisfaction with outpatient psychiatric treatment: the role of diagnosis,
pharmacotherapy and perceived therapeutic change. *The Canadian Journal of Psychiatry,
49*, 315-321. doi: 10.1177/070674370404900507

Hirschfeld, R. M. (2012). The Epidemiology of Depression and the Evolution of Treatment.
The Journal of Clinical Psychiatry, 73, 5-9. doi: 10.4088/JCP.11096su1c.01

Ho, S. C., Jacob, S. A., & Tangiisuran, B. (2017). Barriers and facilitators of adherence to
antidepressants among outpatients with major depressive disorder: a qualitative study.
PLoS ONE, 12, 1-19. doi: 10.1371/journal.pone.0179290

Jorm, A. F., Patten, S. B., Brugha, T. S., & Mojtabai, R. (2017). Has increased provision of

   treatment reduced the prevalence of common mental disorders? Review of the evidence

   from four countries. *World Psychiatry, 16*, 90-99. doi: 10.1002/wps.20388

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., … Wang, P.

   S., (2003). The epidemiology of major depressive disorder: results from the National

   Comorbidity Survey Replication (NCS-R). *JAMA, 289*, 3095-3105. doi:

   10.1001/jama.289.23.3095

Kessler, R. C., & Bromet, E. J. (2013). The Epidemiology of Depression Across Cultures.

   Annual Review of Public Health, 34, 119-138. doi: 10.1146/annurev-publhealth-031912-

   114409

Kirsch, I. (1997). Response expectancy theory and application: A decennial review. *Applied

   and Preventive Psychology, 6,* 69-79. doi: 10.1016/S0962-1849(05)80012-5

Kirsch, I. (2017). Response expectancy and the response to antidepressant medication.

   EBioMedicine, 25. doi: 10.1016/j.ebiom.2017.09.038.

Köhler, S., Unger, T., Hoffmann, S., Steinacher, B., & Fydrich, T. (2015). Patient satisfaction

   with inpatient psychiatric treatment and its relation to treatment outcome in unipolar

   depression and schizophrenia. *International Journal of Psychiatry in Clinical Practice, 19*,

   119-123. doi: 10.3109/13651501.2014.988272

López-Torres Hidalgo, J., López Gallardo, Y., Párraga Martínez, I., Del Campo Del Campo,

   J. M., Villena Ferrer, A., & Morena Rayo, S. (2016). Treatment satisfaction among

   patients taking antidepressant medication. *Community Mental Health Journal, 52*, 738-

   745. doi: 10.1007/s10597-015-9865-5

Magaard, J. L., Seeralan, T., Schulz, T., & Brütt, A. L. (2017). Factors associated with help-

   seeking behaviour among individuals with major depression: a systematic review. *PLoS

   ONE, 12*, 1-17. doi: 10.1371/journal.pone.0176730

McCann, T. V., Lubman, D. I., & Clark, E. (2012). The experience of young people with depression: a qualitative study. *Journal of Psychiatric and Mental Health Nursing, 19*, 334-340. doi: 10.1111/j.1365-2850.2011.01783.x

Mojtabai, R., & Olfson, M. (2008). National patterns in antidepressant treatment by psychiatrists and general medical providers: results from the national comorbidity survey replication. *The Journal of Clinical Psychiatry, 69*, 1064-1074. doi: 10.4088/jcp.v69n0704

National Institute of Mental Health. (2019). Major Depression. Retrieved from https://www.nimh.nih.gov/health/statistics/major-depression.shtml

Oestergaard, S., & Møldrup, C. (2011). Improving outcomes for patients with depression by enhancing antidepressant therapy with pharmacological interventions: a systematic review of reviews. *Public Health, 125*, 357-367. doi: 10.1016/j.puhe.2011.02.001.

Parker, S., Bylett, M., & Leggett, A. (2013). Challenges faced by trainee psychiatrists working towards competency in psychotherapies. *Australasian Psychiatry, 21*, 56-59. doi: 10.1177/1039856212466158

Prins, M. A., Verhaak, P. F., Bensing, J. M., van der Meer, K. (2008). Health beliefs and perceived need for mental health care of anxiety and depression – the patients' perspective explored. *Clinical Psychology Review, 28,* 1038-1058. doi: 10.1016/j.cpr.2008.02.009

Quidé, Y., Witteveen, A. B., El-Hage, W., Veltman, D. J., & Olff, M. (2012). Difference between effects of psychological versus pharmacological treatments on functional and morphological brain alterations in anxiety disorders and major depressive disorder: a systematic review. *Neuroscience and Biobehavioural Reviews, 36*, 626-644. doi: 10.1016/j.neubiorev.2011.09.004

Raue, P. J., Schulberg, H. C., Heo, M., Klimstra, S., & Bruce, M. L. (2009). Patients' depression treatment preference and initiation, adherence, and outcome: a randomised primary care study. *Psychiatric Services, 60*, 337-343. doi: 10.1176/appi.ps.60.3.337

Rief, W., & Glombiewski, J. A. (2017). The role of expectations in mental disorders and their treatment. *World Psychiatry, 16,* 210-211. doi: 10.1002/wps.20427

Rossom, R. C., Solberg, L. I., Vazquez-Benitez, G., Crain, A. L., Beck, A., Whitebird, R., & Glasgow, R. E. (2016). The effects of patient-centered depression care on patient satisfaction and depression remission. *Family Practice, 33*, 649-655. doi: 10.1093/fampra/cmw068

Rutherford, B. R., Wager, T. D., & Roose, S. P. (2010). Expectancy and the treatment of depression: a review of experimental methodology and effects on patient outcome. *Current Psychiatry Reviews, 6,* 1-12. doi: 10.2174/157340010790596571

Saver, B. G., Van-Nguyen, V., Keppel, G., & Doescher, M. P. (2007). A qualitative study of depression in primary care: missed opportunities for diagnosis and education. *Journal of the American Board of Family Medicine: JABFM, 20*, 28-35. doi: 10.3122/jafm.2007.01.060026

Stein, M. B., Roy-Byrne, P. P., Craske, M. G., Campbell-Sills, L., Lang, A. J., Golinelli, D., …Sherbourne, C. D. (2011). Quality of and patient satisfaction with primary health care for anxiety disorders. *The Journal of Clinical Psychiatry, 72*, 970-976. doi: 10.4088/JCP.09m05626blu

Sugarman, M. A. (2016). Are antidepressants and psychotherapy equally effective in treating depression? A critical commentary. *Journal of Mental Health, 25*, 475-478. doi: 10.3109/09638237.2016.1139071

Swanson, K. A., Bastani, R., Rubenstein, L. V., Meredith, L. S., & Ford, D. E. (2007). Effect of mental health care and shared decision making on patient satisfaction in a community sample of patients with depression. *Medical Care Research and Review, 64,* 416-430. doi: 10.1177/1077558707299479

Tiller, J. W. G. (2013). Depression and Anxiety. *The Medical Journal of Australia, 199*, 28-31. doi: 10.5694/mja12.10628

Wang, J. (2018). The survival experiences of people with depression in Taiwan. *Journal of Social Service Research, 44*, 332-342. doi: 10.1080/01488376.2018.1472172

Weitz, E. S., Hollon, S. D., Twisk, J., Van Straten, A., Huibers, M. J. H., David, D., … Cuijpers, P. (2015). Baseline depression severity as moderator of depression outcomes between Cognitive Behavioral Therapy vs. Pharmacotherapy: an individual patient data meta-analysis. *JAMA Psychiatry, 72*, 1102-1109. doi: 10.1001/jamapsychiatry.2015.1516

Winter, S., & Barber, J. (2013). Should treatment for depression be based more on patient preference? *Patient Preference and Adherence, 7,* 1047-1057. doi: 10.2147/PPA.S52746

World Health Organisation (WHO). (2017). Depression and other common mental disorders: Global health estimates. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-eng.pdf

A Qualitative Exploration of Individuals Preferences, Expectations, Lived

Experiences and Satisfaction with Treatment for Depression

Sarah Funnell*

*Corresponding Author:

Sarah Funnell

School of Psychology, The University of Adelaide

Adelaide, South Australia 5000

████████████████████████

███████████████

Key words: Depression; Major Depressive Disorder; Psychotherapy; Pharmacotherapy;

Treatment for Depression

Abstract

Objectives: This study aimed to examine lived experiences of individuals seeking help for depression, an increasingly pervasive and debilitating disorder globally.

Methods: Using a qualitative research design, 17 individuals were interviewed about their experiences of undertaking treatment for depression, with a focus on treatment preferences, expectations and satisfaction with pharmacotherapy or psychotherapy.

Findings: Two superordinate themes were established from thematic analysis. The first, 'Interactions with Health Professionals', comprised four themes that revealed the importance of therapeutic alliance, effective patient-centred care and the adverse effects of negative or invalidating experiences. With five themes, the second superordinate theme, 'Experiences with Therapeutic Treatments', revealed patient preferences, expectations, satisfaction and readiness for treatment as overriding influencers.

Conclusion: Participants described highly individualised experiences of depression, with important implications for clinical practice and future research study designs. The findings may better equip practitioners to provide effective early treatment and patient-centred care.

Introduction

Major Depressive Disorder (MDD) is a commonly occurring disorder that can significantly impact an individuals' quality of life and often results in diminished and/or debilitated functioning (Gerhards et al., 2011; Kessler & Bromet, 2013). While specific criteria must be satisfied for a diagnosis of MDD (American Psychiatric Association [APA], 2013), individuals can experience depressive symptoms including low self-esteem, unremitting fatigue, physical malaise, feelings of worthlessness, general loss of interest, self-harm behaviours and suicide attempts, without satisfying full diagnostic criteria (McCann, Lubman, & Clark, 2012; Wang, 2018). Individuals often report associated social consequences such as feeling stigmatised, poor relationships, impediments to academic learning and/or performance, and unemployment (Wang, 2018).

Alarmingly, depression is now one of the most prevalent mental health disorders, with approximately 300 million people suffering globally (World Health Organisation (WHO), 2017). Depression is also linked closely to suicide, with approximately 800,000 suicide deaths per year, equating to one person every 40 seconds (WHO, 2017). These trends have resulted in substantial medical, economic and societal costs (Anderson & Roy, 2013).

Help-Seeking and Under-Recognition of Depression

The increased prevalence of depression and its subsequent implications emphasise the importance of early detection and treatment. While treatment can reduce much of the burden associated with mental illness, many sufferers do not seek professional help (Harris et al., 2015; Prins, Verhaak, Bensing, & van der Meer, 2008), with the median untreated rate for depression more than 50% worldwide (Magaard, Seeralan, Schulz, & Brutt, 2017). Attempts to understand patterns of low help-seeking behaviour have consistently found reduced service utilisation among males compared to females (BeyondBlue, 2019; Harris et al., 2015). Factors that influence help-seeking behaviours include individuals not recognising

themselves as experiencing psychological difficulties, not believing they will see substantive change in their problems, and general stigma (Prins et al., 2008).

