

**“Who is deciding on depression?” –  
Patients and psychiatrists perspectives  
on decision-making**

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De acordo com o capítulo “Tarefas a Realizar”, do Guia do Curso de Mestrado em Comunicação Clínica, a matéria da dissertação para a obtenção do grau de Mestre consta da realização de um trabalho de investigação com submissão a uma revista científica.

Na presente dissertação é apresentado o trabalho de investigação realizado sob a forma de artigo científico.

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## ARTIGO DE INVESTIGAÇÃO

### Abstract

**Objective:** Shared-Decision Making (SDM) has shown to improve compliance with the therapeutic plan, decrease hospitalization, and enhance the knowledge on the illness and satisfaction with mental health services. We aimed to unveil the perspective of both psychiatrists and patients diagnosed with depression on decision making.

**Methods:** A convenience sample of physicians and patients with depression was recruited at the outpatient unit of a psychiatric hospital and submitted to a battery of self-report questionnaires. Standardized instruments were used to measure decision-making preferences and behaviors, and therapeutic alliance. The study was approved by the Ethical Committee.

**Results:** Patients with depression prefer a model of decision making where their input is taken into account, but ultimately the decisions are relied to the psychiatrist. However, they experience a more participative role, with high levels of SDM behaviors. Therapeutic alliance did not vary according to patients' sociodemographic characteristics. Severity of illness was negatively correlated with SDM behaviors and patient-physician relationship establishment.

**Conclusion:** Depressed patients welcome SDM, and participate in the decisional process. This translates into better therapeutic alliance. Further studies should address the impact in other outcome variables, and unveil barriers and facilitators for SDM in this particular population.

## 1. Introduction

People with mental illnesses are interested in being involved in the management of their conditions [1-3]. Patients consistently report positive attitudes towards shared-decision making (SDM) [4-6], with levels of interest higher than those experienced [2, 7-9]. Patients prefer a collaborative approach [10], rather than an informative or paternalistic one, but these preferences appear to vary in relation to the type of decision being made. Patients prefer to assume a collaborative role when facing psychiatric medications, an autonomous role for decisions related to psychosocial interventions, and a passive role with their primary care provider [8, 11]. Psychiatrists, on the other hand consider psychosocial and lifestyle issues to be more suitable for shared decision-making than medical or legal decisions [12].

Share Decision Model (SDM) is now being practiced at the level of information exchange in both psychiatric and primary care setting [13]. Observational studies found that the majority of professionals do not objectively favor involving the patient in the decision-making process [14-18]. Physicians report higher levels of patient's participation than those experienced by the patient, who state minimum meaningful input into major decisions, especially about medications [7, 17, 19, 20]. Taking into account patient preferences in treatment planning and delivery has been associated with several positive outcomes [19, 21], namely greater knowledge, satisfaction with treatment, feelings of being helped, involvement and activation of decision-making and improvement of treatment adherence with lower need for re-hospitalization [22-24]. There is a tendency to consider the shared approach to decision making as beneficial regarding commitment to therapy [25, 26], but no clear effects on clinical outcomes have yet been found [25, 27-30]. Higher quality of the clinical relationship has been associated with the capacity of involving patients in decisions, and clinicians involvement and alliance as shown to be responsive to enhanced shared decision-making[31].

Therapeutic relationship is an independent predictor of treatment outcome, a mediating factor that captures significant variance in the outcome of treatment interventions such as pharmacological therapies, and an outcome per se [32]. Psychiatric patients who formed good therapeutic alliances with their therapists were found to be significantly more likely to remain in therapy, comply with the prescribed medication regimens, and achieve better outcomes with less medication [33].

Physician may accept a collaborative approach to decision making in depression because patient's involvement may be therapeutic itself, facilitates engagement and responsibility. [20]: Patients perceive a collaborative approach to decision making when physicians consider their opinion, talk with them about different treatment options and mutually agree on a decision [34]. Generally, according to observational studies, physicians tend to focus on the problem definition stage, failing to offer to the patient a variety of treatment options [18]. Involvement in therapeutic decisions has positive effects regarding treatment acceptance [35], adherence [36], clinical outcomes [37] and satisfaction with treatment [38, 39]. It is also claimed that SDM may directly alleviate key depressive symptoms, such as helplessness and hopelessness, indirectly improving clinical [40]. When considering uniquely the patient treatment preference component of SDM, a positive influence has been detected in treatment initiation [41] and adherence, but not in clinical outcomes [29, 41-45].

Implementing SDM in psychiatric settings presents several difficulties. Disease dependent factors, fragmented services, prejudice, discrimination and the fear of coercive consequences can challenge psychiatric patient's ability to actively and fully engage in shared decision-making [19]. Preferences for involvement vary in different patients and within patients over time [46], especially regarding antidepressant therapy. Patients with depression have frequently limited

knowledge on the availability and efficacy of psychiatric treatments [35, 47, 48]. Preference for counseling therapies [29, 35, 43, 49-54] or psychotherapy [41, 55-64] is high, compared to medication. In clinical settings however most patients receive medication, meaning that less than 50% receive the therapy they prefer [35, 58].

This study aims to unveil the perspectives, and preference on decision-making occurring in the clinical encounter with patients with depression and their assistant psychiatrists, furthermore measuring its association with the perceived quality of the clinical relationship.

## **2. Material and Methods**

### **2.1. Population sample**

The study used a convenience sample of patients previously diagnosed with Depressive Disorder by experienced clinicians, working at a state mental health hospital. Inclusion criteria encompass the presence of depressive syndrome as assessed by the assistant psychiatrists. Patients were excluded when presenting other major psychiatric disorders, when unable to fulfill self-report questionnaire, or when the severity of the depressive illness encompassed hospital admission.

A group of psychiatrists was invited to participate in the study using a “snow ball” criteria. All who voluntarily agreed to participate were included in the study.

Patients and psychiatrists received written and verbal information about the study and signed an informed consent form. All the information was anonymized and coded for insuring the privacy of the data collected.

### **2.2. Instruments**

A battery of questionnaires permitted to evaluate sociodemographic characteristics and decision making experience and preferences. An original questionnaire, with a patient and physician versions was built for the present study to assess age, gender, education, and professional characteristics. In the patients form additional questions were included addressing: the onset of the psychiatric treatment, treatment changes in the present consultation and the perception of a decision process. Standardized measures included:

2.2.1. Control Preference Scale (CPS): Originally developed to assess decisional preferences in women with breast cancer[65], it has also been used in various clinical contexts. The scale measures patient's preferred decisional role using a five-point scale, with an agreement (Kendall's tau-b) between self- and researcher-rated score of 0.82[66] and a moderate Test-retest reliability of 0.65[67]. The scores are then converted to a 0-10 scale (0 corresponding to an Informed Model of Decision Making, 5 to a Shared-Decision Making Model, and 10 to a Paternalistic Model). The original scale was further developed by Janz and collaborators[68] in order to include two additional parallel versions to assess for patient-physician concordance – Patient Perception and Physician Perception.

2.2.2. Shared Decision-Making Questionnaire (SDM-9-Q and SDM-Doc-Q). This questionnaire is a brief self-report instrument for measuring shared decision-making in clinical encounters. Two translated versions of the scale were used: patient (SDM-9-Q)[69] and physician (SDM-Doc-Q)[70]. Both questionnaires showed good psychometric properties with a Cronbach's alphas of 0,938 and 0,88 respectively. For the present study three additional items



were included to measure for: self-efficacy “My physician and I discussed the difficulties I might have in following with treatment”; professional disclosure – “My physician gave me his/her opinion on the best treatment for me”; and follow-up plan – “My physician and I planned for a follow-up contact”; found to be essential steps on the shared decision process[71]. Scores were converted to a 0-100 scale [70]. Higher scores represent higher shared decision making.

2.2.3. Agnew Relationship Measure – 12 item (ARM-12): This measure assesses the development of a therapeutic alliance between patient and physician[72], and was used as an outcome measure of shared decision-making. The authors used an adapted version of the ARM-12, found to have good levels of internal consistency and reliability (Cronbach's alpha coefficients of 0,68-0,83)[73]. The maximum score possible is 100, representing the highest quality clinical relationship.

2.2.4. Hospital Anxiety and Depression Scale (HADS): This scale was used to measure the severity of depression[74]. It is composed of two 7-item subscales for measuring the presence of anxiety and depressive symptoms. It is widely used in primary care and psychiatric settings. The authors used the Portuguese version of the scale, translated and validated and presenting similar psychometric properties to the original version[75], with a Cronbach's alpha coefficients of 0.94. A score ranging from 8 to 10 is considered mild, from 11 to 14 moderate and 15 to 21 severe[76].

### 2.3. Clinical assessment

Clinical variables were surveyed regarding the presence of depressive symptoms, length of psychiatric treatment, and changes in therapeutic approaches.

### 2.4. Data collection and analysis

Patient's recruitment and assessment was made immediately after the psychiatric consultation at an outpatient unit of a psychiatric hospital. The assistant psychiatrists were informed of the study beforehand and proposed to the patient to participate in the study at the closure of the consult. Once accepted, the researcher further informed the patient in a separate room of the study aims and procedures and all who accepted to participate signed an inform consent form and invited to fulfil the self-report questionnaires.

A convenience sample of psychiatrists working in the same unit was collected and submitted to the professional's questionnaires.

Statistical analysis were performed using IBM® SPSS® Statistics v2.2. Descriptive statistics were used, for all the variables including Unidirectional ANOVA analysis in the patients' sample, and T-student tests when regarding the professionals' sample. Correlational analysis were performed with Pearson Correlation Test.

### 2.5. Ethical considerations

The study was submitted and approved by the Ethical Committee of Hospital de Magalhães Lemos, E.P.E; document number 1/2016 according to the Declaration of Helsinki.

