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Perspective on shared decision-making for depression and anxiety disorders in clinical practice: a qualitative and quantitative exploration

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Chapter 3

Treatment decision-making for Depression, Anxiety disorders, and Obsessive-Compulsive disorder in specialized psychiatric care:

Patients' and clinicians' perspectives on treatment preferences, treatment decisions and influencing factors.

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ABSTRACT

Objective: To explore patients' and clinicians' decision-making regarding the choice of treatment (psychotherapy and/or pharmacotherapy) for depression, anxiety- and obsessive-compulsive disorders, with the aim to identify key elements of the decision-making process and influencing factors considered important in secondary psychiatric care.

Methods: Seventeen psychiatric outpatients and 33 clinicians participated in eight focus group interviews. We audiotaped, transcribed, and coded the interviews. Data were analyzed using thematic analysis.

Results: Patients and clinicians discussed similar key elements that play a role in the decision-making process: 'communication', 'information/knowledge', 'preferences' and 'decisions'. Relevant influencing factors were related to 'values and attitudes', 'contextual factors' and 'the decision-making process itself'. Contextual factors were categorized into: 'patient', 'illness', 'treatment', and 'clinician' characteristics. Values and attitudes described by patients and clinicians differed, leading to differences in (treatment) preferences and decisions. Contextual factors overlapped but differed in importance and relevance between patients and clinicians. Additional constructs related to the decision-making process were: having treatment options ('choice'); 'weighing' of pros and cons of these options with often 'uncertain' outcomes, 'the patient-clinician relationship', and 'who decides?'.

Conclusion: Treatment decision-making processes of patients and clinicians are characterized by similar key elements and influenced by values/attitudes and contextual factors that are only partly overlapping. Differences in these factors and consequently preferences, could lead to a discrepancy between what patients want and what clinicians (can) offer, thus choice. Clarifying such issues in the clinical encounter could improve collaborative decision-making and optimize treatment decisions.

INTRODUCTION

Depression and anxiety disorders are highly prevalent in general populations worldwide and have substantial personal, social and economic impact^{1–3}. Providing patients with the most advantageous and best fitting treatment is essential. To treat depression and anxiety disorders, including obsessive compulsive disorders (OCD), the first steps recommended by multidisciplinary guidelines are psychotherapy (behavioral therapy, cognitive behavioral therapy (CBT)), pharmacotherapy, or a combination of both^{3–7}. Clinical research shows that CBT/psychotherapy and pharmacotherapy are equally efficacious in many patients^{5,8}, but for some patients, clinicians consider these treatments as less suitable and/or outcomes remain suboptimal. In clinical practice, it remains uncertain which patients will benefit from which treatment⁹.

Considering that no ‘best’ treatment exists, decisions regarding how to treat patients with depression, anxiety disorders or OCD are often complicated and regarded to be ‘preference sensitive’. This means that the best choice is the treatment that best suits the patient, depending on how patients value the benefits versus the harms, and other factors important to them in the decisional process^{10–12}.

Interest in Patient Centered Care (PCC) and Shared Decision Making (SDM) has therefore grown in mental health during recent years and their relevance is now widely recognized. Research has shown that patients in mental health have identifiable treatment- and decision-making preferences^{13–15}. Furthermore, incorporation of such preferences in decisions regarding treatment seems positively related to satisfaction, treatment adherence and possibly also health outcomes^{15–18}. Studies in primary and secondary care have identified influencing factors of treatment preferences and/or treatment decisions^{19–23}. Current clinical guidelines for depression and anxiety disorders explicitly suggest involving patients and their preferences in treatment decision-making^{6,7,24,25}. Still, in clinical practice, the treatment decision-making process is frequently not systematically guided by patient preferences^{13,22,26–31}.

Only few studies have investigated the process of treatment decision-making in routine psychiatric care, especially in secondary care^{28,32–34}. Current research mainly focuses on evaluating interventions to incorporate patient preferences, to deliver or promote PCC, and to implement SDM as well as specific SDM tools (decision aids)³⁵.

More insight in the decisional process and possible target points might be valuable to improve treatment decision-making and support implementation of PCC and SDM in clinical practice. To attain this goal, we need to know more about how treatment decisions are actually made in secondary psychiatric care (i.e. about key elements of the decision-making process such as treatment preferences) as well as the role of influencing factors on patients’ and clinicians’ treatment decision-making for depression, anxiety disorders and OCD³³.

In this qualitative study, we organized focus groups (FGs) in a secondary care setting with the aim to explore outpatients’ and clinicians’ decision-making processes and influencing

factors regarding the choice (start or (dis)continuation) of treatment (psychotherapy and/or pharmacotherapy) for depression, anxiety disorders, and OCD.

METHODS

Sample and recruitment

Recruitment of patients took place at GGZ Rivierduinen (RD), a regional mental health care provider, and the Department of Psychiatry at the Leiden University Medical Centre (LUMC) in the Netherlands. Inclusion criteria to participate in the patient focus groups (PFGs) were: diagnosed with and treated for depression and/or anxiety disorder(s)/OCD, command of the Dutch language, and the ability (mentally and physically) to participate in a focus group (FG).

As depression and anxiety disorders/OCD often co-occur and treatment courses tend to converge, especially in the secondary care setting, we set out to compose two mixed PFGs for patients diagnosed with depression and/or anxiety disorders and a third PFG for patients diagnosed with OCD. We considered the possibility that OCD patients might differ in making (treatment) decisions due to their obsessions^{26,36}.

