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How do we conceptualize depression?: A mixed methods study

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A Mixed Methods Study

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Abstract

Despite being extensively discussed, the concepts of mental disorder in general and depression in particular remain unclear and no consensual definitions are yet established. Empirical research on how professionals and laypeople think about depression also points to tensions and lack of consensus. However, there still remains much work to be done in order to more effectively and clearly elucidate how depression is conceptualized. Specifically, there has not been an in-depth analysis of the beliefs, values, and justification that guide practitioners in their everyday work regarding mental disorders in general and depression in particular. The purpose of the current mixed methods convergent study was to fill this gap. Specifically, this study utilized the Behavioral Shutdown Model as a conceptual framework to develop the Understanding Depression Interview for exploring mental health professionals and laypeople's conceptualizations of depression in terms of its nature, diagnosis, etiology, and treatment. Utilizing qualitative and quantitative research methodology, this investigation found that in certain aspects mental health professionals and non-experts conceptualized depression differently (e.g., psychiatrists tended to confer more importance to the biological aspect of depression than the other groups). The investigation also found that participants shared many beliefs about depression across groups. For instance, mental health professionals differentiated between a disease and a non-disease type of depression. Also, some participants from different groups struggled diagnosing cases where there was a clear psychosocial stressor because they recognized that the symptoms met the criteria for diagnosis with a depression disorder *but* did not want to pathologize a normal reaction to a stressor. Implications and limitations are discussed.

Chapter I: Introduction and Overview

It has been widely stated the there is an absence of a clear conception of mental disorders within the mental health field (Ahn, Flanagan, Marsh, & Sanislow, 2006; Phillips et al., 2012; Widiger & Sankis, 2000). While some experts consider mental disorders diseases of the brain with material causes that can be potentially studied and explained (Insel, 2013), others understand them as social constructions unable, by principle, to be defined by any natural essences (Phillips et al., 2012). This ongoing controversy has practical implications not only in the clinical field, but also in the general population's understanding of and attitudes toward emotional and behavioral problems.

Some of the various conceptions of mental disorders can be observed in the debate surrounding the release of the updated version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). During the last several years, led by the American Psychiatric Association (APA) different task forces have worked on updating the DSM's prior edition (DSM-IV-TR; APA, 2000) in terms of the classification of disorders and diagnostic criteria. As a result of much research, field trials and sustained debates in conferences, papers and correspondence, the DSM-5 Task Force proposed a number of changes that have significant implications and repercussions for the broad field of mental health and related domains (e.g., the educational and forensic systems; Frances, 2012). The relevancy of these changes has caught the attention of the different fields within mental health (i.e., counseling, social work, clinical psychology, and school psychology), calling them to be involved in a rich debate composed of a variety of perspectives (Division of Clinical Psychology, n.d.; Frances, 2011; "Open letter to the DSM-5", n.d.; Phillips et al., 2012).

One of the most discussed topics has been the proposed exclusion of the bereavement exemption in the Major Depressive Episode (MDE). In the DSM-IV-TR (APA, 2000) MDE section a footnote pointed out that if an individual meets the criteria for MDE *but* is going through a bereavement process, the clinician should refrain from diagnosing the individual with Major Depressive Disorder (APA, 2000). The rationale behind this footnote is to avoid diagnosing with a mental disorder individuals who are experiencing intense normal sadness in response to their loss (Wakefield, Schmitz, First, & Horwitz, 2007). The DSM-5 Task Force considered, though, that this footnote should be removed (Kendler, 2010, 2013).

This proposed change in the diagnostic criteria of depression immediately brought about a passionate dialogue and debate among and across psychiatrists, clinical and school psychologists, counselors and social workers (DCP, n.d.; Frances, 2011; Kendler, 2010, 2013; "Open letter to the DSM-5", n.d.). Professionals from the American Counseling Association, for instance, intensely opposed this change (Frances, 2011). Counselors were concerned about how excluding the bereavement exemption from the diagnostic criteria would signify the "pathologization" of a normal reaction, grief (Frances, 2011, para. 5). In contrast, proponents of the change (i.e., the Mood Disorders' Task Force of the DSM-5) were largely psychiatrists who were mainly interested in not excluding from the health system individuals experiencing depression *just because* it arose in the context of the loss of a loved one (Kendler, 2010, 2013). Thus, the bereavement exemption criterion and its proposed elimination motivated several discussions, many of which question the concept of mental disorder and depression

underlying the rationales for keeping the exemption or for removing it (Frances, 2010; Pies, 2009; Wakefield et al, 2007).

The practical implications of this debate are clear (Frances, 2010; Pies, 2009; Wakefield et al., 2007). Maintaining the bereavement exemption criterion has the risk of producing false-negative diagnoses by classifying disordered individuals as non-disordered. This could potentially leave individuals without access to services that they genuinely need. On the other hand, eliminating the bereavement exemption criterion has the risk of producing false-positives, identifying as disordered individuals who are non-disordered. This could potentially stigmatize normal responses to adverse circumstances and expose individuals to unnecessary treatment and to treatment side effects. Different philosophical perspectives on depression, then, would translate in different clinical practices, impacting directly on access to services and quality of care provided. This is a serious problem for it means a patient presenting symptoms of depression may or may not be treated depending on the conceptualization of the mental health professional she consults.

The lack of a clear approach to mental disorders among the community of experts could also have practical implications at a different level: in the population's understanding and attitudes toward their own mental health problems. Somebody experiencing intense sadness after the loss of a loved one is left to decide whether what she is experiencing is a normal human reaction or an illness. It is unclear, also, what the best way to approach the experience is. Should she seek medical or psychological treatment? Should she focus on eliminating the symptoms or on processing them? That these straightforward questions are not easily answered raise the question of whether the

community of experts is doing a good job in educating the population about their emotional and behavioral problems and in effective and healthy ways of coping with them. This is more concerning if we consider that people exposed to media are currently being educated about these matters by advertising. Research suggests, for instance, that the introduction of direct-to-consumers pharmaceutical industry's advertising has had a strong effect on the population's habits as consumers and attitudes toward their maladies (Donohue, Cevasco, & Rosenthal, 2007; Wilkes, Bell, & Kravitz, 2000). Experts in the field have already expressed concerns on the negative impact that this type of advertising is having in the level of health care and call for regulation policies (Bell et al., 1999; Donohue et al., 2007; Wilkes et al., 2000).

In that sense, exploring mental health professionals and laypeople's conceptualizations of mental disorders and depression in particular becomes a relevant task given that people's conceptualizations of depression most likely impact the clinical field practice but also laypeople's approach to their emotional and behavioral problems. Despite the key nature of this discussion, not much empirical research has been conducted to study whether mental health professionals truly present a diversity of conceptualizations of mental disorders in general and depression in particular—and, if so, what the nature of this disagreement is—and how this message is understood by laypeople. This is precisely what motivated the interest in conducting the current study.

The goal of this research, thus, was to explore how different mental health professionals and laypeople conceptualize depression and see whether similarities and differences emerge from the data. The essential point of inquiry that guided this study was: *How do interviewed psychiatrists, psychologists, counselors and non-experts in*

psychology conceptualize depression and are there systematic differences between these groups? In order to address this question the Understanding Depression Interview (UDI) (Appendix A) was developed. The UDI has four sections. The first section describes three hypothetical scenarios of depression, and asks participants to share their perspectives on the diagnosis, etiology, and treatment approach of each scenario. The second section contains statements describing the nature of depression, and asks participants to share their level of agreement with each statement. The third section consists of open-ended questions inquiring participants on their perspectives about the nature of depression, mental disorders, and mental health professionals' approach to depression. Finally, the fourth section is composed of demographic questions addressing participants' personal, educational, and professional information.

Qualitative and quantitative data were gathered through the UDI in this single-phase mixed methods study (Creswell & Plano Clark, 2011). Mixed research methods were used to have a qualitative and quantitative insight of participants' conceptualizations of depression. Given that this study investigated participants' conceptual frameworks of depression, the main weight of the design was on the qualitative piece, which provided an in-depth view of the concept of depression by having access to the individuals' perspectives of depression. The qualitative section of the study addressed one research question: *How do interviewed mental health professionals and non-experts conceptualize depression?* A smaller quantitative piece of the study was focused on finding specific trends and differences among participants' perspectives. The quantitative section of the study addressed five research questions: *How do interviewed psychiatrists, psychologists, counselors and non-experts differ in*: 1)

how likely they are to diagnose each case with a depressive disorder; 2) *how they rate the importance of the biological, psychological, and environmental factors*; 3) *the extent to which they recommend and value psychotherapy*; 4) *the extent to which they recommend and value medication; and 5) their opinions about the nature of depression*. The combination of qualitative and quantitative findings provided a more complete understanding of participants' conceptualizations of depression (Creswell, 2015).

Participants were found to differ but also share many beliefs about depression, regarding its nature, diagnosis, etiology, and treatment. In terms of *diagnosis,* different approaches to diagnosis were observed across groups. Some participants approached diagnosis, for instance, by focusing solely on whether the symptoms met the DSM criteria, whereas others considered that "by principle" doing so was unethical as symptoms should always be contextualized in terms of its triggers and the individual's personal history. One feature that characterized psychiatrists was the requirement of a "vegetative profile" for diagnosing depression. Thus, psychiatrists considered that in order to diagnose a case with a depressive disorder the depressed individual should present biological symptoms of depression, such as lack of appetite or sleep disturbance. This requirement was not observed within psychologists, counselors or non-experts. Interestingly, depressive cases where there was a clear psychosocial stressor (i.e., cases two and three) were more problematic among participants who approached diagnosis contextualizing the symptoms (i.e., not only focusing on whether the symptoms met DSM criteria). Thus, some participants across groups recognized that the presence of depressive symptoms warranted a diagnosis but also stated that providing a diagnosis would imply pathologizing a normal reaction. Some participants "solved" this tension by

diagnosing the case with depression so the individual could have access to treatment, even though they considered that the individual was not "mentally disordered."

In terms of *etiology*, depression was broadly understood as multifactorial, i.e., as caused by biological, psychological and or environmental factors. However, in general, psychiatrists tended to confer more importance to the biological aspects of depression than the rest of the groups. This is observed in the way they define and diagnose depression, in the way they understand its etiology and also in their approach to treatment.

Regarding *treatment*, similarities and differences between groups were observed. Psychotherapy was commonly seen as an adequate treatment for depression. Participants' judgments about medication, on the other hand, were more dissimilar. Not surprisingly, compared to the other groups, psychiatrists felt more comfortable recommending medication for treating depression. On the other side of the spectrum, non-experts expressed strong concerns in regards to medication and approached it as a "last resource." Interestingly, mental health professionals in general were more hesitant to consider medication an adequate treatment in the cases where there was a clear psychosocial stressor (i.e., cases two and three). Another interesting commonality across all four groups was participants' expressed frustration about the current mental health model, which was stated to equate treatment to medicalization, providing a "low quality care."

Finally, in terms of the *nature of depression*, some differences arose between groups. Only among mental health professionals, for instance, there was a distinction between a "disease" and a "non-disease" type of depression. The disease type of

depression was usually described as biologically based, more severe, non-reactive, and ego-dystonic. The non-disease type of depression was usually described as non-biologically based, a reaction to a psychosocial stressor, and "understandable." Non-experts, on the other hand, refused to identify depression as a "disease" or a pathology, and did not provide such distinction. The concept of disease was also considered problematic for some psychologists and counselors. On the one hand, understanding depression as a disease legitimizes the condition, justifies treatment, and removes blame from the patients (given that they are "authentically ill"). On the other hand, defining depression as a disease implicitly considers the condition as pathological, originated as a result of biological malfunctioning, and a candidate to biological type of treatment (e.g., medication). Related to this is psychologists and counselors' hesitancy to conceptualize depression as always a pathological condition and offered a second distinction between a dysfunctional and a non-dysfunctional type of depression. The rationale underlying this distinction was the belief that depression is many times an indicator of dissatisfaction with one's life, and therefore an opportunity for personal growth, whereas other times depression is purely dysfunctional

Chapter II: Literature Review

To provide readers with a background of the literature, three areas are focused on. The first section provides a brief description of the ongoing theoretical discussion on the concept of mental disorder. It is observed from this review that no clear definition of mental disorders is yet established and, on the contrary, the field is composed of a variety of perspectives. This variety of perspectives resonates within the field of practice, and the second section of the literature review focuses on this aspect. The second section, thus, presents examples of how the lack of a clear concept of mental disorders and depression in particular impacts on clinical practice. Finally, the last section of the literature review discusses empirical qualitative and quantitative studies on mental health professionals and laypeople's conceptual models of depression, and sets the stage for exploring these issues in the current project.

Disputes about the definition of mental disorder

The question of what is a mental disorder has been the focus of intense debate and has inspired several theoretical perspectives (Phillips et al., 2012; Thakker, Ward, & Strongman, 1999; Wakefield, 1992; Widiger & Sankis, 2000). Despite being extensively discussed, the concept of mental disorder remains unclear and no definite or consensual definition is yet established (Thakker et al., 1999; Widiger & Sankis, 2000). The mental health field, thus, is composed of a variety of views of mental disorders that range from biomedical (Blashfield, 1984; Phillips et al., 2012) to social constructivist perspectives (Thakker et al., 1999).

In the context of the controversies generated around the DSM-5 Task Force's proposals, psychiatrists James Phillips and Allen Frances decided to continue this discussion in the journal *Philosophy, Ethics, and Humanities in Medicine* under the format of a series of "essential questions" for the DSM-5 (Phillips et al., 2012). Twenty three invited researchers from a broad range of disciplines answered six questions, and these answers were then commented upon by Phillips and Frances. The result was a document that represents the wide range of opinions regarding topics such as the nature of mental disorders, the validity of the current diagnostic system, and the utility of the DSM. A closer look at the authors' responses to the second question ("what is a mental disorder?") and Frances's commentary on these responses offers a valuable opportunity to learn the key perspectives on mental disorders operating in the mental health field.

Frances started his commentary on the authors' answers to the question "what is a mental disorder?" with the following statement: "When it comes to defining the term 'mental disorder' or figuring out which conditions qualify, we enter Humpty's world of shifting, ambiguous, and idiosyncratic word usages. This is a fundamental weakness of the whole field of mental health" (Phillips et al., 2012, p. 24). Certainly, this is not a promising statement if one is hoping to find a clear definition of mental disorders. Frances took a step further and said—with a touch of sarcasm—that a mental disorder is "*what clinicians treat and researchers research and educators teach and insurance companies pay for*. In effect, this is historically how the individual mental disorders made their way into the system" (Phillips et al., 2012, p. 24). Not surprisingly, not everyone agreed with Frances, for it equates acting as if something is true with the thing being true (i.e., by Frances' definition, if we deemed red hair to be a problem and treated

people for the distress of having red hair, then being a red head would be a mental disorder).

Among those who criticize Frances' view is social worker and seminal thinker in the concept of mental disorders, Jerome Wakefield. According to Wakefield (1992, 1999), mental disorders are not pure social constructions but natural entities resulting from internal dysfunctions that are deemed harmful. Thus, the distress observed in mental disorders is not the result of social conflicts about certain conditions, but the essential feature is that the harm is a direct result of the dysfunction of an internal mechanism (Wakefield, 1992). In Wakefield words, mental disorders are nothing but "harmful failures of evolutionarily design functions" (Wakefield, 1999, p. 465).

The idea of a failure of a natural function is critical in Wakefield's definition of mental disorder and it is the key concept for distinguishing between disorders and non-disorders. According to Wakefield, the DSM-IV and 5 do not have a clear criterion for distinguishing true pathologies from maladaptive problems in living (Phillips et al., 2012; Wakefield, 1992). As an example, Wakefield mentioned the DSM-IV-TR's bereavement exclusion criterion from the major depressive episode section (Wakefield et al., 2007). As previously explained, the DSM-IV-TR proposes to refrain from diagnosing with MDD an individual who meets the diagnosis criteria but has recently experienced the loss of a loved one (APA, 2000). The reason behind the bereavement exclusion criterion is to avoid pathologizing a nonpathological experience, grief.

