Research Report

Patients' perspectives on how treatment can impede their recovery from depression

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A R T I C L E   I N F O

A B S T R A C T

Background: More than 50% of all major depressive disorder (MDD) patients experience insufficient improvement from the available treatment options. There is emerging evidence that patients' beliefs and experiences about MDD treatment influence treatment outcomes. The aim was to explore patients' perspectives on impeding characteristics of professional treatment for the recovery of MDD.
Methods: In-depth interviews in a purposive sample with 27 recovered MDD patients who had received professional treatment. Data were qualitatively analyzed using constant comparison.
Results: Participants' accounts yielded four major impeding themes: lack of clarity and consensus about the nature of the participants' MDD and the content of their treatment; precarious relationship with the clinician; unavailability of mental health care; and insufficient involvement of significant others.
Limitations: The external generalizability may be limited due to missed other subgroups within depression.
Conclusions: This study identified a comprehensive overview of impeding characteristics in MDD treatment from patients' perspectives. This may help clinicians to understand how patients experience MDD treatment, and to incorporate patients' perspectives about treatment into their joint decision-making. This can lead towards increased treatment adherence, motivation and finally success.

1. Introduction

Poor recovery from major depressive disorder (MDD) is a major public health problem (Mathers and Loncar, 2006). More than 50% of all patients with MDD experience insufficient improvement from the available treatment options (Rush et al., 2006). After two years, this results in a chronicity rate of almost 20% (Van Randenborgh et al., 2012).

Previous studies suggest that a poor prognosis may be related to *patient/disease characteristics* (e.g. family history of mood disorders, younger age of onset, longer duration of depressive episode) and *treatment/service characteristics* (e.g. underdetection, undertreatment, limited treatment effectiveness) (Holzel et al., 2011; Cantrell et al., 2006). In addition, there is emerging evidence that patients' *beliefs*

and experiences about MDD treatment (e.g. patient preferences regarding treatment conditions, type of treatment or therapist characteristics) influence treatment outcomes (Deen et al., 2011; Winter and Barber, 2013). Treatment guidelines for MDD therefore state that "it is important to collaborate with the patient in decision making and attend to the patients' preferences and concerns about treatment" (American Psychiatric Association (APA), 2010).

In case of MDD, however, little is known about the patients' perspective regarding treatment characteristics that may impede recovery (Gelhorn et al., 2011; Cuijpers, 2011). By increasing our knowledge about the problems patients encounter during MDD treatment, and what characteristics contribute to patients' decisions to not seek or discontinue treatment, clinicians can improve and adjust their treatments to positively influence recovery, engagement, and outcome (Steidtmann et al., 2012; Houle et al., 2013). Therefore, the aim of our study was to explore patients' perspectives on impeding characteristics of professional treatment for the recovery of MDD.

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2. Methods

2.1. Sample selection

We posted a request for study participation on several MDD patient-websites and purposively sampled participants with diverse clinical characteristics (e.g. treatment history, number of depressive episodes) that might influence experiences and perceptions regarding treatment. The Medical Ethics Research Committee considered that ethical approval was not necessary.

To be eligible for the study, participants had to meet the following criteria: 1) a major depressive episode (MDE) at some point during the year preceding participation, 2) current recovery in order to minimize the bias of participants' 'negative' perception during a MDE regarding treatment characteristics. MDE and recovery status were confirmed by the Structured Clinical Interview for DSM-IV (SCID-I) (First et al., 1999) and 3) a history of professional treatment for MDE (e.g. from a psychiatrist or a psychologist), which was finished not earlier than two years prior to the interview, to ensure a vivid remembrance of this treatment. Exclusion criteria were: age younger than 18 years, insufficient command of the Dutch language, a terminal disease, mental retardation, bipolar-, psychotic-, anxiety- or cognitive disorders (to specify the research population for generalizability) and suicidality (because of the sensitivity of the topic).

2.2. Interviews

Data were collected through in-depth individual interviews. The aim of the interview was to provide a viewpoint based on participants' personal experiences, centered on the question: *what, from your experience, are impeding characteristics of professional treatment for recovery of depression?* Two researchers (ACEK and MCBvZ) created a topic list, built upon literature (Dwight-Johnson et al., 2000) and orienting interviews with psychiatrists, to structure the interviews and to ensure that the main issues relating to the research question were discussed by all participants (see Table 1). The topic list consisted of open-ended questions to explore the participants' perspectives regarding the following topics: 1) impeding characteristics of treatment in general, 2) the attitude of clinicians, 3) medication, and 4) contextual influences. This interview method was selected because it offers participants the opportunity to tell about their experiences from their own point of view, and to address characteristics that the researchers might not have anticipated (Britten, 1995).

