

Depression and Psychological Treatments: Who are the expert voices?

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Introduction: Depression is one of the most prevalent diseases among the adult population in Chile, being part of the Explicit Health Guarantees in our country. Their care involves psychiatric and psychological approaches with high costs for the public sector, which do not always manage to ensure the effectiveness of the treatment.

Method: A literature review to document studies on the perspective or opinion of patients undergoing treatment for depressive symptoms. Results: Various sources indicate the benefits of integrating the patient's perspective into treatment, with higher success rates compared to traditional intervention models.

Conclusions: We highlight the role of the patient and their experiences as one of the fundamental pillars of successful treatment. With this, efforts aimed at improving the

coverage and effectiveness of treatment plans for depression would be favored by considering the formulation of clinical models or guidelines where the voice of the patient and their needs are recognized.

Keywords: Depressive Disorder, Treatment Outcome, Patient Involvement, Primary Health Care.

Depression in Chile and its Treatment

Depression is a disease of multifactorial origin, with a heterogeneous clinical presentation, characterized by the degree of dysfunction it may cause and the high social cost involved¹. Depression is also one of the most common public health problems and with the highest burden of disease-associated worldwide². In Chile, almost a third of the population has had a psychiatric disorder throughout their lives, with a 22.2% incidence during the last 12 months. Within this group, depression appears as one of the illnesses with the most significant presence in the adult population, with a life span incidence of 9.2% and 5.7% within the last year³. Similarly, the Pan American Health Organization (PAHO) indicates that the prevalence of depressive symptoms in the Chilean population is 15.8%, with a more significant presence in lower-income sectors and particularly among women⁴, with figures doubling for the latter group¹.

Primary healthcare services (PHC) in our country have reported a life span prevalence of major depression of 23.6% and 10.9% during the last year⁵. Within this group, 42.2% of patients present some comorbidity with chronic illnesses⁶.

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Depression, along with generating high costs to the health system, also involves significant psychosocial deterioration, being one of the most frequent GES (Explicit Guarantees in Health) benefits⁷. The public system offers coverage to around 70% of the population, especially to greater vulnerability areas, senior citizens, and a greater burden of illnesses^{8,9}.

In our country, one of the numerous efforts to increase the coverage of the system is the development of specific clinical guidelines, which establish directives for the approach and treatment of both pharmacological and psychotherapeutic aspects^{7,10}. In the case of depression, these guidelines propose a care model characterized by being the first line of intervention in the primary care setting. The objective of this model is to be decisive in as many cases as possible and to promote collaborative work as part of a high-demand level of care that not always manages to provide timely coverage to all cases^{10,11}.

As part of the professional work, any treatment for depression starts with a physician's screening (not a specialist), who, according to the symptomatic intensity of the patient, prescribes drugs and refers to a psychologist from the CESFAM (Family Health Center), or refers to COSAM (Mental Health Clinic), the latter being a more specific level of secondary care^{7,10}. This is how most clinical interventions in the public system are based on international guidelines aimed at managing the symptoms of depression, where the intervention's success is understood as the attenuation of depressive symptoms and the return to activities usual.

Nevertheless, in the national depression program, there would be some difficulties at the PHC level in detecting depressive disorders and their severity. It has been observed that this is associated with an increased risk of non-response to treatment, chronic or recurrent clinical

pictures, and more significant functional disability¹². Seeking to address these difficulties, it is necessary to explore and evaluate other aspects of the treatment that could influence their effectiveness, which is also a new contribution to current clinical models and guidelines.

The Patient's View

From the patients' perspective, it is possible to find various aspects that are not always considered when proposing treatments, which usually arise from scientific studies and the clinical opinion of experts¹³. This seeks to relieve the patients' perspective and experience, who can offer a different approach to the study of the treatments they themselves receive. Especially when this perspective seems not to be fully covered in the expert planning of the clinical guidelines, which also do not clearly indicate which intervention is more convenient in each case¹³.

Ignoring the patient's opinion often results in cases that do not receive the minimum care required; they tend not to improve, have more relapses, and increase costs for the health system, not only in economic but also psychosocial terms¹⁴. This adds value to the patient's expertise regarding their experience of the illness, especially when discussing and planning healthcare policies.

Indeed, scientific evidence does not always translate into therapeutic success. The same happens with the feeling of well-being and improvement of patients. A systematic review shows how different studies converge on what some of the problems that patients encounter in their treatment for depression are: little continuity in the sessions, difficulty to feel interpreted by the clinical guide, scant communications with caregivers, and confusion in interventions that often follow contradictory indications¹³.

Other reviews have also observed that

patients often reject interventions due to unfavorable attitudes towards drug use or involvement in psychotherapeutic processes¹⁵. Consequentially, ignoring the preferences and opinions of the patient could affect, for example, adherence to treatment and its success (16). Moreover, including patients in decision-making has been shown to significantly improve their treatment outcomes¹⁷.