### 3. RESULTS

#### 3.1. Participants sociodemographic and professional characterization

The patient's sample comprised 36 subjects, 68% (n=27) female, with a mean age of 39.8 (13.4) years. The educational achievement was in mean 11.4 (4.8) years. The majority of the sample were in psychiatric treatment for more than a year and 38.9% attended the first consultation. Ninety-two percent (n=33) were aware of a decision making process, with changes in medications reported in 83.3% (n=30) of cases.

The professional's population assessed included 11 participants, 45.5% (n=6) female, with a mean age of 28.6 years (2.5). Nine were trainees and the sample presented a mean professional experience of 3.5 years (2.2). The reported mean consultation length was 29.9 minutes mean (5.8). Patients and psychiatrists sociodemographic and professional characterization is detailed in Table 1 and 2.

**Table 1:** Patient's sample characterization

		n	Percent
<b>N</b>		36	
<b>Age (years)</b>	0-20	1	2.8%
	20-40	14	38.9%
	40-60	15	41.7%
	60-80	4	11.1%

<b>Gender</b>	Female	27	75.0%
	Male	9	25.0%
<b>Education (years)</b>	<4	3	8.3%
	5-6	6	16.7%
	7-9	8	22.2%
	10-12	5	13.9%
	>13	13	36.1%
<b>Onset of psychiatric treatment (years)</b>	<1	13	36.1%
	1-10	12	33.3%
	>10	8	22.2%
<b>First contact with physician</b>		14	38.9%
<b>Awareness of decision-making process</b>		33	91.7%
<b>Decisions on treatment</b>	Start	7	19.4%
	Maintain	6	16.7%
	Change	16	44.4%
	Terminate	7	19.4%

**Table 2:** Professional's sample characterization

<b>N</b>	11
<b>Age (years)</b>	28.5 (2.5)
<b>Gender</b>	Female 5 (45.4%)
	Male 6 (54,5%)
<b>Experience (years)</b>	3.5 (2.2)
<b>Length of consultation (min)</b>	29.1 (5.8)
<b>Weekly hours of practice</b>	40.0 (0.0)
<b>Consultations/day</b>	9.8 (5.2)

### 3.2. Clinical evaluation

Sixty-one percent (n=22) of the studied patients presented HADS scores compatible with moderate to severe scores, with an average score of 20.9 (9,6). Patients with most severe depression (HADS total > 28) were significantly older (p=.016) and less educated (p=.004) (data not shown). (Table 3)

**Table 3:** Clinical characterization

	Depression		Anxiety		Emotional Distress	
	subscale		subscale		(total)	
	N	percent	N	percent	N	percent
<b>Normal</b>	12	33,3%	6	16,7%	9	25,0%
<b>Mild</b>	11	30,6%	6	16,7%	4	11,1%
<b>Moderate</b>	6	16,7%	9	25,0%	14	38,9%
<b>Severe</b>	6	16,7%	14	38,9%	8	22,2%

### 3.3. Patients' and professionals perceptions on decision-making

Control Preference Scale (CPS) scores revealed that patients perceived their doctor *“made the final decision about which treatment would be used but seriously considered my opinion”* in accordance to a mean score of 6.5 (2.1). The physician's score in the CPS showed a value of 6.8 (2.3). No differences were found regarding age, gender or education level.

Shared Decision-Making Questionnaire (SDM-9-Q) showed a mean score of 77.2 (19.7) reflecting patients perception of a shared decisional process. The patients with most severe disease (HADS>28) reported significantly less SDM behaviors ( $p<.001$ ). The questions with higher scores were *“My doctor and I planned for a follow up contact”*; *“My doctor and I discussed the difficulties I might have in following treatment”* and *“My doctor helped me understand all the information”*.

Professional's perception of shared decision making (SDM-Doc-Q) presented a score of 80.2 (19.7) for a maximum score of 100. The questions with higher scores were *“Me and the patient planned for a follow up contact”*; *“I discussed*

with the patient the difficulties she/he might have in following treatment” and “I made clear to my patient that a decision needs to be made”. No differences were found regarding patient’s gender.

**Table 4:** SDM-Q scores

		<b>N</b>	<b>Mean</b>
<b>Q1</b>	“My doctor made clear that a decision needs to be made.” SDM-9-Q	36	4.3 (1.5)
	“I made clear to my patient that a decision needs to be made.” SDM-Doc -Q	10	4.3 (0.7)
<b>Q2</b>	“My doctor wanted to know exactly how I want to be involved in making the decision.” SDM-9-Q	35	4.0 (1.6)
	“I wanted to know exactly from my patient how he/she wants to be involved in making the decision.” SDM-Doc- Q	10	3.8 (0.6)
<b>Q3</b>	“My doctor told me that there are different options for treating my medical condition.” SDM-9-Q	35	3.3 (1.9)
	“I told my patient that there are different options for treating his/her medical condition.” SDM-Doc- Q	10	3.8 (0.9)
<b>Q4</b>	“My doctor precisely explained the advantages and disadvantages of the treatment options.” SDM-9-Q	35	3.6 (1.8)

	<i>"I precisely explained the advantages and disadvantages of the treatment options to my patient."</i>	SDM-Doc-Q	10	3.9 (1.1)
<b>Q5</b>	<i>"My doctor helped me understand all the information."</i>	SDM-9-Q	35	4.5 (1.2)
	<i>"I helped my patient understand all the information."</i>	SDM-Doc-Q	10	4.1 (0.7)
<b>Q6</b>	<i>"My doctor asked me which treatment option I prefer."</i>	SDM-9-Q	36	3.0 (2.0)
	<i>"I asked my patient which treatment option he/she prefers."</i>	SDM-Doc-Q	10	3.9 (1.0)
<b>Q7</b>	<i>"My doctor and I thoroughly weighed the different treatment options."</i>	SDM-9-Q	35	3.2 (1.9)
	<i>"My patient and I thoroughly weighed the different treatment options."</i>	SDM-Doc-Q	10	3.7 (0.8)
<b>QA1*</b>	<i>"My doctor and I discussed the difficulties I might have in following with treatment."</i>	SDM-9-Q	35	4.6 (1.0)
	<i>"I discussed with the patient the difficulties he/she might have in following with treatment"</i>	SDM-Doc-Q	10	4.4 (0.8)
<b>Q8</b>	<i>"My doctor and I selected a treatment option together."</i>	SDM-9-Q	36	3.3 (2.0)



	<i>“My patient and I selected a treatment option together.”</i>	SDM-Doc- Q	10	3.7 (0.8)
<b>QA2*</b>	<i>“My physician gave me his/her opinion on the best treatment for me.”</i>	SDM-9-Q	36	3.7 (1.9)
	<i>“I gave the patient my opinion on the best treatment for him/her.”</i>	SDM-Doc- Q	10	3.7 (0.9)
<b>Q9</b>	<i>“My doctor and I reached an agreement on how to proceed.”</i>	SDM-9-Q	35	4.1 (1.5)
	<i>“My patient and I reached an agreement on how to proceed.”</i>	SDM-Doc- Q	10	4.2 (0.6)
<b>QA3*</b>	<i>“My physician and I planned for a follow-up contact.”</i>	SDM-9-Q	36	4.8 (0.5)
	<i>“My patient and I planned for a follow-up contact.”</i>	SDM-Doc- Q	10	4.6 (0.7)

\*QA1-3 are added questions to the original questionnaire, vide Methods

### 3.4. Patients' preferences on decision-making

Regarding patient's preferences, CPS presented a mean score of 6.9 (1.8), significantly higher than the patient's perceptions score ( $p=.005$ ). Patients that preferred a collaborative model, choosing options 2-4 in the CPS scale, were older ( $p=.029$ ) with a mean age of 45.1 (11.2) years. Patients attending their first consultation with the psychiatrist, report higher preferences for SDM ( $p=0.018$ ),

with mean CPS scores of 6.0 (1.6). No differences were found regarding gender or education level.

**Table 5: CPS scores**

	<b>Patient's Preferences</b>	<b>Patient's Perceptions</b>	<b>Physician's Perceptions</b>
	N (%)	N (%)	N (%)
<b>1. "I prefer to make the final selection about which treatment will receive."</b>	0 (0.0%)	0 (0.0%)	0 (0.0%)
<b>2. "I prefer to make the final selection of my treatment after seriously considering my doctor's opinion."</b>	1 (2.8%)	2 (5.6%)	2 (18.2%)
<b>3. "I prefer that my doctor and I share responsibility for deciding which treatment is best for me."</b>	11 (30.6%)	16 (44.4%)	0 (0.0%)
<b>4. "I prefer that my doctor make the final decision about which treatment will be used but seriously consider my opinion."</b>	19 (52.8%)	12 (33.3%)	8 (72.7%)
<b>5. "I prefer to leave all decisions regarding my treatment to my doctor."</b>	5 (13.9%)	6 (16.7%)	1 (9.1%)

### 3.5. Clinical relationship evaluation

A mean score of 88.4 (11.3) was found in ARM, for a maximum value of 100.

Mean scores of 91.7 (SD 11.5) and 79.2 (SD 22.1) were found in the ARM-CA

and ARM-O subscales. Female participants presented a tendency to lower scores on ARM-O ( $p=.055$ ). Statistically significant lower score in ARM ( $p=.001$ ) and ARM-CA ( $p=.008$ ) were obtained in patients with higher HADS-D scores. No differences were found regarding age or education level.

### 3.6. Correlation analysis

Patient perception of SDM behaviors in the consultation (SDM-9-Q) was significantly positively correlated with ARM-T subscale ( $r= .513$ ;  $p=.002$ ) and ARM-CA ( $r=.575$ ;  $p=.000$ ).

Depression severity was negatively correlated with the development of a therapeutic alliance between patient and physician: ARM-CA ( $r=-.428$ ;  $p=.012$ ) and ARM-O ( $r=-.490$ ;  $p=.003$ ). The severity of depressive symptoms also showed a negative correlation with educational achievement ( $r=-.578$ ;  $p<.001$ ).