Clinicians (psychiatrists and psychologists) were asked to identify patients meeting the inclusion criteria. Eligible patients were informed about the study and invited to participate by the researcher (SR) in a consecutive manner, until four to eight patients for each PFG signed up.

Clinicians were recruited at RD and LUMC and at the Invitational Conference 2012 of the Dutch Knowledge Centre for Anxiety Disorders, OCD, and Depression (NedKAD) [<https://nedkad.nl/voor-professionals/invitational-conference/invitational-conference-2012/>]. The inclusion criteria to participate in the clinicians' focus groups (CFGs) were employment at RD/LUMC as psychiatrist, psychiatric residents, being a health/clinical psychologist or psychotherapist working in a secondary mental health care setting; and involved in the decision-making processes regarding the treatment of depression, anxiety disorders, OCD. We held two mixed CFGs and three mono disciplinary CFGs for psychiatrists, residents, and psychologists, respectively. For more detailed information on sample and recruitment: see Rodenburg-Vandenbussche et al. (2019)³⁵.

The study was approved by the Medical Ethics Committee of LUMC (P12.003).

Procedures and data collection

The FGs featured a semi-structured approach, following an interview guide (see *Appendix A*, Electronic Supplementary Material 1 (ESM) 1), with fairly broad open-ended questions, in line with the explorative nature of our study. All FGs were moderated by the first author (SR), with assistance of a second researcher, taking notes, the observer (VK, see

acknowledgements), both trained in conducting and analyzing FG interviews. The group interviews were audiotaped and transcribed verbatim.

Based on the literature, the following elements were used as topics in our interview guide: a) knowledge of the illness and indicated treatment options; b) attitudes towards treatments; c) (formation of) treatment preferences; d) (making) treatment decisions; and e) factors that influence preferences and the decisional process.

Participants were welcomed and received information about the topics of the focus group. They were encouraged to respectfully share and discuss their opinions with other members of the group. We informed participants that the interview was audiotaped, ensured confidentiality of the data use and that participation was voluntary, explaining that they could stop and withdraw from the study at any time without consequences regarding their treatment. Participants signed the informed consent and filled out a short background information questionnaire. The CFG started with a personal introduction round. The PFG started with a general opening question to get acquainted, yet to give the patients the opportunity to stay anonymous. The duration of the FG-interviews was approximately 90 minutes, including a 10-minute break.

Data coding and analysis

Atlas ti.7.5 (Scientific Software Development GmbH, Berlin, Germany)³⁷ was used to code and analyze the qualitative data of the FGs. First, the researcher (SR and VK) independently coded the transcripts of the first PFG and the first two CFGs, where open coding was used to label the relevant fragments within the texts³⁸. Both researchers compared their codes and grouped the corresponding codes into clearly defined categories. This process resulted in a working thematic codebook that was used to code subsequent transcripts (for the codebook see *Appendix B*, ESM 2). We used a concept map (see paragraph 3.2 and *Appendix C*, ESM 3) and our research questions as a frame, to group the data and to identify similarities and differences across the data^{38–41}. The analysis focused on the content and relevance of participants' responses, rather than on actual frequencies⁴².

RESULTS

Demographics

We conducted eight FGs on treatment decisions between June 2012 and December 2013³⁵. Patients' and clinicians' characteristics of each FG are shown in *Table 1*. Three six, and eight participants, respectively (total N=17 outpatients) participated in the three PFGs that we conducted. Clinicians participated in five different CFGs, ranging from three to nine participants (total N=33 clinicians). Three psychiatric nurses joined a CFG by mistake, although they did not meet our inclusion criteria. Their statements were therefore not included in the analyses³⁵.

Table 1 Characteristics of focus groups' participants: patients and clinicians

Patients	Total N= 17
Disorder	
Depression and/or anxiety disorder [†]	11
Obsessive–compulsive disorder	6
Gender	
Male	9
Female	8
Age	
Mean years $\pm$ SD (range)	44 $\pm$ 16 (20–75)
Education	
Middle to high	15
Low	2
Employment	
Yes	9
No	8
Professionals	Total N = 30
Profession	
Psychiatrist	11
Resident in psychiatry	8
Clinical psychologist	7
Psychologist/psychotherapist	4
Gender	
Male	15
Female	15
Age	
Mean years $\pm$ SD (range)	47 $\pm$ 12 (27–69)
Professional experience in psychiatry	
Mean years $\pm$ SD (range)	19 $\pm$ 12 (2–40)

[†]Specific information on diagnosis and previous treatments were not available because of the anonymous nature of the focus groups. We gave patients the chance to share this specific information at the beginning of the focus groups, but no one did. Some patients mentioned it during the discussion on specific topics.

Model of treatment decision-making

We used the topic guide to group the codes extracted from the FG interviews into a concept map (Appendix C), and new elements (themes) emerging from the data were added. Based on our concept map, a model of treatment decision-making for patients and clinicians was developed (see *Figure 1*). See Appendix D for supporting quotations.

Key-elements of the decision-making process: Communication, Information/Knowledge, Preferences and Decisions (Fig.1 part I)

Communication: According to patients and clinicians, communication was an important element of the decisional process. This involved not only the content of what was communicated, but also the way in which relevant information is shared (i.e., clear explanation, how personal information is discussed). According to most patients, communication with a clinician should involve a conversation about their illness, relevant treatments, attitudes, experiences, and expectations from both the patients' and the clinicians' perspectives.

