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# Philosophical Ends to Scientific Means: Diagnosis and the Epistemology of Psychology

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PHILOSOPHICAL ENDS

Philosophical Ends to Scientific Means: Diagnosis and the Epistemology of Psychology

by

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DISSERTATION

Submitted in partial fulfillment for the degree of  
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Department of Clinical Psychology

**DISSERTATION COMMITTEE PAGE**

The undersigned have examined the dissertation entitled:

**PHILOSOPHICAL ENDS TO SCIENTIFIC MEANS:  
DIAGNOSIS AND THE EPISTEMOLOGY OF PSYCHOLOGY**

presented on September 13, 2018

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### Abstract

Modern scientific psychology continues to advance toward newer and greater discoveries of the inner workings of the human mind, posited in the belief that a universal objectivity exists if only to be found. Despite the professional emphasis on conducting psychological enterprises in this manner, the field has spent much of its formalized existence struggling to answer some of its most basic questions. This paper thoroughly explores the nature of a scientific psychology, while suggesting that psychology may find wisdom in its philosophical origins. It further suggests that psychology continue toward a postmodern epistemology, in which a unitary psychological reality is abandoned for the realities that exist within the minds of unique individuals. Social constructionism provides the foundation for the postmodern theory throughout the paper. To highlight the character of this discussion, the concept of diagnosis is carefully examined, with the diagnosis of depression serving as the chief example. In the context of this conversation, research was conducted that attempts to explore the contemporary epistemological and diagnostic beliefs of both beginning and advanced clinicians. This research included the use of an online survey that asked current clinical and counseling psychologists about their views regarding the diagnosis of depression, and the practice of diagnosis more generally. Current doctoral students in clinical and counseling psychology programs were also surveyed, to observe chronological changes in perspective.

*Keywords:* diagnosis, depression, social constructionism

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### Philosophical Ends to Scientific Means: Diagnosis and the Epistemology of Psychology

The field of psychology has undergone much reiteration in what constitutes valid and appropriate research and practice. While its origins have been heavily influenced by classic philosophical thought (Gurwitsch, 2009), a more modern era has ushered in an age of prevailing “medical naturalism” that seeks to place suffering and illness within a reductionistic biological domain (Giorgi, 2014; LaFrance & Stoppard, 2006; Pilgrim & Bentall, 1999; Ussher, 2010). This line of thinking is invested in the notion that an objective reality exists, which can be observed and known through careful scientific deliberation and study. Observation serves as a tool for collecting data, while simultaneously determining what *is* from what *is not* (Gergen, 2015).

This paper examines many of the historical roots of psychotherapeutic practice, in order to develop an understanding of how diagnosis has become an essential part of it. It looked specifically at the diagnosis of depression, and attempts to form a coherent narrative of how this illness has been conceptualized and classified over the last several centuries. Later in this paper, new survey research is discussed which examined modern beliefs about diagnosis and depression, as endorsed by clinical and counseling psychologists and clinical and counseling doctoral students.

### **Depression Statistics and Study Overview**

As the modernist scientific ontology has pervaded the clinical landscape, the adjoining epistemological determinants guiding treatment have shaped our understanding of diagnosis. The most formal exemplar of this is found within the pages of the American Psychiatric Association’s *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The most recent edition of this manual, the DSM-5, was released in 2013 and began reshaping diagnosis across the United States once again (APA, 2013). While adding some brief considerations regarding the

role of culture in understanding mental illness, the DSM-5 continues to admonish the importance of a medical naturalist stance, prioritizing the objectivity of the disorders listed (APA, 2013).

Another highly influential text that impacts the global understanding of mental illness is the World Health Organization's, *International Statistical Classification of Diseases and Related Health Problems* (ICD). This classification system has undergone 10 major revisions, with the eleventh due in the next few years. The ICD includes classification for mental disorders and describes the tens of thousands of physiological illnesses that medical professionals encounter as a part of their practice (WHO, 1992). This pairing makes it clear that it is believed mental illness has similar biological origins as the many other illnesses listed within the ICD's pages.

Social and cultural factors are recognized as having some impact on the etiology of mental illness, but these recognitions seem to imply that these factors play a background role in comparison to their biological underpinnings. While used in conjunction with the DSM-5 in the United States, the ICD has been the primary and/or sole manual for diagnosis in much of the rest of the world (WHO, 1992). The medical naturalist epistemology reflected in the ICD further highlights the predominance of the modernist perspective in society today. In many cases, the diagnostic classifications of mental illness listed within the ICD-10 are nearly indistinguishable from those in the DSM-5. In recognition of time and the purposes of this paper, both systems of classification will be viewed as conceptually the same.