In general terms, Wakefield agreed that cases of depression that seem to be *normal* reactions to major losses, for instance, should not be considered mental disorders (Wakefield et al., 2007). The problem is that the DSM-IV-TR's criterion only considers

bereavement as a major loss, when research suggests that other type of losses (e.g., financial loss) could also trigger intense symptoms of normal sadness. Wakefield and colleagues (2007) argued that by singling out bereavement as the only kind of loss that could cause normal sadness, the DSM-IV-TR was unable to distinguish pathological from nonpathological depression in cases triggered by other losses. As Wakefield and colleagues (2007) explained, intense sadness responses are *biologically designed responses* to a variety of circumstances. Intense normal sadness is the result of an internal mechanism performing its natural function and not a pathology. In that sense, the reason why intense sadness—whatever its trigger is—is not a disorder is because it is not the result of the *dysfunction* of an internal mechanism.

It is important to note that the fact that the depressive symptoms are a reaction to a loss does not necessarily mean that the *disproportionate intensity* of the reaction or its *duration* could not imply the possibility of an internal breakdown (Wakefield et al, 2007). In other words, some depressive reactions to the loss of a loved one are disorders, whereas others are not. The key, for Wakefield, is that the existence of a malfunction of an internal mechanism is required for distinguishing appropriately between disorders and non-disorders. Thus, in Wakefield (1992)'s Harmful Dysfunction Analysis (HDA) account, it is precisely this harmful internal failure that is a central feature of mental disorders and what defines them as such.

The HDA is commonly accepted as one of the strongest efforts to define mental disorders (Phillips et al., 2012; Widiger & Sankis, 2000), but this has not protected it from criticism (Henriques, 2002; Lilienfeld & Marino, 1995; Thakker et al., 1999). In Frances' opinion, Wakefield's HDA fails in the intent of providing a useful definition of

mental disorders (Phillips et al., 2012). The HDA works well "on paper" but it is unable to provide any guidance on two fundamental questions: "is this proposed new diagnosis a mental disorder that should be included in the official nomenclature?" and "does this person have sufficient psychiatric problems to warrant a diagnosis of mental disorder?" (Phillips et al., 2012, p.25). Both Wakefield and Frances have expressed concerns with the current diagnosis system's risk of producing false positives, but, according to Frances, the HDA is actually unable to provide a definition that could finely distinguish between a mental disorder and everyday distress and malfunction (Phillips et al., 2012).

Others have also pointed out other weaknesses in Wakefield's HDA account (Henriques, 2002; Lilienfeld & Marino, 1995; Thakker et al., 1999). One of the major concerns regarding the HDA is that it fails to address the specific nature of the construct of psychological disorder, and it mainly works within the realm of biological disorders (Henriques, 2002; Thakker et al., 1999). In order to avoid confusion about this topic, Henriques (2002) stated a distinction must be made between mental diseases– harmful conditions that result from an internal malfunctioning–and mental disorders, which are maladaptive patterns that cause harm and warrant a diagnosis but are not reducible to biological malfunctions. Henriques (2002) argued that by using the same concept for understanding both *medical* and *psychological* disorders, Wakefield was suggesting implicitly that all mental disorders are reducible to biological theory, which Henriques argued to be fallacious. The author made this point in part by pointing out that to the same extent in which there are biological disorders that cannot be considered physical disorders (a point Wakefield himself concedes), there are psychological disorders that cannot be considered biological disorders (Henriques, 2002). Instead, there are emergent

properties in psychological processes that need to be explained under psychological frameworks, specifically:

> …rigid, maladaptive patterns can emerge that do not involve the dysfunction of naturally selected mental mechanisms, but instead are the results of breakdowns in the processes that give rise to behavioral complexity (i.e., learning). Such problems would be considered psychological or behavioral disorders that could not be reduced to biological theory (Henriques, 2002, pp. 29-30).

From Henriques' perspective, the National Institute of Mental Health (NIMH) commits the same error when it defines mental disorders as "*biological disorders* [emphasis added] involving brain circuits that implicate specific domains of cognition, emotion, or behavior," defining mental disorders from a bio-medical perspective (Insel, 2013, para. 4). Interestingly, research suggests that not many clinicians would agree with the NIMH's position as laid out by Insel. In a study conducted by Ahn and colleagues (2006), psychiatrists, psychologists and clinical social workers tended to differentiate *mental* from *medical* disorders across a variety of questions related to whether the conditions have necessary or sufficient features, causal essences, or naturally exist in the world as opposed to being socially constructed. Proponents of the disease or medical model would tend to view mental disorders as real and as having essences because under this account disorders are universal and biologically based conditions with discrete boundaries (Haslam, 2000). In other words, proponents of the disease or medical model would not see much difference between mental and medical disorders. However, surveyed clinicians did find differences between them (Ahn et al., 2006). Contrary to what happened in the case of medical disorders, clinicians tended to believe that mental

disorders are decided upon and created by experts, rather than existing naturally in the real world (Ahn et al., 2006).

This representation of mental disorders as non-universal conditions might seem to align better with Frances' (Phillips et al., 2012) previously mentioned account of mental disorders as social constructions, rather than with the NIMH's position (Insel, 2013). But this is not entirely true. Results from the Ahn and colleagues' (2006) study also show that clinicians are not willing to endorse the view that mental disorders are entirely culturally variable social constructions. Controversies on the nature of mental disorders, thus, are ongoing in the field, and the debate is not only in theoretical arenas but it also resonates among practitioners (Ahn et al., 2006; Ahn, Proctor, & Flanagan, 2009; Kim & Ahn, 2002).

Debate about the DSM-5's proposed changes and its practical implications

As described earlier, the new edition of the DSM was launched in May 2013 (APA, 2013), and in that context a vigorous exchange of ideas emerged about the nature of mental disorders and their practical implications. Allen Frances, the chief editor of the fourth edition of the DSM - Text Revision (APA, 2000), has been one of the most vocal critics. Frances' general concern with the DSM-5's proposed changes resided on the power that the DSM holds inside and outside the clinical practice for influencing the lives of millions of people (Frances, 2012). Not only do mental health professionals rely on it as a major reference for making decisions in terms of diagnosis and treatment, but insurance companies, courts, schools and social programs consult the DSM for deciding who is eligible for special services and who is not. Given the potential impact that the

DSM could have, some even argue that the APA is no longer capable of running this huge enterprise by itself (Frances, 2011, 2012; "Open letter to the DSM-5", n.d.). Frances (2012) recommended that a new structure, open to the needs of *all* mental health professionals, policy-makers, forensic experts, and consumers, should be involved in revising this highly complicated project.

Impact of the DSM-5's proposed changes. The changes proposed on the new DSM version (APA, 2013) will impact directly or indirectly several areas within the mental health field. Experts claimed that the new DSM would directly have an effect on the clinical practice, as it recommended to expand the list of disorders (e.g., Mixed Anxiety-Depression), lower diagnostic thresholds (e.g., reducing the number and duration of symptoms in Generalized Anxiety Disorder), and add a complex dimensional type of assessment (Frances, 2009, 2011, 2012; "Open letter to the DSM-5", n.d.; Phillips et al., 2012). These and other changes were considered as likely having the negative consequences of expanding the population of mentally ill, increasing the number of false positive diagnoses, and exposing individuals to unnecessary and potentially harmful treatments (Frances, 2009, 2011, 2012; "Open letter to the DSM-5", n.d.; Phillips et al., 2012).

But the DSM-5's (APA, 2013) changes could also have some *indirect* consequences as a number of key institutions in the mental health field have announced no longer supporting the DSM framework and taking a step away from this system. Thomas Insel (2013), director of the NIMH, just few weeks before the launch of the DSM-5 expressed direct concerns about the lack of validity of the DSM-5 and stated that the NIMH will reorient its research outside the DSM system. Instead, Insel stated the

NIMH would focus its research on developing a *new* classification system by incorporating genetics, imaging, cognitive science, and other sources of information (Insel, 2013). The NIMH is the largest funding agency for research into mental health, so withdrawing their support from the DSM diagnosis system will probably have a strong impact on the field given that an important volume of research about mental disorders will be oriented under a different paradigm (Phillips et al., 2012).

The British Psychological Society's Division of Clinical Psychology (DCP) also published a position statement a few days before the launch of the manual advocating a paradigm shift in how mental disorders are understood (DCP, n.d.). The DCP explicitly argued for the need to move away from the "disease" model of mental illness toward a model that does not minimize the effect of psychosocial factors in people's behavior (DCP, n.d., p.2). According to the DCP, the current DSM model of mental illness assigns —supported by very limited evidence— biology a primary role in the etiology of mental disorders (DCP, n.d.). As a consequence of the latter, there is an increasing over-medicalization of children and adults' distress and behavior (DCP, n.d.). In that sense, a paradigm shift is advised toward a diagnosis system that also recognizes the role of psychosocial factors in people's distress and contextualizes people's experiences (DCP, n.d.). The DCP statement finishes outlining the new approach that their institution will take, which includes increasing awareness on the limitations of the current system, partnering with other organizations for working on future steps away from the current system, and supporting efforts developing multifactorial and contextual models of diagnosis (DCP, n.d.). Thus, the DCP's perspective on the DSM-5 system will most

likely have an impact in the health field as it recommends a "paradigm shift" in the way mental disorders are diagnosed and treated (DCP, n.d., p.1).

The DSM-5's proposed changes have also resonated among practitioners, who have also been actively involved in the discussion surrounding the development of this manual (Frances, 2011; "Open letter to the DSM-5", n.d.). As noted previously, a particularly contentious debate arose around the proposed elimination of the bereavement exclusion criterion from the MDE section that is directly relevant for the current project. Several voices opposed to this change: the American Counseling Association (Frances, 2011), the Society for Humanistic Psychology, the British Psychological Society, the Danish Psychological Association, the Division of Behavioral Neuroscience and Comparative Psychology, the Division of Developmental Psychology, and the Division of Clinical Psychology among others ("Open letter to the DSM-5", n.d.). The reason behind this opposition is that eliminating the bereavement exemption criterion has the risk of "pathologizing" normal reactions to the loss of a loved one (Frances, 2011, para. 4; "Open letter to the DSM-5", n.d., para. 10).

This controversy is not strange to those in clinical practice, as practitioners often face the question of *when is depression a mental disorder and when is a normal reaction to a traumatic event or extremely difficult life circumstances?* Research indicates that, depending on the setting, depression is sometimes conceptualized as a *normal reaction*—having an effect on diagnosis and treatment— (Burroughs, Lovell, Morley, Baldwin, Burns, & Chew-Graham, 2006; Chew-Graham, May, Cole, & Hedley, 2000). The relationship between how depression is seen and how it is treated is not surprising because studies show that practitioners' and patients' views on mental disorders translate

into specific practices in diagnosis, treatment and clinician-patient relationship (Ahn et al., 2006; Ahn et al., 2009; Ahn, Taylor, Kato, Marsh, & Bloom, 2013; Kim & Ahn, 2002; Burroughs et al., 2006; Chew-Graham et al., 2000). This supports the need for exploring practitioners' and laypeople's views on mental disorders, as they have an effect on the clinical practice. In what follows, empirical studies on clinicians, patients and laypeople's understanding on depression are reviewed.

Empirical research on conceptualizations of depression

Although there is not an extensive literature of empirical research on mental health professionals and laypeople's conceptualizations of depression, there are some studies that provide interesting findings (Ahn et al., 2006; Ahn et al., 2009; Burroughs et al., 2006; Cheng, Fancher, & Paterniti, 2009; Chew-Graham et al., 2000; Karasz, Garcia, & Ferri, 2009). A series of studies conducted by the cognitive lab of Yale University, for instance, have addressed the question of how mental health professionals and non-experts understand the causal basis of mental disorders (Ahn et al., 2009). Psychiatrists, psychologists, and clinical social workers, were asked to judge the extent to which DSM-IV-TR mental disorders were biologically, psychologically and environmentally based, and whether the efficacy of different types of treatment (i.e., psychotherapy and medication) was related to the type of cause of the disorder. Ahn and colleagues (2009) found that, in terms of effectiveness of treatment, clinicians considered that biological type of treatments (e.g., medication) were more effective for depressive cases mainly caused by biological factors, whereas non-biological type of treatments (e.g., psychotherapy) were more effective for cases caused by psychological or environmental

factors. In the case of the causal nature of depression, researchers found that depression was conceptualized as multifactorial. Specifically, using a 5-point Likert scale (1 being "caused by no or very few B/P/E factors", and 5 being "almost completely caused by B/P/E factors"), clinicians rated depression as somewhat biological (*M* = 3.50), psychological (*M* = 3.02) and environmental (*M* = 2.65) (Ahn et al., 2009, p. 157). Interestingly, a similar pattern of responses was observed within each subgroup of clinicians, indicating that clinicians appear to agree on the causal bases of depression (Ahn et al., 2009).

Other studies suggest, however, that in certain settings depression is conceptualized by clinicians as more socio-environmentally based (Burroughs et al., 2006; Chew-Graham et al., 2000). Burroughs and colleagues (2006), for instance, conducted a qualitative study on primary care professionals and patients' view of late-life depression. Researchers found that late-life depression was conceptualized as an "understandable" and "justifiable" condition given the situation that elderly people face in their daily life (Burroughs et al., 2006, p. 372). Chew-Graham and colleagues (2000) found similar results in their qualitative research on general practitioners' attitudes to the management of depressive patients. Clinicians considered that depression was a "normal" reaction given the socioeconomic disadvantage of the area (Chew-Graham et al., 2000, p.138).

These findings align with what have been found in studies conducted with patients from minority population (Cheng et al., 2009; Karasz et al., 2009). In a mixed methods study with patients from three different ethnic groups—European Americans (EA), African Americans (AA), and Hispanic Americans (HA)—, patients' conceptual

models of depression were examined focusing on whether these conceptual models "match" a biopsychiatric model of depression (Karasz et al., 2009). Compared to EA, minority groups were less likely to use psychiatric labels, favor biological treatments and attribute depression to psychological and biological causes (Karasz et al., 2009). According to the authors, the way participants understood depression, its main causes, and treatments supported the "center to periphery hypothesis" (Karasz et al., 2009, p.1053). The center to periphery hypothesis suggests that the differences between EA and minorities show that minorities maintain a more "peripheral" cultural position and, therefore, have been less exposed to the biopsychiatric model, contrary to what happens in the case of EA (Karasz et al., 2009, p.1053).

Similar findings were obtained from a qualitative study conducted with a Hmong community of immigrants (Cheng et al., 2009). The objective of this study was to understand the definition of depression among Hmong immigrants by eliciting their illness narratives about depression. Interviewees defined depression as a condition due to life circumstance or multiple stressors, and none of them viewed it as a biological illness (Cheng et al., 2009). According to Cheng and colleagues (2009), the illness narratives of the Hmong show that there is almost no use of a biomedical model in the way they conceptualize depression. Participants mainly emphasized aspects as lack of familiar role fulfillment and social support, and stressors and social disadvantages for explaining their symptoms (Cheng et al., 2009).

Results from the previous studies suggest there are at least two conflicting models of depression. The disease model of depression (sometimes named "biopsychiatric" or "biological model") is described as representing the hegemonic view of depression

(Cheng et al., 2009; Karasz et al., 2009). People who hold this model of depression utilized psychiatric labels for naming depression (e.g., "mental illness"), attributed depression to primary biological factors (e.g., chemical imbalances), and favored biological treatments (e.g., medication) (Cheng et al., 2009; Karasz et al., 2009).

The second model of depression is the "socio-environmental" model of depression (sometimes called "justifiable," "understandable," "normal reaction," "circumstantial," etc.) (Burroughs, et al., 2009; Cheng et al., 2009; Chew-Graham et al., 2000; Karasz et al., 2009). People who hold this model of depression tended to attribute depression to socio-environmental factors (e.g., financial problems), avoid utilizing psychiatric labels for naming the condition, and favor medication only in very severe cases (Burroughs, et al., 2009; Cheng et al., 2009; Chew-Graham et al., 2000; Karasz et al., 2009). Interestingly, the "socio-environmental" depression model was only observed among populations exposed to adverse circumstances (e.g., elderly people facing loneliness, working-class minority groups, people living in deprived areas) (Burroughs, et al., 2009; Cheng et al., 2009; Chew-Graham et al., 2000; Karasz et al., 2009). Ahn and colleagues' studies would suggest a third model of depression that does not align with either of these models for it describes depression as multifactorial (Ahn et al., 2009). It is important to note, though, that the Ahn and colleagues' (2009) studies focused on measuring participants' views of the causal nature of depression. Thus, strictly speaking, a more extensive exploration of participants' views on depression would be required before interpreting the results in terms of "models" of depression.