## 4. Discussion and Conclusion

### 4.1. Discussion

Recovery from depression may be hampered by several factors as described by Van Grieken and colleagues [77]. “Lack of clarity and consensus regarding the nature of the disorder and its treatment between patients and clinicians” and “precarious relationship with the clinician” both relating to SDM – either to the process itself, or to its outcomes, may delay clinical recovery. In depressive care SDM is only recently being discussed with few information available on the preferences and behaviors of patients and physicians. The majority of patients we studied seem to be aware of their decisional preferences and attentive to physician’s behaviors in the clinical encounter. They report a desire for involvement in the decisional process, in agreement with previous findings regarding patient’s involvement in treatment decisions about depression [18]. In

the present study, both patients and physicians state an ample use of SDM behaviors within the consultation setting, with a positive association between SDM behaviors and an enhanced therapeutic alliance. This suggests that patients interested in a collaborative approach are satisfied when included in the decision-making process, establishing a good and fruitful relationship, which is by itself a favorable clinical outcome, related furthermore to other therapeutic outcomes.

However, we found that patients considered physician unable to elicit their preferred treatment option, and in general lower scores in the SDM behaviors were related to discussion and selection of treatment options. This might relate to the need to improve physician's ability to communicate and negotiate a treatment plan with the patients. Communication skills as the use of simple language, ability to negotiate and provide information were already mentioned by physicians as facilitating a more co-operative relationship and simplify the decision-making task [9]. Physicians seem aware of scarcely weighing the different treatment options with the patient. Interestingly, physicians also report lower scores in the disclosure of his personal opinion on the best treatment. A initial collaborative approach does not require exhaustive information to the patient, but instead a clear communication about therapeutics (treatment doses, time needed for the therapeutic response, potential side effects and ways to alleviate them, expected length of treatment, general idea of drug mechanism and action)[78].

Our findings suggest that those with severest illness experience less participation in the decision process. This may be explained by the advanced illness and significant depressive symptomatology, preventing patient's engagement in SDM behaviors as much as their less severe counterparts. Feelings of helplessness and hopelessness, may play a role inhibiting active participation of depressed

populations in different therapeutic strategies[79]. Severely depressed subjects were also significantly older and less educated, more prone to assume a dependent and submissive position which also might have influenced the adoption of a SDM model, and heighten the correlation exposed. Furthermore this group of patients being excluded from the decisional process, are refrained from the establishment of a productive therapeutic alliance, as shown by the lower satisfaction with the clinical relationship in this population. We may hypothesize that insecure physicians are reluctant in abiding some of the decisional power in more clinically severe conditions, establishing poorer relationships with their patients.

Previous research reports higher desire to participate in decisions in patients with younger age [10, 80], higher education and female gender[6]. In our study, we found a tendency for older people to prefer a collaborative approach, contrary to studies that have suggested older patients to be more likely to accept a more traditional, dominant role for the physician [81]. However, this subgroup was also the most severely ill, and this results may be influenced by this characteristic. Similar levels of preferred and experienced SDM were found in male and female participants. Lower therapeutic alliance scores were found in the female subsample, mainly in the openness subscale, suggesting that female depressed patients feel less comfortable with disclosure within the consultation setting. Whether this is a particularity of the population of depressed patients, a characteristic of our sample, or a reaction to different professional-patient gender, remains unclear. It may be relevant to note the different proportion of female-to-male subjects in the professional and patient's sample. We did not confirmed in our sample previous findings of different attitudes towards SDM according educational level.

Patients who first meet the psychiatrist tend to prefer a more participative role in the decisional process. This may possibly translate the need for time and experience to build a secure, trustful and assuring relationship. This contrasts to what is described in literature, which suggests higher desire to participate in those with greater experience of illness [10, 80]. However, they seem not to engage in more SDM behaviors, demonstrating a gap between preferences and active behavior. Future investigation should address the barriers associated with this withdraw from the decisional arena.

This study presents several limitations. The reduced sample sizes does not permit the generalization of results. Constraints posed upon psychiatric practice in a state hospital (e.g.: time constraints) may have detracted the sample and reduced the collaboration of patients and psychiatrists. Other limitation relate to the eventual different presentations, symptoms and prognosis of depressive illness included in our study, informing different perspectives on information seeking behaviors. Further studies with more strict clinical characterization can help to discern the role of different depressive disorder subtype in SDM preferences and experiences. Regarding the physician group, most of them were interns. This characteristic may hinder the possibility to generalize the results to the general population of more experienced psychiatrists, but may translates accurately the perceptions of the young practitioners.

#### 4.2. Conclusion

The results obtained suggest that patients with depression do not desire a full SDM approach, but are comfortable when such behaviors are present in the consultation. Patients tend to demonstrate their preferences for an informed model of decision making, where their input is taken into account, but ultimately

the decisions are relied to the psychiatrist. Their clinical experience however reveals a more participative role, congruent with physicians' perceptions.

Good therapeutic alliance scores were obtained suggesting that patients are satisfied with the approach psychiatrist assumes in practice. However severity of illness was negatively correlated with SDM behaviors, with the most severely ill reporting lower quality of patient-physician relationship.

Patient's, and physicians', decision aids may play an important role in enabling both psychiatrist and patients in the decision process, as do improved communication skills. A detailed analysis of specific SDM behaviors suggest that physicians can improve their ability to communicate and to involve patients in therapeutic decisions. Several interventions to improve capacities and active engagement in decisional labor, have been suggested by others, either in physicians - improvement of clinicians skills [82], and in patients - patient decision aids [2, 3, 82], communication skills programs [82, 83], and individual preparation.

Further studies may explore the relation of SDM behaviors with clinical outcomes in depressed patients, and the impact of educational measures and decisional aids on both physicians' and patients behaviors. Barriers and facilitators to SDM in this specific population should also be addressed.

Conflicts of interest: none

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

I confirm all patient/personal identifiers have been removed or disguised so the patients described are not identifiable and cannot be identified through the details of the story.



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## ANEXOS

# **DECISION-MAKING MODELS IN PATIENTS WITH DEPRESSION: A REVIEW OF HOW AND WHO SHOULD DECIDE**

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## **ABSTRACT**

The clinical decision process is central to the patient-physician relationship. The paternalistic approach, once the preferential model of medical practice is now under severe criticism. Clinicians find themselves trying to find alternative models where the physician is not a sole source of information as in an Informed Decision Model, nor an agent to interpret the will and decide by the patient as in a Doctor-as-Agent Model. The Shared-Decision Model is in line with this endeavor, inviting the patient and physician to be co-responsible with the information exchange and treatment plan.

This model, based on strong communication ability, shows particular interest in the decisions that are sensitive to personal preferences and entail some degree of uncertainty – as the majority of the decisions made in the psychiatric field. Furthermore depression is thought to place patient's capability to decide at risk. The research shows however that patients with depression still want to participate in the clinical decisions, and reports a positive impact of using this model on the compliance with the therapeutic plan,

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in a decreased need of hospitalization and in better knowledge of the illness and higher satisfaction with health services. Shared-decision appears to be of additional interest, once it promotes the sense of autonomy and self-efficacy, decreasing feelings of helplessness and hopelessness associated with depressive state.

We performed a review of the models of decision making and its application to psychiatric patients. The reviewed literature permitted to uncover the model characteristics more suitable to application in depressed patients and their physicians in the decision process. When dealing with patients with depression, sharing technical knowledge and information and the joined participation in the process of decision seems to be welcomed, and even desired. Results highlight the influence of a Shared-Decision Model on patient's satisfaction and compliance with treatment.

**Keywords:** decision-making, depression

## **INTRODUCTION**

The patient-physician interaction is an essential component of medical practice. Central to this interaction is the communication between both and the relationship established. Patients come into clinical settings commonly seeking help, either searching for information or care, mostly in the search for a solution to their problem. However, the process of finding the right treatment and the answer for this endeavors is not straightforward and is largely dependent on the patient, the physician and the clinical situation.

Several decision-making processes have been described: from a paternalistic approach, built over an authoritarian view of the patient-physician relationship, to more contemporary models of shared decision-making, where a joint and co-responsible decision is aimed. The research on the decision making process, and its goals, has been done in parallel to the evolution of models of patient-physician relationship, highlighting how both influence and enable each other.

Physicians were historically seen as the embodiment of wisdom, alike ancient priests with almost divine powers. The ancient religious leaders helped the populations by translating god's laws. Every ail, health-related or otherwise, was seen as a fault, and for each fault there was an atonement in order. Dealing with eternal and unchanging laws, there was no place for negotiation between the sinful and the deity, just submission and

expiation. With the dawn of Positivism, illnesses were no longer seen as punishments. The disease state became 'notisfault'[1] and so medicine began to brew new explanations and causality inferences between organic derangements and disease. This time, the knowledge of the physician did not come from the heavens, but was founded on scientific knowledge. However, still as hermeneutic and inaccessible for the layman as before. This is the relationship that Parson described in the 1950's, an interaction where the patient was committed to the passivity of the 'sick role'. Parson [1] describes a helpless patient, whose technical incompetence hinders any chance of extricating out of illness by his own effort. In this paradigm, the physician is responsible for the welfare of patient, in line with a Paternalistic Model of decision-making. However this model imposes a considerable burden to physicians in conditions which are known to be uncontrollable or with a high degree of uncertainty.

### **Evidence-Based Medicine and Patient-Centered Care**

Contemporary clinical practice is strongly influenced by empirical science, used as an explicit basis for making judgements about the provision of clinical care [2]. This model assumes that whatever treatment shown to be the most effective is the 'rational' choice to implement, and 'if an informed patient with expressed desire to get well chooses a different treatment this choice must be the result of wither unusual or irrational thinking '[3]. Taken to extreme, evidence-based decision-making has been associated with rational decision-making, in which choices made by patients which deviate from the scientific evidence are labelled as irrational, from which the patient must be protected.