One of the disorders of primary concern within the DSM-5 is Major Depressive Disorder. It is currently viewed as a major health issue worldwide by the World Health Organization (WHO, 2002, 2017). It is the most prevalent psychiatric disorder, and is the leading cause of disability among women across the globe (WHO, 2000). Of the millions who suffer with a Major Depressive Disorder, approximately 15% – 40% may end up making a nonfatal suicide attempt

(Holma et al., 2010). Sadly, nearly 15% of those with a Major Depressive Disorder will end up completing suicide (Gradus et al., 2010; Maris, Berman, & Silverman, 2000; Sainsbury, 1986). Major Depressive Disorder also places a heavy burden on the United States' economy, costing approximately \$210.5 billion dollars annually in medical expenses (Greenberg, Fournier, Sisitsky, Pike, & Kessler, 2015). Overall, the depressive disorders are thought to impact approximately 322 million people around the world (WHO, 2017).

Despite these concerns, there remains a significant amount of debate about whether Major Depressive Disorder is most usefully understood as described by the DSM (Black, White, & Hannum, 2007; Cromby, 2004; LaFrance & Stoppard, 2006; Mulder, 2008; Parker, 2005; Pilgrim & Bentall, 1999; Ussher, 2010). Much of this controversy surrounds the treatment methods that a medical naturalist position recommends for the treatment of depression. When viewed predominantly as a disease with biological origins, a biological solution is implied. This biological solution often takes the form of antidepressant medication and recent research has found that approximately 11% of people in the United States 12 and older are currently taking some form of antidepressant medication (Pratt, Brody, & Gu, 2011).

While modern psychotherapeutic practice can broadly be understood as coming from a predominantly positivist/naturalist paradigm, there are specific models that attempt to paint a clearer understanding of how disorders like depression develop. The foremost of these models is called the "Diathesis-Stress Model" (Chang, Yu, Chang, & Hirsch, 2016; Rioux, Castellanos-Ryan, Parent, & Seguin, 2016; Santor, 2003). This theory suggests that the development of illnesses such as anxiety and depression are largely dependent on the individual's level of vulnerability (diathesis) and the amount of stress they are experiencing. The vulnerability component of the theory pays significant attention to genetic factors, and the

likelihood that some members of society will be naturally more susceptible to the effects of increased stress. When a person with high vulnerability encounters life events that are particularly stressful, it is believed that an illness such as depression may develop as the person becomes overwhelmed and unable to cope (Santor, 2003).

The diathesis-stress model was heavily influenced by the work of Richard Lazarus (1966) who hypothesized that a person's experience of stress is largely dependent on how they conceptualized it in their mind. A person's view of the stress they are experiencing may vary based on their appraisal of the situation, and whether they believe their stress to be manageable or overwhelming (Lazarus, 1966; Lazarus, 2001; Lazarus, Deese, & Osler, 1952). Factors such as hope and trauma (Chang et al., 2003), temperament (Rioux et al., 2016), dependency (Santor, 2003), and motivation (Lazarus, 1966; Lazarus, 2001), and how they affect the likelihood of an individual developing mental illness have also been examined through this lens.

While the diathesis-stress model of mental illness attempts to consider contextual factors that lead to suffering, it is typically seated within the broader modernist epistemology described above. Various articles seek to address the naturalist dilemma of measuring and objectively observing the mediating factors that play a role in the diathesis-stress relationship (Chang et al., 2003; Lazarus, 1952; Rioux et al., 2016; Santor, 2003). While this is likely a noble task, other theoretical models may call into question the likelihood of applying the level of desired objectivity to such complicated social concepts.

In contrast to a modernist and/or medical naturalist perspective, alternative views of mental health, diagnosis, and suffering exist. One perspective is found within the theory of social constructionism. Social constructionism is a postmodern perspective within the field of psychology that rejects many of the previously held modernist views. It challenges the notion

that individual knowledge exists, and that the external world is observable by individuals seeking to discern truth. Instead, it proposes that knowledge is shared between individuals in relationship with one another (Gergen, 2001; Gergen, 2009; Gergen, Lightfoot, & Sydow, 2004).