Clinicians found it important to provide adequate and complete information and to check if the patient has understood the information, so that the patient is equipped to make a good treatment decision. They also recognized the importance of including the patient perspective. Yet, participating professionals also said that the communication often involved steering and negotiating with the patient.

Information/Knowledge: Receiving the right information about their illness and the different treatment options, including effectiveness and side-effects, was very important to patients. Patients said to value the information from their clinician most. Other sources of information patients tended to rely upon included: experiences from family/friends, educational material, and online information. All this information together (knowledge) was found an important element in the decision-making process.

For clinicians, it was also important to receive information from the patient about symptoms, medical history, personal values, and context, in order to give the best fitting treatment recommendation. The clinicians considered it as their responsibility to give their patients adequate and relevant information, this involved the diagnosis, treatment options (effectiveness and side-effects), and the prognosis.

Preferences: Patients' and clinicians' preferences could be divided in treatment preferences (e.g., what therapy) and decision-making preferences (e.g., who decides).

Treatment preferences: many patients had an explicit dislike for medication, which was also recognized by the participating clinicians. OCD patients seemed to have a firmer dislike for medication than patients with anxiety and/or depressive disorders, and they more strongly believed that medication was a last resort. Most patients said they already had formed initial preferences before seeing a clinician in secondary care (pre-consultation). These initial preferences could be modified during the consultation, based on new information and the treatment recommendation of the clinician, and the communication between patient and clinician (*intra-consultation*). After the consultation, patients sometimes discussed the treatment recommendation with family/friends or checked (online) educational material, before deciding (*post-consultation*).

Most of the participating clinicians mentioned that many patients already have a preference when they first visit their clinician and that those preferences (sometimes based on wrong

information and misconceptions) are difficult to change. Clinicians said of themselves that they do not have initial preferences and that they base their professional preference on clinical factors, personal characteristics of the patient, and external/circumstantial factors (e.g., waiting lists, availability). However, some clinicians said that clinician preferences were also influenced (biased) by the clinician's personal characteristics (see paragraph 3.2.2 contextual factors) (Fig.1 part II).

Decision-making preferences: most patients wanted to make the decision about their treatment together with their clinician. Clinicians thought it was their task to prepare the patient to make the decision autonomously.

Decisions: Patients had difficulty differentiating between factors that influenced preferences and factors that influenced the final decision specifically. Indicating that this is a gradual process. Patients thought that they often made the final decision because they could refuse or stop treatment. Most patients did not have the feeling of being forced into a decision. Clinicians agreed that the final decision was often made by the patients and that patients should decide autonomously.

Influencing factors of the decision-making process: Values, attitudes, and contextual factors (Fig.1 part II)

Values: Patients placed most importance on the severity/burden of their illness and the harms (fear of side effects) of the different treatment options, in relation to their own wellbeing (recovery and quality of life) and that of their relatives.

Clinicians placed most importance on the clinical aspects (diagnosis, symptomatology, and its severity) and the indicated treatments according to clinical guidelines (focused on relieving symptoms and recovery of a patient).

Attitudes: The pros and cons of treatment options and participants' attitudes towards them were an important topic in the FGs. *Table 2* shows the pros and cons of CBT/psychotherapy and medication, mentioned in all focus groups. Most participants said that medication could be an effective treatment: it can reduce suicidal thoughts and makes patients less depressive and more susceptible to CBT/psychotherapy. On the other hand, patients were more negative about possible side effects, expected dependency, and effects of discontinuation. Many patients described medication as a last resort or a "necessary evil".

Clinicians recognized the cons of patients but did not have a negative attitude towards medication in general. They also mentioned the placebo-effect as a positive (side) effect of medication.

In contrast to medication, participants were generally more positive towards CBT/psychotherapy. Psychotherapy was said to offer patients useful skills to prevent relapses. Some clinicians mentioned that CBT/psychotherapy could also have side effects for some patients (such as feelings of distress and undermined self-efficacy). In addition, CBT/psychotherapy was considered to require a certain amount of cognitive capacity of patients.

Table 2 Pros and Cons of available treatments from a patients and clinicians' perspective, mentioned by patients and/or clinicians (X).

TREATMENTS		PATIENTS	CLINICIANS
Medication			
Harms			
- Side effects:		X	X
Weight gain		X	X
Sexual dysfunction		X	x
Change of personality (blunted affect)		X	X
Possible dependency (addiction)		X	X
Sweating		X	X
(Unknown) long term effects on physical development (fertility)		X	
Effects of discontinuation (withdrawal symptoms, relapse)		X	X
Feeling disabled in normal functioning when on medication		X	
- Fear of having to use it the rest of their lives		X	
- Interaction effects with other medication			X
- Contra-indications (other illness, pregnancy)			X
- Tapering costs time, with possible withdrawal and relapse		X	X
- Long build up period, with possible deterioration or even suicidality			X
- Possible medicalization and undermining of autonomy and self-worth		X	X
- Only relieves symptoms			
Benefits			
- Effectiveness:		X	X
Can be very effective,		makes patients	stops suicidal
Works (relatively) fast and easy		feel better,	thoughts and
Makes patients more susceptible to CBT/psychotherapy		stronger, easier to be around.	relieves depressive symptoms.
CBT/Psychotherapy			
Harms			
- Often in groups (most patients are anxious in groups and do not want to deal with problems of others)		X	
- Practical issues			X
Waiting lists		X	
Planning appointments into schedule		X	X
Financial costs			X
Costs energy and time			X
- Requires a certain amount of intelligence, insight, active attitude and motivation		X	X
- Teaches certain coping skills			X
Benefits			
- Can prevent relapse			

Table 3 Influencing factors of the decisional processes of patients and clinicians, regarding the choice of treatment (psychotherapy and/or pharmacotherapy) for depression, anxiety disorders, and obsessive-compulsive disorder.