After eight interviews, ACEK, MWJK and AHS reviewed the topic list and incorporated new collected issues, according to interim analysis (Pope et al., 2000). The adjusted topic list was used for data collection in the successive interviews (Boeije, 2002). Participants were guaranteed confidentiality. ACEK ($n=17$) and RAvG ($n=10$) conducted most of the semi-structured interviews at participants'

homes ($n=22$) or, if participants preferred, at the Academic Medical Center (AMC) ($n=5$). All interviews were audio recorded. ACEK and RAvG fully transcribed all interviews and checked them for errors. Data collection was continued until no new themes emerged from the data (saturation).

2.3. Data analyses

For the analyses of interview transcripts, coding procedures and constant comparative method developed by Strauss were used (Strauss, 1987). This is a frequently used inductive, bottom-up method for analyzing qualitative data without a predetermined theoretical framework (Boeije, 2002).

First, each of the two researchers (ACEK and EJAJB) started with an open coding process by examining the transcripts of four interviews, in order to assign a series of codes, which were then grouped into similar concepts (Pope et al., 2000). MAXQDA software (version 10.0) was used to process, order and compare the codes. Discussions between the researchers resulted in a consensus list of preliminary codes. This list was extended and refined as coding progressed in subsequent interviews. Second, according to the axial coding process, recurrent themes within the transcripts were selected, and text fragments were sorted according to the thematic framework that appeared during the axial coding process, divided in main and sub codes (ACEK and EJAJB). To ensure consistency and inter-coder reliability, four interviews were independently coded by two researchers, resulting in negligible inter-coder variance. Third, all transcripts were coded by RAvG, with a subsample also independently coded by ACEK and EJAJB. Broader categories and subcategories were generated through a process of constant comparison. To identify implicit reasoning, researchers searched for explanations and used common sense and literature (Zimmermann et al., 2007) for underlying logic in patients' answers. Throughout the process, meetings were regularly held among ACEK, EJAJB, AHS and RAvG, in order to examine discrepancies in the interpretation of individual statements, and to revise definitions of codes when necessary. Consensus meetings between authors led to the final categorization of themes as described in the *results* section.

3. Results

Thirty-two participants responded to our request for participation in our study and were subsequently interviewed with the SCID-I. After the interview, one participant decided to discontinue (she thought the in-depth interview might be too confronting) and four participants were excluded from the study, as they did not meet the inclusion criteria for MDE in the previous year. This resulted in 27 study participants (10 male, 17 female). There were no reasons to end

Table 1
Topic list.

Ask about participants' views about impeding characteristics of treatment for major depressive disorder:	
Prompts:	Expectations and experiences
	Treatment methods, choices, switches
Elicit personal views about the attitude of clinician towards participant:	
Prompts:	Quality of the relationship
	Space for participants' view
	Joint decisions
Explore the participants' experiences with medication:	
Prompts:	Counseling
	Problems with adherence, stopping, withdrawal
Elicit contextual influences on treatment:	
Prompts:	Availability and accessibility of clinician

any of the interviews prematurely. The average duration was 65 min (SD: 18 min). Participant's characteristics are presented in Table 2.

Analyses of the interview transcripts identified four major themes that described impeding characteristics of professional treatment for MDD: 1) lack of clarity and consensus about the nature of the participants' MDD and the content of their treatment; 2) precarious relationship with the clinician; 3) unavailability of mental health care when needed; and 4) insufficient involvement of significant others. Table 3 provides an overview of these themes with corresponding subthemes and concepts.

3.1. Lack of clarity and consensus about the nature of the participants' MDD and the content of their treatment

The interviews revealed that nearly all participants had a different view about their condition than their clinician (e.g. with regard to the etiology, the goals for treatment, or the appropriate treatment method); as a result, participants lacked trust in treatment. Many participants struggled to discuss their opinions with clinicians (e.g. that the treatment took too long, that they did not feel progress, that they needed more intensive treatment or another type of treatment). Major impeding characteristics in this respect were: having no personalized treatment, receiving insufficient information about treatment and lack of discussion concerning medication.

3.1.1. No personalized treatment
More than half of participants (15/27) felt that their treatment was not personalized and therefore hindered.

'I felt that I was more held back than that there was a connection to what I was experiencing. So the [treatment] method was leading more than I was. It was also really the method that didn't work for me.' (ID26)

Table 2
Participant characteristics ($n=27$).