With the proposal of the biopsychosocial model of illness, which also emphasized the importance of psychosocial factors in the course of illness, the patient's experience of illness acquired a central role in decision-making [4]. The illness centered-care paradigm was replaced by the patient-centered medicine, dethroning the scientific perspective and moving the patient from the periphery to the center of medical decision making [5]. Patient-centered care withdraw health care from the exclusive focus on symptoms and physiological outcomes, taking into account that patients often value functional outcomes and quality of life higher than control of illness. This challenges a science-based paradigm, assuming that the clients are the best judges of their own needs.

Formerly incompatible with either a shared or an informed model of clinical decision-making, the evidence-based approach is being redefined, considering that the scientific information is not exclusively advantageous to find a treatment option, but rather to help create more informed patients and enhance patient choice [6]. Intermingled with the principles of patient-centeredness, evidence-based medicine now assumes that client preferences, expressed as informed choices, outweigh scientific evidence [4].

## **Models of Patient-Physician Relationship**

Medical treatments have become increasingly technologically complex and there is expected that they are justified by scientific evidence. However, taking into account the limitations of empirical health research, the patient-physician relationship has become increasingly valuable [7]. Contemporary with Parson, Szasz and Hollander [8] described three basic models of doctor-patient relationship, which translate into different approaches to treatment [8] – **Table 1**. The first model assumes that in some instances it might not be possible for the patient to participate in the relationship and the physician acquires an authoritarian posture - the Activity-Passivity Model. Conceptually, there is no interaction between patient and physician, since he is unable to contribute. Nowadays, with the increasing use of advance directives, this model may no longer be acceptable (even) in emergency situations.

The other two models assume that an interaction is established, both participants are 'active' in the sense that they contribute to what ensues from the relationship. However patient and physician's functions differ: in the Guidance-Cooperation Model the main difference pertains to power, and to its actual or potential use – the patient is expected to 'look up to' and to 'obey' his doctor; in the Mutual Participation Model, the power is divided and the participants are mutually interdependent, engaging in an interaction satisfying for both.

This last model is highly developed and pointed as ideal when dealing with chronic diseases, where the patient's experience provides reliable and important clues for therapy. Moreover, the treatment program is carried out by the patient, so that the 'physician helps the patient to help himself' [8]. The Mutual Participation Model requires a complex psychological and social organization of both participants, and, according to



Szasz and Hollander, ' is rarely appropriate for children or for those persons who are mentally deficient, *very poorly educated, or profoundly immature*'[8].

Those authors did not consider that patient's participation might extend to involvement in treatment decisions, neither that he could ever assume a dominant role in decision-making. Latter Freidson argued that the patient's status may be equal to, or even higher than that of the doctor – as in private practice. However, neither predicted consumer sovereignty in publicly financed health services [9].

**Table 1. Models of Physician-Patient Relationship and its' concepts of "Treatment"/"Therapeutic Result"**

<b>Model</b>	<b>Physician's/ Patient's Role</b>	<b>Clinical Application of Model</b>	<b>Meaning of "Treatment"</b>	<b>Meaning of "Therapeutic Result"</b>
<b>Activity- Passivity</b>	Does something to patient/ Recipient (inert or unresponsive)	1. Treatment of the unconscious patient; 2. Major surgical operation under general anesthesia	Whatever the physician does; the actual procedures which he employs	Alteration in the structure and/or function of the patient's body (or behavior, as determined by the physician); the patient's judgment does not enter into the evaluation or results
<b>Guidance- Cooperation</b>	Tells patient what to do/Cooperator (obeys)	Most of general medicine and the post-operative care of surgical patients		Patient's judgement is not irrelevant; success of therapy is still the physician's private decision; if patient agrees, he is a good patient, but if he disagrees he is bad or 'uncooperative'

<b>Mutual Participation</b>	Helps patient to help himself/ Participant in partnership (uses expert help)	The treatment of patients with certain chronic diseases or permanent structural defects	An abstraction of one aspect of the relationship, embodying the activities of both participants; “treatment” does not take place unless both participants orient themselves to the task ahead	Evaluation of the result will depend on both the physician's and the patient's judgments and is further complicated by the fact that these may change in the very process of treatment
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(Adapted from “A contribution to the philosophy of medicine; the basic models of the doctor-patient relationship.”, Szasz, T. S. and M. H. Hollender (1956). *AMA Arch Intern Med* 97(5): 585-592.)

## Compliance (vs) Concordance Paradigms

Compliance is the degree a patient’s behavior corresponds to the physician’s prescription [10] and implies obedience to his authority [11], this definition highlights the power imbalance in the patient-physician relationship, hallmark of paternalistic models of medical practice, emphasizing pejorative obedience for the patient. It focuses more on behavior and less in the attitudes toward medication, failing to capture *‘the dynamic complexity of autonomous patients, who must navigate decisional conflicts in learning to manage disorders over the course of decades’*[5].

This paradigm has been criticized for being too simplistic to address the complex decision-making processes that are required to discover the optimal use of medication. It devaluates the patient’s role in health care decisions [5], blaming those who do not follow medical advice [12]. It assumes furthermore that the patient possess adequate information on the condition being treated and its treatment, has access to medication and the ability to take it as instructed, which is not always the case. Research that analyzed compliance from the patient’s perspective found that the main reason why people choose not to follow physician’s prescriptions concerned the drugs themselves [13]. Others were: as a way of expressing their attempts to cope with their disease, as a

reaction to the way they were treated by physicians, or as a way of fighting the system by breaking its symbolic rules [12].

The more neutral concept of adherence aimed to surpass the concept of compliance, hoping that the term would not reflect the same degree of coercion [11]. Adherence definition according the World Health Organization is *'the degree to which the person's behavior corresponds with the agreed recommendations from a health care provider'*. Although it implies a more collaborative perspective by integrating the physician's medical opinion and the patient's lifestyle, values and preferences, the underlying paternalism remained, and a new model of concordance was proposed.

Concordance refers to *'anticipated outcome of the consultation between doctors and patients about medicine taking, if both parties can be encouraged to work together as partners'*. It differs from the previous concepts focusing on the consultation process rather than on a specific patient behavior, and has an underlying ethos of shared approach to decision-making [13, 14]. It advocates a sharing of power in the patient-physician relationship, ensuring they have enough information to participate in making decisions about treatment and supporting them with any problems they might have. Stevenson [15] defines three necessary elements for the concordance practice: the evidence that patients share their beliefs, experiences and preferences, that physicians question about health care preferences and constraints on adherence and that a balanced discussion takes place between health care practitioners and patients. 'It is a process, which entertains patients' views on medication taking, and acknowledges that patients' views have to be respected even if they make choices, which appear to be in conflict with the clinician's views' [16].

For this to be possible, doctors need to recognize patients' decision-making abilities, to try to understand patients' needs and constraints, and work with patients in the development of treatment regimens [12] - beyond a compliance paradigm, towards a therapeutic alliance – in line with share decision-making.

## **MODELS OF CLINICAL DECISION-MAKING**

Increasing relevance is being attributed to the process of medical decision in clinical practice, which draws important characteristics from the interaction established. Several models of decision making have been identified, varying in the roles assumed by the

patient and the physician, the relative sharing of information and the decision-making power.

Different models of treatment decision-making may be more or less appropriate, or feasible, in specific contexts (eg. emergency setting, long-term monitoring of medication in the treatment of chronic disorders, palliative care).

The health-related decision-making process is composed of two steps. The first one involves the evaluation of scientific evidence requiring analytic skills with the prospect that an agreement can be reached [17]. The second step comprises the subjective evaluation of facts, integrating personal values and inclinations. In a patient-centered paradigm, this appraisal should draw from the patient's preferences and be reflected into a meaningful decision. There are no correct answers, nor an obligation that an agreement is reached. The most prominent models of treatment decision-making are the Paternalistic, Informed and Shared-decision Models.

## **1. Paternalistic Model of Decision-Making**

Sometimes called parental, or priestly model, it derives from the early conceptualization of the 'sick role'. The physician is depicted as a guardian of the patient's best interest, without the need to elicit the latter's preferences. Submissiveness to professional authority is based on several assumptions [6]:

1. It assumes that a single best treatment exists, and that there are objective criteria for determining what that is;
2. Physicians know the best treatment available and consistently apply this knowledge when selecting treatments;
3. Physicians are in the best position to evaluate the tradeoffs between different treatment and therefore to make the treatment decision;
4. Physicians have a legitimate investment in each treatment decision, because of their professional concern for the welfare of their patients.

According to this model the patient assumes a passive role, in an encounter dominated by the physician, who uses his skills to diagnose and recommend test and treatments. If any, the patient involvement is limited to providing consent to these recommendations, thankful for the decisions made by the physician even if he would not agree to them at the time [12]. Differences in education, income and gender also contribute to this power disparity.

With the increasing number of illnesses for which no best treatment existed, the decisional context evolved to considerer different treatments with different types of tradeoffs between benefits and risks. The widespread variations in clinical practice underlined the changeable scientific basis of much medical care and heightened the awareness that doctor's values and beliefs influence clinical decisions [9]. Since the patient rather than the physician has to live with the consequences of the decisions, the assumption that the physician is in the best position to evaluate and weigh advantages and disadvantages was increasingly challenged [6]. The objectivity of the professionals has also been questioned given that several factors can cloud their objective judgement [7].

This model has been considered inappropriate for many current treatment decision-making contexts, and is presently limited to emergency situations, where the patient is not able to participate in the decision-making interaction, and there are no advance directives, or in the presence of incompetent patient without a guardian (e.g., under-aged people, some mentally ill patients).