CATEGORIES		PATIENTS	CLINICIANS
Illness (clinical)	Diagnosis	x	x
	Symptomatology	symptoms	symptomatology
	Severity	perceived need for help	risk, vital signs
	Cause	biological/circumstances	explanatory model
Treatment (clinical)	Cons	mostly side-effects	contra-indications, side-effects
	Effectiveness	experience self/others	according to clinical guidelines
	Other benefits	x	x
	Effect on quality of life	x	
	Personal fit	x	
	Accessibility (planning schedule)	x	
	Clinical guidelines	x	x
	Treatment availability		waiting lists/need to refer
	Evidence Based Medicine	x	x
Patient (personal)	Costs (time/effort/financial)	financial	time/effort
	Background	social/cultural	ethnicity
	Experience with illness	personal	medical history
	Experience with treatment	personal	effectiveness previous treatment
	Perceived cause of illness	x	explanatory model
	Preconceptions about illness and treatment	experience, information from others	misinformation, expectations
	Motivation	extrinsic (for someone else)	intrinsic of patient
	Capacity	due to illness	intelligence and insight
Clinician (personal)	Person	personality traits	personal background
	Knowledge	knowledge, experience	expertise/ knowledge
	Background	social/cultural	education
	Professional experience	profession	professional experience
	Personal experience	age	Professional experience
	Personal agenda	x	x
	Department culture		x
	Steering behavior		x
	Prescribing practice		x
Communication	Patient-clinician relation	seen, treated as a person, trust	constructive treatment relation
	Information /	educational material	information exchange
	Continuity	x	x

X: mentioned by patients and/or clinicians in the FGs, with the same meaning.

Contextual: Patients and clinicians described many factors influencing the decisional process, linked to the context. We grouped them in four categories: ‘patient characteristics’, ‘illness characteristics’, ‘treatment’ characteristics’, and ‘clinician characteristics. Regarding influencing factors, we did not find differences between the patients with anxiety and/or depressive disorders versus OCD. *Table 3* shows an overview of the influencing factors mentioned by participating patients and clinicians.

Half of the participating patients said to have past experience with medication treatment, thus having made the decision to start medication. Important influencing factors in this context were: previous treatment experience, severity of symptoms, treatment recommendation (according to clinical guidelines), and information from and the relation with the clinician. Participating clinicians believed the most important determining factors regarding the treatment chosen were diagnosis and severity of the illness as well as (in)effectiveness of a previous specific treatment. They also said that for any treatment to work, it was important that there was a constructive patient-clinician relation, and that the patient gave informed consent and adhered to the treatment (compliance). Therefore, the treatment chosen needed to be a good fit with the patient’s expectations, experiences, and beliefs regarding ‘causes’ of the illness (explanatory model).

Influencing decision-making constructs:

Treatment Choice, the Patient-Clinician relationship and trust (Fig. 1, part I), uncertainty, weighing and who decides (Fig.1, part II)

During the FGs, additional aspects were discussed that determined the decision-making process and were related to communication, information, values, attitudes, and contextual factors (Fig.1).

The patient-clinician relationship (trust) was very important according to both patients and clinicians, as it determined the quality and effect of the treatment. In addition, patients need to like and trust their clinician (there needed to be a fit), especially when CBT/psychotherapy was the treatment of choice.

Having treatment options and thus choice, emerged as an important theme in all focus groups. Some patients in the mixed PFGs mentioned not having been offered a choice, i.e., only one treatment option was offered, or it was not clear that the patient could be involved in the treatment decision. OCD patients felt they had been offered a clear choice between CBT/psychotherapy and medication, where CBT/psychotherapy was recommended first. Overall, clinicians said that clinical factors (e.g., diagnosis and severity) determined the indicated treatments and that they followed Evidence-Based Medicine and clinical guidelines (see table 3). Perceived previous effectiveness of treatments was also of clinical relevance, as were the departmental culture and availability of a certain treatment (e.g., waiting time for CBT). Additionally, the capacity and motivation of a patient influenced the treatment recommendation of the clinician to the patient.

The role of uncertainty in the decisional process was described by both patients and clinicians. Patients often mentioned that they were unsure about their diagnosis (psychiatric illnesses are vague and cannot be visualized) and the (side) effects of their treatment. Clinicians said that in many cases they also are uncertain what the best treatment will be.

The weighing of all variables was according to most participating patients and clinicians an important aspect of treatment decision-making. Patients weigh what they know and what is important to them against the severity of their symptoms (perceived need for help) and quality of life. Many patients also said that, in the end, they just followed their 'gut feeling'. Participating clinicians said to weigh the effectiveness and side effects of one treatment against those of other treatments for a particular patient (considering patient preferences, but also their own professional experience).

Finally, *who decided* influenced the decisional process and final treatment decision. Patients preferred making the decision together with their clinician, but this was not always the case. Clinicians thought that patients should decide autonomously, although clinicians often steered patients and treatment decisions in the direction of their own preference.