From this perspective, the mainstream system of diagnostic classification observed in the DSM-5 would be viewed as a dominant cultural narrative of suffering and illness. While containing some utility and value, it would not be seen as an objective reality explaining the experiences of people in a universal way. Instead, social constructionism suggests that each individual holds their own unique subjective reality, which defines how they experience suffering and pain (Gergen, 2009). The narratives produced by these unique perspectives would be given priority in psychological treatment, as there would be no alternative view believed to be more valid. In this way, social constructionism suggests a very egalitarian approach toward understanding the distress experienced by others (Gergen, 1994; Gergen, 2009).

Since understanding the suffering of others is a primary concern of those practicing within the field of mental health, it is important that the epistemologies utilized for shaping these understandings are continuously placed under thoughtful scrutiny. This paper offers an in-depth examination of the literature describing some of the historical changes in ideology toward understanding human suffering. In particular, it explores a variety of perspectives and their consequent understandings of diagnosis. Diagnoses of depression are explored throughout this paper as a catalyst for facilitating this discussion.

As a part of this scholarly discussion, research was conducted that examined the beliefs of current mental health practitioners. These mental health provider participants included seasoned professionals in the field, and those who are relatively new to the field or still completing their graduate training. Insights into the complexities of topics like diagnosis and

depression were gained through examining the beliefs of those in the mental health field. This research contributed to our understanding of how diagnosis and depression show up in clinical practice in a practical way. The results of this research also highlighted possible changes in the field between those who underwent their graduate training in decades past, and those who are currently making their way through this process. Discrepancies between clinicians' views about diagnosis and their actual use of diagnosis in clinical practice were also of interest. These research findings assisted in the formulation of a more comprehensive understanding of how theoretical epistemologies impact clinical treatment, and the role of diagnosis as a part of this process.

## **Literature Review**

### **Brief History of Psychology**

Before delving into the complex history of psychological classification and the diagnosis of depression, it seems fitting to provide a brief history of the field of psychology in general. As implicitly and explicitly reinforced throughout this paper, context has a profound impact on the development of thoughts and ideas, and thoughts and ideas shape the way we conceive of problems and generate their solutions. This makes it an essential task to understand cultural context so that our awareness of streams of thought and their action-based implications can be thoroughly understood.

Searching for an official beginning to the field of psychology can be an arduous task because the origin of psychology is like a large tree, supported by a myriad of deep roots that support its growth and stability. Like a large tree, many of these roots often go unnoticed, buried by years of historically layered sediment and the by-products of change over time. Given the present contexts and purposes of this paper, I was not able to exhaustively explore each of these



roots, nor dig deep into the specific roles these roots have played in making psychology what it is today. A discussion of this magnitude would likely take a lifetime. Despite this, an awareness of some of these origins was valuable in assessing the ground from which diagnosis sprung, while examining the intellectual conditions that made the past ripe for a modernist epistemology of mental health.

Many searching for the birth of the field of psychology look to the year 1879, when the early psychological experimenter Wilhelm Wundt first set up his laboratory in Leipzig Germany (Hatfield, 2002; Laungani, 2004). Wundt came from a philosophical background, and at one point was the chair of a philosophy department. In his work, however, he began to develop a more modernist notion, that though the mind is an abstract concept, its principles and functions could be understood by utilizing experimental deliberation (Laungani, 2004).

While Wundt's discourse in scientific thought certainly gained detractors, it also fit well with a broader culture of academic progression that was looking to create a new discipline. Adherents to this new way of conceptualizing the mind felt that psychology could become a distinct study from philosophy. By making this distinction, difficult abstractions became less burdensome or were otherwise scrutinized through proper experimentation. Many researchers at the time were also motivated by the possibility of making psychology a science akin to other natural sciences, where ground-breaking discoveries could be made, and revolutionary ideas could have an impact on the world (Hatfield, 2002; Laungani, 2004).

Utilizing the year 1879 as the marker for the origin of the field fits relatively well in a modernist narrative of psychology as a science, where careful observation is thought to beget truth and knowledge. It also fits well in a narrative that seeks to distinguish or separate the field of psychology from philosophy. However, this inauguration does not fit well in a broader

cultural narrative, where the importance of philosophical thought is viewed as critically vital for understanding how psychological inquiry became possible. We can assert that 1879 may be viewed as a meaningful and important birthdate for the *scientific* psychology that has continued to dominate much of the academic and professional landscape, even to the present day (Hatfield, 2002; Laungani, 2004). Alternatively considered, it is likely that there exists no birthday for what we now consider psychology, but rather that “psychology” is a term that was collectively and culturally chosen to describe a broad swath of philosophical thoughts and ideas that were connected to the existential question of what it means to be human and have human experiences.