The instrumental model represents the extreme version of the paternalistic approach to clinical decision making. It rests on an abusive disregard to the patient's values and well-being, such as disrespectful or unethical human experimentation. According to this model the physician acts on behalf of a goal independent of the patient, such as the good of society or the progress of scientific knowledge [16].

The logical next step appeared to be the patient empowerment in treatment decisions. Advocates of patient-centered care invoked two main arguments for increasing patient decisional-power [7]: a philosophical argument – the ethical principle of autonomy; and an economic argument – a free market concept where more consumer choice may increase standards through competition.

## **2. Informed Models of Decision-Making**

Several models were developed in reaction to the paternalistic model. The Informed Models of Decision Making emerged from the recognition of informational asymmetry between patient and physician – technical knowledge resided in one party of the interaction, while personal preferences reside in the other. These models postulate that both types of information need to be combined in the provision of effective care [18].

### ***Informed Decision-Making Model***

This model emphasizes patient sovereignty and patients' rights to make independent, autonomous choices. It embodies the adoption of business terms for medicine, as when physicians are described as health-care providers and patients as consumers [19]. This consumer oriented model, also called scientific or engineering model, rests on two assumptions [6]:

1. Patients possession of current scientific information on treatment enables them to make the best decision for themselves;
2. Physicians should not be involved in the decision-making process, since their interests and motivations may be different from the patients'.

The role of the physician is limited to information exchange, communicating the needed technical or scientific knowledge to the patient. This is seen as an enabling strategy, reducing the asymmetry in the clinical relationship by increasing the patient's knowledge. Patients should therefore be able to make decisions that reflect both their preferences and the best scientific knowledge available, no longer needing to share the treatment decision-making process.

This model also assumes a 'rational actor model' of information transfer, which assumes that the evidence-based information provided is fully understood as stated. Scientific evidence in the form of probability statements is transferred to the patient, who is perceived as a passive and empty vessel. It leaves no active role for the patient to interpret the scientific information or to try to make it personally meaningful [20].

The informative physician lacks a caring approach that requires understanding of the patient values, and is proscribed from giving recommendation for fear of imposing his will on the patient and thereby competing for the decision-making control that has been given to him [3]. It does not consider that an informed patient may still prefer not to lead the treatment decision-making process, ignoring that they are often uncertain and have 'second order desires', that is, the capacity to reflect on their wishes and to revise their own desires and preferences [3].

For these reasons this model is now being criticized, justified only where there is a one-time physician-patient interaction without an ongoing relationship in which the patient's values can be elucidated.

### ***Interpretive Model***

In the Interpretive Model [21] the role of the physician remains an informative one, however, he also helps to elucidate the patient's values and what he actually wants. It places the elucidation of values in the context of the patient's medical condition at the center of the physician-patient interaction. The physician informs and helps the patient to understand and use these values in the medical situation, leaving to him the ultimate decision.

The physician acts as a counselor, whose obligations include those enumerated in the informative model but also require engaging the patient in a joint process of self-understanding leading to autonomy.

### ***Deliberate Model***

According to this decision-making decision process [21] the physician acts as a teacher or friend, engaging the patient in a dialogue on what course of action would be best. The physician using no more than moral persuasion aims to suggest why certain health related values are more worthy and should be aspired to. Here, the conception of autonomy is moral self-development. The patient is empowered not to simply follow unexamined preferences or examined values, but to consider, through dialogue, alternative health related values, their worthiness and implications for treatment.

In this model the physician's values are relevant to patients. They inform their choice as a physician, who would not only help fit therapies to the patient's elucidated values, but also promote health-related principles. It embodies an ideal of a caring physician who

integrates the information and relevant tenets to make a recommendation and, through discussion, attempts to persuade the patient to accept this recommendation.

### ***Professional-As-Agent Model***

Derived from economics, this model also resolves the asymmetry between the physician and patient, this time with information transfer from the patient to the physician. The patient gives information regarding self-knowledge, that the physician has no other way of knowing. The physician's role is one of an agent *'trying to choose what the patient would have chosen, had he been as well-informed as the professional'*[18]. The decision-making process is restricted to the physician, who is refrained from using his preferences – the only preferences that matter are those of the patient. The professional makes the decision, either assuming that they know, or having elicited the patient's preferences [2].

## **3. Collaborative Models of Decision-Making**

The information sharing from the physician to the patient does not lead to a sharing of the decision-making process. This notion of two separate goals in the medical encounter – information sharing and decision-making sharing contributed to the emergence of a effective shared model of decision-making [18].

### ***Shared-Decision Model***

The Shared Decision-Making (SDM) model refers to a patient-physician communicational process, as part of the healthcare delivery, in which both participants collaborate to access information and enable health care decisions to be made [22]. Patient participation in the decision-making process regarding medical treatment encompasses a number of interests [2, 18]:

1. *Legal* - Widespread obligation of informed consent registry implies a minimum of shared decision-making;



2. *Ethical* - The emergence of consumer rights movement and the call for patients' autonomy, demands for a shared process that goes beyond informed consent to include broader principles of patient autonomy and control;
3. *Clinical* – With the shift in the nature of medical practice, from an acute to a more chronic care, caregivers often manage illnesses or combinations of illnesses rather than cure disease, which poses decisional challenges not solved by the sole use of empirical evidence.

This model seems to be of special interest when decisions are sensitive to personal preferences, such as facing uncertain or equivocal evidence of benefit [2]. In the management of chronic illness the patient necessarily is responsible for his own care [4]. To manage his condition, decision-making almost always involves different possibilities with different possible outcomes, and substantial uncertainty regarding impact on physical and psychological wellbeing [18].

Charles [18] sets four necessary criteria for classifying a physician-patient decision-making interaction as a Shared Decision-Making process: 1. *Quorum* - it must involve at least two active participants, comfortable with their level of participation; 2. *Information exchange* - both the physician and the patient share information; 3. *Joint deliberation* - both parties participate in the process of decision, expressing treatment preferences; and 4. *Decision* - a treatment decision is made upon the agreement of both parties.

To the active involvement of the two participants it is essential the respect for the patient's preferences. The physician must first elicit patient's preferences for participation in the decision-making process, give choices as to how this process will proceed and then respect patient's choices by behaving accordingly [18]. Research on patient's attitudes towards medical care revealed that patient vary in their preferred role in medical decision and they want to choose a physician with whom they can have a trusting relationship [4]. Preferences for involvement may also fluctuate over time or depending on circumstances. Patients who express preferences for some form of shared decision-making do not necessarily act accordingly in the medical encounter. Therefore, physicians should regularly review patient's changing preferences for involvement, familiarizing themselves with the competing demands they experience at each decision-making stage [2] and consider situational factors surrounding the doctor-patient interaction [21].

Some patients prefer a passive role in the decision-making process [17]. In a study by Degner [23], 15% of participants believed that they had been forced to assume more responsibility for the decision than they were comfortable with. Those who prefer a more active role tend to be younger, more educated and healthier [9]. People with serious and chronic illnesses or older are less likely to prefer an active role in choosing treatments [5]. Older patients passivity may be explained by a cohort effect – they are cultural prone to see the doctor as a traditional power figure, a aging effect – they tend to rely more on the expertise of others and desire less responsibility in medical care, and/or a companion effect – they are more often accompanied by others participating in the decision-making process instead of the patient. Limiting the conceptualization of SDM to a dyad may not reflect the current realities of clinical practice. The physician-patient interaction often involves more participants, with different patients, physicians, as well as relatives and friends. The range of interactional dynamics is automatically increased, and enables the formation of coalitions that will vary depending of the decisional context [18].

It is not always clear what type and amount of information patients want, or why they want it. Research suggests that physicians misestimate patient's preferences for information [24]. They are not so much interested in average outcomes for aggregate groups of patients as they are in knowing what this information means for themselves. Patients interpret information in order to make them personally meaningful [25]. They combine medical advice with information from other sources, ranging from health education campaigns and media articles to folklore and conversations with friends. All these sources are weighed in order to fit the patient's circumstances. Furthermore patients will use their own expertise about society and everyday life to decide how to use the medical information available [26].

Both patient and physician are required to bring their own expertise to the decision-process, sharing technical knowledge and personal information from both parties. Patients are increasingly literate in medical knowledge, and it is crucial for the physician to ascertain this health-related beliefs. Physicians' values are also important in that they enable the building of a professional opinion, not only based on raw empirical evidence, but on clinical and personal experience. This helps to bridge the empirical evidence base, which is established on population averages, with the unique concerns, values and life context of the individual patient [5]. On the other hand the value of information from the patient's perspective does not lie solely in its potential use as an aid to decision-making, but also as a psychological reassurance, reducing uncertainty at a time of great stress and vulnerability [27].

Agreement between physician and patient about the treatment decision is one possible outcome of a shared process; others include no decision or disagreement as to the preferred treatment. A shared decision does not mean that both parties are necessarily convinced that this is the best treatment possible, but rather endorse it as the treatment to implement - through mutual acceptance both parties share responsibility for the final decision [18].

With emphasis on interaction, based on the bidirectional exchange of information and joint process of deliberation, this model is likely to be more complex and time consuming than either the paternalistic or informed approaches, each of which require less interaction and consensus building [6]. SDM encourages a dialogue between patient and clinician to clarify overt and covert intervenient factors – socio-demographic and cultural, so as to reach treatment decisions which the patient will likely implement.

A number a benefits have been reported when shared decision-making is applied. From the clinical perspective, improvements in the therapeutic relationship as well as in a variety of health outcomes such as treatment adherence, satisfaction and biomedical outcomes were found. Patients who performed the decision-making role tend to be more satisfied and present a higher functional status. Surveys also demonstrate that near the totality of patient desire information on relevant healthcare problems and many want to participate in health care decisions. The application of a shared decision model also possesses economic advantages - as a consumer patient's control represents a mean of tying the healthcare industry into a form of market discipline. From a theoretical and ethical point of view shared decision-making is an end in itself due to the assumption that people with illnesses should determine what happens to their bodies and are best suited to make the decisions because only they can place personal values on the outcomes.