DISCUSSION

Main findings

The results of this FG study on treatment decision-making in patients with depression, anxiety disorder, or OCD in secondary psychiatric care show that the decisional processes of patients and clinicians are characterized by similar key elements and influencing factors (Fig.1). Yet, the meaning, value, and relevance of these factors differed considerably between patients and clinicians: patients placed more importance on personal factors (e.g., values and attitudes, gut-feeling), while clinicians placed more importance on clinical factors (e.g., diagnosis, illness severity, guidelines). Most often, individual perceptions and values of patients and clinicians colored the connotation of factors (individual context). For example, patients based severity on their own perceptions of their illness and perceived need for help, while clinicians based severity on their clinical impression and assessment of symptoms and risks. Furthermore, patients weigh the effective and affective aspects of a treatment against the severity of their symptoms and quality of life, while clinicians weigh the pros and cons of a treatment against those of another treatment.

The fact that psychotherapy, pharmacotherapy, and its combination have been found to be about equally effective for mild to moderate depression and anxiety disorders, might imply there is an equal choice between these treatment options. Our findings suggest otherwise. First, for many patients this choice is not an equal one. To them, the benefits of medication (even in combination with CBT/psychotherapy) do not outweigh its harms, especially compared to CBT/psychotherapy only. In contrast with this, professionals have a less negative attitude regarding medication, and they consider CBT/psychotherapy not suitable for all

patients. As our results show, OCD patients had the same attitudes towards the treatment as patients with depression or anxiety disorders, although they more often were offered a choice between all treatment options. Second, sometimes certain treatments (such as CBT/psychotherapy only) seem not an option, because of clinical and personal experiences of patients or clinicians find this treatment unsuitable. These different perceptions could lead to a discrepancy between a patient's preferred treatment and a clinician's treatment recommendation. As a result, patients may experience limited choice, contributing to less optimal treatment decisions, lower treatment satisfaction, lower adherence, and potentially poorer treatment outcomes.

Comparison to previous literature

Our findings fit other descriptive models of patient decision-making such as the one introduced by Wills and Hovner³³. Following the same key elements, we identified congruent interrelationships, and found similar influencing factors (individual-level variables). In addition to these results, we found that the same model applies to clinician decision-making, although attitudes, values and contextual factors between patients and clinicians may differ. For both patients and clinicians, the context plays an important role in the decisional process, and we were able to identify several contextual factors.

Our findings regarding a preference for CBT/psychotherapy over medication or a general dislike of medication are consistent with the literature on treatment preferences in other psychiatric services and primary care^{9,13,22,26,43–45}. Some authors suggested that this preference against medication may be specific to those suffering from chronic forms of depression. Medication might be perceived as an aid to survive a crisis, but when patients have to use it for a longer time period, some become more ambivalent about medication^{9,45,46}. This is in line with the importance patients in our study laid on the negative influence of it on their quality of life.

Also consistent with the literature, our results showed the importance of patients' experiences with previous treatments and specific characteristics of the treatment modalities^{8,47}. Many of our patients have already experienced (sometimes ineffective or inadequate) treatment in primary or secondary care, which determines their further treatments preferences. Additionally, we found that these experiences influenced the treatment recommendation of the clinician in secondary care. This is in line with results of another study which indicates that previous treatments in primary care were significantly associated with subsequent treatment decisions in secondary care²³.

Strengths and limitations

To our knowledge, this is the first study exploring treatment decision-making for depression, anxiety disorders and OCD for both patients and clinicians in a secondary psychiatric care setting. Most studies have focused on depression and anxiety disorders in primary care, or on severe mental illness (e.g. schizophrenia) in secondary care, and did not investigate

both the patient and the clinician perspective^{13,19–21,44,48}. The results of this qualitative study provide an overview of the most important elements of treatment decision-making and influencing factors (context) in clinical practice and give insight into the decisional processes of both patients and clinicians.

This study also comes with limitations. Although the FGs and analysis of the transcripts were executed by two independent and qualified researchers, participants' and researchers' pre-existing knowledge of the topic may have influenced the conclusions. Since our inclusion criteria required patients to be capable of participating in a FG discussion, only patients with less severe disorders (following the recommendations of patients' attending clinicians) were included. Also, participating patients were possibly, talkative persons, who have a preference for psychotherapy/CBT, which could have biased our results. In addition, some of our eight FGs were rather small. Moreover, clinicians may have selected patients based on their preference for a certain patient, as the recruitment process involved the selection of patients by the clinicians, thus depended highly on the clinicians' limited time and effort³⁵. However, data saturation was attained in both patients' and clinicians' FGs³⁵. It is difficult to draw conclusions about specific differences between patients suffering from a depression, anxiety disorder, or OCD, because we used mixed PFGs. This and the use of a convenience sample from a limited number of sites, could endanger generalizability. Lastly, since the time of our data collection, there have been further developments in PCC and SDM. However, to this date, studies on the decisional process regarding treatment remain limited, and the concepts of PCC and SDM are scarcely implemented in mental health care^{12,49,50}. Therefore, we think that our findings are still relevant for the development and implementation of interventions to improve treatment decision-making.