Disturbingly, for those who seek help, successful symptom recognition by non-psychiatric health professionals remains low (Tiller, 2013). One study reported that fewer than half of individuals had their depression recognised by their primary care practitioner, even after five years of follow-up (Cepoiu et al., 2008). Under-recognition, under-diagnosis and under-treatment can result from inadequate knowledge about diagnostic criteria, insufficient insight into various mental health presentations, time pressures, and lack of psychosocial orientation (Cepoiu et al., 2008).

The inability to recognise and diagnose depression can significantly impact outcomes, as undiagnosed individuals are often not offered or provided appropriate treatment (Cepoiu et al., 2008). Even when diagnosed, many individuals do not commence treatment, do not fully participate in it and/or do not complete an adequate treatment course (Saver, Van-Nguyen, Keppel, & Doescher, 2007). An individuals' decision to not initiate or complete treatment often results from inadequate health literacy, dissatisfaction with treatments offered (Raue, Schulberg, Heo, Klimstra, & Bruce, 2009), or receiving inadequate or insufficient information about mental health (Saver et al., 2007). Choosing and recommending the first treatment is the most fundamental decision health practitioners face in caring for individuals with depression (Dunlop et al., 2017). However, some evidence suggests that practitioners advocate for and provide treatments that are not consistent with clinical practice guidelines (Jorm, Patten, Brugha, & Mojtabai, 2017). Guidelines recommend that individuals with depression should initially be treated with either evidence-based psychotherapy or pharmacotherapy, or a combination of the two (Cuijpers et al., 2014; Dunlop et al., 2017).

Preferences, Expectations and Satisfaction with Treatment

Individuals with depression often express well-defined treatment preferences (Gelhorn, Sexton, & Classi, 2011), frequently developed from previous treatment exposure or experience (Dunlop et al., 2017; Winter & Barber, 2013). An individuals' beliefs about depression and treatment options can vary markedly from those of their health professional (Prins et al., 2008). Individuals offered their preferred treatment are more likely to initiate and engage in treatment, adhere to treatment regimens, and develop a stronger alliance with their practitioner (Dunlop et al., 2017). Clinicians should, therefore, be aware of and when appropriate, follow an individuals' preferences when recommending treatments (Winter & Barber, 2013).

Understanding the role and impact of expectations for pharmacotherapeutic and psychotherapeutic treatments is similarly imperative (Rief & Glombiewski, 2017). As a "central mechanism of change" (Rief & Glombiewski, 2017, p. 210), expectations can have positive or adverse impacts on treatment outcomes (Rutherford, Wager, & Roose, 2010). Irrespective of treatment type, expectations about success are the most salient predictor of outcomes and can occur at any stage of treatment (Rief & Glombiewski, 2017; Rutherford et al., 2010). With significant clinical implications, this is postulated as the primary mechanism of the placebo effect (Kirsch, 2017; Rutherford et al., 2010).

Client satisfaction is another important factor in depression treatment, as it can significantly influence consumer behaviour and treatment efficacy (Köhler, Unger, Hoffmann, Steinacher, & Fydrich, 2015). A multitude of factors including an individuals' clinical profile, comorbidities, symptom severity and duration, social support, socioeconomic characteristics, expectations and previous service experiences are pertinent (Hasler et al., 2004; Köhler, et al., 2015). Satisfaction is also dependent on the quality of care, the content (rather than number) of sessions and outcomes of care (Hasler et al., 2004; Köhler et al.,

2015; Stein et al., 2011). Interestingly, the delivery of high-quality pharmacotherapy has not been as consistently associated with satisfaction (Stein et al., 2011), possibly because there tends to be less intense clinical care (Sugarman, 2016).

Therapeutic alliance and authentic patient-practitioner interaction are other important influencers of client satisfaction (Köhler et al., 2015; Stein et al., 2011; Swanson, Bastani, Rubenstein, Meredith, & Ford, 2007). Individuals who receive patient-centred care report greater satisfaction, which, in turn, improves the client-practitioner relationship and leaves the client feeling more engaged and in control of their care (Rossom et al., 2016).

The Current Study

Given the continued global escalation in depression (WHO, 2017), its impact and clients' experience of treatment are of paramount concern. While a substantial amount of research has focussed on help-seeking, gaps in the literature remain. Greater focus on individual perspectives and experiences is required (Magaard et al., 2017). A better understanding of help-seeking behaviours and factors influencing and/or impeding access to care are crucial to improving access to treatment and client outcomes (Magaard et al., 2017).

Research regarding client preferences, expectations and satisfaction with treatment has important implications for clinical practice and future research (Gelhorn et al., 2011). Given disparities across the literature in regard to treatment preferences, expectations, satisfaction, and lived experiences of pharmacological and psychological treatments, further investigation is required. Research conducted in more naturalistic community settings rather than clinical trials allows the opportunity to collect data on "real-world" experiences of depression (Gelhorn et al., 2011). While each individual's experience of depression is unique, research documenting this variability remains limited. There are also few qualitative studies, even though these provide rich sources of data (McCann et al., 2012). A greater understanding of influencing factors such as client characteristics, symptom severity, and

40

treatment type/setting and cost, from the perspective of the individual, is also required (Winter & Barber, 2013). By gaining an in-depth understanding of individuals' lived experience with depression and its treatment, practitioners may be better equipped to provide early intervention and patient-centred care (Hirschfeld, 2012). The current study, therefore, aimed to use a qualitative approach to examine individuals' lived experience of seeking help for depression, including exploring treatment preferences, expectations and satisfaction with treatment.

Method

Participants

Semi-structured interviews were completed with 17 South Australian individuals who self-identified as having been diagnosed with depression or MDD. Five men and 12 women aged between 18 and 39 years ($M = 23.7$ years, $SD = 6.05$) participated. At the time of their interview, using the Depression Anxiety and Stress Scale (DASS-21), five participants' depression symptoms were within the normal range. Of the others, three were in mild, three in moderate, two in severe, and four in the extremely severe ranges, respectively. Table 1 provides a summary of participant characteristics.

Eligibility criteria for participation included being at least 18 years of age, fluent in English, having experienced self-identified or health professional-diagnosed depression and having undertaken treatment (pharmacotherapy or psychotherapy) for depression. Efforts were initially made to screen and exclude individuals who had comorbid mental health disorders. However, during interviews, some participants disclosed previously unidentified comorbidities. Table 2 provides a summary of participants' psychological history.

Table 1

Summary of Participant Characteristics

Name*	Age	Gender	Ethnicity	Relationship*	Living*	Education*	Studying*	Employed*
Yuri	21	M	Afghan	Single	Family	Year 12	Yes	Yes – P/T
Emma	20	F	Australian	Single	Friends	Year 12	Yes	Yes – P/T
Adam	31	M	Australian	Single	Alone	TAFE	No	Yes – P/T
Kate	20	F	European	Single	Family	Year 12	Yes	No
Natalie	39	F	Asian	Married	Partner	Post Grad	Yes	Yes – F/T
Lucy	28	F	American	Single	Alone	Und Grad	Yes	Yes – P/T
Gemma	19	F	European	Single	Alone	Year 10	Yes	No
Alice	21	F	Australian	Single	Family	Year 12	Yes	Yes – P/T
Sarah	19	F	Australian	Relationship	Alone	Year 12	No	Yes – P/T
Matt	21	M	European	Single	Family	Year 12	Yes	No
Mia	32	F	Australian	Relationship	Family	Und Grad	Yes	Yes – P/T
Claire	19	F	Australian	Single	Family	Year 12	Yes	Yes – P/T

Name	Age	Sex	Ethnicity	Relationship	Living	Education	Studying	Employment
Kim	29	F	Australian	Married	Partner	Und Grad	Yes	Yes – P/T
Colin	18	M	Australian	Single	Family	Year 12	Yes	No
Rachel	23	F	Australian	Relationship	Partner	Und Grad	No	Yes – P/T
Sally	18	F	European	Single	Family	Year 12	Yes	No
David	25	M	Australian	Relationship	Partner	Year 10	Yes	No

Note: Participant names are pseudonyms; Relationship = Current relationship status; Living = Current living arrangements; Education = Highest level of educational achievement; Studying = Currently studying, Employment: F/T = Full-time employment and P/T = Part-time employment.

Procedure

This research was approved by the University of Adelaide Human Research Ethics Committee (H-2018-250). Information and flyers were submitted to local psychology and medical practices, such as the University of Adelaide's Counselling Service and the University Health Practice. Recruitment also occurred via a second flyer posted to online forums and social media platforms, and snowball sampling. Potential participants were invited to contact the researcher to express their interest. Written consent was obtained from all participants before participation.

Participants also completed a brief questionnaire, including demographic information, before their interview. All participants also completed the DASS-21 to determine the severity of their depression at the time of interview (See Table 2).

Semi-structured interviews were employed. Interview questions were developed based on previous studies across relevant literature (Bosman et al., 2016; Buus, Johannessen, & Stage, 2012; Jaffray, Cardy, Reid, & Cameron, 2014; Saver et al., 2007). Example questions included: "Can you describe what depression has been like for you", and "How satisfied would you say you are with medication [and/or psychotherapy] as a treatment option for depression?". Following inductive reflexive thematic analysis research methods (Braun & Clarke, 2006; 2013), two pilot interviews were conducted to assess the appropriateness of the interview schedule. Minor adjustments were made to the order of questions; these pilot interviews were included in the data set.

Fifteen interviews were conducted face-to-face, and two interviews were via telephone. Interviews ranged between 27 and 85 minutes, with an average length of 58.3 minutes. Data saturation usually occurs at between eight to twelve interviews (Guest, Bunce, & Johnson, 2006). However, due to the diverse array of participants and their experiences, data collection continued for 16 interviews. Following the completion of data collection, an

44

additional individual expressed interest in participating. Due to the sensitive nature of the research topic, the researchers wanted to allow all interested individuals to share their experience; therefore, this individual was interviewed and included in the data set. Following the completion of the seventeenth interview, strong re-emerging themes were observed. However, given the diversity of participants and their experiences, it is difficult to know if total saturation had been reached. All interviews were audio-recorded with participants' permission and transcribed verbatim using an orthographic method (Braun & Clark, 2006; 2013). Confidentiality and anonymity were maintained by allocating each participant a pseudonym. All names and any identifying features were removed from the transcripts.