The findings from the discussed empirical studies raise some interesting questions: Is depression a *disease* or a *normal reaction*? Should depression that results

from being exposed to traumatic events or adverse circumstances be conceptualized as a disorder or as a natural way to react given the stressors? And, what should be the treatment plan? Henriques (2000; 2002; 2011) has argued that approaching the concept of depression by first focusing on whether depression is or is not a disease or a mental disorder, and should or should not be defined as such is problematic.

A Model of Depression. Consistent with the above review of the literature, Henriques (2000) claimed that the field of mental health was fundamentally confused about the nature of depression and offered the Behavioral Shutdown Model (BSM) as a way forward. Henriques (2000) argued that "depression", as used currently, is a confounded term that implies etiology in some instances and a cluster of symptoms in others (Henriques, 2000). Henriques (2000) claimed that "depression" ought to be defined, first and foremost, as a state of behavioral or psychological shutdown. Apathy, social withdrawal, fatigue, melancholy, anhedonia, loss of initiative, hopelessness are some of the common symptoms of a depressive individual. Under the framework of the BSM, an individual with these symptoms is described as being in a state of behavioral and psychological shutdown.

The BSM stems from Behavioral Investment Theory (BIT) as a conceptual framework that supports its logic (Henriques, 2003, 2011). The central claim of BIT is that the nervous system is an investment value system, and actions are performed on a benefit to cost ratio system. In other words, in the daily relation of the organism with its environment, the nervous system is devoted to the task of maintaining a positive balance between the organism's energy expenditure (costs) and the benefits obtained from this

energy expenditure, along with other secondary features such as risk and opportunity costs (Henriques, 2011). Under this theory, the brain of higher animals (birds and mammals) is seen as being fundamentally organized around *approach* and *avoidance* behavioral systems that are mediated by *positive* and *negative* affect systems. Put simply, pleasure and other positive affect are nature signals to *approach* benefits and pain and other negative affect are signals to *avoid* costs.

From this "neuro-economic behavioral" perspective, when the usual pathways of investment are not offering enough benefits compared to the expenditures, the organism either tries to *increase* the benefits or to *reduce* the costs. Henriques (2000) argued that this simple framework allows for the understanding of the symptom clusters of depression. Specifically, the BSM postulates that the symptoms of depression are very much akin to behaviors that are aimed to *reduce* costs of the behavioral investment (Henriques, 2000). In other words, if we observe some of the common symptoms of depression—e.g., anhedonia, fatigue, heightened negative emotional reactivity, lack of interest and joy, tiredness, etc. —it seems that the individual could be described as being in a state of shutting down behavioral investment.

There are many advantages of adopting the BSM for conceptualizing depression. Given that depression is defined as a *state* of behavioral and psychological shutdown, this model proposes to frame depression first at the descriptive level and is not compromised or confounded with any particular etiological commitments. In other words, the symptoms manifested by a depressive individual could either be caused by neurophysiological malfunctions, psychological problems, environmental stressors, or a complex mixture of these factors. The BSM further deconstructs depression in three

types depending on the *main* causal basis of the symptoms (Henriques, 2011). Thus, a depressive scenario mainly caused by a biological malfunction is called a Depressive Disease. A depressive scenario mainly caused by a cyclical maladaptive pattern of behaviors is called a Depressive Disorder. Finally, a depressive scenario mainly caused as a reaction to an environmental stressor is called a Depressive Reaction.

In this sense, the BSM has a unifying power of the different conceptualizations of depression that have different underlying etiological theories for depression. Independently of what it is considered to be the main cause of the depressive symptoms (biological, psychological or environmental), the resulting pattern of depressive symptoms is called depression because it could be described as a state of behavioral/psychological shutdown. Definitions of depression that mainly emphasize one causal basis (for instance, the biological causal basis), on the other hand, do not have that unifying power and are left to solve the issue of whether depressive cases resulting from being exposed to adverse circumstances should or not be considered depression. In the current study, the BSM is used as a conceptual framework for exploring participants' conceptualizations of depression.

Purpose of the current study

As reviewed, there is an intense discussion about what actually constitutes a mental disorder in general and depression in particular. Empirical research on how professionals and laypeople think about depression also points to tensions and lack of consensus. However, there still remains much work to be done in order to more effectively and clearly elucidate the various aspects of this discussion. Specifically, there

has not been an in-depth analysis of the beliefs, values, and justification that guide practitioners in their everyday work regarding mental disorders in general and depression in particular. In addition, although much research suggests that there is tension between thinking about depression as either a disease or a psychological disorder or a normal reaction, there has not been a systematic exploration of how professionals and laypeople approach this issue. The purpose of the current research was to fill this gap. Specifically, this study utilized the conceptual framework of depression provided by the BSM to develop a structured interview to assess the deep conceptual structures underlying in professionals and laypeople's thinking about depression and to assess the degree to which the tensions identified in the literature about depression actually play themselves out in the thinking of modern professionals and laypeople.

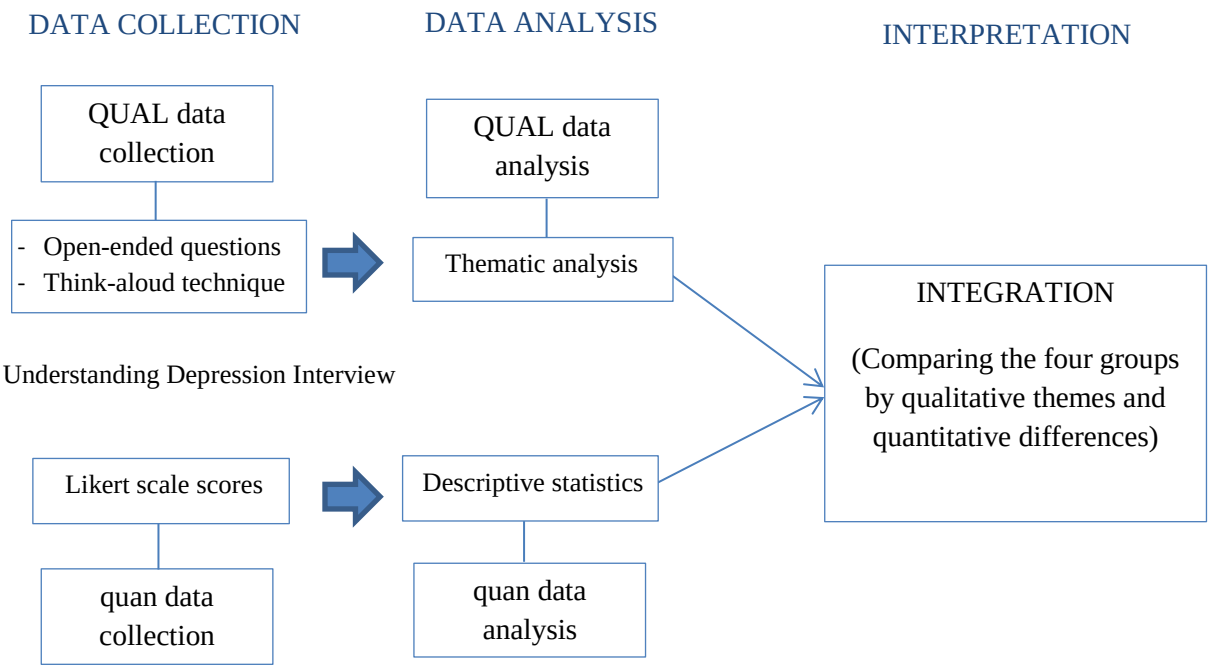
Chapter III: Methods

This study has a mixed methods convergent design (Creswell & Plano Clark, 2011). A mixed methods convergent design was chosen because of the appropriateness of the approach for addressing the main research question: *How do psychiatrists, licensed psychologists, licensed counselors and lay people conceptualize depression and are there systematic differences between these groups?* As explained by Creswell (2015), a mixed methods convergent design is used when the study aims for reaching a more complete understanding of the phenomenon being studied. Mixed research methods will be used to obtain a qualitative and quantitative insight from the phenomenon. The main weight of the design is on the qualitative piece, aimed at providing an in-depth perspective of the concept of depression by having access to the individuals' perspectives of depression. The quantitative piece of the study is focused on finding specific trends and differences among participants' perspectives. The combination of both findings provides a more complete understanding of the participants' conceptualization of depression.

The qualitative piece of the study will address one research question: *How do interviewed psychiatrists, psychologists, counselors and non-experts conceptualize depression?* The quantitative section of the study will address five specific research questions: *How do interviewed psychiatrists, psychologists, counselors and non-experts differ in*: 1) *how likely they are to diagnose each case with a depressive disorder*; 2) *how they rate the importance of the biological, psychological, and environmental factors*; 3) *the extent to which they recommend and value psychotherapy*; 4) *the extent to which they recommend and value medication; and 5) their opinions about the nature of depression*. The merger of the qualitative and quantitative research findings will address the main

research question: *How do psychiatrists, licensed psychologists, licensed counselors and lay people conceptualize depression and are there systematic differences between these groups?* The following diagram (Figure 1) illustrates the data collection, analysis and interpretation procedures utilized in this single-phase convergent design.

Figure 1. Data Collection, Analysis, and Interpretation



Participants

Six psychiatrists, twelve clinical psychologists, five counselors, and five non-experts in psychology were recruited for this study. Non-experts in psychology were defined as professionals working in an area not related to psychology or mental health. Specifically, in this study non-experts hold degrees in Engineering, Philosophy, Literature, and English as a Second Language. See Table B1 (Appendix B) for complete

demographic information about participants. Participants were recruited using the snowballing and the convenience sampling technique (Creswell & Plano Clark, 2011). Therefore, participants were either professionals working at institutions from the area (e.g., James Madison University, Western State Hospital, Mary Baldwin College) or their acquaintances. IRB permissions from James Madison University and Western State Hospital were obtained and all participants signed an informed consent before the interview started.

Data collection

Qualitative and quantitative data were collected in one phase, using a face-to-face structured interview, the Understanding Depression Interview (UDI), which was composed of four sections (Appendix A). The first section of the interview consists of three vignettes describing hypothetical scenarios of depression, a set of questions related to diagnosis, etiology, and treatment of the scenarios (responded using 7-point Likert scales), and a final open-ended question inquiring participants' definition of clinical depression. The second section contains seven statements describing the nature of depression. The third section consists of four open-ended questions inquiring participants on their perspectives about the nature of depression, mental disorders, and mental health professionals' approach to depression. The last section of the interview is composed of demographic questions about personal information (e.g., age, gender, etc.), educational information (e.g., degree), and professional information (e.g., experience, type of patient they treat, etc.). During the first and second sections participants were asked to think aloud while they were rating for getting participants' rationale behind their scores.

Qualitative data, thus, came from the think-aloud procedure utilized in these sections and the responses to the open-ended questions from sections one and three. Quantitative data come from the participants' scores on the 7-point Likert scales utilized in sections one and two. The interviews were recorded using an audio recording device. The audios were transcribed by a team of coders.

Team of coders. Three undergraduate students majoring in psychology enrolled in an Independent Study course (Psyc 402) for participating in this research project. The course content was designed by the main researcher of this project and her supervisor, and the sessions were led by the main researcher. Given that more help was needed for transcribing the audios, four additional undergraduate students majoring in psychology joined the group later without enrolling in the Independent Study course. All students received training on IRB ethical guidelines, transcripts, qualitative data analysis methods, and the theoretical background of the study (e.g., models of illness and the Behavioral Shutdown Model). Students never had access to identifiable information.

Data analysis

Qualitative and quantitative data analyses were conducted separately, as is arranged in a convergent design. Following Creswell's (2015) recommendations for interpreting mixed methods results within a convergent study design, the merging of the qualitative and quantitative findings was made in the discussion section.

Qualitative data analysis. Qualitative data were analyzed using thematic analysis (Braun & Clarke, 2006). The analysis process was conducted in four steps: developing a list of themes, analyzing the data using the observed themes, building a

conceptual map for each group of participants, and writing a final report narrating the findings of the thematic analysis. Thus, initially, the team of coders (i.e., four undergraduate students) read sections of the data and identified emergent themes. Through an iterative process that included coding the data with these themes and discussing the results with the team of coders, a final list of themes was developed. In the second step, the main researcher organized the transcripts by group (psychiatrists, psychologists, counselors, and non-experts) and analyzed each group with the list of themes. In the case of psychologists, only five cases were selected for the analysis, given the extent of the data. The cases were selected following the technique of saturation. As this technique suggests, the researcher knows that it is no longer necessary to keep reading more data once it is observed that no new themes emerge from the new transcripts (Creswell, 2013). During the third step, a conceptual map was developed for each group for capturing the specific way how these themes relate to each other in the case of psychiatrists, psychologists, counselors, and non-experts. Finally, the main researcher wrote a report of the conceptual maps narrating the findings from the thematic analysis embedding participants' quotes for supporting the findings and illustrating the themes using participants' own voice.

Quantitative data analysis. Quantitative data were analyzed by the main researcher utilizing descriptive statistics (mean, standard deviation, mode, and standardized mean differences). Cohen's *d* benchmarks for evaluating practical significance of the effect sizes were utilized for interpreting the standardized mean differences (Cohen, 1988). Given that the sample size is very small, no inferential tests were conducted.

Materials and procedure

The Understanding Depression Interview (UDI). The UDI (Appendix A) was developed with the purpose of learning participants' perspectives regarding depression, specifically, its diagnosis, etiology, treatment, and nature. The theoretical framework utilized for constructing the UDI was the Behavior Shutdown Model (Henriques, 2000). Following the BSM, three scenarios were developed describing similar symptoms (i.e., "shutdown" behaviors) but different causal bases (i.e., biological, psychological, and environmental causal bases). The rationale behind utilizing the BSM as a framework is to observe whether participants would approach diagnosis, treatment, and nature of depression differently depending on the specific etiology of the case.

The interview protocol was designed following Creswell's key points for interviewing concerning selection of interviewees, place, time, and type of interview, and recording procedures (Creswell, 2013). The development of the UDI followed an iterative process that included a series of pilots for evaluating the time length of the interview and participants' reactions to the questions being asked and their specific wording (e.g., whether participants understood the words utilized and the scope of each question) (Glesne, 2006; Merriam, 2009). The UDI was finally reviewed by a content-expert (Gregg Henriques) for assessing the soundness of the instrument for learning participants' perspectives on depression.

The UDI has four parts. The first part consists of three vignettes describing different depression scenarios and an open-ended question; the second part consists of seven statements describing the nature of depression; the third part has four open-ended

questions; and the fourth section includes thirteen demographic questions. The following subsections describe more deeply each of these materials.

Vignettes. For the purpose of this study three vignettes were developed using as an example cases from the *DSM-IV-TR case studies* (Spitzer, Gibbon, Skodol, Williams, & First, 2002). The first vignette describes the hypothetical case of Ms. Smith, a successful business woman who suddenly begins to present symptoms of depression without any clear trigger. The second vignette describes the hypothetical case of Ms. Jones, a woman who started to experience depressive symptoms shortly after her two-year boyfriend broke up with her. The third vignette describes the hypothetical case of Ms. Taylor, a woman who started to experience depressive symptoms after a huge storm hit her town, losing her home and business. The vignettes were developed to maintain the main features equivalent in the three cases (i.e. same gender, similar age, and similar symptoms), so the main difference would be the information about the possible triggers of the symptoms.

As described earlier the scenarios were produced using the BSM as a framework. Thus, the cases depicted similar symptoms of "shutdown" behavior (e.g., fatigue, social isolation, anhedonia, feelings of discouragement, disappointment, worthlessness, etc.) but provided different causal bases. The first scenario (i.e., Ms. Smith) occurs with no clear socio-environmental trigger and represents a sudden change of mood and behavior, implying the presence of a biological trigger. The second scenario (i.e., Ms. Jones) occurs as a result of a break-up and the way this experience is processed by the individual (e.g., intense feelings of failure, fear of loneliness and abandonment). The third scenario

(i.e., Ms. Taylor) occurs as a result of being exposed to a major socio-environmental stressor (i.e., the loss of the individual's house and business because of a storm).