CONCLUSION

A broad range of factors influence the treatment decision-making process, according to patients and clinicians in secondary psychiatric care. Although seemingly overlapping, many of these influencing factors are of different value for patients and clinicians. This can lead to different attitudes towards treatments, different treatment- and decision-making preferences, and eventually to a discrepancy between what a patient wants (or expects) and what a clinician (can or will) offer, and thus choice. Having a choice is essential in treatment decision-making. Building a good patient-clinician relationship with trust, and creating choice awareness (i.e., make clear to patients that there are two or more relevant options, where having no treatment can also be an option [47]) can further improve communication. Such collaborative decision-making may integrate the decisional processes of patients and clinicians and optimize treatment decisions.

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

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ETHICAL DECLARATIONS

Funding

This research was funded by the mental health care provider GGZ Rivierduinen

Conflict of interest

The authors declare that they have no conflict of interest.

Ethical approval

All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards. The trial has been approved by the Medical Ethics Committee of Leiden University Medical Center (P12.003).

Informed consent

Informed consent was obtained from all individual participants included in the study.

SUPPLEMENTARY MATERIAL

Appendix A. Interview Guide Focus Groups

PATIENTS:

Opening round: "Did you feel you had a choice regarding your treatment and why?"

Treatment options

I) Knowledge and attitudes

- What do you think about the available treatment options (i.e. medication and/or CBT/ psychotherapy) for your complaints?

II) Preferences

- Personal preferences for medication and/or CBT/psychotherapy.
- Personal opinion on the different treatments (harms and benefits).
- Ideas about treatment preferences of professionals (treatment provider).

Decision-making process

III) Forming treatment preferences

- Factors determining/influencing own preferences. (values)
- Ideas on factors influencing preferences of professionals (treatment providers).

IV) Making treatment decisions

- The way (process) final decisions are made (who makes the final decision, did you feel there was a choice).
- Factors influencing own decisions. (values)
- Ideas on factors influencing decisions of professionals (treatment providers).

CLINICIANS:

Opening round: introduction

Treatment options

I) Knowledge and attitudes

- What do you think about the available treatment options (i.e. medication and/or CBT/psychotherapy) for depression, anxiety disorders and OCD?
- Personal treatment preferences for medication and/or CBT/psychotherapy.
- Personal opinion on the different treatments (harms and benefits).

II) Preferences

- Ideas about own treatment preferences.
- Ideas about the treatment preferences of patients.

Decision-making process

III) Forming treatment preferences

- Factors determining/influencing own preferences. (values)
- Ideas on factors influencing preferences of patients.

IV) Making treatment Decisions

- The way (process) final decisions are made (who makes the final decision).
- Factors influencing own decisions. (values)
- Ideas on factors influencing decisions of patients.

Appendix B: Codebook Focus groups

Level 1	Level 2	Level 3 (4)
A Decisions		
	A.1 Decision Making Process (DM)	A.1.1 Aspect Decision Making
		A.1.1.1 Discussion/Negotiation
		A.1.1.2 Weighing
		A.1.1.3 Explanation model
		A.1.2 DM in Clinical Practice
	A.2 Who decides	A.2.1 Patient
		A.2.1.1 Patient makes decision
		A.2.1.2 Noncompliance/ drop out
		A.2.1.3 Motives for compliance
		A.2.2 Clinician
		A.2.2.1 Clinician makes decision
		A.2.2.2 Steering Clinician
		A.2.3 Together
B Preferences		
	B.1 Formation of Preferences	B.1.1 Pre-consultation
		B.1.2 Intra-consultation
		B.1.3 Post-consultation
	B.2 Preference Patient	
	B.3 Preference Clinician	
C Information	C.1 Content	
	C.2 Communication	
D Values		
E Context		
F Factors	F.1 Patient	F.1.1 Patient Characteristics
		F.1.1.1 Ethnicity
		F.1.1.2 Age
		F.1.1.3 Gender
		F.1.1.4 Social status
		F.1.1.5 Personality (coping style)
		F.1.1.6 Intelligence

- F.1.1.7 Illness Insight
- F.1.1.8 Capacity
- F.1.1.9 Attribution
- F.1.1.10 Background/ values
- F.1.1.11 personal environment
(family/friends)
- F.1.1.12 Previous experiences
with treatment
- F.1.1.13 Knowledge of treatment
- F.1.1.14 Bias/ preconceptions
medication
- F.1.1.15 Experience (versed)
- F.1.1.16 Assertiveness
- F.1.1.17 Expectations

F.1.2 Treatment preference

- F.1.2.1 Medication
- F.1.2.2 CBT
- F.1.2.3 Combination
- F.1.2.4 No preference

F.1.3 Decision making preference

- F.1.3.1 Shared Decision making
- F.1.3.2 Follow patient wishes

F.1.4 Decisions

- F.1.2.1 Medication
- F.1.2.2 CBT
- F.1.2.3 Combination
- F.1.2.4 No preference

F.2 Factors Clinician

F.2.1 Characteristics Clinician

- F.2.1.1 Personal agenda
- F.2.1.2 Experience
- F.2.1.3 Attitude/ working style
- F.2.1.4 Uncertainty
- F.2.1.5 Department culture
 - F.2.1.5.1 hierarchy
 - F.2.1.5.2 team communication
 - F.2.1.5.3 discussion psychiatrist-
psychologist
- F.2.1.6 Experience (versed)
- F.2.1.7 Knowledge of treatment
(expertise)

F.2 Factors Clinician (cont.)