Table 2

Summary of Participant Psychological History

| Name* | Diagnoses* | Status* | Treatment Undertaken | DASS-21* | | |
				Depression	Anxiety	Stress
Yuri	Depression	Ongoing	Therapy and medication	Moderate (18)	Moderate (14)	Severe (26)
Emma	Depression; Anxiety	Resolved	Therapy	Normal (2)	Normal (2)	Normal (8)
Adam	Depression; Anxiety; ADHD	Ongoing	Therapy and medication	Moderate (18)	Normal (4)	Mild (16)
Kate	Depression	Ongoing	Therapy and medication	Normal (6)	Moderate (10)	Moderate (22)
Natalie	Depression	Ongoing	Therapy and medication	Normal (2)	Normal (2)	Normal (10)
Lucy	Depression	Ongoing	Therapy and medication	Mild (12)	Normal (6)	Normal (14)
Gemma	Depression	Ongoing	Therapy and medication	Severe (22)	Normal (4)	Normal (6)
Alice	Depression; Anxiety	Ongoing	Therapy and medication	Extremely Severe (34)	Extremely Severe (26)	Severe (26)
Sarah	Depression; Anxiety	Ongoing	Therapy and medication	Mild (10)	Severe (18)	Mild (18)
Matt	Depression; ASD	Ongoing	Therapy	Extremely Severe (34)	Moderate (12)	Moderate (24)

Mia	Depression; Anxiety	Ongoing	Therapy and Medication	Normal (6)	Extremely Severe (20)	Normal (12)
Claire	Depression	Ongoing	Therapy and Medication	Mild (12)	Moderate (14)	Normal (12)
Kim	Depression; Anxiety	Ongoing	Therapy and Medication	Severe (22)	Moderate (12)	Moderate (22)
Colin	Depression	Ongoing	Therapy and medication	Extremely Severe (40)	Moderate (14)	Mild (16)
Rachel	Depression; Anxiety	Ongoing	Therapy and Medication	Normal (4)	Normal (6)	Normal (12)
Sally	Depression; AN	Ongoing	Therapy and Medication	Extremely Severe (32)	Extremely Severe (22)	Normal (8)
David	Depression	Ongoing	Therapy and Medication	Moderate (16)	Normal (6)	Normal (14)

Note: Participant names are pseudonyms; ADHD = Attention Deficit Hyperactive Disorder; AN = Anorexia Nervosa; ASD: Autism Spectrum Disorder; DASS-21 = Depression Anxiety Stress Scales-21; (no.) = The raw scores of each subscale of the DASS-21; Diagnoses = Diagnosis/diagnoses participants had received; Status = If depression had resolved or was ongoing.

Meticulous qualitative research methodology was followed to enhance methodological rigour (Tracy, 2010). An audit trail was maintained to facilitate data analysis, continuously reflect on the quality of the interview process and subsequently inform any potential modifications to future interviews. The audit trail also included records of all interactions with participants and attempted contact made with various organisations during recruitment. Member reflections were sought, with all participants provided with the opportunity to review their transcripts (Tracy, 2010). A total of 12 participants responded, confirming their transcript; no changes were made to any transcripts.

Self-reflexivity, the process of engaging in an honest and transparent self-awareness process, is considered a crucial component of qualitative research (Tracy, 2010). Moreover, self-reflexivity assists in identifying and minimising the effect of researcher bias (Tracy, 2010). The primary researcher has not experienced depression, although concurrently practices as a provisional psychologist. Some participants were aware of the researcher's role, and while any questions concerning this were deferred until after the interview, this may have influenced how participants interacted with the researcher. Furthermore, awareness of the researcher's role may have led to assumptions that certain experiences were understood by the researcher and thus did not require further explanation by the participant. However, during the interviews, several participants stated that they were sharing their experiences, as they hoped that by doing so, they may help others who experience depression.

Data Analysis

Thematic analysis was used to examine and synthesise the data from a realist ontological position (Braun & Clarke, 2006; 2013). This position postulates that reality is independent from human knowledge, interpretation and understanding (Braun & Clarke, 2006; 2013). Each interview was therefore analysed and interpreted as a direct reflection of lived experiences. Braun and Clarke (2006; 2013) describe six main steps involved in

48

undertaking thematic analysis. The initial step comprised immersion and subsequent familiarisation with the data which was achieved via transcription, continuous reading, and noting of preliminary concepts and ideas. Secondly, initial codes were generated by categorising interesting features of the data which captured the research aim. The third step involved collating the initial codes into prospective emergent themes and sub-themes. During the fourth step, themes were reviewed and reconsidered with respect to the raw data, initially established codes and applicability to the research aim. Fifth, themes that best captured and epitomised the data were refined, defined and named, resulting in the development of two superordinate themes and nine themes. Finally, compelling extracts were selected and used to represent each theme.

An inductive approach was used to examine the data, whereby numerous themes were identified. The primary researcher completed the initial coding. However, to ensure consistency and trustworthiness of the chosen codes and themes, the research supervisor concurrently coded four transcripts. These four transcripts, codes and initial themes were then discussed collaboratively. Following discussion and refinement, the remaining transcripts were revisited, and a final thematic structure was established and agreed upon by both researchers.

Results

Two superordinate themes, Interactions with Health Professionals and Experiences with Therapeutic Treatments, were identified and are described below.

Superordinate Theme 1: Interactions with Health Professionals

Within this superordinate theme, four themes were identified, "The importance of therapeutic alliance", "Dismissive and invalidating experiences are detrimental to satisfaction", "Health professionals who exert undue pressure are demonstrating inappropriate practice", and "Effective patient-centred care".

Theme 1: The importance of therapeutic alliance

Therapeutic alliance emerged as a dominant theme, particularly in relation to participants experience, and the perceived importance of therapeutic alliance. However, both of these parameters also showed variation across participants. Some participants reported strong therapeutic relationships with their health professionals which positively influenced their experience. More specifically, participants often referred to their health practitioners as "*emotionally supportive*" (Emma). For example:

> "*I found it really helpful and just that like – that relationship with the person and, yeah, just being so safe and accepting and, you know when I first started going I didn't have any sort of positive male role models or relationships in my life so that was really empowering as well, to be in that safe space.*" –
> Rachel

Many participants indicated a positive therapeutic alliance to be extremely important. For some, their health professional was the only conduit to express their current circumstances. This is demonstrated by one example:

> "*Of course it's comfortable. I feel safe. I guess since I don't talk with many people, I don't talk to at all with anyone, she kind of fills a – oh, I don't want*

to say role. We want to be with others. You know, I guess she's the only line I

have." – Yuri

Conversely, others described less positive relationships, where they did not feel comfortable with their practitioner, and this subsequently impacted on their experience. In some instances, it also affected treatment outcomes as noted by one participant:

"I guess part of it was I was bowing to the authority. It was I'll go with what

she says because she's the trained professional but yeah, I probably should've

spoken up and said 'I don't think this is working." – Adam

Most participants commented on the importance of not settling for just any health professional. They reiterated the criticality of finding a health professional that they felt comfortable with and who fitted their needs. For example:

"I think you just try to find a counsellor that you're comfortable with and not

just go with anyone. Like if you're not satisfied with one of the counsellors just

try another one and try another one until you find someone who you're

comfortable with." – Natalie

Many participants reflected that their experience with their health professional tarnished their perceptions, experience of and/or engagement with therapy. More specifically, participants described how their health professional deterred them from continuing therapy. For example:

"I went to a lot of sessions and even after that it was just kind of like I still

didn't see this therapist as someone I could openly talk about my life so I think

part of me wishes that maybe I'd gone on and maybe tried to find a different

therapist. I think if you can find the right person to kind of click with and the

right person to kind of talk to I think it can help." - Claire

Some participants also noted differences in therapeutic relationships dependent on the discipline of the health professional:

51

"*I don't know why it felt very comfortable talking to the psychiatrist and when*

I went to the psychologist I didn't feel that comfortable. I have no idea why.

Maybe its because you have to have like a personal connection with... like you

have to like the person and my first sessions I didn't really connect with her."

– Lucy

Theme 2: Dismissive and invalidating experiences are detrimental to satisfaction

Participants described instances where they felt their health professional was not

listening and/or did not take them seriously. This attitude not only affected their satisfaction

with treatment but also their propensity to seek help. While participants often acknowledged

that their health professional was 'the expert', they also reflected that they had hoped their

health professional had taken them seriously. Many participants reported incidents where

they were told "*you don't know what you are talking about*" (David) or when their concerns

were dismissed, and they were advised to "*get over it*" (Natalie). This is illustrated by Sarah

and Yuri:

"*It kind of just made me feel like they would be very blasé about stuff I told*

them that was very serious to me but I felt wouldn't be serious to them." –

Sarah

"*Sometimes it felt like she was cutting through the fat and getting straight to it*

but sometimes it [she] felt she was deaf or something." – Yuri

Several participants expressed concern that their health professional did not acknowledge the

severity of their symptoms and/or experiences. For example:

"*Then when things were really bad I saw a doctor and I was thinking that, you*

know, I really wanted to go on medication because I was just feeling out of

control. She didn't want to give me any medication and suggested that I do

some yoga and I was like 'things are a little bit worse than that right now'." –

Rachel

Furthermore, subsequent treatment modalities suggested by health professionals sometimes resulted in participants feeling frustrated, invalidated and dissatisfied with the current health services being provided:

"I was really frustrated at the time with psychiatrists, I still have that

frustration today because I have been in hospital two times and every time I

have talked to a psychiatrist they have been incredibly dismissive and

sometimes narcissistic and it's frustrating, and I just feel like I wasn't getting

the help that I needed." – David.

Many participants admitted that due to previous invalidating and dismissive experiences, they subsequently ceased engagement with their health professional and/or treatment and remain reluctant to engage in mental health services. This is highlighted below:

"I didn't think they'd understand. Because of this experience I had with

doctors I thought I would just be disregarded because of my age. I felt I've

been disregarded a lot for health issues, apart from this, because of my age,

because people don't believe me." – Sarah

Theme 3: Health professionals who exert undue pressure are demonstrating inappropriate

practice

While many participants described positive experiences with their health professionals, some recounted instances where their health professional exerted undue pressure. More specifically, participants recounted instances where they had expressed concerns to their health professional regarding their treatment that were subsequently ignored:

> *"Once I realised that the level that it's set at was not a particularly happy*
>
> *one, like I was kind of keen to try something different, but he was saying 'No.*
>
> *We'll keep trying on this one, see how it goes."* – Adam

Moreover, many participants described a desire for their health professional to respect their opinions, input and decisions more. For example:

> *"She said 'I very strongly think that you should tell your mother because then*
>
> *she'll be able to help you if something, you know, in regards to that (sexual*
>
> *abuse) comes up' and I said 'I don't really feel comfortable doing that' and*
>
> *she said 'I think you really should'. Like she really pushed it."* – Kate

Participants also reflected concern in instances where their health professional had breached confidentiality, and stated that this had subsequently impacted and ruptured rapport with the therapist:

> *"Well there was a bit of a wobble when she brought my mum in and I felt she*
>
> *disclosed things to my mum that I wasn't ready for her to share with her and I*
>
> *hadn't intended to share with her."* - Gemma

In the context of psychotherapy, many participants expressed concern about the quality of therapy and/or the approach taken. More specifically, one participant described sessions that ultimately ended up "*being a coffee date more than a therapy session*" (Sarah). Another participant stated:

> *"She would kind of touch me that would make me feel <gesture>. I would*
>
> *hate it, like she would touch my hand and do things like that. I have no idea*
>
> *what that is.*" – Lucy.