Accompanying the vignettes there are eight questions using 7-point Likert scales. The first question addresses whether the person should be diagnosed with clinical depression (scale: from 1 "not likely at all" to 7 "very likely"). Although "clinical depression" does not represent a technical term for diagnosing depression—such as Major Depressive Disorder or Persistent Depressive Disorder, for instance—, it allows participants to think whether the depressive symptoms require a diagnosis. No precise technical terms were used in this question because the study wanted to address participants' beliefs on depression in general. Utilizing precise terms would have limited the phenomenon being studied to the specific term and its diagnosis requirements. For controlling for the variety of definitions of clinical depression, at the end of the first section of the interview participants were asked to provide the definition of clinical depression that they used while answering these questions.

The next three questions address how important are the biological, psychological, and environmental factors for understanding this person's symptoms (scale: from 1 "not important at all" to 7 "very important"). Two following questions ask participants whether they think psychotherapy and medication should be recommended (scale: from 1 "not likely at all" to 7 "very likely"). Two final questions ask participants their perspective about the effectiveness of psychotherapy and medication for treating this person (scale: from 1 "not effective at all" to 7 "very effective").

Statements about the nature of depression. The next section of the interview is composed of seven statements describing the nature of depression. Participants are asked

to answer their level of agreement with each statement utilizing a 1 to 7 Likert scale (being 1 “I do not agree at all” and 7 “I definitely agree”). All of these statements represent perspectives about the nature of depression maintained by different experts in the field. Indeed, they were largely taken almost verbatim as statements made by these experts. The rationale behind selecting these statements is to capture a variety of views about depression. Thus, some statements emphasize the biological aspect of depression, whereas others emphasize the non-biological aspect of depression. Also, some statements identify depression with a pathology/disease, whereas others identify it with a non-pathological/non-disease condition. See the second section of the UDI (Appendix A) for the complete list of statements.

Open-ended questions. During the third section of the interview interviewees answer orally four open-ended questions regarding the nature of depression, mental disorders, and mental health professionals’ perspectives about depression. See the third section of the UDI (Appendix A) for the complete list of open-ended questions.

Demographic questions. The end of the interview contains thirteen demographic questions asking participants personal information (i.e., gender, age, race, origin, and whether they or a close relative have ever suffered from depression), information about their education (i.e., level of education and degree), and professional information (i.e., their profession, their experience, job title, type of patient they treat, and school of training).

Enhancing rigor

A few words need to be said about how the researcher enhanced rigor during the collection, analysis and interpretation processes. In terms of the data collection, the interview protocol was developed taking into account experts' guidelines for appropriate interview procedures (Creswell, 2013; Glesne, 2006; Merriam, 2009), was piloted four times with participants with different background (two clinical psychologists, one counselor, and one non-expert), and was finally evaluated by a content expert. During the analysis process, a group of coders was recruited for observing the data and developing the list of themes. Several team sessions were focused on discussing the themes in group to seek agreement on the interpretation.

Finally, in order to enhance rigor in research it is important to be transparent in terms of the interpretive framework that structures this study. This study is embedded in a pragmatic interpretive framework. Pragmatism focuses on the research question and the specific problem being studied, and considers that research methods should be selected only in terms of their appropriateness for addressing the research questions (Creswell, 2013). In other words, pragmatism is not committed to a specific philosophical worldview (e.g., positivism, postmodernism), and results from studies using this interpretative framework are not interpreted taking into account ontological and epistemological metanarratives (Creswell, 2013). The findings are interpreted within the scope of the study.

Chapter IV: Results

Quantitative results

Quantitative data from sections one and two of the UDI were analyzed. Five research questions guided these analyses, which focused on the extent to which the interviewed psychiatrists, psychologists, counselors, and non-experts differed in: 1) how likely they are to diagnose each case with a depressive disorder; 2) how they rate the importance of the biological, psychological, and environmental factors; 3) the extent to which they recommend and value psychotherapy; 4) the extent to which they recommend and value medication; and 5) their opinions about the nature of depression. The results of the analyses are presented by section.

Section one. All analyses were conducted using SAS 9.3. Descriptive statistics were conducted to analyze participants' responses to the questions referring to diagnosis, etiology, and treatment of depression from the first section of the UDI. Specifically, utilizing a 7-point Likert scale, participants answered the following questions for each of the three vignettes: 1) Do you think this person should be diagnosed with clinical depression?, 2.a) How would you rate the importance of the biological factors for understanding this person's symptoms?, 2.b) How would you rate the importance of the psychological factors for understanding this person's symptoms?, 2.c) How would you rate the importance of the environmental factors for understanding this person's symptoms? , 3.a) Would you recommend psychotherapy for managing or controlling this person' symptoms?, 3.b) To what extent psychotherapy could be an effective treatment for managing or controlling this person's symptoms?, 4.a) Would you recommend

medication for managing or controlling this person' symptoms?, 4.b) To what extent medication could be an effective treatment for managing or controlling this person's symptoms?

Table 1 lists the mean, mode, and standard deviation of each group, and Table 2 lists the standardized mean differences between groups. Standardized mean differences are interpreted using Cohen's (1988) benchmarks for interpreting practically significant standardized mean differences (0.20 = *small*, 0.50 = *medium*, 0.80 = *large* meaningful differences; Cohen, 1988). With the purpose of maintaining a conservative interpretation of the results, in the current study only large mean differences are considered practically significant. No statistical significance (*t*-tests) tests are computed given the small sample size.

Table 1

First Section. Group Averages

CASE	Item		Psychiatrists *n* = 6			Psychologists *n* = 12			Counselors *n* = 5			Non-experts *n* = 5		
			M	***Mode***	***SD***	***M***	***Mode***	***SD***	***M***	***Mode***	***SD***	***M***	***Mode***	***SD***
Case 1	1	Diagnosis	6.00	7	1.26	5.75	5	1.06	6.00	6	1.22	5.10	5	0.74
	2.a	Biological factor	6.00	5	0.89	5.83	6	1.34	5.60	5	1.34	4.90	7	2.13
	2.b	Psychological factor	5.83	7	1.60	5.17	5	1.19	6.20	6	0.84	5.20	5	2.05
	2.c	Environmental factor	5.67	5	1.21	4.96	5	1.18	5.60	7	1.67	6.00	5	1.00
	3.a	Psychotherapy	6.60	7	0.89	6.42	7	0.79	60	6	1.22	6.50	7	0.87
	3.b	Effectiveness	6.00	6	1.22	5.83	6	1.11	6.30	6	0.67	6.10	6	0.55
	4.a	Medication	5.83	7	1.60	4.83	6	1.64	4.70	4	0.67	2.40	2	1.52
	4.b	Effectiveness	5.17	5	0.98	4.92	6	1.68	5.60	4	1.52	3.70	4	1.64
Case 2	1	Diagnosis	4.50		1.87	5.21	5	1.30	4.40	3	1.67	4.90		1.95
	2.a	Biological factor	4.50		1.87	4.08	2	1.98	3.80	2	1.79	3.40	2	2.19
	2.b	Psychological factor	7.00	7	0	6.67	7	0.65	6.40	6	0.55	6.60	7	0.55
	2.c	Environmental factor	6.17	7	1.60	6.25	7	1.14	5.60	4	1.52	6.40	6	0.55
	3.a	Psychotherapy	6.83	7	0.41	6.58	7	0.67	6.40	6	0.55	6.40	7	0.89
	3.b	Effectiveness	6.67	7	0.52	6.25	7	1.06	6.20	6	0.84	6.60	7	0.55
	4.a	Medication	4.17		2.32	3.67	3	1.97	4.30	2	2.28	3.00	1	2.45
	4.b	Effectiveness	4.17	2	2.04	3.42	2	1.73	4.60	2	2.51	3.20	1	2.28
Case 3	1	Diagnosis	5.08	7	2.11	4.92	6	1.44	4.70	5	1.57	5.10	4	1.14
	2.a	Biological factor	5.25	7	1.78	3.17	2	1.80	3.10	2	1.52	3.30		2.33
	2.b	Psychological factor	6.00	7	1.55	5.17	5	1.34	5.80	5	0.84	5.80	7	1.30
	2.c	Environmental factor	7.00	7	0	6.75	7	0.45	6.60	7	0.55	6.90	7	0.22
	3.a	Psychotherapy	6.00	7	1.26	5.50	7	1.62	6.20	6	0.84	6.80	7	0.45
	3.b	Effectiveness	5.33	6	1.97	4.92	5	1.68	6.00	6	0.71	6.40	7	0.89
	4.a	Medication	4.67	4	1.75	3.88	2	2.26	3.50	2	1.50	2.80	1	2.17
	4.b	Effectiveness	4.83	4	1.47	3.75	1	1.99	3.80	4	1.10	3.10	4	1.52
TOTAL	1	Diagnosis	5.19	7	1.58	5.29	5	0.94	5.03	5	1.28	5.03	4	0.94
	2.a	Biological factor	5.25	7	1.27	4.36	2	1.25	4.17	2	1.35	3.87	2	2.13

	2.b	Psychological factor	6.28	7	0.68	5.67	7	0.71	6.13	6	0.56	5.87	7	1.26
	2.c	Environmental factor	6.28	7	0.88	5.99	7	0.75	5.93	7	1.21	6.43	7	0.52
	3.a	Psychotherapy	6.44	7	0.46	6.17	7	0.77	6.20	6	0.84	6.57	7	0.70
	3.b	Effectiveness	5.97	7	0.81	5.67	7	1.11	6.17	6	0.53	6.37	7	0.58
	4.a	Medication	4.89	7	1.54	4.12	4	1.41	4.17	2	1.25	2.73	1	1.96
	4.b	Effectiveness	4.72	4	1.32	4.03	2	1.35	4.67	4	1.56	3.33	4	1.70

Table 2

First Section. Standardized Mean Differences

			Psychiatrists	**Psychologists**	**Counselors**	**Non-experts**	**Standardized Mean differences**					
			A	**B**	**C**	**D**	**Cohen's *d***					
CASE	**Item**		**n = 6**	**n = 12**	***n* = 5**	**n = 5**	**A - B**	**A - C**	**A - D**	**B - C**	**B - D**	**C - D**
			M	***M***	***M***	***M***						
Case 1	1	Diagnosis	6.00	5.75	6.00	5.10	0.211	0	**0.776**	-0.215	0.626	**0.806**
	2.a	Biological factor	6.00	5.83	5.60	4.90	0.133	0.329	0.642	0.163	0.555	0.355
	2.b	Psychological factor	5.83	5.17	6.20	5.20	0.472	-0.257	0.318	**-0.883**	-0.019	0.577
	2.c	Environmental factor	5.67	4.96	5.60	6.00	0.568	0.045	-0.269	-0.457	**-0.870**	-0.262
	3.a	Psychotherapy	6.60	6.42	6.00	6.50	0.208	0.523	0.104	0.431	-0.094	-0.426
	3.b	Effectiveness	6.00	5.83	6.30	6.10	0.141	-0.271	-0.093	-0.441	-0.258	0.295
	4.a	Medication	5.83	4.83	4.70	2.40	0.585	**0.811**	**2.004**	0.085	**1.434**	**1.769**
	4.b	Effectiveness	5.17	4.92	5.60	3.70	0.159	-0.315	**1.022**	-0.394	0.694	**1.085**
Case 2	1	Diagnosis	4.50	5.21	4.40	4.90	-0.450	0.051	-0.192	0.546	0.196	-0.249
	2.a	Biological factor	4.50	4.08	3.80	3.40	0.206	0.349	0.498	0.138	0.317	0.181
	2.b	Psychological factor	7.00	6.67	6.40	6.60	0.583	**1.496**	**0.997**	0.410	0.106	-0.328
	2.c	Environmental factor	6.17	6.25	5.60	6.40	-0.059	0.333	-0.169	0.493	-0.140	-0.632
	3.a	Psychotherapy	6.83	6.58	6.40	6.40	0.396	**0.824**	0.589	0.267	0.232	0
	3.b	Effectiveness	6.67	6.25	6.20	6.60	0.432	0.631	0.120	0.047	-0.349	-0.509
	4.a	Medication	4.17	3.67	4.30	3.00	0.228	-0.052	0.450	-0.291	0.302	0.496
	4.b	Effectiveness	4.17	3.42	4.60	3.20	0.390	-0.174	0.412	-0.569	0.110	0.527

CASE	Item		Psychiatrists A n = 6 *M*	Psychologists B n = 12 *M*	Counselors C *n* = 5 *M*	Non-experts D n = 5 *M*	Standardized Mean differences Cohen's *d* A - B	A - C	A - D	B - C	B - D	C - D
Case 3	1	Diagnosis	5.08	4.92	4.70	5.10	0.091	0.184	-0.010	0.141	-0.125	-0.263
	2.a	Biological factor	5.25	3.17	3.10	3.30	**1.104**	**1.177**	**0.873**	0.038	-0.063	-0.092
	2.b	Psychological factor	6.00	5.17	5.80	5.80	0.561	0.142	0.127	-0.487	-0.450	0
	2.c	Environmental factor	7.00	6.75	6.60	6.90	0.638	**0.997**	0.623	0.297	-0.354	-0.647
	3.a	Psychotherapy	6.00	5.50	6.20	6.80	0.314	-0.167	-0.742	-0.457	**-0.877**	**-0.804**
	3.b	Effectiveness	5.33	4.92	6.00	6.40	0.220	-0.397	-0.618	-0.690	**-0.93**	-0.449
	4.a	Medication	4.67	3.88	3.50	2.80	0.356	0.651	**0.878**	0.173	0.458	0.339
	4.b	Effectiveness	4.83	3.75	3.80	3.10	0.558	0.714	**1.060**	-0.026	0.329	0.477
TOTAL	1	Diagnosis	5.19	5.29	5.03	5.03	-0.081	0.101	0.110	0.237	0.263	0
	2.a	Biological factor	5.25	4.36	4.17	3.87	0.675	**0.756**	0.739	0.141	0.303	0.152
	2.b	Psychological factor	6.28	5.67	6.13	5.87	**0.829**	0.218	0.382	-0.648	-0.213	0.241
	2.c	Environmental factor	6.28	5.99	5.93	6.43	0.348	0.308	-0.185	0.064	-0.600	-0.485
	3.a	Psychotherapy	6.44	6.17	6.20	6.57	0.374	0.334	-0.205	-0.036	-0.505	-0.432
	3.b	Effectiveness	5.97	5.67	6.17	6.37	0.279	-0.261	-0.510	-0.480	-0.667	-0.325
	4.a	Medication	4.89	4.12	4.17	2.73	0.505	0.464	**1.135**	-0.035	**0.837**	**0.791**
	4.b	Effectiveness	4.72	4.03	4.67	3.33	0.490	0.032	**0.847**	-0.431	0.458	0.742

Note: Large mean differences are bolded (Cohen, 1988).

Regarding the first research question whether the respondents differed in how likely they were to diagnose the individuals presented in the vignettes with a depressive disorder, there were no practically significant differences when the totals were collapsed across the cases. The interviewed groups ranged from 5.03 (*SD* = 1.28) to 5.29 (*SD* = 0.94), indicating that, in general, the interviewers tended to see the cases as warranting a diagnosis. There were some practically significant differences found in regards to the first case. Non-experts (*M* = 5.10, *SD* = 0.74) were less likely to diagnose the case in the first vignette with depression than psychiatrists (*M* = 6.00, *SD* = 1.26, *d* = -0.78), and counselors (*M* = 6.00, *SD* = 1.22, *d* = -0.81) (see Table 1 and 2 for these and the following results from section one).

The second quantitative research question of this study focuses on whether interviewed mental health professionals differ in their judgment about the importance of the biological, psychological and environmental factors for understanding the symptoms from each vignette. In terms of the *biological factors*, when the totals were collapsed, practically significant differences were found between psychiatrists (*M* = 5.25, *SD* = 1.27) and counselors (*M* = 4.17, *SD* = 1.35, *d* = 0.76), psychiatrists giving more importance to these factors than counselors. The analysis of standardized mean differences also revealed meaningful differences in the third vignette. Psychiatrists (*M* = 5.25, *SD* = 1.78) rated higher the importance of biological factors than psychologists (*M* = 3.17, *SD* = 1.80, *d* = 1.10), counselors (*M* = 3.10, *SD* = 1.52, *d* = 1.18), and non-experts (*M* = 3.30, *SD* = 2.33, *d* = 0.87).