F.2.1.8 Prescribing practice

F.2.1.9 Steering behaviour

F.2.2 Treatment preference

F.2.2.1 Match preference/wishes patient

F.2.2.2 Weighing pro's and cons

F.2.3 Tasks Clinician

F.2.3.1 Diagnostics

F.2.3.1.1 Obtaining info

F.2.3.1.2 Reconsruction illnes

F.2.3.1.3 Explanation model

F.2.3.2 Providing information

F.2.3.2.1 Provision of information

F.2.3.2.2 Explaining illness

F.2.3.2.3 Discussing progression

F.2.3.2.4 Discussing pro's/cons

F.2.3.2.5 Explain treatment options

F.2.3.2.6 Giving treatment advise

F.2.3.3 Giving treatment

F.2.3.3.1 Constructive relation

F.2.3.3.2 Building trust

F.2.3.3.3 Giving advise

F.2.3.3.4 Formulating goals

F.2.3.3.5 Continuous adaptation

F.2.3.3.6 Evaluation/ check effects

F.2.3.4 Communication

F.2.3.4.1 Negotiate

F.2.3.4.2 Enticing

F.3 Factors Illness

F.3.0 Diagnosis

F.3.0.1 Depressive disorder

F.3.0.2 anxiety disorder

F.3.0.3 Psychotic disorders

F.3.1 Characteristics Illness

F.3.1.1 Symptomatology

F.3.1.2 Severity

F.3.1.2.1 Vital signs

F.3.1.2.2 Perceived need for help

F.3.1.3 Etiology/ explanation model

- F.3.1.3.1 Biological cause
- F.3.1.3.2 Psychological cause

F.4 Factors Treatment

F.4.0 Treatment Options

- F.4.0.1 CGT
- F.4.0.2 Medication
- F.4.0.3 Combination
- F.4.0.4 Other

F.4.1 CGT

- F.4.1.1 Characteristics CGT
 - F.4.1.1.1 works preventive
 - F.4.1.1.2 locus of control with patient
 - F.4.1.1.3 more expensive
 - F.4.1.1.4 requires homework
 - F.4.1.1.5 requires more effort of clinician
 - F.4.1.1.6 requires more time to full recovery
 - F.4.1.1.7 costs more energy / time
 - F.4.1.1.8 effects last longer
 - F.4.1.1.9 requires more effort patient
 - F.4.1.1.10 need to refer
 - F.4.1.1.11 effects in other area's
- F.4.1.2 Cons CGT
- F.4.1.3 Pro's CGT
- F.4.1.4 Requirements CGT

F.4.2 Medication

- F.4.2.1 Characteristics Medication
 - F.4.2.1.1 Effectiveness, easy and quick
 - F.4.2.1.2 Effectiveness, takes time to work
 - F.4.2.1.3 Effectiveness, relieves symptoms
 - F.4.2.1.4 Effectiveness, no effect after stop
 - F.4.2.1.5 Placebo effect

- F.4.2.1.6 Side effects
 - F.4.2.1.6.1 Withdrawal effects
 - F.4.2.1.6.2 Sexual dysfunction
 - F.4.2.1.6.3 Kinetic disorders
 - F.4.2.1.6.4 Weight gain
- F.4.2.1.7 Dependence
- F.4.2.1.8 Less effort for clinician
- F.4.2.1.9 Less effort patient
- F.4.2.1.10 Makes CBT possible
- F.4.2.1.11 Legitimation of illness
- F.4.2.1.12 Undermines intrinsic motivation
- F.4.2.1.13 Medicalization illness
- F.4.2.1.14 Externalization illness
- F.4.2.2 Cons Medication
- F.4.2.3 Pro's Medication

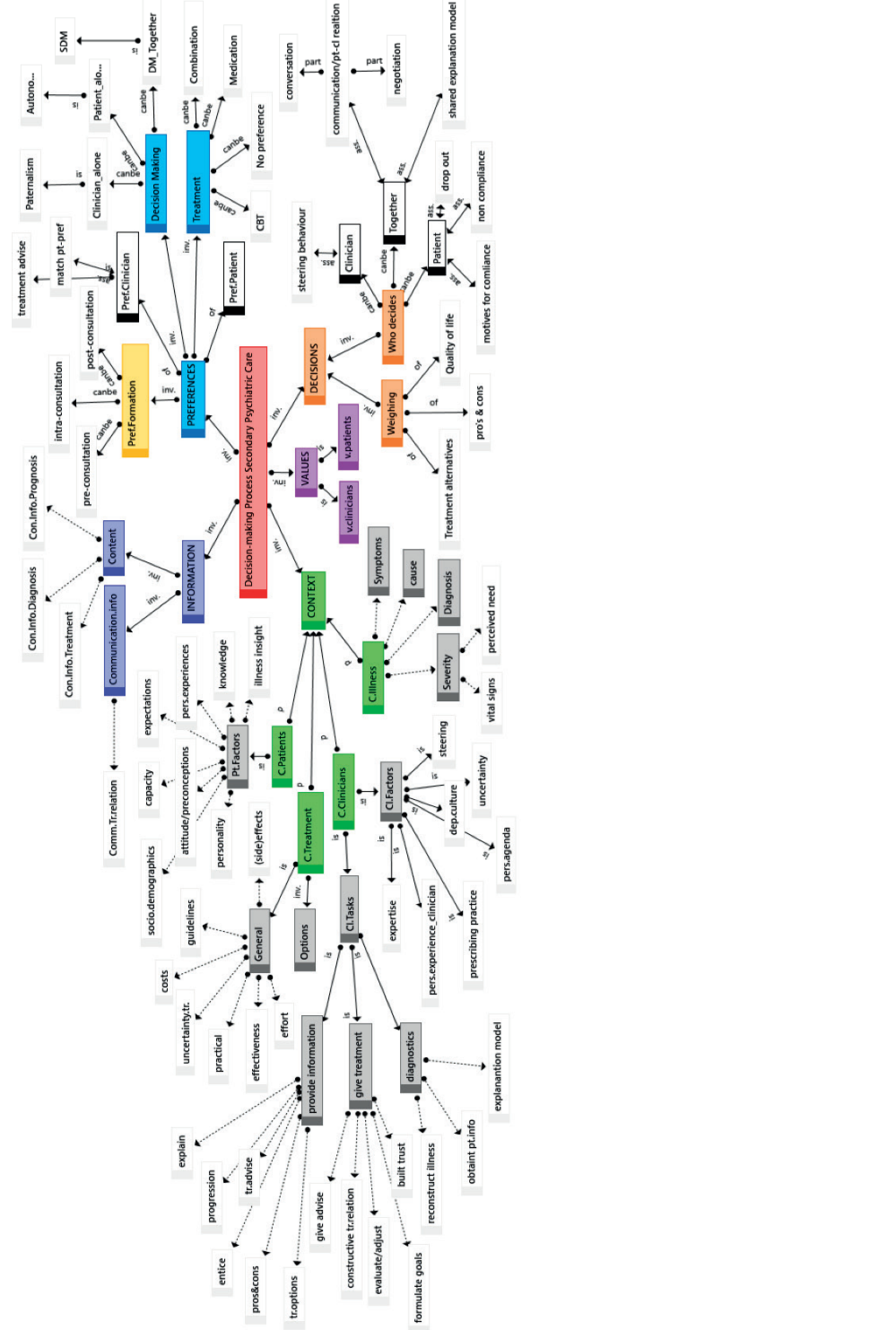
F.4 Factors Treatment (cont.)