Concerns on possible disadvantages of offering patients a shared process of information exchange and decision have also been suggested [4, 9, 28-30]:

1. *Sense of overwhelming* – Choices can be debilitating for those who have difficulty with important decisions;
2. *Fear of decision regret/Increased sense of lost opportunities* – Patients may experience regret or reject options to spare themselves the possibility of regret;
3. *Difficulty in valuing outcomes* – Patients may be unable to anticipate how they will adapt to illness or react to treatment;

4. *Dissatisfaction with clinical realities* – The expectation of choice and decisional control may lead to dissatisfaction when expectations meet clinical realities;
5. *Discomfort with assuming unsought responsibility*;
6. *Nocebo effect* – Disclosing information about risks may increase the experience of adverse effects due to suggestibility;
7. *Impracticability* – Unfeasibility to provide information on the potential risks and benefits of all treatment options available;
8. *Utopic usage of resources* – Greater patient involvement in decision-making may lead to a greater demand for unnecessary, costly or harmful procedures which could undermine the equitable allocation of health resources;

There are situations in which shared decision making is not fully applicable, such as in emergency situations or in situations in which there is a decisional incapacity. In these situations, advance directives can help to protect the patient autonomy and provide practitioners with a guide to making treatment decisions that are conducted by the clients' preference and values – a method consistent with client-centered care and SDM [5].

Several interventions to improve patient's decisional capacities have been suggested, either from the physicians (e.g., improvement of clinicians skills [18]) or from the patients perspective (e.g., patient decision aids [2, 6, 18], communication skills programs [18, 31], individual preparation of patients).

## **DECISION-MAKING IN PSYCHIATRY**

Since 1970s, the process of negotiating a treatment approach, with the attainment of a mutually acceptable option between the patient and the physician, has been discussed in psychiatry. The roles played and the imbalance of power between physicians and patients, have been questioned with the rising of cultural and professional movements such as the anti-psychiatry movement, consumer-led services, the alternative treatment movement and the critical psychiatry networks [7]. The evolving policy of informed consent including patient's values define physicians interventions aiming to enhance patient's control over their options, treatment, health and lives [32]. The participation of

patients in medical decisions affecting their treatment is increasingly being advocated in the field of mental health [33]. This desire and the need to frame medication within the context of the client's desires, life goals and history, brought the concept of therapeutic alliance to the frontline of psychiatric practice [5]. This alliance implies a collaborative approach, based on co-responsibility and trust, hopefully translating into better clinical and personal outcomes, with careful consideration of both consumer and provider perspectives.

Most studies show that people with mental illnesses are interested in being involved in the management of their conditions, and welcome opportunities to be informed and share the process of decision-making [2, 6, 34]. Patients consistently report positive attitudes towards shared-decision making [32, 35, 36], with levels of interest higher than those experienced [6, 37, 38][39]; and similar [36] or higher [33, 38] than patients with somatic diseases.

The patient's desire to be informed about his mental condition and treatment has been shown to be higher than the desire to participate in decision-making [33, 40, 41]. They seek information about their illness, welcome scientific evidence and like to be kept up-to-date about illness and treatment as well as other supports within the mental health system [42]. This information is frequently not volunteered by physicians or other health professionals [39], forcing patient to be proactive in obtaining information, either in the consultation, or with other professionals, family, social contacts, and/or digital resources. Similar levels of desire for information were found in all ages [43]. However the decision aid material created for general health does not translate perfectly to mental health. The power differential, coupled with providers' ability to use legal means to override consumer preferences, creates a different dynamic in psychiatric practice [44]. There is moreover a lack of instructions to providers on the use of such aids, and the limited technical assistance makes them difficult to implement.

Decisional conflict in psychiatric patients may be explained by stigma, symptom suppression, and delayed onset of consequences due to discontinuation of medicine. This highlights the need for support resolving the ambivalence regarding the use of psychiatric medications or other therapeutic tools [5].

Patients have a strong desire to be involved in decisions about their medications [38] but fear taking full control or responsibility over the decision taken or the treatment to follow [33, 36]. They wish a collaborative approach [45], rather than an informative or paternalistic model. A tendency to prefer a lesser role in the decision-making process was exclusively found when more severe clinical pictures were present [45].

Preferences appear to vary in relation to the type of decision being made. Patients prefer to assume a collaborative role when facing psychiatric medications, an autonomous role for decisions related to psychosocial interventions, and a passive role with their primary care provider [38, 43]. Psychiatrists, on the other hand consider psychosocial and lifestyle issues to be more suitable for shared decision-making than medical or legal decisions [46].

Differences in participation preferences across different psychiatric conditions are negligible [36] and demographic or situational variables explain less than 20% of the variability in decision-making preferences [47]. Research reports higher desire to participate in decisions in patients with:

1. *Experience of involuntary treatment* [33] - In mental health some patients may be forced to treatment, but even those treated involuntarily some degree of autonomous choice is possible. This partial inclusion in treatment decisions may improve their attitude toward treatment and thus enhance compliance.
2. *Negative attitudes toward treatment* [33] - Patients unsatisfied with treatment, namely those with less insight into the necessity of treatment [37], expectation of side effects or uncertain of treatment benefits [32], are more likely to non-adherent. When dealing with patients with poor insight and negative drug attitudes, psychiatrists tend to use authoritative decision-making styles despite the patient desire to participate [37].
3. *Younger age* [40, 45] - Studies report higher desire to participate in younger patients or in those with greater experience of living with illness. Others suggest that older adults are more likely to experience a passive role in psychiatry medication decisions [43].
4. *Female gender* [36]
5. *Higher education* [36]

Regarding mental health problems SDM is being practiced at the level of information exchange in both psychiatric and primary care setting [48]. Observational studies accurately assessing the SDM process in mental health consultations have found that the majority of professionals do not objectively favor involving the patient in the decision-making process [49-53]. Physicians report higher levels of patient's participation than

those experienced by the patient, who state little meaningful input into major decisions, especially about medications [37, 44].

This discrepancy underscores the importance of explicitly inquiring the patient's preference in the decision-making process. Occasionally professionals, even if interested in a SDM process, resist directly asking patients about their preferences for involvement in decision-making [49] and describe to intuitively feel if the patient is able and interested in participating. Some investigators explain this behavior as a defensive routine, managing the environment unilaterally and controlling the task [49]. When patients initiate discussion about treatment options, however, physicians respond with greater patient involvement [52].

Taking into account patient preferences in treatment planning and delivery has been associated with several positive outcomes [44, 54], namely greater knowledge, satisfaction with treatment, feelings of being helped, involvement and activation of decision-making and improvement of treatment adherence with lower need for re-hospitalization [55-57].

Nonadherence to treatment in mental health is high and the lowest adherence rates are found in chronic conditions, when treatment is prophylactic or suppressive or the consequences of stopping treatment are delayed [58, 59]. Decisions regarding treatment are moreover influenced by patient's expectations, attributions and beliefs, as exemplified below:

1. The patient may perceive treatment as "worse" than the disorder [5, 39, 60], either by the presence of intolerable side effects or by the experience of a transformation of self into a "drugged me" or a "not-me";
2. Using medication is seen as not worth the discrimination and social rejection associated [13, 39, 61, 62];
3. Treatment is an unwanted reminder of illness [63];
4. There is no need for treatment because they are not certain of being actually ill [13, 63];
5. Medications is needed to deal exclusively with specific symptoms, or when the symptoms are present and experienced as distressing;
6. It is best not to use medications because it is ineffective [64].

The concept of shared-decision making is also relevant to health decisions such as lifestyle modifications. Given the high morbidity and mortality of psychiatric populations, and the deleterious effects of psychiatric medication, promoting healthy lifestyles can have a major impact [64]. The model allows the physician to help the patient to identify personal resources as self-initiated, non-pharmaceutical self-care activities that serve to decrease symptoms, avoid undesirable outcomes such as hospitalization, and improve mood, thoughts, behaviors and wellbeing [60]. Nevertheless patients do not routinely disclose their personal resources and coping mechanisms to physicians and physicians do not routinely inquire about them. These strategies optimize the process of managing illness and promote health [45]. Physicians should learn to monitor their use.

The Recovery Model applied to mental health emphasizes and supports each individual's potential for recovery, seen as a personal journey that involves choice, self-determination, and empowerment [2]. Mastering a sense of self-efficacy that fostered accomplishment, control, and improvement in one's life have been found to be essential to recovery in psychiatric disorders [65]. A mismatch between treatment priorities and needs of patients with serious and persistent mental illness results in a fail to provide integration in the community [66]. Conversely, patient's participation in the decision-making process contribute to his autonomy and reinforce self-confidence.

Research reports diverse, and sometimes contradictory results regarding outcomes associated with SDM. There is a tendency to consider the shared approach to decision making as beneficial regarding commitment to therapy [67, 68], but no clear effects on clinical outcomes have been found [7, 67, 69-71]. Chan and Mak described in 2012 four ways in which share decision-making could play a role in promoting aspects of mental health recovery [22]:

1. In the personal involvement and intimate commitment to the process of illness management and recovery. A recovery-oriented dialogue links the patients lived experience to their own concepts and understanding of recovery, and with this a new personal vision can be created, constituting a self-transformation of the patient. A recovery-oriented care for people with severe mental illness implies that the person in treatment should have the greatest role possible in collaborating with the provider to define the goals of treatment and plan for ways to reach these goals [72].