In the case of *psychological factors*, when the totals were collapsed, there were practically significant differences between psychiatrists (*M* = 6.28, *SD* = 0.68) and

psychologists (*M* = 5.67, *SD* = 0.71, *d* = 0.83), with psychiatrists considering psychological factors *more* important than psychologists. The groups ranged from 5.67 (*SD* = 0.71) to 6.28 (*SD* = 0.68), indicating that psychological factors were considered as moderately to very important. The statistical analysis revealed meaningful differences between the groups in the first and second vignettes. In the first scenario, psychologists (*M* = 5.17, *SD* = 1.19) rated lower the importance of psychological factors compared to counselors (*M*= 6.20, *SD* = 0.84, *d* = -0.88). In the second scenario, psychiatrists (*M* = 7.00, *SD* = 0.00) rated higher the importance of the psychological factors compared to counselors (*M* = 6.40, *SD* = 0.55, *d* = 1.50) and non-experts (*M* = 6.60, *SD* = 0.55, *d* =1.00). It is worth noting here that this difference is largely a function of strong consistency of psychiatrists to respond to the psychological factors with the highest rating.

In terms of the *environmental factors*, statistical analyses revealed practically significant differences when the totals were collapsed. Groups ranged from 5.93 (*SD* = 1.21) to 6.43 (*SD* = 0.52), indicating that participants considered environmental factors as very important. Meaningful differences were found in the first and third vignettes. In the first scenario there is a meaningful difference between psychologists (*M* = 4.96, *SD* = 1.18) and non-experts (*M* = 6.00, *SD* = 1.00, *d* = -0.87), non-experts rating higher the importance of environmental factors than psychologists. In the third scenario, psychiatrists (*M* = 7.00, *SD* = 0.00) provided higher scores to the importance of the environmental factors than counselors (*M* = 6.60, *SD* = 0.55, *d* = 1.00).

The third research question of this study inquires whether interviewed mental health professionals differ in their approach to psychotherapy. In terms of *recommending*

psychotherapy no meaningful differences were observed when the totals were collapsed. Groups ranged from 6.17 (*SD* = 0.77) to 6.57 (*SD* = 0.70), indicating that respondents tended to strongly recommend psychotherapy. Meaningful differences were reported in vignettes two and three. In the second scenario, psychiatrists (*M* = 6.83, *SD* = 0.41) rated higher their likelihood to recommend psychotherapy compared to counselors (*M* = 6.40, *SD* = 0.55, *d* = 0.82). In the third scenario, non-experts (*M* = 6.80, *SD* = 0.45) rated higher their likelihood to recommend psychotherapy compared to psychologists (*M* = 5.50, *SD* = 1.26, *d* = 0.88) and counselors (*M* = 6.20, *SD* = 0.84, *d* = 0.81). In terms of *the effectiveness of psychotherapy*, no meaningful differences were found when the totals were collapsed. Groups ranged from 5.67 (*SD* = 1.11) to 6.37 (*SD* = 0.58), indicating that respondents tended to consider psychotherapy as an effective treatment for managing the depressive symptoms. Statistical analysis revealed meaningful differences in the third case between non-experts (*M* = 6.40, *SD* = 0.89) and psychologists (*M* = 4.92, *SD* = 1.68, *d* = 0.93), non-experts rating higher the effectiveness of psychotherapy.

The fourth research question in this study investigated whether interviewed mental health professionals differ in their approach to medication. In terms of *recommending medication*, when the totals were collapsed, meaningful differences were found between non-experts (*M* = 2.73, *SD* = 1.96) and psychiatrists (*M* = 4.89, *SD* = 1.54, *d* = -1.14), psychologists (*M* = 4.12, *SD* = 1.41, *d* = -0.84), and counselors (*M* = 4.17, *SD* = 1.25, *d* = -0.79), with the non-experts being less likely to recommend medication than all the other groups. The groups ranged from 2.73 (*SD* = 1.96) to 4.89 (*SD* = 1.54), indicating that, in general, respondents did not strongly endorse recommending medication. Meaningful differences were also found in scenarios one and three. In the

first scenario, psychiatrists (*M* = 5.83, *SD* = 1.60) were more likely than counselors (*M* = 4.70, *SD* = 0.67, *d* = 0.81) and non-experts (*M* = 2.40, *SD* = 1.52, *d* = 2.00) to recommend medication. Non-experts, on the other hand, were less likely to recommend medication compared to psychiatrists, psychologists (*M* = 4.83, *SD* = 1.64, *d* = -1.43), and counselors (*d* = -1.77). In the third scenario, psychiatrists (*M* = 4.67, *SD* = 1.75) were more likely to recommend medication than non-experts (*M* = 2.80, *SD* = 2.17, *d* = 0.88).

In terms of *effectiveness of medication*, when all cases were collapsed meaningful differences were found between psychiatrists (*M* = 4.72, *SD* = 1.32) and non-experts (*M* = 3.33, *SD* = 1.70, *d* = -0.85), non-experts being less likely to consider that medication was an effective treatment. Groups ranged from 3.33 (*SD* = 1.70) to 4.72 (*SD* = 1.32), indicating that participants did not strongly endorse the effectiveness of medication for treating the depressive symptoms. Statistical analysis also revealed meaningful differences in the first case, where non-experts (*M* = 3.70, *SD* = 1.64) rated lower the effectiveness of medication compared to psychiatrists (*M* = 5.17, *SD* = 0.98, *d* = -1.02), and counselors (*M* = 5.60, *SD* = 1.52, *d* = -1.09). In the third case, again, non-experts (*M* = 3.10, *SD* = 1.52) rated lower the effectiveness of medication compared to psychiatrists (*M* = 4.83, *SD* = 1.47, *d* = -1.06).

Section two. Descriptive statistics were conducted to analyze participants' responses to the questions referring to their level of agreement with different statements about the nature of depression from the second section of the UDI. Specifically, utilizing a 7-point Likert scale participants rated their level of agreement with the following

statements: 1) Depression is a disease of the brain; 2) Depression is a normal reaction to an environmental stressor; 3) Depression is caused by maladaptive psychological patterns; 4) If a person is grieving, he or she should be exempted from being diagnosed with clinical depression; 5) It is a myth that depression is a disease, like cancer; 6) Given that depression is biological in nature, people are not responsible for having depression; 7) Depression arises as a result of not being able to meet socially constructed standards defining "the good person."

Table 3 lists the mean, mode, and standard deviation for each group and Table 4 lists the standardized mean differences between groups. Standardized mean differences are interpreted using Cohen's (1988) benchmarks for interpreting practically significant standardized mean differences (0.20 = *small*, 0.50 = *medium*, 0.80 = *large* meaningful differences; Cohen, 1988). With the purpose of maintaining a conservative interpretation of the results, in the current study only large mean differences are considered practically significant. No statistical significance (*t*-tests) tests are computed given the small sample size.

Table 3

Second Section. Group Averages

#	Statements	Psychiatrists *n* = 6			Psychologists *n* = 12			Counselors *n* = 5			Non-experts *n* = 5		
		M	***Mode***	***SD***	***M***	***Mode***	***SD***	***M***	***Mode***	***SD***	***M***	***Mode***	***SD***
1	Depression is a disease of the brain.	5.67	7	1.51	4.83	7	2.08	5.00	5	1.87	1.80	1	1.30
2	Depression is a normal reaction to an environmental stressor.	2.75	2	2.14	4.04	2	1.98	4.40	6	2.07	5.20	7	1.79
3	Depression is caused by maladaptive psychological patterns.	4.67	3	1.63	5.42	6	1.56	5.88	5	1.03	4.40	6	1.82
4	If a person is grieving, should be exempted from being diagnosed with clinical depression.	3.50	1	2.59	3.79	3	1.80	4.63	5	1.11	3.70	4	2.22
5	It is a myth that depression is a disease, like cancer.	1.17	1	0.41	2.75	1	1.76	4.60	5	2.07	4.60	3	2.19
6	Given that depression is biological in nature, people are not responsible for having depression.	3.67	6	2.07	4.54	4	1.85	4.20		1.92	3.80	3	2.17
7	Depression arises as a result of not being able to meet socially constructed standards defining the "good person."	3.33	5	1.86	2.58	2	1.44	4.20	4	1.10	3.90		2.30

Table 4

Second Section. Standardized Mean Differences

		Psychiatrists	Psychologists	Counselors	Non-experts	Standardized mean differences					
		A	B	C	D	Cohen's *d*					
		n **= 6**	***n*** **= 12**	***n*** **= 5**	***n*** **= 5**	**A - B**	**A - C**	**A - D**	**B - C**	**B - D**	**C - D**
#	**Statements**	***M***	***M***	***M***	***M***						
1	Depression is a disease of the brain.	5.67	4.83	5.00	1.80	0.42	0.37	**2.49**	-0.08	**1.51**	**1.80**
2	Depression is a normal reaction to an environmental stressor.	2.75	4.04	4.40	5.20	-0.61	-0.72	**-1.12**	-0.17	-0.57	-0.37
3	Depression is caused by maladaptive psychological patterns.	4.67	5.42	5.88	4.40	-0.45	**-0.79**	0.14	-0.30	0.59	**0.90**
4	If a person is grieving, should be exempted from being diagnosed with clinical depression.	3.50	3.79	4.63	3.70	-0.13	-0.50	-0.08	-0.49	0.04	0.48
5	It is a myth that depression is a disease, like cancer.	1.17	2.75	4.60	4.60	**-1.02**	**-2.22**	**-2.10**	**-0.95**	**-0.93**	0
6	Given that depression is biological in nature, people are not responsible for having depression.	3.67	4.54	4.20	3.80	-0.43	-0.24	-0.06	0.17	0.36	0.18
7	Depression arises as a result of not being able to meet socially constructed standards defining the "good person."	3.33	2.58	4.20	3.90	0.45	-0.51	-0.25	**-1.13**	-0.73	0.15

Note: Large mean differences are bolded (Cohen, 1988).

There were several practically significant differences in the way the groups responded to these statements. In terms of *Depression is a disease of the brain,* the analysis of standardized mean differences revealed meaningful differences between non-experts and the other groups, with non-experts (M = 1.80, SD = 1.30) rating lower their level of agreement compared to psychiatrists (M = 5.67, SD = 1.51, d = -2.49), psychologists (M = 4.83, SD = 2.08, d = -1.51), and counselors (M = 5.00, SD = 1.87, d = -1.80) (see Table 3 and 4 for these and the following results from section two). In the case of *Depression is a normal reaction to an environmental stressor,* psychiatrists (M = 2.75, SD = 2.14) rated lower their level of agreement with this statement compared non-experts (M = 5.20, SD = 1.79, d = -1.12). In the case of the third statement, *Depression is caused by maladaptive psychological patterns,* counselors (M = 5.88, SD = 1.03) rated higher their level of agreement with this statement compared to psychiatrists (M = 4.67, SD = 1.63, d = 0.79) and non-experts (M = 4.40, SD = 1.82, d = 0.90). No meaningful differences were found in participants' responses to the statement *If a person is grieving, he or she should be exempted from being diagnosed with clinical depression.* Statistical analysis did reveal meaningful differences in the case of the statement *It is a myth that depression is a disease, like cancer.* Psychiatrists largely were in strong disagreement with this statement (M = 1.17, SD = 0.41), more so than psychologists (M = 2.75, SD = 1.76, d = -1.02), counselors (M = 4.60, SD = 2.07, d = -2.22), and non-experts (M = 4.60, SD = 2.19, d = -2.10). Psychologists disagreed with this statement more so than counselors (d = -0.95) and non-experts (d = -0.93). No meaningful differences were found in participants' responses to the statement *Given that depression is biological in nature, people are not responsible for having depression.* Finally, in the case of

Depression arises as a result of not being able to meet socially constructed standards defining the "good person," psychologists (M = 2.58, SD = 1.44) rated their level of agreement lower compared to counselors (M = 4.20, SD = 1.10, d = -1.13).

Summary of results. Quantitative analysis revealed that the strongest differences occurred between non-experts and psychiatrists. These groups differed in several areas but one particularly clear pattern is observed in participants' attitude toward medication. Compared to psychiatrists, non-experts tended to strongly avoid recommending medication for treating depression. Several differences were also found between non-experts and psychologists and non-experts and counselors. Interestingly, fewer differences were observed among mental health professionals. Within the groups of clinicians, counselors and psychiatrists were the groups that differed the most, and psychiatrists and psychologists were the groups that differed the least. One pattern that did emerge among mental health professionals was the difference between psychiatrists and the rest of the clinicians in terms of their judgment about the importance of biological factors (in case three), and in their disagreement with the statement *It is a myth that depression is a disease, like cancer*.

Qualitative results

The qualitative data in the Understanding Depression Interview are derived from the think-aloud technique utilized in the first and second sections, and from the open-ended questions from the first and third sections of the interview. The research question that guided the analysis of these data was *how do the interviewed mental health*

professionals and non-experts conceptualize depression? The qualitative data were analyzed using thematic analysis for identifying patterns of responses that emerge from the data (Braun & Clarke, 2014). For the purpose of the study it was particularly interesting to capture instances where participants struggled presenting their perspective because they recognized a contradiction or tension within their conceptual framework. These instances are categorized as "tensions". Table 5 lists the main themes and tensions found in the data.

Table 5

Results from the Thematic Analysis: Themes and Tensions that Emerged from the Data

Main Themes	Themes	Tensions
APPROACH TO DIAGNOSIS	Focus on DSM criteria	**Tensions in case 2 and 3:**
	Focus etiology of symptoms	Between clear impairment and no vegetative profile
	Focus on patient's narrative of the experience.	Between symptoms and understandable reaction
	Symptoms represent a drastic change, and person needs help	Between understandable reaction and need of treatment
	Vegetative profile	Between symptoms and the fact that symptoms would go away if there is an intervention in the environment
	Concerns with diagnosis system:	
	Diagnosis means pathology	
	By principle people should not diagnose without knowing the person.	
CAUSAL BASIS	Depression is multifactorial	
	Depression is not multifactorial (biologically based)	
CLINICAL DEPRESSION	Depression that meets DSM criteria (in general, for MDD or for Dysthymia)	
	Depression that meets DSM criteria and is defined as depression by clinical judgment	
	Cluster of depressive symptoms that impair functioning and impact brain chemistry	
	Depression that requires medication for treatment	Between presence of severe depressive symptoms and not requiring medication
	Condition that is getting worse, interferes with life, and requires intervention.	
	Depression that requires hospitalization.	
	Technical word, a made-up word	

TYPES OF DEPRESSION	Disease type of depression Biologically based No psychosocial stressor Patient is less responsible for her condition Symptoms are ego-dystonic Depression occurs suddenly Symptoms are more severe Requires strong intervention Non-disease type Reactive depression Normal reaction Understandable Presence of psychosocial stressor Patient is more responsible for her condition Functional or adaptive Sign that something is not OK in our life Treatment approach should not be focused on "eliminating it" Non-Pathological Situational depression Adjustment disorder Natural reaction Existential Crisis Clinical depression Concern with identifying depression as a disease	On the one hand, understanding depression as a disease legitimizes the condition, removes blame from the patient, and supports the need for treatment. On the other hand, it assumes that it is a pathology, that is biologically based, and that should be treated with biological intervention.
TREATMENT APPROACH	**Approach to treatment:** Combination is the best approach Psychotherapy as "first line of defense" Medication as "last resource" **Reasons for recommending medication:** Cause is biological Severity of symptoms (e.g., suicide risk) Patient is not able to focus on therapy "Cutting the vicious cycle" (e.g., get out of bed) Psychotherapy is not working **Concerns with medication:** Side effects Does not target the real problem Overmedicated society	Between "severity of symptoms requires medical intervention" but "cause of the symptoms is not biological but situational" Between "severity of symptoms requires medical intervention" but "not wanting to convey the wrong message to their patient (i.e.,

	'reaction is pathological')"
Sends the message that we are dealing with a pathology	
Medication blunts emotions and the pain has a function in the healing process	
Disempowers people	
Concern with current health model:	
Concern about low level of care	
Reducing care to medication	
Overmedicated society	
There are differences among different mental health professions	
Listed differences:	
Psychiatrists: medical model perspective, focused on symptoms, focused on how to cure symptoms with drugs, sometimes overemphasizing biological aspects	
Psychologists: non-medical model, focused on symptoms and the context, focused on weaknesses and psychopathologies, overlooking biological aspects, easier for them to see the whole picture.	
Counselors: non-medical model, focused on socio-environmental aspects, strengths, and growth, sometimes overlooking psychopathologies and biological aspects	
Social workers: non-medical model, focused on socio-environmental aspects	
No concern regarding these differences	
Concern:	
Psychiatrists have reduced their care to medication, they are no longer therapists	
Importance of team approach	
Differences are positive	

DIFFERENCES AMONG MENTAL HEALTH PROFESSIONALS

Qualitative Analyses of the Groups. This section reports the results of the qualitative analysis by group and themes, and provides extracts of the interviews to illustrate the themes and tensions using participants' voices.

