ORIGINAL RESEARCH

Depressed patients' preferences for type of psychotherapy: a preliminary study

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Background: The treatment recommendations for depressed patients by the American Psychiatric Association encourage a focus on the patient's preferences. The focus of this study was the preference of depressed inpatients for the type of psychotherapy.

Methods: Twenty-nine subjects of both sexes who were hospitalized with a major depressive episode were interviewed at 5-day intervals with the same questions after the depressive episode resolved, as indicated by a score less than 7 on the Hamilton Depression Rating Scale (HDRS). The selection of items was performed by expert consensus.

Results: The supportive psychotherapy scores were the highest, followed by psychodynamic psychotherapy and cognitive behavioral therapy. The two sessions conducted at 5-day intervals showed no significant difference, which reflected the stability of choices and preferences of patients.

Conclusion: In this study, the patients preferred supportive psychotherapy as first-line therapy compared to psychodynamic psychotherapy and cognitive behavioral therapy.

Keywords: depression, depressive disorder, psychodynamic psychotherap, supportive psychotherapy, cognitive behavioral therapy

Introduction

The recommendations for the treatment of depressed patients by the American Psychiatric Association encourage a focus on the patient's preferences.[1] If this recommendation is followed, a small but beneficial therapeutic effect occurs if patients receive the treatment they prefer.[2] The results of a meta-analysis conducted to compare the effectiveness of various forms of psychotherapy in the treatment of depression did not show overall differences.[3] We know that the preference for type of psychotherapy and antidepressant treatment depends on the patient's beliefs and perceptions about the nature and characteristics of their treatment.[4] There are, to our knowledge, few studies focused on a patient's choice of psychotherapy.[5,6] Psychotherapy includes various types, including Internet psychotherapy; psychotherapy from artificial intelligence; personal development books focused on patient education; conventional forms of psychotherapy such as cognitive psychotherapy; and dynamic, interpersonal, or supportive therapy.[5,7] For example, Berle et al made a significant contribution to the issue of patient preferences for treatment or therapy delivered face-to-face or via the Internet. In the study, the survey asked respondents to rate their preferences for five forms of therapy delivery: individual face-to-face therapy, group face-to-face therapy, bibliotherapy (where therapy is exclusively provided by means of books and reading materials that are posted to patients), online therapy without therapist contact, and online therapy with weekly therapist phone contact.[5]

The assessment of patient preferences is extremely heterogeneous, and studies have used both preference and attitude questionnaires,[7,8] with descriptions of various forms

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of psychotherapy.[9] Finally, psychotherapy types, in terms of their framework and processes, including their technical nature, can be difficult for patients to understand.

The objective of this preliminary study was to define psychotherapy preferences to simplify the essential concepts, technical aspects, and goals for improvement. Our intent is to allow patients to choose a psychotherapy that is adapted to their difficulties in the context of depression.

Methods

Ethical aspects

All patients provided informed consent and agreed to answer a list of questions, many of which are usually informally asked in clinical interviews. Based on this context, the institutional ethics committee of CHU-Toulouse determined that approval was not necessary.

Population

The inclusion criteria were as follows: over 18 years of age, diagnosis of major depressive disorder (according to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* [*DSM-IV-TR*] criteria),[10] a history of at least one major depressive episode, and current hospitalization in a psychiatric department.

The exclusion criteria were as follows: incapacitation, neurological disorders, and psychotic disorders.

Patients were selected from the Psychiatry Department of the University Hospital of Toulouse (Toulouse, France). Once sufficient clinical improvement (Hamilton Depression Rating Scale [HDRS] <7) was observed, the patient was asked the questions at 5-day intervals to prepare for treatment as an outpatient.

Depression was diagnosed with the Mini International Neuropsychiatric Interview questionnaire (based on *DSM-IV-TR* criteria).

Twenty-nine subjects of both sexes who were hospitalized with a major depressive episode were interviewed at 5-day intervals with the same questions after the depressive episode resolved, as indicated by a score less than 7 on the HDRS. We chose 7 as the cutoff value for the 17-item HDRS because, according to Zimmerman et al[11] this is the likely threshold of remission of clinical signs.

Patients did not receive any of the three types of psychotherapy.

Psychotherapy questions

The questions were generated by an expert psychiatrist panel and were based on the work of Gabbard.[13] No scales or validated psychotherapies are currently available in France.

For this reason, the items were written by psychiatrists who are experts in the fields of supportive, psychodynamic, or cognitive behavioral psychotherapy. The questions were developed in French.

The selection of items was performed by expert consensus. For each question, the possible answers were as follows: "very unattractive", "uninteresting", "moderately attractive", "interesting", and "very interesting". Thus, the patient responses followed a scale ranging from 0 to 4.

Regarding cognitive behavioral therapies, we included items related to thought and emotion patterns, including "analysis of attitudes", "reactions", and "behavior".[12] "Various conflicts in the work environment" and "defining personality or character problems" were important factors to analyze.[13] Anticipating difficulties and considering an appropriate course of action to respond to the daily pitfalls is important. An example question for cognitive behavioral therapies was "Are you willing to discuss subjects that question oneself, such as one's attitudes, behaviors and reactions?"

Psychodynamic psychotherapy

The items included "parent relationships" in reference to oedipal concepts, "identity evidence about self-image", and "aspects of the ideal self". The questions on feelings of personal inadequacy were based on the ideal concept of the self. The perception of needing to do more or a negative image of oneself indicated narcissism. Examples of questions for psychodynamic psychotherapy were "Do you want to discuss the highly difficult or traumatic events you have experienced?" and "Do you want to discuss evidence about your self-image?"