In exploring the origins of these important questions, we must look to antiquity, and the early writings of philosophers who sought answers to difficult human questions. Before this exploration, it is important to observe the role of “Historical Myopia.” Historical Myopia is the idea that when events and ideas are closer to us historically, we tend to have a greater sense of their meaningful details and the knowledge they pass along. This can lead to a tendency to perceive comparatively recent events or ideas as more frequent, intense, or important because the information we have about them is more robust (Pinker, 2011). This valuable perspective informs us that though we look to ancient philosophers of historical acclaim for our academic or professional ancestry, it is likely that many relevant and related questions were considered by humans who existed in the many millennia before them. Their relevant stories or writings no longer exist, and therefore we are unable to hear from them or consider their contributions. This may serve as an egalitarian reminder about what it means to be human and understand human suffering. It is something that is shared by each person, not only those who make it their profession or choose to study it for a lifetime.

Aristotle, Plato, St. Augustine, Thomas Aquinas, John Locke, Rene Descartes, Immanuel Kant, Søren Kierkegaard, Martin Heidegger and others should be recognized as some of the most influential philosophers who have had an impact on present day psychology. For the purposes of this study, I did not go deeply into the histories of each classic thinker, but a few are covered, with concise summaries of their major works. Aristotle spent a great deal of time considering the “mind-body problem” and the role of the “soul” in human experience. He further spoke of the importance of reason, and how this quality separates humans from animals (Watson, 1963).

St. Augustine, a theologian and early member of the Christian church, had a dramatic impact on the development of western philosophy, and thus the field of psychology centuries later. St. Augustine spoke at length about the relationship between the body, the soul, and the spirit. He also formulated early ideas about the roles of sensation and perception as parts of personal experience. One of St. Augustine’s major contributions also includes the importance of personal reflectivity, and an observation of the inner self as a means of developing knowledge and wisdom (Hölscher, 2013).

Influenced heavily by Aristotle and St. Augustine, Thomas Aquinas was another theologian who began thinking about a variety of concepts central to modern-day psychology. Of these, Aquinas continued a historical discussion on the body, mind, and soul, while also considering the role of knowledge as reality-shaping. Aquinas furthered our understandings of reason, rationality, and truth (Butera, 2010; Pasnau, 2002). Recent research has taken a close look at the similarities between Aaron Beck’s Cognitive Therapy and the writings of Thomas Aquinas. This work suggests Aquinas had developed and considered many of the key principles central to a more modern understanding of cognitions and their impact on emotions (Butera, 2010).

As can be seen from the last two historical contributors, the field of psychology would likely not be what it is today without influences from the field of theology. Many of the concepts described above were often seated within a Christian or theological frame, but advanced the thinking of secular philosophers and psychologists for many centuries to follow. On this same note, it is oft overlooked that the term “psychology” is derived from the word “psyche,” which meant “spirit” or “soul” in traditional Greek (Haubrich, 2003). Taken together with the suffix “ology,” psychology would therefore be the “study of the soul.” In similar derivations, the word “psychiatry,” which would mean “healing of the soul,” or “psychologist,” to connote an “attendant to the soul” (Haubrich, 2003).

Continuing with historical influences, John Locke’s efforts should be briefly highlighted. With ideas clearly influenced by Aristotle and Plato, John Locke popularized the concept of “tabula rasa” or “blank slate.” This suggested that when we are born, our minds are void of pre-determined material, but are quickly inscribed with sensory experiences and their related memories (Locke, 2009). Rene Descartes advanced thinking related to “mind-body dualism” which proposed that our mind, or soul, is distinctly separate from the body, and can be influenced by divine intervention (Descartes, 2009).

Søren Kierkegaard, often considered to be one of the first existentialist philosophers, spoke directly about some of the problems of objectivity and truth. He strongly believed that truth was something to be found within subjective experiences and personal knowledge. In Kierkegaard’s work, this was often connected to the role of faith and one’s spiritual truth (Kierkegaard, 2009). In other works, Kierkegaard spoke of the roles of choice, freedom, and anxiety upon the human experience (Bretall, 1946).

From Kierkegaard's writings we can clearly see that debates surrounding objectivity and subjectivity have existed for a very long time, reiterating the presence of "looping effects" (Hacking, 2002; Smith, 2010). Looping effects are exemplified by those circumstances through which bodies of knowledge are re-discovered by individuals, which can then lead to a transformative experience for the person doing the discovering. It is not that the individual created the knowledge anew, but that they have taken in something new to them. This new experience can then be shaped by how this knowledge changes their views and interactions with the world. This pattern explains how scientists or researchers are often quick to suggest a new theory or idea has been discovered, when often their work likely existed in some form at some point in the past (Hacking, 2002; Smith, 2010).