***Psychiatrists*.** Among psychiatrists, two approaches to diagnosis were identified: 1) focusing on the symptoms and the DSM criteria, and 2) focusing on the symptoms *and* the presumed etiology. The majority of psychiatrists seemed to require a "vegetative profile" for identifying a depressive case as clinical depression. Some psychiatrists struggled in the cases where they considered there was a clear impairment but no vegetative profile. During the diagnosis of cases 2 and 3, some participants struggled when they considered the presence of depressive symptoms but also considered the reaction as a "logical reaction," or as a response to a "traumatic event." For example:

> For her I am not sure if I would diagnose with depression. Maybe it could be an adjustment disorder. I am not sure, maybe a Depressive Disorder, NOS or something like that. And again, I wouldn't want her to feel like her response is pathological. I think it is a pretty normal response to what she has been going through.

The psychiatrists understood "clinical depression" in different ways. This is understandable because the term was expected to have some degree of ambiguity. As expected, the majority of psychiatrists equated it to a condition that meets DSM criteria (DSM criteria in general or for Major Depressive Disorder or Dysthymic Disorder specifically). When asked to further explain their perspective about depression it was mainly defined as a *neurobiological syndrome* that *impairs functioning*. Some

psychiatrist participants understood clinical depression not only as a *neurobiological syndrome* that *impairs functioning*, but as an entity that "only responds to medication." These individuals experienced a tension when considering depressive syndromes that respond to psychotherapy. For example:

> I am reserving clinical depression for a neurobiological syndrome that clearly impairs functioning and that clearly needs medication or some other biological treatment. So, I do acknowledge and understand that there are some people receiving purely psychotherapy and if you ask them they will say they are depressed. So, in a way that is clinical depression. But, in those cases if they are not on meds… the way I understand the terms, I would expect their level of functioning not to be as impaired, and that is the difference. So, do you want to call that clinical depression, too? I don't call that clinical depression, but that is partly the result of my training. I was taught to call clinical depression the neurobiological kind that we treat with meds.

In terms of the basis of depression, the majority of participants considered that depression could either be biologically based (e.g., having a biological predisposition to be depressed) or non-biologically based. Only one psychiatrist considered that clinical depression could only be biologically based:

> I think of depression as a condition of the brain. You can probably test various neurotransmitters and see that they are depleted, and the manifestation of it are changes in thinking… and people get stuck in the thoughts. But, in fact, it is not the thoughts that are causing the problem. The thoughts are a symptom of the illness.

Two identifiable types of depression emerged from psychiatrists' responses: the disease type and the non-disease type of depression. The disease type of depression was characterized as biologically based, occurring outside the presence of a psychosocial stressor, and implying that the patient is not responsible for her condition. The non-disease type of depression was characterized as non-biologically based, occurring in the presence of a psychosocial stressor, and implying that the patient is more responsible for her condition. One psychiatrist mentioned that depression was a group of disorders that differ in terms of their cause. This participant considered that one is not able to differentiate these disorders because does not have enough knowledge about the causes. He also considered that it was important to differentiate them because of treatment plans and for not stigmatizing the person who is depressed but is having a "logical reaction."

In terms of treatment approach, interviewed psychiatrists either recommended a combination of psychotherapy and medication ("because research shows this is the best treatment approach"), or considered that medication should not be the "first line of defense." Reasons for not recommending medication were the need to rule out other problems, patient's objection to receive medication, the idea that medication does not solve the real problem, and the use of alternative interventions (e.g., "doing exercises"). Participants who thought that medication should not be the "first line of defense," expressed a strong frustration with the current health model and the level of care (e.g., "we are overmedicalizing people," "we are reducing treatment care to medicalization"). The following quote from one participant illustrates this frustration:

> Psychiatrists have sold their soul to the pharmaceutical industry and the insurance industry. They let themselves be med-check machines that really don't care what

> is going on inside your mind. They just want to know what code to put on the line and to know what pill to give you.

Some of these participants also expressed some concern when asked about whether there were differences among mental health professionals. In general, all interviewed psychiatrists considered that there were differences among mental health professionals, but only some participants showed concern about it, specifically, about psychiatrists' role in treatment care. The following quote illustrates this point:

> Over the past decades, we [psychiatrists] have been marginalized into medication prescribers and that is pretty much what psychiatrists have been trained to do. …That is low quality care. The reason why is because treatment does not only involve being able to understand theories of how drugs work and be able to look at someone medically and prescribe a drug, treatment also requires knowing how to ask the right questions and be able to pick up subtle cues from people and that is why I thing psychiatrists should be trained as therapists.

Psychologists. Diagnosis was approached in different ways among psychologists. In contrast to psychiatrists, psychologists did not focus on "neuro-vegetative symptoms" for diagnosing depression. Some psychologists mainly focused on whether the patient met the DSM criteria for depression, whereas others also focused on the etiology of the symptoms, and one participant also took into account the patient's narrative of the situation. This last participant claimed that "by principle, we shouldn't diagnose without knowing the patient." There were some tensions observed among those who considered the DSM criteria and the etiology for diagnosing. Similar to the tensions expressed by several psychiatrists, several psychologists struggled when diagnosing case two and three

because they recognized the presence of depression symptoms but, at the same time, they considered them "a normal reaction" to a traumatic event. Some participants also struggled when diagnosing case three because they recognized the presence of clinical depression but, at the same time, they considered that "the symptoms would go away if we change the environment."

"Clinical depression" was understood by the group of psychologists in different ways. Some participants equated it to a condition that meets DSM criteria, whereas others considered that on top of meeting DSM criteria, psychologists needed to refer to their clinical judgment and theoretical background for judging whether a condition could be considered clinical depression or not. In terms of causal basis of depression, all participants considered that depression could have different causal basis, as illustrated by this quote: "in some cases it is organic, there are no clear situational reasons for it… but a lot of times depression is understandable… we see clear connections between the environmental triggers or the person's own personality development and … depression." When reflecting about the causal basis of depression, one psychologist expressed his concern on putting too much emphasis on biological explanations:

> …the bias in the mental health field is very much toward biological explanations for these phenomena because they are less blaming, they induce less guilt, insurance companies like them more… It is easier to wrap your mind around if we have concepts of bad genes and chemical imbalances. The problem is human beings are a lot more complex than that.

As observed among the psychiatrists, psychologists differentiated between a "disease type" of depression, and a "non-disease type" of depression. The first one was

described as “biochemical,” “biologically based,” “organic,” as happening “suddenly,” and “ego-dystonic.” The non-disease type of depression was described as “reactive,” a “normal response,” and as “understandable.” When reflecting on the idea of depression as a disease, some participants struggled between understanding depression as an illness that “could be cured,” “could be addressed,” and as a condition that is not always the result of “a defect in an organ,” and could be a “normal response to a traumatic event.”

Another difference was found between a functional or adaptive form of depression and a dysfunctional or maladaptive form of depression. For some participants, some types of depression carry the function of helping us “to make sense of ourselves,” of “telling us something we need to know,” as illustrated by this quote:

> There is something about what is happening in their life that if they pay attention to that and use that as a fuel for doing something, making a change, their life circumstances could improve. What I am saying is that there is an adaptable form of clinical depression.

In terms of treatment approach, participants considered that psychotherapy should be “the first line of defense,” unless the patient is not stable enough for engaging successfully in therapy. Some of them shared some concerns with respect to medication (e.g., “it does not treat the real problem,” “no long term effects”). One participant mentioned that medication could even have adverse effects in the therapeutic process: “…before I strip them of their ability to make sense of their own experience through medication, I would want to give them at least the opportunity to understand why they are having the experience they are.” Reasons for recommending medication were “if the cause is biological,” “if symptoms are too severe (e.g., suicidal thinking),” “if therapy is

not working," and if patients lack clarity for engaging in psychotherapy (e.g., "foggy thinking").

Finally, when asked whether there are differences in the way different mental health professionals conceptualize depression, all interviewed psychologists considered that mental health professionals differed in their treatment approach, their focus on different type of causes, and/or in the way they conceptualize depression. Psychiatrists were generally described as maintaining a medical model, focusing on the symptoms and on how to treat them through medication; psychologists were generally defined as focused on deficiencies, psychopathologies, developmental processes and cognitive aspects; and counselors and social workers were defined as focusing on strengths, personal growth, and socio-environmental aspects. One participant considered that there were as many between groups as within group variations. When reflecting on the differences among the disciplines, one psychologist shared some concerns on psychiatrists' perspective of mental disorders:

> Most psychiatrists emerge from this medical model of looking at the world, which is incredibly reductionist, and the belief is that everything can be reduced to brain processes… We are kind of missing the big picture by focusing on such a very specific little thing.

Counselors. All interviewed counselors approached diagnosis focusing on the symptoms *and* the context, and one counselor also took into account the patient's narrative of the situation (i.e., meaning of the experience). Tension was observed in cases two and three between participants' recognition of the severity of symptoms and the belief that the symptoms were environmentally based (what one counselor referred to

as “situational depression”), and or the belief that if intervention would have happened at the right time, people would have not developed depression. Similar to the other groups, the counselors generally conceptualized clinical depression in two ways. Some characterized it as a cluster of depressive symptoms that impairs functioning and impacts brain chemistry, whereas others conceptualized it as cluster of symptoms that meet DSM criteria. From the second group, one participant mentioned that among these symptoms there are usually “somatic symptoms.” She wanted to make a clear distinction between somatic and biological symptoms, given that somatizations are physical symptoms that do not have a *physical cause*. In terms of causal basis of depression, all interviewed counselors considered that depression could be caused by biological, psychological, and or environmental factors.

As in the case of psychiatrists and psychologists, a distinction between a disease and a non-disease type of depression emerged from counselors’ responses. The first one being characterized as more biologically based and as experienced as “coming out of nowhere,” and the second one as less biologically based, and functioning as a signal of a deeper psychological problem (e.g., identity issues) that should be addressed in the therapy. One tension associated with this distinction was observed when counselors described depression as a disease: on the one hand, understanding depression as a disease legitimizes depression as a real problem, eliminates blame from those who suffer from it, and justifies intervention. On the other hand, it pathologizes normal reactions, and reduces the complexity of depression to its biological dimension. The following quote illustrates this tension:

> "Depression is a disease of the brain," this is interesting because we want to legitimize depression as being real and important… and [on the other hand] a disease model often assumes a medical intervention and that it is in your brain… to me that somewhat limits the influence of environmental factors… minimizes the complexity of what we think of when we treat depression.

Interviewed counselors also established a difference between a non-pathological depressive condition (i.e., "situational depression," "adjustment disorder," "natural reaction," "existential crisis") and clinical depression. One tension associated with this distinction was observed when participants diagnosed cases two and three. On the one hand, the symptoms were described as severe enough to require intervention, but on the other hand they were described as "situational" or as the result of not having a support system:

> …this one is pretty much gonna be an environmental situation… Although… well wait a minute. For six months… it is a long time, but then again if she would have counseling back when it happened I don't think it would have been clinical depression… So, maybe it is a *situational depression*, whatever that is.

In terms of treatment approach, all interviewed counselors were very likely to recommend psychotherapy, but were generally hesitant to recommend medication at least as an early intervention. Among the reasons for not recommending medication at the beginning were "because it targets the symptoms, not the problems," "because it has side effects," "because too many people receive medication," and "because medication blunts emotions and the pain has a function." Among the reasons for recommending medication were whether the symptoms were severe enough, whether the patient does not respond to

therapy, and whether the cause of the symptoms seems to be biological. One tension related to participants' treatment approach was observed at the discussion of their treatment plan for cases two and three. On the one hand, severity of symptoms required medical intervention; on the other hand, the cause of the symptoms was not biological but situational. A similar tension was observed when participants wanted to recommend medication because of the severity of symptoms but, at the same time, did not want to convey the wrong message to their patient ("I really don't like to stigmatize natural reactions and I think if we jump to medication too quickly we say that this should be taken away, this is a process you shouldn't be experiencing").

Finally, when asked whether there are differences in the way mental health professionals conceptualize depression, all interviewed counselors considered that mental health professionals differed in their treatment approach, their focus on different type of causes, and/or in the way they conceptualize depression. Some participants considered that there were as much differences between professional groups as within the groups, because of the influence of schools of thought. Finally, some participants emphasized the importance of maintaining a team approach for dealing with the problem in a more holistic way: "I think our training biases us a little bit. Consultation and collaboration is important… There is value in what they each bring to the conceptualization and the treatment."

***Non-experts*.** When considering whether a person should or should not be diagnosed with depression, non-experts focused on the symptoms, whether they represented a drastic change in the person's behavior, and on whether the person needed help. One participant also considered patient's own narrative of her experiences, the

specific meaning of her experiences. Some non-experts expressed clear concerns with the diagnosis system. One of them considered that only focusing on meeting the DSM criteria was "too Western," and a second participant mentioned "I would be hesitant to diagnose her with anything because that to me indicates medication and a pathology." Some tension related to diagnosis was observed when participants described the reaction as "understandable," and "not pathological," and, at the same time, as justifying help. This was observed mainly among those participants who focused on the need of intervention when deciding whether a person should be diagnosed with depression.

Related to this is non-experts' understanding of "clinical depression." Thematic analysis revealed a variety of responses in this topic. Some people reported understanding clinical depression as a depressive condition that "is getting worse," "is lasting too much time," "interferes with life," and "requires an intervention." Others equated clinical depression to a pathology and to a scenario severe enough that requires hospitalization. However, in a different section of the interview, one of these participants mentioned that clinical depression was actually a "technical term" used by clinicians:

> Clinical depression to me is made-up… is something that people have named in order to manipulate, control. Depression is an actual response to something… Clinical depression is the meta-language that we use to talk about that response and what we do when we consider it clinical is we turn it into something that is inaccessible to the individual.

In terms of non-experts' perspective about the causal basis of depression, all participants sustain that clinical depression is *sometimes* biological in nature (e.g., caused by "hormonal imbalances," by "not eating well"), but not always. When looking into

different kinds of depression embedded in the data it was observed that, contrary to what happens in the other groups, only one participant made a distinction between a disease type of depression (i.e., "if it is truly clinical, something is off," "requires hospitalization," "person cannot take care of herself") and a "normal depression" ("normal depression, you get depressed a little bit but then you work through it with friends or family and then you can move on"). According to this participant, though, a normal depression could become a "clinical depression" if people cannot recover from it. The rest of the non-experts were very reluctant to call depression a disease, because it implies that it is only biologically based, or because it implies that it is a pathology that needs to be eradicated. One participant mentioned that some depressions could be considered "healthy depressions": "It's a natural process of slowing down, of exploring. Depression sort of stops you in your tracks and pushes you inside." In a different section of the interview the same participant mentioned that he would feel comfortable calling depression a disorder but not a disease, because "disease" implies that the problem is biological when it is actually psychological. In other words, according to this participant, even if the cause is biological, the "disease" does not become a problem unless it impacts the individual's psychology:

> "Depression is a disease of the brain"? I do not agree at all. Disease and disorder are very different. A disease… sounds like a deterioration of biological tissues… it is quite biological, and it can be. But I think when people have a brain disease it doesn't mean that the problems they have are biological problems. I don't think the disease itself [is the problem]… that alone is not considered psychological.