Some participants described pressure from their health professional to cease therapy when they were not necessarily ready to do so. For example:

> *"Things would get better for me a little bit and then they would say 'you are*
>
> *feeling a bit better so we are going to stop the treatment, stop the counselling'*
>
> *and I would go off and things would get worse again."* – David

Conversely, other participants reported instances where their health professional exerted pressure on them to remain in therapy, as illustrated below:

> *"I remember he tried a lot to keep going, keep going, just kept going, because*
>
> *it was kind of like the moment of – he was very persistent with the counselling*
>
> *but you could tell that I didn't want to be there and it was kind of just this*
>
> *awful thing where he kept going and my parents kept kind of making me go."*
>
> – Claire

Theme 4: Effective patient-centred care

Many participants described receiving compassionate, empathetic care, responsive to their specific needs and/or preferences. Participants reported experiences where their health professional comprehensively explained various treatment options before collaboratively reaching a decision. Other participants reported that their health professional advocated for them to lead their own care. For example:

> *"It was more my decision kind of thing. He was always open about it. He*
>
> *never really recommended one over the other. He was kind of just very open*
>
> *with the idea and he always just kind of left it up to me so at the end of the day*
>
> *it was my choice to kind of be able to take the time and to think about what I*
>
> *wanted to do before I went further and went back and told him, he would*
>
> *discuss with me where we'd go from there kind of thing."* – Claire

Conversely, other participants described being uninvolved in the decision-making process about their treatment options. Some participants reported that they preferred being directed

by their health professional, others reflected they wished their health professional had demonstrated a more collaborative approach:

> *"Like kind of me but also it wasn't an active decision. I wasn't like*
> *empowered to make it, I just kind of took the medication and went to the*
> *psychologist and hoped for the best, kind of. Yeah I think it didn't feel like – it*
> *felt like a passive sort of decision, just following what everyone, the doctor*
> *and the psych were telling me was probably a good plan. Yeah I definitely*
> *wasn't like empowered or didn't feel like I was in charge, but I was just kind*
> *of getting by and doing what I had to." – Rachel*

As noted by Natalie, the apparent lack of patient-centred care demonstrated by some health professionals often resulted in patient dissatisfaction:

> *"I don't think they actually care. Like my GP, she spend too much time on –*
> *you know, she spend half an hour with me. The psychiatrist just 'tick, tick, tick,*
> *tick' didn't even look up, and just – yeah I don't think they care. No. No, I*
> *didn't really have much choice at all." –* Natalie

Superordinate Theme 2: Experiences with Therapeutic Treatments

Within this superordinate theme, five themes were identified, "Patient preferences make all the difference", "The reality of patients' expectations", *"*Readiness influences uptake and satisfaction", "Factors influencing and/or impeding therapeutic success", and "Satisfaction with treatment".

Theme 1: Patient preferences make all the difference

Participants indicated varying preferences towards pharmacotherapy and psychotherapy. Preferences were based on a myriad of factors including prior experience, previous treatment and input from friends or family members. For example:

56

"Of course the opinion of my family counted a lot so my father and my mother not being very encouraging about it also made me not want to go so I think that's the reason. I didn't really want to be active, I just wanted to take my medication and make it go, make the symptoms go away." – Lucy

Participants offered their preferred treatment were more likely to initiate and engage in treatment, adhere to treatment regimens, and develop a stronger alliance with their practitioner, as exemplified below:

"I sort of took matters into my own hands and I said to my doctor I want to go and see a psychiatrist, I did and I said to her, "look I am here today and I just want Phenelzine, because this is what I think I have". And she was like "fair enough you have been on a bunch of different ones", and she gave it to me sort of thing. And it worked really well." - David

Similarly, when participants undertook a non-preferred treatment, it often resulted in them feeling dissatisfied and discouraged from remaining in treatment. This is emphasised in the extract below:

"I don't think therapy was the right answer personally for me because I was always very much – I didn't want to talk about things in my life to a complete stranger. I didn't think it was ever something that I wanted to do" - Claire

While some participants expressed uncertainty and ambivalence towards medication, many indicated a preference for medication as they perceived it as an "easy option" and a "quick fix". Several participants explained that they were seeking short-term gains and thus were predominately interested in commencing pharmacotherapy:

"I was a bit biased because I had my mind set of getting medication to get me through my year 12 exams because this was a time where I didn't want to be looking at long term; I wanted short term solutions." – Sarah

Some participants described instances where their preferences and right to preferences were taken away from them. This predominately occurred for those considered minors at the time they undertook treatment or those who were forcibly admitted to hospital. For example:

> *"I don't think I had one. I think at the time because it was never – I think I wished it would've been my choice to go and seek help because it was always just my parents that kind of played that role, I guess, and what I was doing and where I was going."* – Claire

In these instances, participants highlighted that they "*didn't really have any choice*" and were "*forced*" (Natalie) into undertaking various treatments. As noted by Alice below, such instances corresponded with strong dissatisfaction with the treatment experience:

> *"I was really scared and I just wanted to go home. So when they told me that I didn't have a choice in going to see the therapist, yeah it made me really, really angry."* – Alice

Finally, many participants discussed preferences about psychologist characteristics. Preferences were discussed in terms of clinician gender, age, experience and speciality. These preferences also subsequently impacted therapeutic alliance and engagement in therapy. For example:

> *"I just liked the idea of talking to a girl than a boy I think because I was younger and just found it more comfortable and I would have found the girl easier to talk to."* – Emma

Due the specificity of preferences, many participants described and advocated for the importance of conducting independent research into potential health professionals before engaging in therapy.

Theme 2: The reality of patients' expectations

Participants recounted a diverse range of expectations concerning treatments. Many participants reflected that they did not have expectations before treatment. They described not possessing expectations because they were adamant that nothing could change the way they were feeling. For example:

> *"Thinking back I think I was too depressed to even think about a better future,*
>
> *better alternative. Everything looked bad in general."* – Yuri

In contrast, other participants described having positive expectations before undertaking either psychotherapy or pharmacotherapy because they believed that they could not feel any worse than they already were:

> *"I thought I couldn't be any worse than like I was already so I kind of*
>
> *changed my perspective, I guess. I was pretty hopeful. Maybe not like certain*
>
> *but I was hopeful."* – Kate

Furthermore, a lack of understanding of what treatments entailed appeared to correspond with minimal expectations.

> *"Yeah I mean I wasn't really sure what to expect. We sort of have this idea of*
>
> *what therapy is, you know lying on the couch and what not but yeah I guess I*
>
> *didn't really have any expectations going in."* – Alice

Many participants explained they could not understand how talking to someone "*about it was going to make it go away*" (Emma), and thus, initially perceived therapy as a "*waste of time*" (Sarah). Moreover, numerous participant responses indicated that their confidence in, and expectations of treatments were often dictated and determined by their prior knowledge and understanding. For example:

> *"Wouldn't say I was confident at all. I don't think I knew enough. I didn't*
>
> *know if people recovered. I didn't know if you lived with it forever, or if it*
>
> *goes away, gets better or worse."* – Rachel

Not surprisingly, participants expressed minimal expectations when they had previous, unsuccessful experiences with treatment:

> *"I didn't really expect anything out of it because I had a bad experience with*
>
> *a counsellor before I went to the hospital so I just thought 'this is useless and*
>
> *a waste of my time'."* – Natalie

Similarly, many participants described initially feeling confident and having high expectations about their treatment. However, this optimism and positivity often waned as the duration of treatment increased, while their perceived positive outcomes decreased. For example:

> *"Going to see the psych and talking about my feelings and the medication,*
>
> *none of it really felt like it was making me feel better about stuff, it's just the*
>
> *medication I hate it because of how flat it made my feelings go and, you know,*
>
> *maybe if I had more sessions with the psych or a [slightly different approach]*
>
> *then it might've felt better but I just – I felt so down."* – Adam

Many participants reflected that they expected that treatment would remove their depression:

> *"I didn't really know how long it would take to resolve and it has – over time*
>
> *I've found that it's something I'm just always going to have to live with and*
>
> *that's not what I originally expected. I didn't expect that I would spend the*
>
> *next decade with coming and going of major mental health problems."* - Kim

More specifically, many participants described having high expectations about the impact of antidepressants due to pre-conceived ideas. However, many participants described feeling 'let down' by the reality of their experience with medication:

> *"I expected the medication to solve everything, which was unrealistic of me but I expected to take the medication and turn back into the person I was before I started feeling depressed. So it didn't meet my expectations at all."* – Sarah

Moreover, some participants reflected that despite their expectations, antidepressants were not a panacea and that their recovery was longer and harder than they anticipated:

> *"I wouldn't say so because I kind of expected more from it. I expected a real boost, a real kind of perk up, and I expected to take the medication and be able to function but there's actually like 80 percent more hard work that you need to do. I think I went into it thinking that it would fix all the problems but it really doesn't, it's just a kind of a little booster, so that was really different to my expectations."* – Rachel

Similarly, participants described never anticipating that treatment could make them feel worse. Many participants reflected how they often found psychotherapy challenging and draining; however, reiterated that it was worth it in the end:

> "*I never expected that, that I would sometimes feel worse and she's like 'it might feel worse initially but it'll end up being better. It's because you're probably just getting a lot of, you know, home truths and lightbulb moments and things like that but it will become easier' but I did not expect it to be like that, so, yeah, draining and challenging but also probably that all worked out to be really beneficial."* - Mia

Theme 3: Readiness influences uptake and satisfaction

Readiness to undertake treatment was another emerging theme described variously by participants. For example, some people described readiness in terms of motivation,

willingness to accept they had a problem and therefore needed treatment or wanting to initially manage self-sufficiently. For example:

> *"I felt that it was something that I could just get over without them. It was something that I could just move on from in my life, that I needed to change my lifestyle and once I could do that, things would improve and after realising that wasn't working… I said screw it."* - David

Many participants reportedly commenced treatment despite not being "ready" and subsequently had negative experiences, resulting in dissatisfaction:

> *"I don't like admitting that I had a problem, that I needed help. It frustrated me because I didn't want to admit that there was a problem so yeah I just hated it."* – Alice

In contrast, other participants discussed readiness from a more positive perspective:

> *"Like I was kind of ready to do whatever it took, so was pretty sure that you, it would work, well, I was hoping it would."* – Matt

Furthermore, some participants, irrespective of previous experience, indicated that their readiness influenced their willingness to undertake treatment:

> *"I haven't really had a lot of good experiences with therapy but I was like very willing to like participate in that."* – Kate

Participants often reflected that they engaged in therapy because of their friends and/or family members. However, participants also indicated that they would advise others not to undertake treatment simply because someone else recommended them to:

> *"I think that was the issue, that it was never like I was walking into this room and being like 'I am willing to tell you about my life' it was just 'I am here because I am forced to be here' so personally for me it wasn't something that worked."* – Claire

Theme 4: Factors influencing and/or impeding therapeutic success

Given that each participant had highly individualised experiences of depression, the factors that influenced or impeded therapeutic success were also highly varied. Many participants reported extremely inconsistent experiences and satisfaction relating to antidepressant use. For example:

"It was getting worse, especially when I was on Escitalopram. I remember feeling like I was probably at my lowest point on Escitalopram when I tried to commit suicide at the time. But the overall arching picture is that it didn't help with the depression." – David

While some participants reported positive experiences with antidepressants, many reported concerns and/or factors that impeded satisfaction and success with medication. For example, all participants noted complicating and at times, debilitating side-effects of antidepressant medication. Participants reported that the side-effects varied depending on the medication type. Side-effects included increased suicidal ideation, changes to libido, nausea, physical pain, weight gain, memory difficulties, lethargy, increased irritability and/or anger, and suppressed emotions or emotional responses such as crying. For example, Sarah noted:

"I felt it was harder to feel emotion. I felt kind of numb a lot of the time. I also found that I couldn't cry, which was strange. Like stuff that would normally make me cry or whatever, I just kind of didn't have that access to let emotion out. I kind of felt very trapped in my body, which was part of the reason why I took myself off medication." – Sarah

Many participants described antidepressants as making them feel "numb" and that they were not themselves. Participants expressed how before medication they were 'depressed' but that they were still able to have moments of happiness and euphoria. Participants reported

dissatisfaction with antidepressants because those moments were taken away. Claire provided an illustrative example of this phenomenon:

"It was like third person perspective again but it was almost like a different filter, like someone had kind of taken away that dark filter and then suddenly put on like this motivational music for my life and I was like 'I don't want it'. I wanted an experience where it was still going to be me at the end of the day and even with everything, how bad it was, like I could still experience some moments and the better moments as myself and look back at them later on and be like 'I felt present. I felt there' rather than like that third person being like 'I remember that, but that wasn't me that was there, that was somebody completely different'." - Claire

Participants also explained they needed to take additional medication to counteract anti-depressant side-effects:

"I had lots of different types of medication. Some were for the side-effects of the previous one so it was kind of messy and I didn't really have a say on how much I wanted to do it and for how long and if I wanted to do it." - Lucy

Many participants expressed uncertainty around the duration they would remain on medication. Moreover, they conveyed concern around the potential long-term impacts of remaining on antidepressant medication indefinitely. For example:

"Yeah I feel like it boosts me up a little but potentially not enough to warrant taking them forever." – Rachel

Despite this, participants noted that the ease and accessibility of accessing antidepressants was a positive factor. Participants who undertook pharmacotherapy advised that they were able to access medication that day or within the following few days. In contrast, participants

described that the waitlists and challenges associated with accessing a psychologist were a significant barrier and deterrent to therapeutic success:

> *"If you can just like ease up on the waiting time because if somebody needs to see a psychologist it needs to be now, like they're not going to be like 'oh I think I'm going to be really bad in a few days."* - Mia

Participants had engaged in various forms of therapy including Cognitive Behavioural Therapy, Acceptance and Commitment Therapy, Dialectical Behavioural Therapy, mindfulness, chair work and trauma-based therapy. Participants reflected that every psychologist is very different in their approach to therapy:

> *"There is no standard to the treatment, if I would say anything. It is very much the own philosophy of that therapist and how they treat depression. I wouldn't say it was outside the bounds of their professional training but there is a difference between them all."* – David

Participants reflected that irrespective of the therapy modality, having a good psychologist was imperative to treatment satisfaction and outcomes. For example:

> *"Yeah, its been really good and I don't think I'll ever stop going because I find it so helpful and if my psychologist moves away I'll be screwed."* – Mia

Another factor that participants identified as influential to their therapeutic success was that treatment helped them to develop insight into themselves and their experience and allowed them to consider things from different perspectives:

> *"Maybe helped me to understand why I was thinking certain things because sometimes you don't necessarily analyse why I do things and why I think a certain way, you know. Made me kind of understand maybe a bit more about myself."* – Kate

Treatment also helped some participants to notice that gains can be slow, or small, but that they are all beneficial and should be recognised:

> *"Recognising that small steps are still steps, they're still improvements. Being able to tell myself that its not my fault, that it is actually – you know, it's depression."* – Adam

Theme 5: Satisfaction with treatment

Many participants initiated discussion about their satisfaction with treatment. Some participants positively endorsed their experience, outcomes and satisfaction with psychotherapy. For example:

> *"Well, I don't think I would be recovered without it and I don't think I would be well without it and I'm not even sure if I would be alive because I was struggling so much, so probably a lot. I think it's been like the core of my recovery. It's been my biggest tool and where I've probably learnt the most. It's like the foundation, almost, of my recovery."* – Mia

Similarly, other participants spoke positively about their experience, outcomes and satisfaction with pharmacotherapy:

> *Phenelzine which is the one I am on now, that has completely changed my life. That one has all but cured my depression, oh, I wouldn't say cured it, that's a bit of a stretch but it has helped significantly. I have never had anything like it, it was just insane how much it changed things for me."* – David

However, many participants reported disappointment with their treatment. For example, participants described that they had expected better outcomes which subsequently resulted in reduced satisfaction:

> *"I thought that it would help a lot better than it has."* – Sally

> *"It would be nice if things were done a lot quicker rather than suffering for*
>
> *however long it is." –* Colin

Despite their experiences, many participants indicated that they would still recommend treatment to others:

> *"I would because like I've heard good things about it, not necessarily because*
>
> *it worked well for me but that it kind of usually works well for a lot of people.*
>
> *I'd still recommend it." –* Sally

In contrast, many participants previous experience and satisfaction with treatment subsequently influenced the likelihood of them engaging in treatment again:

> *"It's a bit difficult now because I don't really want to go back on medication*
>
> *because I hated it. I don't really want to be going back and seeing a*
>
> *psychologist because I hated the sessions I was doing that. I can recognise the*
>
> *signs of depression coming back and I really don't want them to because if it*
>
> *gets much worse I'm going to have to try again." –* Adam

Similarly, due to dissatisfaction with their treatment, many participants reported ambivalence in recommending treatment to others:

> *"I don't think I'd recommend it but I also wouldn't say 'don't bother'." –*
>
> Colin

Discussion

MDD is the most common and debilitating psychiatric disorder globally, yet it is often underdiagnosed and undertreated (Kraus, Kadriu, Lanzenberger, Zarate, & Kasper, 2019). This is despite ongoing efforts to increase knowledge and skills for health professionals. It is therefore imperative that there is a greater focus on understanding an individual's preferences, expectations, experiences and satisfaction with pharmacotherapy or psychotherapy as treatments for depression. Using thematic analysis of qualitative interviews,

this study explored treatment preferences, expectations and satisfaction to examine the lived experiences of individuals seeking help for depression.

Two superordinate themes were identified. The first, 'Interactions with Health Professionals' comprised four themes that revealed the importance of therapeutic alliance, effective patient-centred care and the adverse effects of negative and/or invalidating experiences. Participants described interactions with health professionals as pertinent to their experience of accessing and engaging in treatment. While some reported strong, positive relationships with their health professionals, others described less positive relationships. More specifically, there were examples of dismissive and/or invalidating experiences. While these instances were often experienced differently across individuals (i.e. feeling judged, not listened to or not taken seriously), they were consistently regarded as detrimental to the individuals' satisfaction with treatment. These findings are consistent with previous research concerning the quality of care, which report that mental health care can be suboptimal in terms of quality and appropriateness (Stein et al., 2011; Young, Klap, Sherbourne, & Wells, 2001).

In the current study, many participants also described instances where they felt their health professional had not respected their opinions, input and decisions and had divulged sensitive information to others. Participants also talked about the quality of the therapy they had received, with potentially inappropriate conduct by some health professionals. When this occurred, it ruptured rapport and in some instances, deterred participants from completing treatment and/or reduced the likelihood of them undertaking it in the future. Malpractice and unethical conduct appear to be relatively under-reported in current literature, and prevalence rates remain unknown (Moritz et al., 2019). However, researchers acknowledge that these forms of practice have existed for decades (Moritz et al., 2019). Clearly, more work needs to be undertaken to understand this better.

Results from this study also established that therapeutic alliance and quality of care varied depending on the discipline of the health professional. In particular, participants described adverse and/or invalidating experiences with their General Practitioner (GP) where they were not offered their preferred treatment, their preference was disregarded, or they were not referred to a mental health specialist. This finding is consistent with previous research which, for example, found that poor quality care occurred in 80.5% of individuals who accessed mental health treatment through their primary care practitioner, compared to 11.4% accessing it via a mental health specialist (Young et al., 2001). These findings have important implications given that most individuals initially seek help via primary care settings and practitioners (Young et al., 2001). Moreover, they echo the importance of ongoing mental health training and education for primary care practitioners (Acharya, Hirachan, Mandel, & van Dyke, 2016).

Rossom et al. (2016) postulated that individuals who had received patient-centred care report higher levels of satisfaction, as they felt more in control of their treatment. In the current study, participants strongly endorsed and reported high levels of satisfaction when their health professional had comprehensively explained and advised them of the various treatment options available before making a collaborative decision. These findings are consistent with other research that reported a positive association between shared decision making and patient satisfaction (Unützer & Park, 2014). Furthermore, the current study also found that individuals reported complete dissatisfaction when they were not involved in decisions relating to their treatment or when their treatment was dictated entirely by the health professional. These findings reiterate the importance of clinicians practising and adhering to patient-centred care.

The second superordinate theme 'Experiences with Therapeutic Treatments" established in this study encompassed five themes which highlighted patient preferences,

expectations, satisfaction and readiness for treatment as dominant influencers. Findings indicated that individual preferences develop from a multitude of factors including prior experience, previous treatment and input or influence from close friends or family. These findings corroborate previous research concerning factors that influence an individual's willingness to trial particular treatments (Dunlop et al., 2017; Winter & Barber, 2013). Despite clear documentation in the literature and treatment guidelines that advise health professionals to consider and/or adhere to patient preferences (Gelhorn et al., 2011; Winter & Barber, 2013), many participants in the current study reported that they were not offered their preferred treatment and that this subsequently resulted in dissatisfaction and/or discouraged them from remaining in treatment. These findings reinforce the notion that client preferences play a critical role in initiation, continuation and engagement in treatment, and thus should not be overlooked by health professionals (Gelhorn et al., 2011). Health professionals who successfully ascertain and acknowledge client preferences have a much greater opportunity to positively impact and enhance treatment experiences and potentially the subsequent treatment outcomes (Gelhorn et al., 2011).

Expectations were another reoccurring theme that influenced individuals' experiences with treatment. Interestingly, some participants expressed no particular expectation before commencing treatment, as they did not believe anything could change their depression. Results also indicated that nominal understanding of treatments corresponded with minimal expectations. More specifically, many participants described stereotypical perceptions and understandings of treatment such as "lying on a couch" and thus could not comprehend how "talking" would help. Previous research asserts that individuals across all clinical contexts can develop expectations about treatment and how much they will improve based on the information provided to them (Rutherford et al., 2010). Therefore, the findings from the current study reiterate the importance of health professionals providing adequate

70

psychoeducation to clients. It also confirms that health professionals should endeavour to appropriately instil optimism about outcomes to their clients, given that previous research stipulates that irrespective of treatment type, expectations about treatment and treatment success are the most prominent predictor of outcomes (Rief & Glombiewski, 2017; Rutherford et al., 2010).