Characteristic	
Gender, n	
Male	10
Female	17
Age, years	
Mean (SD)	46 (12,8)
Range	22–63
Relational status, n	
Married/partnership	14
Single/separated	13
Ethnicity, n	
Dutch	23
Surinam	1
Turkish	1
German	1
Indian	1
Educational level, n	
Low (primary school or none)	6
Intermediate (secondary school)	9
High (college or university)	12
Treatment history setting, n*	
Psychiatric hospital admission	9
Day care treatment	7
Outpatient treatment	27
Type of treatment history, n*	
Psychotherapy	22
Medication	25
Electroconvulsive therapy	2
Number of depressive episodes, n	
Single episode	7
Recurrent episodes	20

 * Including overlap.

Some participants (4/27) had troublesome experiences during group therapy related to patients with heterogeneous symptomatology following the same therapy.

'… Everybody was in the same process and at the same courses… I think it was primarily the people who were taking a lot of antipsychotic medication, and were sometimes suddenly screaming loudly or demanding a lot of attention, and were physically very slow at the time that we were doing an activity, interfering more than that they were able to participate. I sometimes found that horrible, I really had trouble with that.' (ID28)

3.1.2. Insufficient explanation about treatment
Nearly all participants (24/27) mentioned they had received no clear explanation about why they received a specific treatment. From the clinician, they desired more clarity and explanation about the treatment, its goals and overall structure. In addition, participants desired more opportunity to discuss their own expectations.

'The lack of a framework has a very negative impact: what are you working on, where are you headed, how long will it take? If I know what his or her perspective is, I can speak more easily. Then I know what's being measured, and in what direction someone wants to take me. It also has to be clear, I really missed that. You see, of course there is an end. At a certain moment you'll be discharged. And that doesn't mean that you'll be 100% recovered and healthy, but it's nice to know that in advance.' (ID23)

According to one third of participants (9/27), clear goals or action plans that could have made the treatment much more effective were lacking.

'There must be a plan, a beginning and an end, and you have to have goals. I found that lacking very much. … What you were working towards and what you wanted.' (ID4)

Two-thirds of participants (19/27) expressed the absence of a discussion with their clinician about the nature of their MDD. Consequently, some participants disagreed with the focus of treatment.

'Because then if I went into therapy, very frequently I had to go through my whole childhood, family, and work, whereas that's not where the problem was. It lay primarily with the way I was thinking and incorrectly reacting to situations. You don't solve that directly by discussing your marriage, parents, or childhood, that in fact had nothing to do with it.' (ID4)

Two-thirds of participants (18/27) commented that the type of treatment they received (e.g. medication, group- or cognitive behavioral therapy with homework assignments) did not match their own preferences. Participants also doubted treatment effectiveness, as they felt that clinicians provided insufficient information about the rationale for the type of treatment.

'Then I was referred to a psychologist for [therapy] sessions. And I thought, I'd also find medication perfectly fine. But I thought, they'll know… I would have preferred to think along and be involved in the decision-making. … So, we weren't making any progress, we were only talking about my past and meanwhile I was not recovering from my depression. … I experienced several times that in hindsight I thought: why are we doing it this way?' (ID19)

Furthermore, almost half of participants (13/27) felt they lacked clarity about how the clinician evaluated the progression of their treatments. Participants experienced some treatments as a waste of time due to the lack of evaluations.

Table 3
Perceived impeding characteristics of professional treatment for major depressive disorder (MDD).

No.	Characteristic	Subtheme	Concepts
1.	Lack of clarity and consensus about the nature of the participants' MDD and the content of their treatment	No personalized treatment	Treatment not fitting
		Insufficient explanation about treatment	Lack of structure
			No setting clear treatment goals
			Absence of discussion about causes
			Methods
			No evaluations
		Lack of discussion concerning medication	Lacking explanation and support
2.	Precarious relationship with clinician	No trust in the clinician	No hope
			Many switches between clinicians
		Inappropriate professional attitude	Lack of respect
		Lack of professional guidance	Clinician too authoritative
			Feelings of dependency
			Missing a leadership role
3.	Unavailability of mental health care	Waiting list period	Demotivation for treatment
		Unavailability of clinician	Unavailability outside regular appointments
			No main responsible clinician
		Lack of aftercare	Feeling to be left alone
4.	Insufficient involvement of significant others	–	No explanation for social network

'If, for example, every psychiatrist would tell a client: we're going to work together for four sessions, and after those four sessions, you can say whether you think it's working or not. I've never experienced a psychiatrist who evaluates.' (ID15)

3.1.3. Lack of discussion concerning medication

Of those who had used antidepressant medication, most participants (19/25) reported negative experiences either before (insufficient explanation) or after starting medication (side effects, lack of explanation and support about the short and long term side effects). Participants explained that they often were anxious about taking medication, but at the same time their clinician did not recognize this. The interviews revealed that support and sufficient information of the clinician are extremely important for treatment adherence.