In terms of treatment approach all interviewed non-experts felt comfortable recommending psychotherapy but, except for one participant, felt very uncomfortable recommending medication. Medication was mainly considered as a "last resource." The reasons for recommending medication were "if psychotherapy does not work," "if biological factors are more relevant," "if symptoms are getting worse," and "if it is an extreme situation." Participants listed many concerns regarding medication. In general, they considered that medication "masks the real problem," "sedates people," and "disempowers people." The following quote illustrates this position:

> There are all kinds of things that could be highly successful at helping someone to figure it out a better way to respond or cope. I think medication instead of allowing that person to feel her feelings and experience them, and learn to sit with them and be comfortable with them… medication sedates people or give them the opportunity to feel better about their shitty situation they are in without ever recognizing that they can be empowered to change it.

Related to participants' perspective on medication is participants' concern with the health model. All interviewed non-experts expressed some concerns with "western medicine," but mainly those who were reluctant to define depression as a disease. Thus, participants considered that mental health professionals tend to pathologize human experiences, disempower people, reduce care to medication instead of trying alternative routes, sometimes overmedicating society. The following quote represents some participants' perspective on this matter:

> A lot of MD's doesn't really know anything about health, they know about medicine. And I think psychiatrists are of a similar point of view: "Here is your

problem, here is the drug". It is not "well, could you change your lifestyle, what are you doing that might be undermining your good mood…?"

Finally, when asked whether there were differences among mental health professionals, some non-experts mentioned "probably yes." Those who expressed more concerns about the health model considered that there were big differences in terms of how they conceptualized depression and in their treatment approach. Participants described psychiatrists as "more focused on the biological aspects," "focused on medicating you;" psychologists as "focused on working with your mind," "on changing some psychological circumstances at home;" counselors as those who "provide a safe space to dialogue about whatever is happening in your life," "tend to be more empathetic;" and social workers as "having a more sociological point of view," "their goal being to provide conditions that promote help," and "not trying to get to the bottom of the problem."

Mixed Methods Results

Following Creswell's (2013) recommendation for merging qualitative and quantitative data analyses within a convergent study, the results of the quantitative and qualitative analyses are displayed using a joint display (Table 6). The joint display has been developed taking into account the main themes that emerged from the thematic analysis of the qualitative data. The final integration of both types of data is presented in the Summary of results section of this thesis.

Table 6

Joint Display of Qualitative and Quantitative Results

Themes	Qualitative Results	Quantitative Results
APPROACH TO DIAGNOSIS	Focus on DSM criteria Focus on etiology of symptoms Focus on patient's narrative of the experience Symptoms represent a drastic change, and person needs help Vegetative profile **Concerns with diagnosis system:** By principle people should not diagnose without knowing the person Diagnosis means pathology **Tensions in case 2 and 3:** Between clear impairment and no vegetative profile Between symptoms and understandable reaction Between understandable reaction and need of treatment Between symptoms and the fact that symptoms would go away if there is an intervention in the environment	Case 1: Non-experts were less likely to provide a diagnosis of clinical depression compared to psychiatrists, and counselors
CAUSAL BASIS OF DEPRESSION	Depression is multifactorial Depression is not multifactorial (biologically based)	**Biological factors** In general, psychiatrists rated biological factors as more important compared to counselors Case 3: Psychiatrists rated higher the importance of biological factors compared to all the other groups **Psychological factors** In general, psychiatrists rated higher the importance of these factors compared to psychologists Case 1:

		Counselors rated higher the importance of psychological factors compared to psychologists Case 2: Psychiatrists rated higher the importance of psychological factors compared to counselors and non-experts **Environmental factors** Case 1: Non-experts rated higher the importance of environmental factors than psychologists. Case 3: Psychiatrists rated higher the importance of environmental factors compared to counselors.
CLINICAL DEPRESSION	**Understanding of clinical depression:** Depression that meets DSM criteria (in general, for MDD or for Dysthymia) Depression that meets DSM criteria and is defined as depression by clinical judgment Cluster of depressive symptoms that impair functioning and impact brain chemistry Depression that requires medication for treatment Condition that is getting worse, interferes with life, and requires intervention Depression that requires hospitalization Technical word, a made-up word **Tension:** Between presence of depressive symptoms and not requiring medication	
TYPES OF DEPRESSION	**Different types of depression emerged from the data:** Disease type of depression Biologically based No psychosocial stressor Patient is less responsible for her condition Symptoms are ego-dystonic Depression occurs suddenly Symptoms are more severe Requires strong intervention Non-disease type	***Depression is a disease of the brain*** Non-experts were less likely to agree with this statement than all the other groups ***Depression is a normal reaction to an environmental stressor*** Psychiatrists were less likely to agree with this statement than non-experts ***Depression is caused by maladaptive psychological patterns*** Counselors were more likely to agree than psychiatrists and non-experts

Reactive depression	
Normal reaction	***If a person is grieving, he or she should be exempted from being diagnosed with clinical depression.***
Understandable	
Presence of psychosocial stressor	No meaningful differences were found
Patient is more responsible of her condition	***It is a myth that depression is a disease, like cancer***
Functional or adaptive	Psychiatrists were less likely to agree than all the other groups
Sign that something is not OK in our life	
Treatment approach should not be focused on "eliminating it"	Psychologists were less likely to agree than counselors and non-experts
Non-Pathological	***Given that depression is biological in nature, people are not responsible for having depression.***
Situational depression	
Adjustment disorder	No differences were observed
Natural reaction	
Existential Crisis	**Depression arises as a result of not being able to meet socially constructed standards defining the "good person"**
Clinical depression	
Concern with identifying depression as a disease	Psychologists were less likely to agree than counselors
Tension:	
Legitimizes de condition but implies that it is a biological condition	

TREATMENT APPROACH

Approach to treatment:	**Recommendation of Psychotherapy**
Combination is the best approach	Case 2:
Psychotherapy as "first line of defense"	Psychiatrists were more likely to recommend psychotherapy than counselors
Medication as "last resource"	Case 3:
Reasons for recommending medication:	Non-experts were more likely to recommend psychotherapy than psychologists, and counselors.
Cause is biological	**Effectiveness of psychotherapy:**
Severity of symptoms (e.g., suicide risk)	Case 3:
Patient is not able to focus on therapy	Non-experts rated higher the effectiveness of psychotherapy compared to psychologists
"Cutting the vicious cycle" (e.g., get out of bed)	**Recommendation of medication**
	In general, non-experts were less likely to recommend medication compared to the other groups
Psychotherapy is not working	Case 1:
Concerns with medication:	Psychiatrists were more likely to recommend medication compared to counselors and non-experts
Side effects	

Does not target the real problem Overmedicated society Sends the message that we are dealing with a pathology Medication blunts emotions and the pain has a function in the healing process Disempowers people	Non-experts were less likely to recommend medication compared to all the three groups Case 3: Psychiatrists were more likely to recommend medication compared to non-experts
Concern with health system: Concern about low level of care Reducing care to medication Overmedicated society	**Effectiveness of medication:** In general, non-experts were less likely to consider medication as an effective treatment compared to psychiatrists Case 1: Non-experts rated lower the effectiveness of medication compared to psychiatrists and counselors
Tensions: Between "severity of symptoms requires medical intervention" but "cause of the symptoms is not biological but situational" Between "severity of symptoms requires medical intervention" but "not wanting to convey the wrong message to their patient (i.e., 'reaction is pathological')"	Case 3: Non-experts rated lower the effectiveness of medication compared to psychiatrists
DIFFERENCES AMONG MENTAL HEALTH PROFESSIONALS There are differences among different mental health professions **Listed differences:** *Psychiatrists*: medical model perspective, focused on symptoms, focused on how to cure symptoms with drugs, sometimes overemphasizing biological aspects *Psychologists*: non-medical model, focused on symptoms and the context, focused on weaknesses and psychopathologies, overlooking biological aspects, easier for them to see the whole picture *Counselors*: non-medical model, focused on socio-environmental aspects, strengths and growth, sometimes overlooking psychopathologies and biological aspects *Social workers*: non-medical model, focused on socio-environmental aspects No concern regarding these differences	

Concern:

Psychiatrists have reduced their care to medication, they are no longer therapists

Importance of team approach

Differences are positive

Summary of Results. Findings of the quantitative and qualitative analyses are merged in this section for answering the mixed methods research question that guided this investigation: *How do mental health professionals and non-experts conceptualize depression, and are there systematic differences?* The interpretation of the results is organized by topics for understanding psychiatrists, psychologists, counselors and non-experts' conceptualization of depression in terms of its diagnosis, etiology, treatment, and nature.

Diagnosis of depression. Different approaches to the diagnosis of depression were observed. Only among psychiatrists and psychologists there were participants approaching diagnosis focusing *solely* on whether the symptoms meet the DSM criteria. Only among psychologists, counselors, and non-experts there were participants considering patient's own narrative of her experience. These participants were interested in knowing what this experience meant to the patient, whether it was an indicator of personal growth or not. For those who emphasized this aspect, it is very different to be suffering because one is going through a major change in life than because of a chemical imbalance. The reason is because this experience should be interpreted as an opportunity for personal growth rather than as a pathology that should be eliminated.

Psychiatrists are the only ones who require a vegetative profile for diagnosing depression. Interestingly, when asked to name vegetative symptoms some psychiatrists mentioned "self-esteem" and "lack of interest," symptoms that are identified as "psychological" factors by other groups. One counselor required "somatic" symptoms for providing a diagnosis of depression, pointing out that somatic symptoms are biological symptoms that do not necessarily have a biological cause.

According to the quantitative results, non-experts were less likely to consider that case one warranted a diagnosis of depression compared to psychiatrists and counselors. One possible explanation of this difference is that, as opposed to what happens in the other groups, many non-experts also considered this case as an "understandable reaction" rather than a pathology. Psychiatrists, psychologists, and counselors, on the other hand, mainly considered cases two and three as truly understandable reactions to stressful situations: the loss of a loved-one through a break-up and the loss of all personal belongings through the storm, respectively.

For all the interviewed participants, cases two and three were more difficult to diagnose. Participants recognized the presence of symptoms and the need of assistance, and, at the same time, did not want to conceptualize the case as pathological, but as a logical or understandable reaction that could go away if early non-clinical intervention (i.e., talking with friends, family, having social support) would have occurred. Interestingly, this tension was only observed among those who focused on the *etiology* of the symptoms for diagnosing depression. Respondents who only focused on whether the symptoms met the DSM criteria did not pay attention to the cause and, thus, whether the result was a logical reaction or not.

Etiology of depression. In general, participants considered that depression could either have a biological cause or a non-biological cause. The exception was one psychiatrist who considered that depression could only be biologically caused. The results of the quantitative analyses show that groups sometimes differ in how they rate the importance of the biological, psychological and environmental factors in the three cases. The largest differences are observed in cases two, where psychiatrists considered

psychological factors more important than counselors and non-experts; and in case three, where psychiatrists considered *biological* factors more important than the rest of the groups. The qualitative analysis helps to build a possible explanation of these findings. In terms of psychiatrists' perspective about the importance of *psychological* aspects, some psychiatrists—and this occurred only among psychiatrists—considered that "psychological and environmental factors are the same." Thus, psychiatrists' rating for second case's psychological factors (e.g., patients' negative thinking about her parents' divorce and about her own relationships, patient's attachment issues, etc.) could have been representing also their perspective about factors that are considered as environmental by the other groups (i.e., the break-up, not having social support, etc.).

In terms of psychiatrists' perspective of the importance of *biological* aspects, in general, psychiatrists seem to confer more importance to the biological aspects of depression (in terms of causes, effects, and treatments) than all the other groups. This is observed not only in their higher scores to the importance of the biological factors, but also in their requirement of a vegetative profile for diagnosing depression, in the definition—only observed among psychiatrists—of clinical depression as a "neurobiological syndrome," or as a condition that only responds to biological intervention (e.g., medication), and in their lower level of agreement with the statement "It is a myth that depression is a disease, like cancer." This conclusion is also supported by participants' responses to the open-ended question regarding the differences among mental health professionals. In general, participants from different groups described psychiatrists as focused more on biological causes of depression and biological-type of treatments.

Treatment of depression. All groups considered psychotherapy as an adequate treatment for depression. The largest differences were observed in case three were non-experts were more likely to recommend psychotherapy than psychologists and counselors, and also rated higher the effectiveness of psychotherapy compared to psychologists. One possible explanation of non-experts' more positive attitude toward psychotherapy could be that mental health professionals, in general, considered that what this patient actually needed was assistance from a social worker (i.e., access to social help, a new home, financial assistance, etc.). Thus, it could be that, given that they have more experience with crisis interventions, they have a clear distinction between psychotherapy from social assistance. Non-experts, on the other hand, could be interpreting both types of interventions as non-medical interventions. Had they know more about social assistance, they would have had lower expectations about psychotherapy. Another possible reason could be that non-experts understood psychotherapy as interventions aimed at providing support in general, whereas psychologists understood psychotherapy as psychological interventions aimed at "fixing the problem." Given that in case three there is no apparent psychological problem to be fixed, psychologists considered that psychotherapy would not be too efficient. This interpretation is supported by participants' responses to the question regarding differences among mental health professionals. Psychologists and psychiatrists are described as focused on psychopathologies and weaknesses, rather than on providing a safe space for processing experiences or personal growth, for instance.

Bigger differences among groups were observed, though, in the case of participants' attitude toward medication. In cases one and three psychiatrists were the

group with more positive attitude toward medication and non-experts were the group with less positive attitude toward medication. Qualitative analyses revealed that mainly among psychiatrists participants approached treatment utilizing medication since the beginning (i.e., "research has found that combination is the best approach"). In the other groups, participants considered medication as "not first line of defense," and only if "psychotherapy does not work," "symptoms are too severe," "symptoms fog patient's thinking so she cannot engage in psychotherapy," and "if cause is biological." Among those who considered the cause of the symptoms for recommending medication a tension was observed between the recognition that the severity of symptoms required medical intervention, and the fact that the symptoms were not biologically based.

In terms of non-experts' attitude toward medication, through thematic analysis it was observed that, except for one participant, non-experts strongly denied the need of medication. Participants claimed that medication should be considered "a last resource." Participants not only considered that medication would not be effective (e.g., because "it does not treat the real problem," "it does not have long term effects") but also that it would be harmful for the healing process. Concerns about medication were observed across groups, but the last group was the one expressing more strongly these concerns (e.g., "medication sedates people," "disempowers people," "masks the real problem," "does not allow people to make sense of their experience").

Finally, participants from all four groups expressed frustration regarding the current health model. Participants were concerned on equating health care to medication, on overmedicating society, and on pathologizing normal human experiences. The main sources of these problems were the educational training psychiatrists and medical doctors

receive (i.e., focused on educating them as "med-check machines" instead of therapists or experts in mental health), pharmaceutical companies and their push toward understanding mental disorders as biological conditions that should be fixed with medication, insurance agencies and their push toward lowering care to medication, and a society that prefers an "easy fix" instead of confronting their real problems.

Nature of depression. For some psychiatrists, psychologists and counselors clinical depression equated a cluster of symptoms that meet DSM criteria. Only among psychiatrists clinical depression was also understood as a "neurobiological condition," and as a condition that only responds to medication. Non-experts, on the other hand, mainly understood depression as a continuum that achieves the category of "clinical" when the condition requires some kind of intervention. Two identifiable types of depression emerged from psychiatrists, psychologists, and counselors' responses: a disease type of depression and a non-disease type of depression. The first one was described as biologically based, non-reactive, and ego-dystonic. The non-disease type of depression was described as non-biologically based, as a reaction to a psychosocial stressor, and as understandable. Non-experts, on the other hand, were very reluctant to identify depression as a disease. This is also observed in non-experts non-agreement with the statement "Depression is a disease of the brain," and agreement with "It is a myth that depression is a disease, like cancer."

Among psychologists and counselors, the concept of disease was observed as a source of tension in many different sections of the interview. When participants were asked their level of agreement with the statements "Depression is a disease of the brain," and "It is a myth that depression is a disease, like cancer," some participants were not

completely sure how to answer. On the one hand, they considered that understanding depression as a disease legitimizes it as a serious condition, eliminates blame from depressive individuals (because that would mean that they have a *real* problem, rather than being lazy or weak), and supports the need of assistance. On the other hand, understanding it as a disease would imply that it is a pathology and that the causes are biological, which would also legitimize a medical and symptom-oriented type of intervention.

