Table 3: Age at first contact, gender, number of admissions and type of disorder (depressive or bipolar disorder) in relation to the values of the four components of the Mood Stabilizer Compliance Questionnaire.

	Perceived doctor-patient relationship Component 1	Positive beliefs on Mood stabilizers Component 2	Preserved Autonomy: general Component 3	Preserved Autonomy: dosing of mood stabilizers Component 4
	B (95 % CI)	*B* (95 % CI)	*B* (95 % CI)	*B* (95 % CI)
Age	-0.010 (-0.02 – 0.004)**	-0.010 (-0.02 – 0.005)**	-0.015 (-0.02 – 0.005)**	-0.003 (-0.009–0.002)
Female gender	-0.19 (-0.41–0.03)	-0.01 (-0.23–0.20)	0.14 (-0.11–0.38)	-0.03 (-0.11–0.16)
Number of admissions	-0.006 (-0.076–0.064)	-0.008 (-0.08–0.06)	0.003 (-0.06–0.08)	0.007 (-0.04–0.05)
Depressive versus bipolar disorder	-0.18 (-0.41–0.04)	-0.20 (-0.42–0.02)	0.02 (-0.22–0.26)	-0.03 (-0.17–0.10)

* $P \leq 0.05$ ** $P < 0.01$
All variables were included at the same time in the multiple regression models.

Table 3 presents results from multiple regression analyses with component 1, 2, 3, 4 as outcome, respectively, and with inclusion of gender, age at first contact, number of admissions and type of disorder (depressive versus bipolar disorder) as predictive variables. As can be seen, age at first contact was negatively associated with all four components (higher age associated with lower score), however not significantly with component 4 (B = -0.003, p = 0.2). There were no significant associations between any component and gender, number of admissions or type of disorder (depressive disorder versus bipolar disorder). Including further a variable of educational level (dichotomised as primary school versus high school) did not change the results substantially, although age only was marginally associated with component 3 in this model (B = -0.009, p = 0.07). In these models, educational level was significantly and positively associated with component 3, only (B = 0.40, p = 0.002).

The above mentioned multiple regression models were repeated including further the variable describing the type of current doctor during outpatient treatment (general practitioner, private psychiatrist, community psychiatry doctor, hospital doctor, other doctor). There were no significant associations between any of the scores and type of doctor ($p > 0.05$).

4. Discussion

The most consistent finding in the study was that among patients discharged from hospital with depressive or bipolar disorders, older patients consistently had a more negative view on the doctor-patient relationship (Component 1), a more negative view on mood stabilizers (Component 2) and more non-correct views on the effect of mood stabilizers (Component 3). Further, adjusting for differences in age, there were no differences between patients with depressive and patients with bipolar disorder in any component. There was no difference in the attitudes and beliefs according to the number of psychiatric hospitalisations or according to the type of the current doctor (general practitioner, private psychiatrist, community psychiatry doctor, hospital doctor, other doctor).

Although the major proportion of patients with depressive disorder and as well as with bipolar disorder agreed on the diagnosis and the choice and effect of pharmacological treatment and the majority felt content with their doctor and with information a large proportion of the patients had non-correct views on the effect of mood stabilizers (Component 3 and 4 (Preserved autonomy)). A total of 77.4 % of patients believed that as long as you are taking a mood stabilizer you do not really know if they are actually necessary and 36 to 50 % that you can become addicted or that mood stabilizers can alter your personality. It is most probably that such attitudes may result in reluctance to take mood stabilizers in the long run.

We included questions on reasons for discontinuing treatment but to few patients answered these questions. It is well known that direct questions on reasons for stopping treatment is flawed by a low response rate and by low validity of the answers. Thus, there is no single valid way to measure non-adherence [17]. Questionnaires on attitudes and beliefs concerning illness and treatment such as the ADCQ and the MSCQ may be less provocative for patients and with a higher response rate.

We have previously reported on finding on attitudes and beliefs on antidepressants among the larger population of patients who received antidepressants [18]. Thus, among the 493 patients who participated in the survey, 422 reported that they previously or currently were in treatment with an antidepressant (and these patients fulfilled the ADCQ, [18]) and 256 that they previously or currently were in treatment with a mood stabilizer (and these patients fulfilled the MSCQ). The main proportion (88 %) of patients who previously or currently were in treatment with a mood stabilizer had at one point in time received an antidepressant and these patients fulfilled both questionnaires. The findings on attitudes and beliefs