The current study also uncovered the dangers of overly ambitious expectations. Some participants had a pre-conceived notion that treatment would immediately "remove" their depression. Many patients explained that they never anticipated or expected that psychotherapy would make them feel worse, be such hard work and take so long. Similarly, participants described initially expecting that antidepressants would be a panacea. Across both treatment modalities, participants described feeling let down and dissatisfied when their expectations did not eventuate. These findings suggest the importance of health professionals accurately advising clients of treatment regimens and outcomes, and helping to set realistic expectations. Despite this recommendation, advising patients of potential adverse events poses a dilemma for health professionals, since it might exert a detrimental effect on outcomes and increase the likelihood of an adverse experience resulting (Moritz et al., 2019). Therefore, health professionals must tread a careful line between instilling hope in a client by emphasising the likely benefits of treatment, while simultaneously appraising them of possible risks and/or drawbacks of treatment (Moritz et al., 2019). This requires considerable skill by the health professional and again emphasises the importance of adequate education.

Interviews in the current study indicated that if clients were not "ready" for treatment, there was a correspondence with negative experiences and dissatisfaction with treatment. Lack of readiness encompassed not wanting to admit they had a problem, not being ready to access help, and reduced motivation to successfully engage in or undertake treatment. In contrast, participants who were ready to engage in treatment tended to report more positive

experiences and uptake of treatment. These findings are consistent with the theory of readiness to change (Prochaska & DiClemente, 1982), and concur with previous research findings which report that individuals who endorse a "high action orientation" respond best to treatment irrespective of modality (Lewis et al., 2009). Given that readiness to change is understood as a pivotal construct for treatment, it may be useful for health professionals to assess readiness to change in individuals with depression to assist in tailoring appropriate treatments (Krampe et al., 2017; Lewis et al., 2009). A holistic patient-centred approach that includes assessing an individuals readiness for treatment, preparing them to accept treatment and communicating realistic treatment expectations may also be important for enhancing treatment adherence (Casey, Perera, & Clarke, 2013).

Participants in the current study reported a myriad of treatment side-effects that impacted not only satisfaction but also impeded appropriate utilisation of treatment and treatment outcomes. More specifically, many participants explained how they had to take additional medication to mitigate adverse side-effects of antidepressants. Moreover, others described modifying or ceasing their medication without consulting a doctor due to confounding side-effects. These findings are consistent with international studies that report many clients cease medication prematurely because of side-effects or other concerns, or take medication irregularly and do not follow up with their primary care provider to change treatments (Sugarman, 2016; Unützer & Park, 2014). This may be in part because there tends to be less intense clinical care and fewer follow-up appointments for individuals taking antidepressants (Sugarman, 2016).

Regardless, in this study, many participants noted the ease and accessibility of accessing antidepressants. In contrast, participants described that waitlists and other challenges associated with accessing psychotherapy were significant barriers and deterrents to therapeutic success. Long waiting times for psychotherapy may serve as a potential

72

explanation for individuals increased preferences towards medication (Cartwright, Gibson, Read, Cowan, & Dehar, 2016). Furthermore, lower immediate access to psychotherapy may necessitate more immediate action by GP's to prescribe antidepressants (Sreeharan, Madden, Lee, Millett, & Majeed, 2013). These findings reinforce the urgency and importance of improving availability and access to evidence-based psychological treatment (Patel, Chowdhary, Rahman, & Verdeli, 2011).

Consistent with previous research, participants in the current study reported that increased satisfaction with care was related to the provision of quality of care (Stein et al., 2011). More specifically, participants who received high-quality psychotherapy, including perceived competence of the psychologist, were more satisfied with their treatment. Satisfaction with treatment has important clinical implications as it is a driver for consumer behaviour, treatment efficacy and future engagement (Hasler et al., 2004). In the current study, participants reported that their previous experience and satisfaction with treatment subsequently influenced the likelihood of them engaging in future treatment and also influenced the likelihood of whether they would recommend treatment to others. Given these findings, it is critical that clinicians endeavour to provide positive experiences so that individuals are not deterred from accessing and engaging in treatment, and similarly do not deter others from accessing and engaging in treatment.

Implications

Overall, the findings of this study suggest that factors influencing client preferences, expectations and satisfaction with treatment for depression are highly individualised and complex. It is, therefore, imperative that individual diversity and experience are taken into consideration at all stages of treatment. In concordance with previous literature, the current study posits the importance of health professionals to consider a range of parameters when initially treating clients. This includes attention to depression severity, symptomology and

longevity of past and recent depressive episodes, as well as the propensity for side-effects for available treatment options, and the likelihood of 'refractoriness to particular treatment approaches' (Kraus et al., 2019, p. 12).

The current findings have other important implications for health professionals. Firstly, it is evident that health professionals and particularly GP's require a much greater understanding of mental health and how to manage it appropriately. Research indicates that individuals are more likely to receive mental health care from their primary care provider than from a mental health specialist (Unützer & Park, 2014). Given that primary care providers are often the "first responders" and the conduit to alternative referral pathways, further (and ongoing) training and education in mental health is critical.

Irrespective of speciality, these findings confirm that health professionals should strive to maximise the satisfaction of clients across the health system, and that individual client perspectives and experiences should be listened to and taken seriously (Moritz et al., 2019). These results also advocate for the importance of providing authentic patient-centred care and engaging in dual decision-making processes. Health professionals should endeavour to elicit and gain information from their client about their experiences and preferences relating to various treatment types, and concurrently provide balanced information on all treatment options and likely outcomes before collaboratively formulating a treatment decision (Raue et al., 2009). While these findings are undoubtedly relevant to current practising health professionals, they are also relevant to future health professionals. This emphasises the importance of integrating a greater focus on mental health training during undergraduate, postgraduate and graduate medical education (Acharya et al., 2016).

Finally, the findings of this study have important implications for individuals experiencing depression. Individuals must be adequately educated about their depression and the treatment options available to them. Moreover, the importance and realities of treatment

74

need to be emphasised, and individuals should be supported throughout their journey via regular contact with treating health professionals (Casey et al., 2013).

Strengths, Limitations and Future Research

This study has provided significant insight into the preferences, expectations, lived experiences and satisfaction of individuals who had engaged in pharmacotherapy or psychotherapy for depression, and provides a much-needed contribution to the relatively limited qualitative literature within this area. A strength of the current study was that it included a relatively large and diverse array of participants. A qualitative design and methodology that used semi-structured interview questions was pertinent to the exploratory nature of the research aim. Moreover, study participants were open and forthcoming with in-depth information, thus resulting in an extremely rich data set to inform the results.

Like any research, this study has several limitations that should be considered. While the sample was relatively large and diverse, all participants were from South Australia and thus cannot be expected to be representative of all individuals' experiences of depression. While diversity is advantageous, without segmentation that diversity may also have created greater variability in responses received and inhibit elucidation of potentially important cohort trends (i.e. male/female, age-related etc.).

Analysis of the sample indicates that more women than men participated in this study. This is consistent with previous literature which asserts that men are often reticent to seek help and engage in treatment for depression (Seidler, Rice, Oliffe, Fogarty, & Dhillon, 2018). Given the high rates of suicide in males, and the increasing propensity of underreporting and underdiagnosing of mental health conditions in men (Seidler, Dawes, Rice, Oliffe & Dhillon, 2016), future research could therefore consider further exploring men's experience of help-seeking and engagement in treatment. Such research could play an important role in

improving understanding as well as increase help-seeking behaviours and engagement in treatment for men experiencing depression (Seidler et al., 2016).

There was also a lack of cultural diversity among participants, and the generalisability of the findings from this study should, therefore, be considered in that context. Depression and mental health more broadly can be culturally dependent, and thus future research might consider similar studies that explicitly consider culturally diverse populations and various demographic cohorts.

The current study was also not able to account for the high prevalence of comorbidity and poly-treatment modalities that became evident. Future research may, therefore, aim to examine depression without the presence of comorbidities and/or examine individuals experiences when only one form of treatment has occurred (i.e. only psychotherapy or only pharmacotherapy). However, there needs to be consideration of whether this is necessarily realistic in contexts other than randomised control trials.

The current study relied on a self-selected sample, and it could, therefore, be argued that the higher rates of adverse experiences resulted from a somewhat biased sample. However, many participants explained that they wanted to share their experiences to promote and elicit change. Finally, future research may consider exploring the views and opinions of health professionals. Triangulation of individuals and their health professionals' opinions and experiences would strengthen the credibility of findings.

Conclusion

The occurrence and impact of depression continue to escalate despite significant attention to this debilitating disorder. There is a clear need for targeted research on this topic, particularly in relation to understanding patient experiences. The present study thus makes a valuable contribution to the literature. It not only addresses gaps in our knowledge but also provides important recommendations that will enhance clinical practice and approaches to

treatment. There are several unique contributions of this study. One was the elucidation of the criticality of education for current and emerging primary health care practitioners, as well as specialists in mental health. The study also uncovered the importance of taking into account a clients' perspectives and preferences, and the need for health professionals to acknowledge that a client can make a valuable contribution to their treatment efficacy.

References

Acharya, B., Hirachan, S., Mandel, J. S., & van Dyke, C. (2016). The mental health education gap among primary care providers in rural Nepal. *Academic Psychiatry, 40*, 667-671. doi: 10.1007/s40596-016-0572-5

American Psychiatric Association (APA). (2013). Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. Washington, DC, American Psychiatric Association.

Anderson, C., & Roy, T. (2013). Patient experiences of taking antidepressants for depression: a secondary qualitative analysis. *Research in Social and Administrative Pharmacy, 9*, 884-902. doi: 10.1016/j.sapharm.2012.11.002

Beyond Blue. (2019). Statistics. Retrieved from https://www.beyondblue.org.au/media/statistics

Bosman, R. C., Huijbregts, K. M., Verhaak, P. F. M., Ruhe, H. G., van Marwijk, H. W. J., van Balkom, A., & Batelaan, N. M. (2016). Long-term antidepressant use: a qualitative study on perspectives of patients and GPs in primary care. *British Journal of General Practice, 66,* 708-719. doi: 10.3399/bjgp16X686641

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101. doi: 10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2013). *Successful Qualitative Research: A practical guide for beginners*. London, UK: SAGE Publications.