2. Empowerment and reinforcement of a sense of self-direction. Patients with severe psychiatric symptoms seem to be less empowered and experience diminished self-confidence, which was not found to be correlated with global functioning. Instead, those with larger social support network reported more self-orientation to empowerment [73], including self-esteem and efficacy, community confidence and optimism. Greater self-orientation was associated with better quality of life, fewer symptoms and better social support [73]. The impact of empowerment on the community is manifested by the patients' desire to change his stigmatizing community. Patients believe they have some power within society, are interested in affecting change, and wish to promote community action [73].
3. Improvement of patient-physician relationship, by reducing the informational and decision-making asymmetry. Therapeutic relationship is an independent predictor of treatment outcome, a mediating factor that captures significant variance in the outcome of treatment interventions such as pharmacological therapies, and an outcome *per se* [74]. Schizophrenic patients who formed good therapeutic alliances with their therapists, for example, were found to be significantly more likely to remain in therapy, comply with the prescribed medication regimens, and achieve better outcomes with less medication [75].
4. Assurance of the selection and implementation of a consumer-desired plan.

Implementing SDM in psychiatric settings presents several difficulties. Fragmented services, learned helplessness, prejudice, discrimination and the fear of coercive consequences can challenge psychiatric patient's ability to actively and fully engage in shared decision-making [44]. Research shows, however, that those with severe mental health illness are able to participate in decision-making [48, 76], and that legal definitions of impaired competency to make health decisions affect only a minority of people diagnosed with mental disorders namely those with dementia or learning disabilities [2].

Among other problems patients commonly mention time restrictions as a barrier against SDM behaviors. It takes time to share information and preferences for treatments and to negotiate a course of action, as indicated by the finding that greater SDM behaviors are associated with longer visit duration [39, 49, 52, 77]. For instance discussion of health behaviors using SDM in the negotiation of behavior change is feasible in a 15- to 20-minute visit [50]. Consultation setting and organizational characteristics was also found to influence SDM behaviors. Physicians working in a health maintenance organization

practice made fewer attempts to involve patients in the decision process [52], constrained by organizational factors such as formularies and treatment guidelines.

Culturally influenced attitudes and customs may represent facilitators or barriers to patient participation. Discrepancies in the ethnic, racial, cultural or social background of physicians and patients were described as obstacles to gather information regarding preferences and sharing decision-making processes [77].

Communication skills as the use of language that patients could understand, ability to negotiate and provide information were mentioned by physicians as facilitating a more co-operative relationship and simplify the decision-making task [39].

Shared decision-making is not suitable to all mental health situations. Autonomy of the patient should prevail in elective procedures or when treatment decisions are more controversial. However, in emergency and life-threatening situations, some authors consider that the paternalistic approach may still be desirable [7]. Due to acute and severe illness, an individual may be withdrawn from the decision process because of his inability to consciously participate. However, following improvement in their health status, he may be able to make a choice regarding continuing therapy. This change in ability should be accompanied by a change in the decision-making model used, supported by the physicians [39]. Even in situations where patient's decision-making capacity may be affected by the pathology, Psychiatric Advance Directives, where the person sets out their wishes beforehand, could be used [78]. These documents allow patients with severe and chronic mental illnesses to notify their treatment preferences for future crisis or relapses and to appoint a surrogate decision-maker for a period of incompetence. A recent review of the effects of advance treatment directives for people with severe mental illnesses provided little evidence on the benefits of these directives. Their completion rates remain very low [79] although well-suited for conveying patients' preferences congruently with patient-centered care.

## **DECISION-MAKING IN PATIENTS WITH DEPRESSION**

Van Grieken and coworkers [80] identified several characteristics of psychiatric treatment negatively influencing recovery, engagement in treatment and clinical outcome in major depressive disorder (MDD):

1. Lack of clarity and consensus regarding the nature of the disorder and its treatment between patients and clinicians;
2. Precarious relationship with the clinician;
3. Unavailability of mental healthcare when needed;
4. Insufficient involvement of significant others.

All these characteristics may impinge shared-decision, which is only recently been discussed in depressive care. The extension of shared decision making to the psychiatric context and in particular to depression reveals that most patients with depression are seeking information about their illness and treatment, and desire a collaborative involvement.

Preferences for involvement vary in different patients and within patients over time. They frequently revisit decisions, requiring ongoing decision support [81], especially during antidepressant therapy [82]. It is common for the same patient to experience both collaborative and paternalistic models in different decisional contexts. Preferences for involvement may not always fit the main models of involvement, requiring more flexible processes incorporating complex combinations. Older patients are more likely to accept a more traditional, dominant role for the physician, and report less confidence in discussing treatment options [47]. Less involvement is also experienced by inpatient in detoxification and forensic units [83], or whenever more difficult decisions have to be performed [84]. On the contrary, younger [83] patients and those with depression [35] demonstrate a greater level of interest for an active role in decision-making.

Patients with depression have frequently limited knowledge on the availability and efficacy of psychiatric treatments [85-87] and (moreover) convey to the clinical encounter various preconceived treatment preferences [88]. Raue and coworkers suggest that acknowledging patient's *a priori* treatment preferences may be conceptualized as a pre-shared decision-making strategy. A fully developed SDM intervention would determine the patient's preferences and also engage him/her in a dialogue about these preferences, review patient decision-aid materials, and conclude with a formulation satisfactory to both the patient and the clinician [88].

Previous experience with a treatment modality was found to be the strongest predictor of preference, with some contradictory results [89]. Preference for counseling therapies

[71, 86, 90-96] or psychotherapy [62, 89, 97-105] is high, compared to medication. Individuals who believe that their depression has more serious consequences on their lives and attribute their depression to marital, family or interpersonal problems are prone to prefer psychotherapy [101]. Higher education is also related to psychotherapy preference. Depressed patients frequently attribute improved well-being to psychotherapy [102], but rarely to antidepressant medication, being less likely to believe that their underlying problems can be solved with just medication [89]. In clinical settings however most patients receive medication, meaning that less than 50% receive the therapy they prefer [86, 101].

On the other side, although a collaborative care model may improve the access to the preferred treatment, meeting a patient's preference appears not to affect symptom reduction or remission rates [71, 92, 99, 106].

The majority of patients report the need for more information in order to improve the decision-making process. Concerns about depression treatments including fears about the addictive and harmful properties of antidepressants, worries about taking "too many pills" and the stigma attached to taking psychotropic medication [62] are mainly discussed with the psychiatrist, but other sources of information (other professionals, social contacts or media) may be used as decision aids [81, 84]. Patients feel the need for basic information about illness and that treatment options [76] drew on existing personal knowledge in order to be personally meaningful and accurate [83]. Low preferences for information are associated with higher depression scores and increasing age [107] with some patients declaring to feel unable to ask the information they need to be involved in the decision-making process [83]. Patients with all severity grades of depression are highly interested in information, but moderately interested in participating in decision-making [87].

Pharmacotherapy has become the main modality of depression treatment, but its efficacy is reduced by low patient adherence and premature discontinuation [108-110]. Low adherence is associated with unrealistic expectations [111], lack of treatment efficacy or unacceptable adverse effects [101], and discrepancy between symptom relief and cure [110]. The selection of the best antidepressant drug is difficult. There is a lack of evidence on their comparative effectiveness [112, 113], no perfect drug [114], and clinicians struggle to deliver this information meaningfully while dealing with their own preferences [115-117].

In a study on the physicians perspective of the decision-making process [118], they reported to provide a description of the disorder and to mention the potential risks and

benefits of medication, without discussing the potential outcomes of therapy. The most common topic was about the risks of taking medication, including side effects. The initial collaborative approach does not require exhaustive information to the patient, but requires a clear communication about [119]:

1. The chosen drug;
2. Treatment doses and time;
3. Time needed for the therapeutic response;
4. Potential side effects and ways to alleviate them;
5. Expected length of treatment;
6. General idea of drug mechanism and action.

Patients receiving this kind of information are more educated and have more positive initial beliefs about their medication. Consequently they are more likely to maintain follow up appointments and refer to be more satisfied with treatment. Aikens and colleagues propose specific educational messages to improve adherence during the first month of antidepressant therapy [120] taking into account the patient's beliefs about the disease and about medication, and tailoring the physician behavior to his preferences and expectations [121].

Information must be tailored according patient's age, education and literacy and the presence of cognitive impairment inherent to the disorder [88]. Physicians generally report to convey information orally and use fact-sheets from public or not-for-profit organizations. A recent article [117] reports that the use of depression decision aids improves the decision-making process, but no differences were detected in the evolution of depressive symptoms, remission rate or responsiveness to treatment.

Etiologic attributions of depressed patients were found to vary across cultural groups [62, 104, 122-126], and Vega et al. [127] emphasize the importance of communicating with depressed patients in their own language, using a participatory decision-making style intrinsic to the patient's culture, attending to culturally guaranteed expressions of depression. These explanatory models may assign milder illness attributions to depression and influence help-seeking choices, acceptance to proposed treatments and treatment preferences [125, 128].

As an example, religion beliefs can influence help-seeking and service utilization [129-131]. Correlations were found between religious involvement and major depressive disorder: lower prevalence among persons who use religious coping (attending religious services weekly) and higher prevalence in those who listen to religious radio programs [132]. Shared decision making interventions should support complementary and faith-based approaches as treatment adjuncts when appropriate and help patients articulate their beliefs about depression's etiology, severity and factors [88].

In primary care, first visits of patients with depressive symptoms showed a low rate of SDM behaviors [52]. These behaviors did not vary with the severity of the symptoms, but were influenced by the setting, patient-initiated requests for medication and physicians age [133]. This is consistent with the finding of lack of patient's involvement in treatment decisions in consultations about depression [53]. In contrast physicians report to employ a collaborative approach to the decision-making process, leaving the ultimate decision to the patient, unless they were being treated involuntarily [118]. Interestingly physicians relayed on their ability to gauge non-verbal cues rather than asking the patients explicitly how and if they wanted to be involved in SDM.