The following sections highlight major theorists that take the history of psychology through the end of the 19th century and into the 20th. Since this paper aimed to maintain a consistent appreciation of context, large scale cultural trends are covered briefly. Relevant narratives from the individual local cultures of the theorists discussed are also included to round out the perspective provided.

**Freud, Witmer, and the origins of psychotherapeutic practice.** Beginning a historical dialogue with Freud may be considered arbitrary in many ways, however, it denotes a place in time where a clear focus on the inner workings of the mind took hold of public imagination, and therefore solidified its place in history. This point also represents a moment in history when psychology as a research discipline began expanding its degree of practical application, and began assisting others more psychotherapeutically.

Freud was born in Moravia in 1856 to a 40-year-old father and a 20-year-old mother. He also had two half-brothers who were closer to his mother's age than his father's, which added

some confusion to his early upbringing. During his birth, Freud was born in a caul, which carried with it the cultural belief that the baby would become someone important or successful. On a later occasion, Freud's mother was told by an older woman that "she had brought a great man into the world" (Demorest, 2005, p. 45). These cultural and somewhat superstitious beliefs likely influenced the way his mother viewed him, and the expectations she may have had for his future.

Later in life, Freud recalled having seen his mother naked when he was an infant, and his subsequent sexual urges at this sight. It is likely the salience of this event stuck with Freud and played some role in the development of his theory of childhood sexual urges and the Oedipus complex (Demorest, 2005). These theories were introduced at a time in history when the mainstream society experienced a significant amount of sexual repression, and viewed his sexual theories with both disgust and intrigue. If it were not for society's specific reception of these theories, it is possible Freud would not have become the influential figure he did (Benjamin, 2007).

Freud's life was also transformed by the birth of his younger brother, Julius, who interrupted the close relationship Freud had with his mother. Freud reflected on this time in his later writings, and remembered harboring ill wishes toward his brother. These wishes were given increased potency, from Freud's perspective, when his brother passed away at 8 months old. The young Freud began experiencing guilt at the belief that his wishes had in some way contributed to his young brother's death. In connecting these ideas to Freud's theories, it seems plausible that significant events like this had shaped his views regarding infantile aggression and the importance of undesirable impulses in people's psychological life (Demorest, 2005).

At a similar point in history, the field of psychotherapy was finding its footing through the work of a little known founder to the field, Lightner Witmer. Witmer was born in

Philadelphia in 1867. He was of Swiss ancestry, and grew up in a family of five. He was the oldest of his parent's three children. As Witmer was beginning his professional life in psychology, he spent a significant amount of time studying the experimental method, and even earned his doctorate studying under Wundt. At this point in time, Witmer was utilizing these experimental methods to study things like reaction times, psychophysics, and individual differences. It wasn't long before he began to consider how psychology might be used more practically for the lay population (McReynolds, 1987).

In 1896, Witmer was approached by a teacher who inquired about whether he thought psychology might help one of her 14-year-old students who was having significant difficulty learning how to write. Witmer accepted the challenge and took it upon himself to assist. This became a notable moment in Witmer's career, eventually leading him to establish one of the first psychology clinics. Witmer later wrote papers on the practical uses of psychology, and developed the term "clinical psychology," which might not have come into widespread use without his influence (McReynolds, 1987).

During the course of his immensely impactful career, Witmer went on to help found the American Psychological Association, develop some of the first clinical psychology curricula, and have a major impact on the clinical treatment of children and adolescents. He also started one of the first journals on clinical psychology, "The Psychological Clinic." At times, Witmer's views conflicted with other prominent thinkers of the era. He disagreed with William James's methods, believing them to be unscientific and numinous at times. He also eschewed many of Freud's psychoanalytic ideas, and would often employ methods more consistent with behaviorism (McReynolds, 1987).

Despite his respect for the scientific method and its place in clinical psychology, he was open-minded about clinical psychology's place in the professional world (McReynolds, 1987). He believed the new field he was helping to create was related to medicine, as well as closely connected to other disciplines like sociology and more pedagogical studies (Witmer, 1907). He also saw value in the use of psychological tests and measures, but felt that they alone were incapable of providing a full picture of a person's experience. He strongly valued the role of the individual, eventually becoming skeptical of the use of statistics as a means of understanding people's experiences. During the later part of his career, he grew to appreciate the role of the environment more and moved away from his earlier position which gave increased emphasis to hereditary factors and their contributions to psychological functioning (McReynolds, 1987).