Buus, N., Johannessen, H., & Stage, K. B. (2012). Explanatory models of depression and treatment adherence to antidepressant medication: A qualitative study. *International Journal of Nursing Studies, 49,* 1220-1229. doi: 10.1016/j.ijnurstu.2012.04.012

Cartwright, C., Gibson, K., Read, J., Cowan, O., & Dehar, T. (2016). Long-term antidepressant use: patient perspective of benefits and adverse effects. *Patient Preference and Adherence, 10*, 1401-1407. doi: 10.2147/PPA.S110632

Casey, M. F., Perera, D. N., & Clarke, D. M. (2013). Psychosocial treatment approaches to difficult-to-treat depression. *The Medical Journal of Australia, 199*, 52-55. doi: 10.5694/mjao12.10629

Cepoiu, M., McCusker, J., Cole, M. G., Sewitch, M., Belzile, E., & Ciampi, A. (2008). Recognition of Depression by Non-psychiatric Physicians – a systematic literature review and meta-analysis. *Journal of General Internal Medicine, 23*, 25-36. doi: 10.1007/s11606-007-0428-5

Cuijpers, P., Sijbrandij, M., Koole, S. L., Andersson, G., Beekman, A. T., & Reynolds, C. F. (2014). Adding psychotherapy to antidepressant medication in depression and anxiety disorders: a meta-analysis. *World Psychiatry, 13,* 56-67. doi: 10.1002/wps.20089

Dunlop, B. W., Kelley, M. E., Aponte-Rivera, V., Mletzko-Crowe, T., Kinkead, B., Ritchie, J. C., … Mayberg, H. S. (2017). Effects of patient preferences on outcomes in the predictors of remission in depression to individual and combined treatments (PReDICT) study. *American Journal of Psychiatry, 174*, 546-556. doi: 10.1176/appi.ajp.2016.16050517

Gelhorn, H. L., Sexton, C. C., & Classi, P. M., (2011). Patient preferences for treatment of major depressive disorder and the impact on health outcomes: a systematic review. *The primary care companion for CNS disorders, 13*. doi: 10.4088/PCC.11r01161

Gerhards, S. A., Abma, T. A., Arntz, A., de Graaf, L. E., Evers, S. M., Huibers, M. J., & Widdershoven, G. A. (2011). Improving adherence and effectiveness of computerised cognitive behavioural therapy without support for depression: a qualitative study on patient preferences. *Journal of Affective Disorders, 129,* 117-125. doi: 10.1016/j.jad.2010.09.012

Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field Methods, 18*(1), 59-82. doi: 10.1177/1525822X05279903

Harris, M. G., Diminic, S., Reavley, N., Baxter, A., Pirkis, J., Whiteford, H. A. (2015). Males' mental health disadvantage: an estimation of gender-specific changes in service utilisation for mental and substance use disorders in Australia. *Australian & New Zealand Journal of Psychiatry, 49,* 821-831. doi: 10.1177/0004867415577434

Hasler, G., Moergeli, H., Bachmann, R., Lambreva, E., Buddeberg, C., & Schnyder, U. (2004). Patient satisfaction with outpatient psychiatric treatment: the role of diagnosis, pharmacotherapy and perceived therapeutic change. *The Canadian Journal of Psychiatry, 49*, 315-321. doi:10.1177/070674370404900507

Hirschfeld, R., (2012). The Epidemiology of Depression and the Evolution of Treatment. *The Journal of Clinical Psychiatry, 73*, 5-9. doi: 10.4088/JCP.11096su1c.01

Jaffray, M., Cardy, A. H., Reid, I. C., & Cameron, I. M. (2014). Why do patients discontinue antidepressant therapy early? A qualitative study. *European Journal of General Practice, 20*, 167-173. doi: 10.3109/13814788.2013.838670

Jorm, A. F., Patten, S. B., Brugha, T. S., & Mojtabai, R. (2017). Has increased provision of treatment reduced the prevalence of common mental disorders? Review of the evidence from four countries. *World Psychiatry, 16*, 90-99. doi: 10.1002/wps.20388

Kessler, R. C., & Bromet, E. J. (2013). The Epidemiology of Depression Across Cultures. *Annual Review of Public Health, 34*, 119-138. doi: 10.1146/annurev-publhealth-031912-114409

Kirsch, I. (2017). Response expectancy and the response to antidepressant medication. *EBioMedicine, 25*. doi: 10.1016/j.ebiom.2017.09.038.

Köhler, S., Unger, T., Hoffmann, S., Steinacher, B., & Fydrich, T. (2015). Patient satisfaction with inpatient psychiatric treatment and its relation to treatment outcome in unipolar depression and schizophrenia. *International Journal of Psychiatry in Clinical Practice, 19*, 119-123. doi: 10.3109/13651501.2014.988272

Krampe, H., Salz, A. L., Kerper, L. F., Krannich, A., Schnell, T., Wernecke, K. D., & Spies, C. D. (2017). Readiness to change and therapy outcomes of an innovative psychotherapy program for surgical patients; results from a randomised controlled trial. *BMC Psychiatry, 17*, 1-16. doi: 10.1186/s12888-017-1579-5

Kraus, C., Kadriu, B., Lanzenberger, R., Zarate, C. A., & Kasper, S. (2019). Prognosis and improved outcomes in major depression: a review. *Translational Psychiatry, 9*, 1-17. doi: 10.1038/s41398-019-0460-3

Lewis, C. C., Simons, A.D., Silva, S. G., Rohde, P., Small, D. M., Murakami, J. L., High, R. R., & March, J. S. (2009). The role of readiness to change in response to treatment of adolescent depression. *Journal of Consulting and Clinical Psychology, 77*, 422-428. doi: 10.1037/a0014154

Magaard, J. L., Seeralan, T., Schulz, T., & Brütt, A. L. (2017). Factors associated with help-seeking behaviour among individuals with major depression: a systematic review. *PLoS ONE, 12*, 1-17. doi: 10.1371/journal.pone.0176730

McCann, T. V., Lubman, D. I., & Clark, E. (2012). The experience of young people with depression: a qualitative study. *Journal of Psychiatric and Mental Health Nursing, 19*, 334-340. doi: 10.1111/j.1365-2850.2011.01783.x

Moritz, S., Nestoriuc, Y., Rief, W., Klein, J. P., Jelinek, L & Peth, J. (2019). It can't hurt, right? Adverse effects of psychotherapy in patients with depression. *European Archives of Psychiatry and Clinical Neuroscience, 269*, 577-586. doi: 10.1007/s00406-018-0931-1

Patel, V., Chowdhary, N., Rahman, A., & Verdeli, H. (2011). Improving access to

psychological treatments: lessons from developing countries. *Behaviour Research and

Therapy, 49*, 423-528. doi: 10.1016/j.brat.2011.06.012

Prins, M. A., Verhaak, P. F., Bensing, J. M., van der Meer, K. (2008). Health beliefs and

perceived need for mental health care of anxiety and depression – the patients' perspective

explored. *Clinical Psychology Review, 28,* 1038-1058. doi: 10.1016/j.cpr.2008.02.009

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more

integrative model of change. *Psychotherapy: Theory, Research & Practice, 19*, 276–288.

doi: 10.1037/h0088437

Raue, P. J., Schulberg, H. C., Heo, M., Klimstra, S., & Bruce, M. L. (2009). Patients'

depression treatment preference and initiation, adherence, and outcome: a randomised

primary care study. *Psychiatric Services, 60*, 337-343. doi: 10.1176/appi.ps.60.3.337

Rief, W., & Glombiewski, J. A. (2017). The role of expectations in mental disorders and their

treatment. *World Psychiatry, 16,* 210-211. doi:10.1002/wps.20427

Rossom, R. C., Solberg, L. I., Vazquez-Benitez, G., Crain, A. L., Beck, A., Whitebird, R., &

Glasgow, R. E. (2016). The effects of patient-centered depression care on patient

satisfaction and depression remission. *Family Practice, 33*, 649-655. doi:

10.1093/fampra/cmw068

Rutherford, B. R., Wager, T. D., & Roose, S. P. (2010). Expectancy and the treatment of

depression: a review of experimental methodology and effects on patient outcome.

Current Psychiatry Reviews, 6, 1-12. doi: 10.2174/157340010790596571

Saver, B. G., Van-Nguyen, V., Keppel, G., & Doescher, M. P. (2007). A qualitative study of

depression in primary care: missed opportunities for diagnosis and education. *Journal of

the American Board of Family Medicine: JABFM, 20*, 28-35. doi:

10.3122/jafm.2007.01.060026

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review, 49*, 106-118. Doi: 10.1016/j.cpr.2016.09.002

Seidler, Z., Rice, S., Oliffe, J., Fogarty, A., & Dhillon, H. (2018). Men in and out of treatment for depression: strategies for improved engagement. *Australian Psychologist, 53*, 405-415. doi: 10.1111/ap.12331

Sreeharan, V., Madden, H., Lee, J. T., Millett, C., & Majeed, A. (2013). Improving access to psychological therapies and antidepressant prescribing rates in England: a longitudinal time-series analysis. *British Journal of General Practice, 6*3, 649-653. doi: 10.3399/bjgp13X671641.

Stein, M. B., Roy-Byrne, P. P., Craske, M. G., Campbell-Sills, L., Lang, A. J., Golinelli, D., …Sherbourne, C. D. (2011). Quality of and patient satisfaction with primary health care for anxiety disorders. *The Journal of Clinical Psychiatry, 72*, 970-976. doi: 10.4088/JCP.09m05626blu

Sugarman, M. A. (2016). Are antidepressants and psychotherapy equally effective in treating depression? A critical commentary. *Journal of Mental Health, 25*, 475-478. doi: 10.3109/09638237.2016.1139071

Swanson, K. A., Bastani, R., Rubenstein, L. V., Meredith, L. S., & Ford, D. E. (2007). Effect of mental health care and shared decision making on patient satisfaction in a community sample of patients with depression. *Medical Care Research and Review, 64,* 416-430. doi: 10.1177/1077558707299479

Tiller, J. W. G. (2013). Depression and Anxiety. *The Medical Journal of Australia, 199*, 28-31. doi: 10.5694/mja12.10628

Tracy, S. J. (2010). Qualitative quality: eight "big-tent" criteria for excellent qualitative research. *Qualitative Inquiry, 16*(10), 837-851. doi: 10.1177/1077800410383121

Unützer, J., & Park, M. (2012). Strategies to improve the management of depression in

    primary care. *Primary Care: Clinics in Office Practice, 39,* 415-431. doi:

    10.1016/j.pop.2012.03.010

Wang, J. (2018). The survival experiences of people with depression in Taiwan. *Journal of*

    Social Service Research, 44, 332-342. doi: 10.1080/01488376.2018.1472172

Winter, S., & Barber, J. (2013). Should treatment for depression be based more on patient

    preference? *Patient Preference and Adherence, 7,* 1047-1057. doi: 10.2147/PPA.S52746

World Health Organisation (WHO). (2017). Depression and other common mental disorders:

    Global health estimates. Retrieved from

    https://apps.who.int/iris/bitstream/handle/10665/254610/WHO-MSD-MER-2017.2-

    eng.pdf

Young, A. S., & Klap, R., Sherbourne, C. D., & Wells, K. B. (2001). The quality of care for

    depressive and anxiety disorders in the United States. *Archives of General Psychiatry, 58,*

    55-61. doi: 10.1001/archpsyc.58.1.55

Appendix A

Author Guidelines for the *Journal of Clinical Psychology*

Manuscript Submission

Manuscripts for submission to *The Journal of Clinical Psychology* should be forwarded to the Editor as follows:

1. Go to your Internet browser (e.g., Netscape, Internet Explorer).
2. Go to the URL **http://mc.manuscriptcentral.com/jclp**
3. Register (if you have not done so already).
4. Go to the Author Center and follow the instructions to submit your paper.
5. Please upload the following as separate documents: the title page (with identifying information), the body of your manuscript (containing no identifying information), each table, and each figure.
6. Please note that this journal's workflow is double-blinded. Authors must prepare and submit files for the body of the manuscript that are anonymous for review (containing no name or institutional information that may reveal author identity).
7. All related files will be concatenated automatically into a single .PDF file by the system during upload. This is the file that will be used for review. Please scan your files for viruses before you send them, and keep a copy of what you send in a safe place in case any of the files need to be replaced.