From the physician point of view several reasons were mentioned to abide for a collaborative approach to decision making in depression [118]: patient's involvement may be therapeutic itself, facilitates engagement and responsibility. Even though, they described several situations where they would not follow this model, possibly including caregivers in the decision-making process:

1. Severity of depressive symptoms and the associated decline in functioning;
2. Perceived risk levels, to self or others;
3. Perceived/own assumption of client preference of involvement;
4. Age or developmental stage of the client.

Concerns on decisional capacity are also raised in depression with some authors reporting a high use of maladaptive decision-making coping patterns [134] like decision avoidance and irrational decisions. An inverse correlation between severity of illness and confidence about decision-making was also found and the authors concluded that *"the greater the level of decisional conflict, the lower the level of confidence, the higher the level of irrational choice, and the more pessimistic and distorted was information*

*processing*'. Other authors on the contrary, found no association between depressive symptoms and the level of performance on the decision-making process [135].

Patients perceived a collaborative approach to decision making when physicians considered their opinion, talked with them about different treatment options and then mutually agreed on a decision [84]. Generally, according to observational studies, physicians tend to focus on the problem definition stage, failing to offer to the patient a variety of treatment options [53].

In depression it is common to involve more participants than the patient-physician dyad in decision-making. Caregivers and other relatives are often present in the consultation, particularly in the elderly. They have important supportive roles in line with the desired by the patient [83, 118, 136].

Potential negative outcomes of involving caregivers were cited by physicians, such as disagreements, critical or unhelpful comments or difficulties in establishing boundaries for clinicians not offering family therapy [118]. Research shows conflicting results regarding the influence of the involvement of caregivers in the presence of depressive symptoms [136]. Pressure from others may contribute to higher levels of decisional conflict. Family dynamics may be mostly powerful among particular ethnic groups [88, 104]. When disagreements with caregivers arose, physicians were reported to respond by involving caregivers earlier in the process, exploring and understanding the perspective of the caregiver, or restating the rationale or justification for their position [118].

It is claimed that SDM may directly alleviate key depressive symptoms, such as helplessness and hopelessness, indirectly improving clinical outcomes by increasing patient adherence [88]. While some studies show that this involvement has positive effects regarding treatment acceptance [86], adherence [137], clinical outcomes [138] and satisfaction with treatment [139, 140], others fail to show these benefits [71, 90].

When considering uniquely the patient treatment preference component of SDM a positive influence has been detected in treatment initiation [99] and adherence, but not in clinical outcomes [71, 92, 99, 106, 141, 142]. Patients who enact involvement roles consistent with their preferences report greater satisfaction or reduced depression than those with mismatches [133]. However, preference strength for assigned treatment, but not simply congruence, was associated with better treatment initiation and adherence [99]. Congruence of preferences per se with assigned treatment was related with treatment initiation, but not adherence. This findings suggest that when preferences lack intensity or are similarly intense, the most accessible treatment should be offered first.

Alternatively, where patient treatment preferences are particularly strong, that option should be offered [99].

Reasons for the patient involvement included: engagement process, adherence to treatment, safety, autonomy and empowerment [83]. This involvement surpasses traditional treatment type decisions, including decisions about location of care and employment. Negative aspects of involving patients were also mentioned, such as disengagement from treatment, refusal of a treatment option that could offer some benefit and overwhelming of the patient when they were unwell [118].

Dealing with decision-making in depressive disorders implies considering specific difficulties namely the perception of the disorder including the stigma, the delay in seeking help and the absence of information given to patients about depression treatment options [84]. These specificities may represent barriers for a shared-decision-making approach, which may be grouped in four categories [83, 118]:

1. *Patient or caregiver related*: depressive symptoms, level of risk assigned to patient, poor engagement, preconceived perceptions (e.g., perception of paternalism and coerciveness), confidentiality, family conflict;
2. *Physician related*: lack of communication, breaks in trust, reluctance to disclose side-effects, disagreement between professionals, different styles and approaches to individual patients, disorganization, underestimation of patient's abilities;
3. *Service related*: time constraints, a priori decisions, inpatient settings, accessibility;
4. *Broader*: stigma, lack of evidence, restriction of funding.

It has been suggested that these barriers can be overcome by explicitly offering involvement when making decisions about treatment, and involving the caregivers when appropriate [83]. Stigmatization may be avoided by treatment in general practice [91], but patients were aware of the limited treatment options available in this setting [84]. For older patients, for example, accessibility and stigma can be particularly troublesome, and they may be persuaded to use natural herbal remedies rather than evidence-based therapies, or misconstrue depressive symptoms as natural consequences of aging or medical illness, minimizing the need for treatment [143]. Older adults who met diagnostic



criteria for mental disorders were less likely to perceive a need for mental health care, to receive specialty mental health care or counseling, or to receive referrals from primary care to mental health specialty care than young or middle-aged adults [144-146].

Time constraints are present in current medical system. Patients request substantially more time to communicate with their physician [102]. Time pressure has been considered a barrier to SDM; research in primary care settings regarding depression treatment found that the longer the consultation time, the higher scores on decision-sharing behaviors were reported [49]. However, these behaviors, while increasing patient participation and satisfaction, did not increase consultations time significantly [140].

Conversely some factors were already identified which contribute to facilitate SDM such as: adequate time, culture of the team, treating voluntary clients, having referral options, professional culture and a general shift in healthcare culture towards collaborative approaches and informed clients [118].

## **CONCLUSION**

The patient-physician relationship is embodied with therapeutic actions. The communication between both and with the social network around becomes central to the process of cure. In this rich discussion between medical knowledge, its individualization to the patient's reality and the patient values, preferences and needs, there is a tendency for the patient to take the frontline.

Shared-decision appears to be the ideal commitment in the majority of clinical situations, even in most psychiatric settings. When dealing with patients with depression, sharing technical knowledge and information and the joined participation in the process of decision seems to be welcomed, and even desired. The consequent decision model promotes feelings of self-value and capacity, aspects withdrawn by the illness and valuable to the recovery.

This idealized collaboration poses new challenges to the physician in developing new strategies for interacting and new ways of navigating the relationship with the psychiatric patient, focused in understanding, towards a new and better care. In order to use a model of shared disease management, there are new habits and skills that need to be learnt.

On the patient side, there is a necessity to promote autonomy and empower him with the necessary information to exercise it, training his ability to disclose preferences and tenets. On the physician side, there is a need to defy the paternalistic approach and help the patient to develop self-efficacy and exert more control. This means increased demands on the communication ability and deliberation skills of both intervenient. Only fulfilling this requirements, the proposed benefits of a shared relationship will become real and translate into measurable personal and clinical outcomes.

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Parecer Nº A/2016

**Identificação do(s) Proponente(s)**

**Nome(s):** Hugo Sérgio Teixeira Reis de Almeida

**Filiação Institucional:** Interno de Psiquiatria do Hospital Magalhães Lemos (HML), EPE

**Investigador Responsável/orientador:** Professora Doutora Margarida Figueiredo Braga (FMUP)

Distribuído na CES em: 20/01/2016

**Título do Projecto:** *Como e por quem são tomadas as decisões? – Perspectivas sobre o modelo de decisão clínica no doente com síndrome depressivo*

**Considerandos**

O autor, no âmbito de um Mestrado em Competências de Comunicação Clínica da Faculdade de Medicina da Universidade do Porto, pretende “perceber de que modo, face a uma síndrome depressiva os profissionais e os doentes perspectivam a tomada de decisão clínica no que respeita ao envolvimento recíproco nessa decisão” e “avaliar de que modo estas perspectivas influenciam a prática clínica.”

Os dados serão colhidos através de versões experimentais de escalas não-validadas para a população portuguesa, uma aplicada a profissionais (psiquiatras e internos da especialidade) em funções no Serviço da Consulta Externa do HML, a segunda a utentes do mesmo Serviço com diagnóstico de síndrome depressiva.

Não são identificados riscos para os sujeitos.

É garantida a confidencialidade dos dados em todo o processo.

O projecto foi considerado “de acordo com os normativos do Serviço de Formação e Investigação” do HML pelo seu Responsável a 15/01/2015.

**Parecer**

O estudo não apresenta risco significativo ou custos para os sujeitos envolvidos e é garantido o consentimento informado e a confidencialidade dos dados, pelo que o nosso parecer é positivo.

O relator: Victor Mota  
(Victor Mota)

Data: 17/02/2016

*Approved in meeting of Commission of Ethics of the Hospital of H.M. Lemos*

O Presidente da Comissão de Ética: João D. Santos

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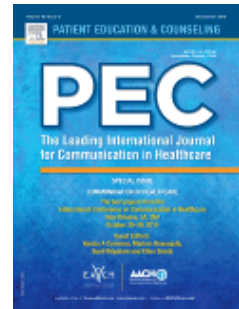
# PATIENT EDUCATION AND COUNSELING

Official journal of **EACH**, the European Association for Communication in Healthcare and **AACH**, the American Academy on Communication in Healthcare

## AUTHOR INFORMATION PACK

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ISSN: 0738-3991

### DESCRIPTION

*Patient Education and Counseling* is an interdisciplinary, international journal for **patient education** and health promotion researchers, managers and clinicians. The journal seeks to explore and elucidate the educational, **counseling** and **communication** models in **health care**. Its aim is to provide a forum for fundamental as well as applied research, and to promote the study of organizational issues involved with the delivery of patient education, counseling, health promotion services and training models in improving communication between providers and patients.

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## ABSTRACTING AND INDEXING

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Patient Education and Counseling is an interdisciplinary, international journal for patient education and health promotion researchers, managers, physicians, nurses and other health care providers. The journal seeks to explore and elucidate educational, counseling and communication models in health care. Its aim is to provide a forum for fundamental as well as applied research, and to promote the study of the delivery of patient education, counseling, and health promotion services, including training models and organizational issues in improving communication between providers and patients.

Patient Education and Counseling is the official journal of the European Association for Communication in Healthcare (EACH) and the American Academy on Communication in Healthcare (AACH).

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