A study on the abandonment of depression treatment in primary care in Chile, from the perspective of patients, raises as central aspects of desertion: beliefs about depression as a disease, dissatisfaction with psychological care, negative perception of pharmacological treatment, low availability of hours in the healthcare center, interruption of care in the healthcare center, difficulties in attending the healthcare center, perception of improvement, and forgetting appointments¹⁸. The authors propose the latter as an indicator of low perception of need or relevance of the treatment. It is also important to note that, in this study, most of the people interviewed did not consult in the first instance due to a depressed mood. All the above, in addition to the difficulties in understanding the treatment received and its consequences, make it even more challenging to make sense of the process as something necessary and important.

Similar studies in our country indicate that many of the problems described by patients are the difficulty of access, infrequent sessions, lack of caregiver continuity, very short sessions, insufficient attention to personal problems, and excessive interest in knowing the symptoms^{11, 19}. Additionally, the perception of little flexibility in the allocation of care hours and long waiting times become substantial barriers to treatment access¹. In this context, many times, the assessment that patients make of their treatment does not always coincide with that of their caregivers, who tend to

place emphasis on following indications rather than addressing the problems that the patient experiences. This is characteristic of the symptomatic medical model that does not contemplate a motivational perspective in the treatment of the patient²⁰.

Different studies show how patients who participate in decisions about their treatments become more involved in self-care awareness and are more empowered in their recovery^{15, 17}. Likewise, patient groups often appear as a support network for people with pathologies that, from a medical-professional perspective, do not achieve good adherence to conventional treatments, including depressive disorders^{21, 22, 23}.

In the case of depression, several successful experiences with approaches that integrate the patient's perspective during their preparation and implementation have been described worldwide. This adds a realistic look to the therapeutic work that considers the patient's "expertise" in formulating the problem and the solutions offered^{24, 25}. On the other hand, the attitudes and behaviors of doctors and health professionals also contribute to adherence and patient satisfaction, especially the concern to communicate the indications for treatment effectively¹⁸.

Communication and dialogue between professionals and patients: Listening to all voices.

When a fluid dialogue between the treating team and the patients is achieved, better results are usually obtained. This is reflected in a decrease of symptoms and the strengthening of interpersonal relationships and the feeling of well-being. Positive communication is the first element of effective treatment^{26, 27}. On the other hand, the optimism of both the patient and caregiver and the initial reduction of symptoms are fundamental conditions

for a successful treatment. However, when the health system is confusing, the caregivers are distant and fail to establish a sincere and empathetic dialogue with the patient, and the treatments show a marked tendency to fail²⁸.

Since the last century, it has been documented that the attributes that most favored collaborative work between patients and therapists for depression have been: a) the copying of problem-solving stress (modeling), b) own adjustments of the therapeutic relationship (feeling), c) social support of feeling helped, and d) closeness attributes of the therapist (treatment, gestures, and genuine attention)²⁹. These aspects often arise from the dialogue with patients after their therapies and not as strategies or objectives previously defined as part of the treatment. In this line, positively valued post-treatment aspects are the closeness of the therapist, concern, time, and disposition^{30, 31}. On the other hand, among the aspects most criticized by patients are the differences in perspective between professionals of the treating team, biases against the use of drugs over psychotherapy (or vice-versa), the feeling of not being heard, and of receiving standard treatment that does not suit their needs³².

Final Discussion: Uniting Expertise

The various causes of mental health problems and mental disorders extend beyond individual characteristics (such as the ability to manage thoughts, emotions, behaviors, and interactions with others), including also social, cultural, economic, political, and improvement³³. Therefore, mental health interventions should be capable of incorporating the complexity of each case to design more effective and relevant interventions. In this task, those who best know the intricacies of contextual realities are the patients themselves.

All of this should lead us to admit

the importance of listening to multiple experiences and voices when making decisions. It is important that the experiences of all those involved are understood when conceptualizing the disease and defining its therapeutic approach. However, in this process, the patient's voice is usually not sufficiently heard. This, despite evidence that shows how active patient participation and dialogue are elements that often favor the success of treatments. The foregoing also contributes to psychotherapy, which is part of the treatment offered for depression, establishing a better connection between patient and therapist, opening the way to intervention models closer to motivational and participatory, moving away from the rigid perspective and protocols that are often promoted by clinical guidelines. Although the latter are tools that have proven to be useful for deciding courses of action at the level of public health policies, they do not ensure the success of any treatment, so looking for new contributions that help improve the user experience of the system audience will always be valuable. This essay intends to remind and rescue the importance of the personal experience of those who suffer from disease when treating it²⁰.

There are multiple therapeutic offerings for the treatment of depression. In all of them, the doctor-patient relationship is key to the success of the therapy, as is the communication between professionals on the treating team. With the above, it is reasonable to maintain that, based on good treatment for depression, it is essential to install a holistic understanding of the disease, understanding not only its physical but also socio-emotional components, recognizing the patient's voice as another pillar in the treatment of depression.

This proposal is accompanied by a series of challenges, among which are integrating the opinion of patients in the preparation of treatment plans, in addition to improving

the training and education of therapists as part of the transition to a more complex model, but also more complete.

Finally, as health professionals, it is essential to stay vigilant about the way in which the population and its needs evolve over time, along with understanding that treatments not only require adapting to the possibilities of the system but also to the needs of people.

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