'The only reason why I am on medication now, is because friends and family have given me incredible support with this. Otherwise I wouldn't have taken pills. Thirty minutes with my psychiatrist was not enough to convince me. He didn't take enough time for that. I had a very serious fear that was not being recognised. And it was also not taken seriously. And that has a very large influence on adherence.' (ID11)

3.2. Precarious relationship with the clinician

All participants frequently commented that they experienced contact with their clinician as precarious and not conforming to their desires. Major impeding characteristics in this respect were: having no trust in the clinician, an inappropriate professional attitude of the clinician, and a lack of professional guidance.

3.2.1. No trust in the clinician

Nearly all participants (23/27) mentioned that a lack of trust in the clinician resulted in a hesitation to begin treatment and to show their emotions during treatment. In addition, the lack of trust resulted in losing hope and prematurely ending treatment.

'I don't think that the confidence was really there to just talk about myself over there. It's just very important that there is a click in order to move forward together.' (ID16)

One third of participants (9/27) did not feel that the clinician gave them hope.

'Hope is incredibly important. That always has been a tremendously important basis for me. Therapists who have the balls to say that everything will be all right: that requires courage. Because there are also therapists who do not dare to say that, because they don't know whether that's true and they think it's not right to say it then.' (ID20)

Half of participants (14/27) thought that the lack of continuity in treatment impeded their recovery. The many changes between clinicians withheld them from building a trustful relationship. Meanwhile, the transfer of their medical records from one clinician to another was often perceived as insufficient and annoying, as they had to revisit their entire disease history again.

'I had a very good psychiatrist, but then I couldn't go to him anymore and I had to go to someone else. And then you feel you need to start all over again.' (ID2)

3.2.2. Inappropriate professional attitude

Almost all participants had experiences with an inappropriate professional attitude of the clinician and judged this as impeding their treatment progress and outcome. These included: not taking the participant seriously; too much hurry or being too confronting; a lack of respect, compassion, authenticity, pro-activeness, humor or 'humanity'; and not regarding the participant as an 'equal human being', a person with whom the clinician could sometimes share little details about his/her own private life.

'What doesn't work: someone who doesn't take you seriously. He wasn't warm, he didn't show any compassion…. Apparently I felt 'you're not going to help me'. No, I didn't even start with him.' (ID20)

However, a clinician who comes too close or is too submissive is not desired either.

'There has to be a good mix between a professional attitude and not too much distance, And also not someone who sits across from or next to me and will continuously say 'oh yeah, that's horrible'… yes, who will only commiserate. So also there will have to be a balance actually. That I have someone who confronts me with

things, but where I also feel, whenever there is a confrontation, that he understands me.' (ID9)

Thus, the balance between showing empathy and maintaining professional distance seems to be crucial.

3.2.3. Lack of professional guidance

Nearly half of participants (13/27) perceived the clinician as an authority who made decisions about treatment on their behalf (e. g. beginning or ending treatment without explanation, or providing insufficient information). This resulted in participants feeling more dependent and distressed, thereby increasing patients' passive behavior during treatment (especially when the clinician's behavior was authoritarian). In most participants, these feelings of dependency and distress remained unspoken, as participants were afraid of irreparable damage to the therapeutic relationship if they were to discuss these issues.

'You also feel very dependent. I actually felt growing smaller and smaller during that conversation. I absolutely did not have a good feeling then.' (ID16)

However, participants reasoned that authority itself was not always an impeding factor in treatment, as long as they had a trusting relationship with their clinician. Participants needed a leadership role of their clinician: to be the expert, to choose a focus, to guide and to set boundaries. Within these boundaries, however, participants needed the clinician to stimulate autonomy, motivation and self-management. More than half of participants (16/27) felt they were missing this leadership role.

'I would rather have someone who knows better than I do. That's what you need. There are certain phases where you really need to be told what to do. If that doesn't happen then, that works badly.' (ID23)

3.3. Unavailability of mental health care when needed

A common complaint of participants was the unavailability of professional care due to waiting list periods (pre-treatment), uncertainties about how to contact the clinician outside the regular treatment appointments (during treatment), or availability of the clinician after ending treatment.