Timothy R. Elliott, Editor-in-Chief
The Journal of Clinical Psychology
4225 TAMU
Texas A&M University
College Station, TX 77843-4225
Email: **timothyrelliott@tamu.edu**

All *Journal of Clinical Psychology: In Session* articles are published by invitation only. Individuals interested in nominating, organizing, or guest editing an issue are encouraged to contact the editor-in-chief:

Barry A. Farber, Ph.D.
Department of Counseling & Clinical Psychology
Teachers College
Columbia University
New York, NY 10027
E-mail: farber@exchange.tc.columbia.edu

By submitting a manuscript to or reviewing for this publication, your name, email address, and affiliation, and other contact details the publication might require, will be used for the regular operations of the publication, including, when necessary, sharing with the publisher (Wiley) and partners for production and publication. The publication and the publisher recognize the importance of protecting the personal information collected from users in the operation of these services, and have practices in place to ensure that steps are taken to maintain the security, integrity, and privacy of the personal data collected and processed. You can learn more at **https://authorservices.wiley.com/statements/data-protection-policy.html**.

Manuscript Preparation

Format . Number all pages of the manuscript sequentially. Manuscripts should contain each of the following elements in sequence: 1) Title page 2) Abstract 3) Text 4) Acknowledgments 5)

References 6) Tables 7) Figures 8) Figure Legends 9) Permissions. Start each element on a new page. Because the ***Journal of Clinical Psychology*** utilizes an anonymous peer-review process, authors' names and affiliations should appear ONLY on the title page of the manuscript. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Style . Please follow the stylistic guidelines detailed in the *Publication Manual of the American Psychological Association, Sixth Edition*, available from the American Psychological Association, Washington, D.C. *Webster's New World Dictionary of American English, 3rd College Edition* , is the accepted source for spelling. Define unusual abbreviations at the first mention in the text. The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Reference Style and EndNote . EndNote is a software product that we recommend to our journal authors to help simplify and streamline the research process. Using EndNote's bibliographic management tools, you can search bibliographic databases, build and organize your reference collection, and then instantly output your bibliography in any Wiley journal style. *Download Reference Style for this Journal:* If you already use EndNote, you can **download the reference style** for this journal. *How to Order:* To learn more about EndNote, or to purchase your own copy, **click here** . *Technical Support:* If you need assistance using EndNote, contact **endnote@isiresearchsoft.com** , or visit **www.endnote.com/support** .

Title Page . The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address (including e-mail address), telephone and telefax numbers of the author responsible for correspondence. Authors should also provide a short title of not more than 45 characters (including spaces), and five to ten key words, that will highlight the subject matter of the article. Please submit the title page as a separate document within the attachment to facilitate the anonymous peer review process.

Abstract. Abstracts are required for research articles, review articles, commentaries, and notes from the field. A structured abstract is required and should be 150 words or less. The headings that are required are:
Objective(s): Succinctly state the reason, aims or hypotheses of the study.
Method (or Design): Describe the sample (including size, gender and average age), setting, and research design of the study.
Results: Succinctly report the results that pertain to the expressed objective(s).
Conclusions: State the important conclusions and implications of the findings.

In addition, for systematic reviews and meta-analyses the following headings can be used, Context; Objective; Methods (data sources, data extraction); Results; Conclusion. For Clinical reviews: Context; Methods (evidence acquisition); Results (evidence synthesis); Conclusion.

Permissions . Reproduction of an unaltered figure, table, or block of text from any non-federal government publication requires permission from the copyright holder. All direct quotations should have a source and page citation. Acknowledgment of source material cannot substitute for written permission. It is the author's responsibility to obtain such written permission from the owner of the rights to this material.

Final Revised Manuscript . A final version of your accepted manuscript should be submitted electronically, using the instructions for electronic submission detailed above.

Artwork Files . Figures should be provided in separate high-resolution EPS or TIFF files and should not be embedded in a Word document for best quality reproduction in the printed publication. Journal quality reproduction will require gray scale and color files at resolutions yielding approximately 300 ppi. Bitmapped line art should be submitted at resolutions yielding 600-1200 ppi. These resolutions refer to the output size of the file; if you anticipate that your images will be enlarged or reduced, resolutions should be adjusted accordingly. All print reproduction requires files for full-color images to be in a CMYK color space. If possible, ICC or ColorSync profiles of your output device should accompany all digital image submissions. All

illustration files should be in TIFF or EPS (with preview) formats. Do not submit native application formats.

Color Figures. Figures submitted in color may be reproduced in colour online free of charge. Please note, however, that it is preferable that line figures (e.g. graphs and charts) are supplied in black and white so that they are legible if printed by a reader in black and white. If an author would prefer to have figures printed in color in hard copies of the journal, the journal charges for publishing figures in color in print. If the author supplies color figures at Early View publication, they will be invited to complete a color charge agreement in RightsLink for Author Services.

Software and Format . Microsoft Word is preferred, although manuscripts prepared with any other microcomputer word processor are acceptable. Refrain from complex formatting; the Publisher will style your manuscript according to the journal design specifications. Do not use desktop publishing software such as PageMaker or Quark XPress. If you prepared your manuscript with one of these programs, export the text to a word processing format. Please make sure your word processing program's "fast save" feature is turned off. Please do not deliver files that contain hidden text: for example, do not use your word processor's automated features to create footnotes or reference lists.

Article Types

- **Research Articles** . Research articles may include quantitative or qualitative investigations, or single-case research. They should contain Introduction, Methods, Results, Discussion, and Conclusion sections conforming to standard scientific reporting style (where appropriate, Results and Discussion may be combined).

- **Review Articles** . Review articles should focus on the clinical implications of theoretical perspectives, diagnostic approaches, or innovative strategies for assessment or treatment. Articles should provide a critical review and interpretation of the literature. Although subdivisions (e.g., introduction, methods, results) are not required, the text should flow smoothly, and be divided logically by topical headings.

- **Commentaries** . Occasionally, the editor will invite one or more individuals to write a commentary on a research report.

- **Editorials** . Unsolicited editorials are also considered for publication.

- **Notes From the Field** . Notes From the Field offers a forum for brief descriptions of advances in clinical training; innovative treatment methods or community based initiatives; developments in service delivery; or the presentation of data from research projects which have progressed to a point where preliminary observations should be disseminated (e.g., pilot studies, significant findings in need of replication). Articles submitted for this section should be limited to a maximum of 10 manuscript pages, and contain logical topical subheadings.

- **News and Notes** . This section offers a vehicle for readers to stay abreast of major awards, grants, training initiatives; research projects; and conferences in clinical psychology. Items for this section should be summarized in 200 words or less. The Editors reserve the right to determine which News and Notes submissions are appropriate for inclusion in the journal.

Editorial Policy

Manuscripts for consideration by the *Journal of Clinical Psychology* must be submitted solely to this journal, and may not have been published in another publication of any type, professional or lay. This policy covers both duplicate and fragmented (piecemeal) publication. Although, on occasion it may be appropriate to publish several reports referring to the same data base, authors should inform the editors at the time of submission about all previously published or submitted reports stemming from the data set, so that the editors can judge if the article

represents a new contribution. If the article is accepted for publication in the journal, the article must include a citation to all reports using the same data and methods or the same sample. Upon acceptance of a manuscript for publication, the corresponding author will be required to sign an agreement transferring copyright to the Publisher; copies of the Copyright Transfer form are available from the editorial office. All accepted manuscripts become the property of the Publisher. No material published in the journal may be reproduced or published elsewhere without written permission from the Publisher, who reserves copyright.

Any possible conflict of interest, financial or otherwise, related to the submitted work must be clearly indicated in the manuscript and in a cover letter accompanying the submission. Research performed on human participants must be accompanied by a statement of compliance with the Code of Ethics of the World Medical Association (Declaration of Helsinki) and the standards established by the author's Institutional Review Board and granting agency. Informed consent statements, if applicable, should be included with the manuscript stating that informed consent was obtained from the research participants after the nature of the experimental procedures was explained.

The **Journal of Clinical Psychology requires** that all identifying details regarding the client(s)/patient(s), including, but not limited to name, age, race, occupation, and place of residence be altered to prevent recognition. By signing the *Copyright Transfer Agreement*, you acknowledge that you have altered all identifying details or obtained all necessary written releases.

All statements in, or omissions from, published manuscripts are the responsibility of authors, who will be asked to review proofs prior to publication. No page charges will be levied against authors or their institutions for publication in the journal. Authors should retain copies of their manuscripts; the journal will not be responsible for loss of manuscripts at any time.

Data Sharing and Data Accessibility

 The journal recognizes the many benefits of archiving research data. The journal expects you to archive all the data from which your published results are derived in a public repository. The repository that you choose should offer you guaranteed preservation (see the registry of research data repositories at **https://www**.re3data.org/) and should help you make it findable, accessible, interoperable, and re-useable, according to FAIR Data Principles (**https://www.force11.org/group/fairgroup/fairprinciples**).

All accepted manuscripts are required to publish a data availability statement to confirm the presence or absence of shared data. If you have shared data, this statement will describe how the data can be accessed, and include a persistent identifier (e.g., a DOI for the data, or an accession number) from the repository where you shared the data. Authors will be required to confirm adherence to the policy. If you cannot share the data described in your manuscript, for example for legal or ethical reasons, or do not intend to share the data then you must provide the appropriate data availability statement. The journal notes that FAIR data sharing allows for access to shared data under restrictions (e.g., to protect confidential or proprietary information) but notes that the FAIR principles encourage you to share data in ways that are as open as possible (but that can be as closed as necessary).

Sample statements are available **http://authorservices.wiley.com**. If published, all statements will be placed in the heading of your manuscript.

Additional Reprint Purchases. Should you wish to purchase additional copies of your article, please click on the link and follow the instructions provided: **https://caesar.sheridan.com/reprints/redir.php?pub=100898&acro=JCLP**

Cover Image Submissions

This journal accepts artwork submissions for Cover Images. This is an optional service you can use to help increase article exposure and showcase your research. For more information, including artwork guidelines, pricing, and submission details, please visit the **Journal Cover Image page.**