F.4.3 Combination therapy

- F.4.3.1 Characteristics
 - Combination
 - F.4.3.1.1 Holistic approach
- F.4.3.2 Cons Combination
- F.4.3.3 Pro's Combination

F.4.4 General Characteristics Treatment

- F.4.4.1 Options
- F.4.4.2 Indication
- F.4.4.3 Practical aspects
- F.4.4.4 Availability
- F.4.4.5 Treatment effect
 - (effectiveness)
- F.4.4.6 Legislation
- F.4.4.7 Guidelines
- F.4.4.8 Financial costs (insurance)
- F.4.4.9 Logistics
- F.4.4.10 Evidence based
- F.4.4.11 Patient-clinician
 - relationship
- F.4.4.12 Uncertainty



Appendix D: Supporting Quotations

Box a. Communication

"I am all for a dialogue, in liaison with your clinician. It is about the input you provide; they can work with that." (PFG RD Resp.6)

"The difficulty is, that diagnostics and treatment can hardly be separated. During the first consultation you need to compromise, create trust, that is more than just getting information, other factors play a role." (CFG Psych. Resp. 1)

Box b. Information/Knowledge

"I would like to know what they are going to do, because I have not started yet and I am not sure what exactly is understood by behavioral therapy" (PFG OCD Resp. 5)

"It is also important that the clinician, at least takes into account evidence-based medicine and stays up to date with regard to the latest guidelines and is able to inform the patient about this." (CFG Res. 1)

Box c. Preferences

"But there is not always one preference better than the other right? Then, you should be able to choose the treatment that suits you." (PFG OCD Resp. 1)

"Knowledge in general, knowledge helps and experience. For instance, I have less experience with interpersonal therapy (IPT) than with CBT and I tend to go for CBT because of that." (CFG Psych. Resp. 4)

Box d. Decisions

"For me, it started with the choice, what do you want? We talked about that, what the pros and cons were. She [clinician] left it up to me, so not really an advice what I should do, I was allowed to make my own choice." (PFG OCD Resp. 1)

"Recurrence, severity, familial, fails or successes of previous treatments, these are important criteria". (CFG Mixed Resp.3)

Box e. Values and Attitudes

“I felt it was too easy. You want to try to solve it yourself and it felt like the easy way to take medication before I tried the other options.” (PFG OCD Resp.2)

“Clinicians discard that too easily, I think, “it is just gaining weight”, it is a big deal when you gain 10-20 kg.” (CFG Ther. Resp. 4)

Box f. Contextual factors

“It does feel as a sacrifice every time, another few hours off work” (PFG OCD Resp. 2)

“When we prescribe medication, we can treat patients ourselves, when we prescribe CBT we have to refer. I see referral as a disadvantage, it is customer-unfriendly and often patients are put on a waiting list.” (CFG Res. Resp.6)

Box g. Having treatment options and Uncertainty

“The options are offered by clinicians, that know about it, preferably not too many options, but at least an option. You need to be able to trust your clinician. It is a complex matter; you cannot do it all by yourself that is the problem. (PFG RD Resp. 2)

“I find it disappointing that it is difficult to predict what will be the best treatment for an individual.” (CFG Mixed Resp.5)

Box h. Weighing and who decides.

“Weighing everything, 123 and hope for the best, you try to think it all over, do it in a cognitive matter, but in the end it is on good luck, because you really don’t know” (PFG LUMC Resp. 2)

“In most cases, we, clinicians, make a proposal and the patient agrees, I think.” “It is a continuum, but a lot depends on the persuasiveness of the clinician, I think.” (CFG Psych. Resp. 2)

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