3.3.1. Waiting list period

Waiting lists demotivated almost half of all participants (13/27) from treatment. Because of these waiting lists, participants hesitated to seek or begin treatment, felt that the severity of their MDD increased, or even attempted suicide.

'A three month-waiting list! And one week afterwards I attempted suicide. Exactly because you're going there to ask for help because you can't deal with it anymore.' (ID21)

3.3.2. Unavailability of the clinician

During the treatment period, participants could be very insecure, and some (3/27) explained that they really needed the feeling that the clinician was always available in case of crucial moments, especially outside regular treatment appointments.

'What can be worse for someone with a depression than to be abandoned? I attempted suicide, amongst others because I could not get a hold of my therapist… who was just not available. Then I thought now I'm done…. What I really find heart-warming, I now have an agreement with my psychiatrist: 'I will never call you. And if I call you, all alarms are on red. Then I want you to directly intervene, to put me on medication, and to set me up with a

specialist.' That kind of agreements has a very high value for me.' (ID20)

One participant in day care treatment explained that it is often unclear who the responsible clinician is, and who is being the point of contact for patients.

'At a certain point you're not sure who your primary contact person is. I also found that to be something very difficult. I never had the feeling that there was one person who I could always contact.' (ID28)

3.3.3. Lack of aftercare

One-third of participants (9/27) felt ignored and dependent on clinicians' decisions (e.g. ending treatment when participants felt that it was premature). Five participants (5/27) explained that transparency about the treatment duration would be helpful in order to prepare themselves for the end of treatment. Others (6/27) wished they had a winding-down in the frequency of treatment sessions, or felt that being left alone after ending treatment increased the risk of relapse. Two participants compared their treatment with that of other chronic or recurrent diseases, such as diabetes, where patients receive aftercare appointments once or twice a year for control and prevention.

'You end therapy and after a while, you relapse again. Aftercare, that was not available. I think that it's better if you follow-up on people, that you let them return every month or every two months, and that you just go through those check-lists, like how is this going, how is that going, how is the other thing going? Because that's my experience, you yourself do not ring an alarm bell. Because you're already so fed up and you're ashamed that you failed again, and then you think, tomorrow things will be better again.' (ID4)

3.4. Insufficient involvement of significant others

Half of participants (14/27) mentioned the difficulty of knowing when and how to seek help within their own social network. Meanwhile, they underscored the importance of involving significant others in treatment, in order to gain support during their MDD. Participants also felt this would have facilitated easier discussion about their MDD within their social network. According to participants, involving relatives during treatment improves their understanding of MDD and its treatment, especially since MDD also has an enormous impact on the lives of relatives. These participants explicitly wanted clinicians to actively invite a significant other, in order to provide them with information about the disease and course of treatment.

'To involve the significant other is important, not in the least for the significant other him/herself. Also that attention be paid to the possibilities of the partner to be supportive or to need support themselves. That should be part of treatment, as at least for me, one of the success factors has been my system.' (ID20)

4. Discussion

4.1. Main findings

Our study shows that from the patients' perspective, several characteristics of professional treatment in MDD may impede or slow down their recovery, engagement in treatment and clinical outcome. The main perceived impeding characteristics were: 1) lack of clarity and consensus about the nature of the participants' MDD and the content of their treatment, 2) precarious relationship

with the clinician, 3) unavailability of mental healthcare when needed, and 4) insufficient involvement of significant others. The first two impeding characteristics may be related to patients' feelings of not being taken seriously by the clinician, and a lack of trust in the clinicians' therapeutic skills. This may be resolved by a more open and more informative type of communication between patient and clinician. The latter two impeding characteristics may affect the patients' feelings of safety and security, thereby further impeding the patient's recovery. This may be resolved by improving structural characteristics of our mental health services on the one hand and by giving more attention to the role of natural support systems on the other.

Similar to the study of McGuire et al. (2013), our results suggest that the focus on professional clinical goals, rather than the patients' personal goals, may impede recovery. Badger and Nolan (2007) identified similar treatment characteristics perceived as important by patients, such as the therapeutic relationship, receiving information, family support and medication. However, their focus was on *helpful* instead of impeding characteristics, and only included primary care MDD patients. In our previous study (Van Grieken et al., 2013), we found that 'finding someone new when the relationship between therapist and patient is not compatible' or 'when there is limited progress' was among the most important self-management strategies for recovery as mentioned by patients. These results are in line with our finding that patients' feelings about the contact with their clinician do not conform to their wishes and impeded their recovery. Our study therefore shows that there is room for improvement in the therapeutic relationship with MDD patients, because empathy is not only a patients' wish, but also an evidence-based communication strategy that contributes to the health of patients (Derksen et al., 2013).