Supportive psychotherapy

This section included questions related to "the relationship between the couple", "transitions in various life situations", "the development of conflict", "thinking about the attitude of children or relatives in reference to the person", and "the fact we can develop or talk about these difficulties". Examples of questions for supportive psychotherapy were "Do you want to discuss the fact that we can talk about these difficulties?" and "Do you want to discuss your relationship as a couple?"

The three types of psychotherapy proposed here (psychodynamic psychotherapy, supportive psychotherapy, and cognitive behavioral therapies) are those that are most commonly proposed in France.

Statistical analyses

This is a nonrandomized preliminary study. We did not calculate the number of subjects required to obtain sufficient

statistical power, because there are no similar studies to use as a basis for such a calculation. Therefore, we recruited patients with the inclusion criteria in a given time.

The validity of the questions was assessed using Cronbach's alpha. When different items are used, it is important that all items assess the same aspect and, thus, are correlated. This correlation was assessed by Cronbach's alpha. The Cronbach's alpha coefficient for all items was 0.91; that for items intended to be used for the psychodynamic psychotherapy was 0.82; that for items intended to be used for cognitive behavioral therapy was 0.75; and that for items intended to be used for supportive psychotherapy was 0.82.

A score was calculated based on the variables for each specific form of psychotherapy. The three scores corresponded to three quantitative variables that were analyzed using means and standard deviations. The reproducibility of these three variables was studied by first calculating a correlation coefficient (ranging from −1 to +1, indicating a strong and positive correlation if the coefficient was close to 1 and a strong and negative correlation if the coefficient was close to −1). We used a test to determine if the coefficient was significantly different from 0.

Results

The 29 eligible subjects completely responded to the test items at each assessment.

The sample comprised 16 women and 13 men. The average age of the participants was 47.3 years.

All patients presented at least one prior major depressive episode. They showed no associated pathologies, and in particular no neurological pathologies, which was one of the exclusion criteria. No patients had previously undergone a psychotherapy session.

Three scores corresponding to the preferences (Table 1) for cognitive behavioral therapy, psychodynamic psychotherapy,

or supportive psychotherapy were obtained. These three scores corresponded to three quantitative variables that were analyzed using means and standard deviations. The supportive psychotherapy scores were the highest, followed by psychodynamic psychotherapy and cognitive behavioral therapy. The two sessions conducted at 5-day intervals showed no significant difference, which reflected the stability of choices and preferences of patients.

Discussion

The purpose of this preliminary study was to specifically address themes or concepts belonging to three of the most used psychotherapies for depression. The focus of this study was to find a specific psychotherapy preference and not to evaluate the elements of the psychotherapies.

As evidenced by preference for supportive psychotherapy during a depressive episode, patients feel the need to reflect on various themes that include relational aspects and consequences of life events. High scores indicate the importance that subjects attach to these themes, and because they prioritize therapy in relation to other matters, more guidance, teaching, and conflict resolution are needed.

Cognitive behavioral therapy appeared to be the least preferred by patients. However, this finding may be due to the complicated representation of this therapy perceived by patients. Also, the included patients had no previous experience with psychotherapy and were not familiar with the processes and goals of cognitive behavioral therapies. This may partly explain their hesitation toward receiving these types of therapy.

This study had some limitations, including a small sample size which caused low power. We could not include outpatients, as one of the inclusion criteria was current hospitalization.

Patients were hospitalized and had other psychiatric comorbidities. Several of the items assessed may relate to more than one form of psychotherapy in terms of personality,

Table 1 Evaluation of patients' choice of psychotherapies

Psychotherapy	Mean ± standard deviation	Minimum–maximum	Correlation coefficient (Pearson's)	P-value
Psychodynamic psychotherapy score				
Time 1 (day 0)	18.6±6.43	7–34	0.90	<0.0001
Time 2 (day 5)	19.2±6.21	10–33		
CBT score				
Time 1 (day 0)	10.2±4.13	4–19	0.78	<0.0001
Time 2 (day 5)	10.5±4.03	4–17		
Supportive psychotherapy score				
Time 1 (day 0)	25.6±8.56	11–50	0.93	<0.0001
Time 2 (day 5)	26.4±9.22	11–50		

Abbreviation: CBT, cognitive behavioral therapy.

relationships with others, parental influence, and conflicts. These concepts are used in different forms of psychotherapy and are not absolutely specific to one form.

There was selection bias of the items because the expert panel only comprised psychiatrists. However, the choice of words was based on the literature.[13]

Preference for one form of psychotherapy is often influenced by the training and theoretical guidelines of the therapist, the geographic availability of a particular form of psychotherapy,[7] and the patient's subjective perception of their needs. However, the true construction of a therapeutic working alliance requires the patient and therapist to agree on the goals of care. By not precisely defining specific preferences, the relationship may become a surface alliance that does not result in therapeutic adherence.

Future studies should distinguish whether patients' preferences vary among various conditions, including unipolar depression, bipolar disorder, and depression with comorbidities, or various ages.

Conclusion

According to our knowledge, this study is the first to evaluate patient choice for the type of psychotherapy in depression treatment. In this study, the patients preferred supportive psychotherapy as first-line therapy compared to psychodynamic psychotherapy and cognitive behavioral therapy. The consideration of the patient's choice is essential for effective therapy.

Disclosure

The authors report no conflicts of interest in this work.

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