From these brief biographical accounts, the origins of psychotherapeutic practice can be observed. Both of the men described above contributed in significantly different, but meaningful ways. Freud developed a new dynamic model for understanding pathological behavior and suffering, while Witmer stressed the notion that the experimental methods of the day could be used outside of the academic realm to better the lives of the lay population. Both pioneers had roots in the philosophical realm, with Witmer even becoming a member of the American Philosophical Society (McReynolds, 1987). Without the influences of these men, it is likely that clinical psychology, if it were still called that, would be significantly different than it is today.

**Watson, Skinner, and the behaviorist focus on objectivity.** During the first couple decades of the 20th century, behaviorism began to have a more substantial impact on the field of psychology. Behaviorism was largely advanced by the observations of the research psychologist John Watson. This theory sought to change the focus from the complex inner workings of the mind and onto a person's observable behaviors. Watson preferred his new behaviorism over



psychoanalysis because it prioritized a strictly objective perspective. He believed it left little room for assumption or speculation regarding its explanations of behavior, and thought this was the direction the field of psychology ought to go (Watson, 1913).

Watson cherished the relationship between psychology and the natural sciences. He felt strongly that if it were going to survive as a respected discipline, psychology needed to adopt more objective scientific practice. Watson was dissatisfied with the degree to which psychoanalytic studies could be replicated, and felt that behaviorism offered an approach that lent itself to scientific inquiry. It is worth noting that Watson experienced difficulty practicing introspection and other psychoanalytic methods, and generally felt uncomfortable interacting frequently with human research participants. It appears to be no small coincidence that Watson directed his research toward animal subjects, and felt that the data collected from animals would transfer proficiently to conceptualizations of human behavior (Pickren & Rutherford, 2010).

Watson's ideas were well received by an early 20th century culture that was seeking specialists who were viewed with more authority on the subject matter they studied. Psychological testing was also being developed and finding its way into the knowledge of mainstream society. This accompanied Watson's motivation toward a psychology field utilizing more objective data. While Watson already made a significant impact on the field of psychology at an early age, it is likely he would have contributed even more had it not been for his scandalous affair with one of his students, whom he later married. This relationship cost him his academic position, and eventually led him to a career in advertising (Pickren & Rutherford, 2010).

Behaviorism's rise to power didn't decline with Watson's retreat into the background of the psychological research community. B.F. Skinner began to have an impact on the thoughts of

academics and mainstream culture. He was greatly influenced by Watson's work though this may be due to the benefits behaviorism offered him on a more personal level. Skinner had just experienced failure in college while trying to be a successful writer. In order to explain this failure, he found that behaviorism provided a tolerable interpretation. Rather than having to explain his difficulty through some fault in his own abilities, Skinner could assert that it was his environment that was responsible for his failure as a writer (Demorest, 2005).

Skinner expanded upon the preexisting theories of classical conditioning by developing a concept called "operant conditioning." This theory suggested that not only are people conditioned to act in a reflexive way by the environment, but that they also behave in certain ways based on the consequences of these actions. When a behavior is positively reinforced with a desired outcome, the behavior is more likely to be performed later. When an action ends in some form of punishment, it is less likely to be performed in the future (Skinner, 1935). Skinner (1971) was convinced by the strength of this idea and took a more extreme position on the matter in his book *Beyond Freedom and Dignity*. In this writing, he encourages people to accept that there is no such thing as free will or choice in life. Every decision, from the smallest to the most important, is predetermined by the many systems at work in people's lives. Culture often manipulates some of the larger outcomes in human life and the events that take place throughout them (Skinner, 1971).

**Carl Rogers, empathy, and a rejection of environmental power.** As the 20th Century progressed, American culture was rapidly changing and began pushing for a perspective that offered understanding rather than criticism. The powerful anti-war movements of the 1960s created a motivated American sub-culture that wanted to be listened to rather than directed. Carl Rogers was aware of these societal complaints and formulated the idea that people need the

opportunity to be heard, empathized with, and regarded with great positivity no matter what they might have to share. He felt that some of the pain people experience is brought on by a coercive demand to meet cultural norms and values. Rogers concluded that mental health might be achieved through opportunities to embrace one's own individuality, creativity, and autonomy. He felt strongly that individuals have all the wisdom they need to experience personal health, and that therapy might be more effective if advice giving were removed from it (Pickren & Rutherford, 2010).