Impeding characteristics identified in the present study are relevant in light of the current debate on how to improve effectiveness of MDD treatment. Although we did not examine whether the perceived impeding characteristics actually hinder recovery in practice, recent studies found that patient involvement and adjusting to the patients' preferences in shared decision making might positively influence treatment adherence and clinical outcome (Houle et al., 2013; Derksen et al., 2013; Loh et al., 2007). The present findings indicate that in clinical practice, patients may not always perceive a balance between collaboration and participation on the one hand, and structure and guidance on the other. Although some of the impeding characteristics identified in this study may feel like common sense and seem logical (e.g. insufficient explanation of treatment, hindering waiting lists, or a precarious therapeutic relationship), in clinical practice, patients apparently do not always experience that these characteristics are taken into account. Our results indicate an unmet need (by patients) to be much more informed, or for being informed *at all*, about goals, methods, and evaluation of treatment, as well as for involvement of significant others in treatment. Therefore, it is relevant for clinicians to examine and acknowledge potential treatment barriers from the patients' perspective, and to adjust and collaborate with patients in order to optimize treatment.

4.2. Strengths and limitations

This study has several strengths: first, the present study is, to our knowledge, the first to examine impeding characteristics of MDD treatment from the patients' perspective. This focus on the patients' perspective is often a 'blind spot' in treatment guidelines and other studies. Second, in contrast to previous MDD research which normally takes place in hospital settings, most interviews were held in participants' homes, which may have facilitated a high degree of openness from participants. Furthermore, although some influence from a subjective interviewer is inevitable, we chose to conduct the interviews from an inter-disciplinary perspective (ACEK as a researcher without clinical experience, and RAvG as a resident in psychiatry with specific MDD-treatment experience), in order to increase the likelihood of open conversations due to a variety of perspectives from different backgrounds.

However, this study also has some limitations. First, the generalizability of the study results may be limited because all participants were ethnic Dutch adults (22–63 years) who received clinical treatment from a psychiatrist or a psychologist. Therefore, our results are generalizable to adult patients from countries comparable to the Netherlands in terms of population and (mental) health care system. In addition, answers may be colored because of a negative bias and perception caused by the MDD during the treatment period. Furthermore, the recruitment of participants through a request on MDD patient-websites could have attracted participants who had particularly negative experiences with MDD treatment. For sure, this may have colored the interviews, but we like to strengthen that our aim was to qualitatively explore the different patients' perspectives on impeding characteristics of professional treatment for the recovery of MDD. Having done so, a next step can be a more quantitative study in which we try to find out for instance how often, in what type of treatments, with what type of therapists these factors are actually impeding. Finally, two researchers (RAvG and AHS) have experience with treatment of MDD patients; therefore, their personal opinions may have colored the interpretation of the results. However, to guarantee objectivity, coded interviews were checked at random by researchers (ACEK and EJAJB) without treatment experience; furthermore, the plausibility of results was discussed with all co-authors.

4.3. Clinical implications

Our findings give a comprehensive overview of MDD treatment characteristics that are considered important in impeding recovery from the patients' perspective. These results may help clinicians as a practical addition to the MDD treatment guidelines when preparing for treatment consultations, understanding how patients experience MDD treatment, and involving the patients' perspective and concerns about treatment in decision-making. Although each individual patients' perspective is unique, clinicians may learn from this study about the importance of paying attention to 'minimal cues' concerning the patients' feelings about diagnosis, treatment, and outcome, because patients rarely express their views about these issues explicitly (Zimmermann et al., 2007). Clinicians may also like to improve their skills and knowledge regarding the direction in which they should explore the patients' perspectives: patients' trust in the clinician and treatment, their understanding of the treatment goals, and patients' concerns about availability of the clinician. Finally, clinicians who educate others in mental health traineeships can prepare more realistic training scripts for simulation exercises, and develop and implement a structured training program on how to incorporate the patients' perspective.

In conclusion, the present study highlights the importance of clinicians taking a more exploring role in uncovering the patients' perspective to MDD treatment. More awareness of the patients' perspective may increase treatment adherence, motivation and finally success.

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