In the case of psychologists and counselors, another distinction was observed between a pathological and a non-pathological type of depression. The first one was described as dysfunctional, non-adaptable, and the second one was described as functional, adaptable, and a source of personal growth. This distinction was not found among psychiatrists and non-experts. In the case of non-experts because they tended to understand clinical depression as an originally normal reaction that at some point reaches a level of severity that requires intervention. Supporting this is the fact that they agreed more with the statement that "Depression is a normal reaction to an environmental stressor," than psychiatrists, who felt very uncomfortable with the word "normal."

Finally, some participants from different groups shared the idea that depression should be considered a group of disorders that differ in terms of their causes. These participants also considered that focusing on the cause of depression was useful for deciding the type of intervention and the conceptualization of the specific depressive condition (e.g., a pathology or a logical reaction).

Chapter V: Discussion

Supporting what have been already said in previous studies, the current study found that different conceptual models of depression coexist among mental health professionals and laypeople. Thus, different approaches to diagnosis, etiology, treatment, and the understanding of the nature of depression emerged from the data. Some of these differences are related to discipline or group. For instance, psychiatrists were the only group defining depression as a "neurobiological syndrome," requiring a "vegetative profile" for diagnosing depression, and, compared to the other groups, were more likely to recommend medication for treating depression. Non-experts, on the other hand, differed from the mental health professionals in their reluctance to both: defining depression as a disease and considering medication an adequate treatment for depression.

However, several patterns were also observed across groups, mainly among mental health professionals, indicating that groups do not entirely differ among each other. A close observation of these patterns and specifically of the tensions repeated in the data, suggests the existence of two conflicting models of depression already observed in the literature review (i.e., a disease and non-disease model of depression) (Burroughs, et al., 2009; Cheng et al., 2009; Chew-Graham et al., 2000; Karasz et al., 2009). A review of these models and the tensions that generate provides interesting insights about how depression is conceptualized.

Thus, across groups, participants who approached diagnosis contextualizing the symptoms, for instance, often struggled in cases where there was a clear socio-environmental stressor (i.e., cases two and three). The presence of a clear non-biological trigger raised some questions regarding the true nature of the condition (i.e., whether it

was a disorder or a logical reaction) and whether it warranted a diagnosis. Tension was observed among these participants because they recognized the presence of depressive symptoms and the need for intervention, but also stated that providing a diagnosis would imply pathologizing a normal reaction. Related to this, some participants also struggled diagnosing cases two and three because, although they considered that the symptoms met DSM criteria, the cause was external to the individual (e.g., a storm), and therefore nothing was *internally* wrong with the individual. Moreover, according to these participants, a truly appropriate intervention would have to target the environment, not the individual. This made them question whether the individual had a mental disorder or was simply reacting to a *disordered* environment.

A second source of tensions was related to participants' consideration of medication for treating depression. Thus, in cases two and three, some participants struggled because considered that the severity of the symptoms warranted medical intervention but, at the same time, realized that the cause of the symptoms was not biological and, therefore, a non-biological type of treatment was more appropriate. Also, some participants struggled because again considered that the severity of the symptoms required medication but, at the same time, did not want to convey the wrong message to their patients (e.g., they are experiencing a *pathological* reaction that should be eliminated).

Finally, another pattern of responses was observed among some psychologists and counselors who struggled when considering whether depression was a disease. On the one hand, understanding depression as a disease legitimized the condition, justified treatment, and removed blame from the patients (given that they were "authentically ill").

On the other hand, understanding depression as a disease implicitly considered the condition as pathological, originated as a result of biological malfunctioning, and a perfect candidate to biological type of treatment (e.g., medication).

The tensions described above suggest the existence of conflicting models of depression, a disease and a non-disease model of depression. Under the disease model of depression, depression is considered a pathology, a dysfunctional condition, mainly caused by biological factors—or more precisely a biological malfunction—, and a condition severe enough to require more extreme interventions such as biological interventions (e.g., medication, Electro Convulsive Therapy) or hospitalization. Under the non-disease model of depression, depression is considered non-pathological, a normal response to a stressful situation or a traumatic event, understandable, sometimes even "functional" (i.e., an opportunity for personal growth), and requiring non-biological type of interventions.

Thus, the source of tensions observed in the data seems to be the *conflict* between these models. Participants struggled only in cases where there was a clear socio-environmental stressor (i.e., cases two and three), suggesting that depression was a reaction to a traumatic event and not the result of an internal biological malfunction. This feature questioned participants' understanding of depression. Participants did not feel comfortable approaching the case as a pathology but, on the other hand, did not want to deny the severity of the symptoms and the need for treatment.

The results of this study raise the question whether there is a need for a conceptual model of depression that could represent different types of depression in a way that these conflicts could be solved. Such a model would have to recognize the

existence of different types of depression, distinguishing between a pathological and a non-pathological type of depression. At the same time, this conceptual model would have to unify these different types of depression identifying what is shared by all of them.

The Behavioral Shutdown Model utilized as a conceptual framework for the current study could potentially provide a conceptual structure of depression that could solve some of the issues observed here. The BSM provides a *descriptive* definition of depression as a state of behavioral and psychological shutdown. Given that depression is not defined by its causes, the BSM unifies depressive conditions resulted from different causes (e.g., biological malfunctions or socio-environmental stressors). It further deconstructs this concept by its *main* causes differentiating between three types of depression: a "depressive disease," (a biologically based condition), a "depressive disorder," (a psychologically based condition), and a "depressive reaction" (an environmentally based condition). This model, thus, recognizes the existence of different types of diagnosable depressions and it does not automatically equate depression with a pathology. Under this model, cases such as the one described in the third scenario, for instance, are considered authentic depressive cases warranting a diagnosis and requiring intervention. But, given that the main cause of the depressive reactions is a socio-environmental stressor, these cases are not defined as pathological because there is nothing *internally* wrong with the individual. This person's depression is mainly the result of being exposed to a highly stressful environment.

BSM's differentiation between types of depression depending on their main cause could potentially solve some of the tensions observed in this study but more research is needed to see whether the BSM truly represents the different kinds of diagnosable

depressions. One type of depression that emerged from the data, for instance, was a "functional" or "healthy" depression. Some participants described depressive cases resulting from a profound dissatisfaction with one's life. These kinds of depression were considered "functional" because they provided an opportunity for personal growth. It would be interesting to see, then, whether this type of depression is also represented in the BSM. Future research, thus, could focus on testing the BSM utilizing quantitative research methodology.

Limitations

The current study has several limitations. Given that the main purpose of the study was to obtain an in-depth observation of mental health professionals and non-experts' perspectives of depression, the study was mainly supported by qualitative research methodology. In that sense, there was no intent at generating generalizable findings. Although this is not a limitation per se, the interpretation of the findings should be made with caution given that the sample obtained is most likely not representative of the population. A second limitation of the study was the language utilized in the instrument used for gathering the data. Terminology utilized in the UDI was intentionally ambiguous (e.g., "clinical depression") for capturing participants' perspectives of depression without restricting the phenomenon being addressed. This allowed to have access to participants' own definitions and conceptualizations of depression but also introduced a level of ambiguity in the data that needs to be carefully considered when interpreting the findings. Finally, researcher's preconceived knowledge

and prejudices about mental health professionals and laypeople's perspectives of mental disorders and depression could have been a considerable source of bias in this process.

Appendix A

Understanding Depression Interview

FIRST SECTION

Case 1

Ms. Smith is a successful business woman and mother of two children who has been experiencing increasingly severe depressive symptoms for the past six months. She initially noticed feeling very tired, and having difficulties waking up and going to work. She was also feeling discouraged and disappointed with her life, but did not have a clear sense as to why. As the months passed, Ms. Smith started to experience a considerable change in mood, loss of interest in her work and eventually in all the things she used to enjoy, including being with her kids. Ms. Smith described this stage as an "overwhelming nightmare" because she did not know what was happening in her life. Although Ms. Smith recalled being in a stressful situation at work when these symptoms began, she claimed that she had been exposed to this type of situations many times in her life and never reacted like this. She told the doctor that she could not recognize herself in these behaviors because she has always been able to keep her head up and been proud of that.

Please circle your response:

Do you think this person should be diagnosed with clinical depression?

1	2	3	4	5	6	7
Not likely at all						Very likely

How would you rate the importance of each of these factors for understanding this person's symptoms?

Biological factors

1	2	3	4	5	6	7
Not important at all						Very important

Psychological factors

1	2	3	4	5	6	7
Not important at all						Very important

Environmental factors

1	2	3	4	5	6	7
Not important at all						Very important

Do you think this person should be recommended for psychotherapy?

1	2	3	4	5	6	7
Not likely at all						Very likely

To what extent psychotherapy could be an effective treatment for controlling or managing this person's symptoms?

1	2	3	4	5	6	7
Not effective at all						Very effective

Do you think this person should be recommended to receive medication?

1	2	3	4	5	6	7
Not likely at all						Very likely

To what extent medication could be an effective treatment for controlling or managing this person's symptoms?

1	2	3	4	5	6	7
Not effective at all						Very effective

Case 2

Ms. Jones has been experiencing increasingly severe depressive symptoms for the past six months. The downward spiral started when Ms. Jones' boyfriend of two years unexpectedly broke-up with her and left her for another woman. Shortly after the break-up, Ms. Jones felt discouraged and disappointed with her life. She had shared many friends with her boyfriend and now felt isolated. She also did not feel like doing anything, so she stopped participating in many of the activities she used to enjoy. She reported that the incident reminded her of when her father left her mother, and that she now knew she would end up broken and alone just like her mother was. She told her doctor that deep down she always feared she would be a failure and now it has become a reality for her.

Please circle your response:

Do you think this person should be diagnosed with clinical depression?

1	2	3	4	5	6	7
Not likely at all						Very likely

How would you rate the importance of each of these factors for understanding this person's symptoms?

Biological factors

1	2	3	4	5	6	7
Not important at all						Very important

Psychological factors

1	2	3	4	5	6	7
Not important at all						Very important

Environmental factors

1	2	3	4	5	6	7
Not important at all						Very important

Do you think this person should be recommended for psychotherapy?

1	2	3	4	5	6	7
Not likely at all						Very likely

To what extent psychotherapy could be an effective treatment for controlling or managing this person's symptoms?

1	2	3	4	5	6	7
Not effective at all						Very effective

Do you think this person should be recommended to receive medication?

1	2	3	4	5	6	7
Not likely at all						Very likely

To what extent medication could be an effective treatment for controlling or managing this person's symptoms?

1	2	3	4	5	6	7
Not effective at all						Very effective

Case 3

Ms. Taylor has been experiencing increasingly severe depressive symptoms for the past six months. She reported that around eight months ago a massive storm hit Ms. Taylor's area and demolished her home. Ms. Taylor was a small business owner and did not have flood insurance, and the storm ruined both her home and her business. She had been living with a friend for the past six months, but was recently asked to leave because the friend needed the living space. She is currently living in a shelter. When she was evaluated by a mental health professional, she described feeling discouraged and disappointed with her situation. Over the past several months, she has lost her motivation to try to recover her home and business and has been having trouble sleeping and feeling hopeless and ashamed that she was so dependent on others. Now she reports having deep feelings of loneliness and abandonment.

Please circle your response:

Do you think this person should be diagnosed with clinical depression?

1	2	3	4	5	6	7
Not likely at all						Very likely

How would you rate the importance of each of these factors for understanding this person's symptoms?

Biological factors

1	2	3	4	5	6	7
Not important at all						Very important

Psychological factors

1	2	3	4	5	6	7
Not important at all						Very important

Environmental factors

1	2	3	4	5	6	7
Not important at all						Very important

Do you think this person should be recommended for psychotherapy?

1	2	3	4	5	6	7
Not likely at all						Very likely

To what extent psychotherapy could be an effective treatment for controlling or managing this person's symptoms?

1	2	3	4	5	6	7
Not effective at all						Very effective

Do you think this person should be recommended to receive medication?

1	2	3	4	5	6	7
Not likely at all						Very likely

To what extent medication could be an effective treatment for controlling or managing this person's symptoms?

1	2	3	4	5	6	7
Not effective at all						Very effective

How have you understood "clinical depression" while answering the previous questions?

SECOND SECTION

How would you rate your level of agreement with each of the following statements?

"Depression is a disease of the brain"

1	2	3	4	5	6	7
I do not agree at all						I definitely agree

"Depression is a normal reaction to an environmental stressor"

1	2	3	4	5	6	7
I do not agree at all						I definitely agree

"Depression is caused by maladaptive psychological patterns"

1	2	3	4	5	6	7
I do not agree at all						I definitely agree

"If a person is grieving he or she should be exempted from being diagnosed with clinical depression"

1	2	3	4	5	6	7
I do not agree at all						I definitely agree

"It is a myth that depression is a disease, like cancer."

1	2	3	4	5	6	7
I do not agree at all						I definitely agree

"Given that depression is biological in nature,
people are not responsible for having depression."

1	2	3	4	5	6	7
I do not agree at all						I definitely agree

"Depression arises as a result of not being able to meet socially constructed standards defining the 'good person'"

1	2	3	4	5	6	7
I do not agree at all						I definitely agree

THIRD SECTION

Open-ended questions

- What is depression?
- What is a mental disorder?
- Do your cultural beliefs and/or religious beliefs influence how you think about mental disorders and depression?
- Do you think mental health professionals (i.e. psychiatrists, psychologists, counselors, and social workers) see "depression" differently?

FOURTH SECTION

Demographic Questions
Please answer the following questions:

Gender
1. Male
2. Female
3. Other
4. Prefer not to answer

Age
In what year were you born? _____

Racial/Ethnic identity

Select all that apply:

1. American Indian / Native American
2. Asian
3. Black / African American
4. Hispanic / Latino
5. White / Caucasian
6. Pacific Islander
7. Other
8. Prefer not to answer

Where were you born?

1. United States
2. Other country (please specify) _____

Professional experience

What is your profession?

1. College Student (Major:_____)
2. Licensed Psychologist
3. Primary Doctor
4. Licensed Psychiatrist
5. Licensed Social worker
6. Licensed Professional Counselor
7. Other (please specify) _____

Which of the following best describes your professional experience in your field?

1. New professional with less than one year of experience
2. Moderately new professional with 1 - 4 years of experience
3. Moderately experienced professional with 4-7 years of experience
4. Well-experienced professional with more than 7 years of experience

What is your job title? _____

What is the kind of patients that you treat? (Choose all that apply)

1. Severely mentally ill patients (e.g., hospitalized patients)
2. Patients who have mental disorders but are not severely ill (e.g., patients are not hospitalized)
3. Patients with mental, behavioral or emotional problems (e.g., adjustment problems)
4. Other (please specify)_____
5. Not applicable

Education

What is the highest level of education you have completed?

1. Some college
2. Bachelor's degree
3. Some graduate school
4. Master's degree
5. Professional degree
6. Doctorate degree
7. Other (please specify) _____

What is your degree in? _____

School of training

Select the model that aligns better with your professional/personal perspective about mental disorders:

1. The Biomedical model
2. The biopsychosocial model
3. Other (please specify) _____
4. Not applicable

Depression

1. Have you ever been diagnosed with depression or have you ever suffered from depression? **Yes / No**
2. Do you have a close relative that has been diagnosed with depression or has suffered from depression? **Yes / No**

Appendix B

Table B1

Demographic information

	Psychiatrists *n* = 6	Psychologists *n* = 12	Counselors *n* = 5	Non-experts *n* = 5	Total
Gender					
Male	4	6	2	2	14
Female	2	6	3	3	14
Ethnicity					
White	6	12	5	4	27
African American	0	0	0	1	1
Origin					
U.S.	6	9	5	3	23
Other country	0	3	0	2	5
Professional experience					
Less than 1 year	0	2	0	0	2
1 - 4 years	0	2	1	0	3
4 - 7 years	0	0	1	1	2
More than 7 years	6	8	3	4	21
Type of patient					
Severely mentally ill	6	6	1	-	13
With mental disorders	2	7	4	-	13
With emotional problems	2	9	5	-	16
Other	1	4	1	-	6
Level of education					
Master's degree	0	0	2	1	3
Professional degree	1	0	0	0	1
Doctorate degree	5	12	3	4	24
Model of training					
Biomedical model	0	0	0	-	0
Biopsychosocial model	5	9	5	-	19
Psychodynamic	1	0	0	-	1
Other	0	3	0	-	3
Have suffered from depression					
Participant	3	4	0	3	10
Participant's close relative	3	5	3	2	13

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