Rogers grew up in a family that observed strict religious values, eventually leading to fundamentalist practice. He later recalled having no doubts that his parents loved him but felt certain they would be judgmental toward him if he behaved in ways that were considered taboo. Rogers also reflected on the frequency of the teasing he received from his siblings, and he felt that this had a corrosive effect on his relationships with them. This led Rogers to have a very private inner life from an early age because he did not want to be judged by his parents or chastised by his siblings. This caused a young Rogers to feel as though his deeply personal self was only regarded positively when he fit within particular familial norms (Demorest, 2005). It may be no surprise then that he later prioritized "unconditional positive regard" as one of the qualities he saw as essential to effective psychotherapy. Based on a familial history that includes these kinds of interactions, it is also not surprising that Rogers began to see a person's environment as something that can inhibit individuality, autonomy, and overall mental health (Rogers, 1946).

**Aaron Beck and the cognitive revolution.** Cognitive psychology began to take shape as a formal domain of interest in the late 1960s. Ulric Neisser proposed that the human mind works similarly to a computer. As individuals live their lives and experience events, their minds are

constantly taking in information, storing it, and retrieving it later on when useful (Neisser, 1967). Richard Lazarus theorized that appraisal plays a significant role in people's ability to tolerate stress. He recognized that when people are able to develop optimistic appraisals of the difficult situations they face, they are more likely to experience a lower level of stress and view the situation as less threatening (Smith & Lazarus, 2001).

As cognitive psychology developed, it lent itself more readily to therapeutic use. As a pioneer in this work, Aaron Beck formalized the modality of Cognitive Therapy and hypothesized that as people grow and develop they create sets of "schemata" that are based on their past experiences. These schemata are believed to be socially constructed and serve as rules that govern how a person understands their life and the world around them. Beck observed that people with mental illness tend to utilize maladaptive thinking styles in regard to what he called the "Cognitive Triad." The cognitive triad includes peoples' core beliefs regarding themselves, other people, and the outside world. Beck saw core beliefs as deep schematic structures that influence the shallower levels of processing taking place in the form of people's "underlying assumptions" and "automatic thoughts" (Beck, Rush, & Shaw, 1979).

Beck suggested that the treatment of mental illness ought to involve assisting clients in a process of "cognitive restructuring." He found that if clients can begin engaging in more reflective thought, they may be able to challenge some of the maladaptive or distorted thinking that they are inclined to use. As this takes place it should ultimately lead to a reduction in their level of pathological symptoms (Beck & Clark, 1997).

Since its roots in the 1960s, cognitive psychology has undergone a variety of changes in how it has conceptualized mental health and the operations of the mind. Some recent theorists have placed the roots of social constructionism, or constructivism more broadly, in the cognitive

tradition (Mahoney, 1991). To locate social constructionist theory in the cognitive tradition, one might observe the advancement from modernist to post-modernist thinking through their ontological beliefs. Early cognitive theory might have been more modernist, as it sought to measure processes of the mind like reaction times, memory (Miller, 1956), or symptom levels. This data would then be utilized to form an objective understanding of how the mind works. Cognitive psychology would have branched into post-modernism when it deviated from such objectivity, instead valuing the constructive nature of reality, the narrative value of schemata and the cultural differences inherent in creating meaning (Mahoney, 1991).

Now that the broader historical, cultural, and theoretical landscape has been described, a narrower focus is necessary to explore the roots of diagnosis and depression. The following narrative begins again in antiquity, this time exploring a different set of profound thinkers, and their work as related to the topic being discussed.

### **History of Depression**

We have distilled our modern-day understanding of “depression” from a uniquely multifaceted historical context, with diagnostic classification ebbing and flowing over time. “Melancholia” was one of the precursors to today’s depression. To understand the term in its most literal sense, we must briefly examine the ancient theory of “humorism.” This perspective was largely developed by the Greek physician Hippocrates, who is often considered to be the father of medicine. According to humorism, the body consists of four primary humors which are said to impact a person’s well-being: (a) yellow bile, (b) black bile, (c) phlegm, and (d) blood. Of primary importance to this discussion is the black bile humor, or in the Greek “*melaina chole*” (Bell, 2014; Berrios, 1988; Drabkin, 1955; Hippocrates & Schiefky, 2005; Richet, 1910; Stelmack & Stalikas, 1991).

It is from the theory and tradition of humorism that the term *melancholia* predominantly originates. A humoristic conceptualization of the illness would suggest that the suffering individual had an excess of black bile resulting in the presenting painful disposition (Hippocrates & Schiefky, 2005; Stelmack & Stalikas, 1991). The philosophical nature of the illnesses' proposed etiology is also noteworthy. The idea of physiological chemicals leading to psychological distress draws some interesting parallels to our modern naturalist understanding of mental illness. At the same time, the four humors were often said to be related to the four planetary elements: (a) earth, (b) fire, (c) water and (d) air (Bell, 2014; Hippocrates & Shiefky, 2005; Stelmack & Stalikas, 1991).

The cosmological view, including the four planetary elements, dates back to the Greek philosopher Empedocles and the Pythagoreans. They determined that the number four could be found in many areas of meaningful human life. They considered the four seasons, four qualities of the four primary elements, and an overall conception of the "harmony of life" as being connected to these numbers (Stelmack & Stalikas, 1991). This cosmological view supplemented the humorist perspective by connecting the importance of the chemicals in one's body to one's connection with nature, the earth, and the surrounding planets in our galaxy (Stelmack & Stalikas, 1991).

In this sense, the humorist understanding of illness began to stray from the scientific realist perspective and began to cling to a naturalist philosophical understanding. It is not hard to observe the connections between this train of thought and the religious or cosmological beliefs of Hippocrates's time (Bell, 2014). Much of the Greek humorism developed in tandem with an ancient culture that both sought an objective understanding of the world, while also seeking answers from the celestial skies above. These parallels remind us that, just as in today's modern

society, medical and/or psychological practice develops in close relationship to the prevailing culture and cannot help but be at least indirectly influenced by it.

Discussion of the history of melancholia would not be complete without some mention of the premiere Roman physician Galen, and his study of the transformation of illnesses over time. Galen's impressive historical reputation is supported by his accreditation of having written more medical texts than any other physician in antiquity. Galen was also an ardent follower of Hippocratic medicinal practice, and he became so intricately connected to much of Hippocrates's work that professionals down through the ages have begun seeing both theorists' work as part of the same canon. While he considered himself to be a preeminent interpreter of much of Hippocrates's work, Galen also expanded upon the research and experimentation that had come before him (Bell, 2014).

Galen advanced much of the early system of classification, which grew to include illnesses like "phrenitis" and "lethargus," which were thought to be primarily mental in nature but included fever as a predominate symptom. This fever would be observed in combination with significant "excitement" in the case of phrenitis, or depression in the case of lethargus. These illnesses were believed to be separate from existing ideas of mania and melancholia which were thought to exist more chronically, and without the presence of fevers (Drabkin, 1955.) Galen also developed the notion that the four humors were connected to four psychological character types. The black bile humor was representative of a *melancholy* type that was thought to be pervasive and long-lasting in the lives of those suffering with it (Bell, 2014; Drabkin, 1955; Stelmack & Stalikas, 1991). These kinds of classificatory subtleties seem to have led to a new understanding of psychological experiences, while potentially adding some diagnostic confusion to the extant understanding of individual suffering.

These kinds of differential diagnostic puzzles can be seen as precursors to the rampant diffusion that later impacted both melancholia and depression. With the subtle change to a language of character types, the idea of melancholia invited comment and discussion from those outside the field of medicine. In the years that followed, writers, politicians, ethicists and lay people began speaking of being melancholy. This took the relatively professional and scholarly concept of *melancholia* and transformed it into a broad cultural expression of feeling, *melancholy*. As the term left its academic holdings, it lost not only the precision, but its previous power (Bell, 2014).

Physicians of later centuries could no longer discuss melancholia without some influx of lay societal understanding. Melancholia began to mean a variety of different things, even to the physicians who continued to use it. Once the idea of being melancholy had pervaded the broad vocabulary of western civilization, it left many of its theoretical underpinnings behind. This disconnection from theory usurped the professional power from the everyday physician. As this took place, the physician could not assert (to the same extent) his authority as a holder of professional knowledge, because the world at large had adopted the term and made it its own. Research and experimental theory provided an edifice of authority for those in medicine to stand upon and this no longer existed when melancholia and/or melancholy became topics of everyday discussion or “reality constructing” (Bell, 2014). This kind of linguistic power and transformation is discussed again in later sections of this paper.

As the centuries passed, the term melancholia continued to take on new meanings. Prior to the 19th century, it remained a comparatively broad term, and its detection was based primarily upon its behavioral features, principally a decrease in behavioral output. It was also thought to be a subtype of mania, including symptoms like agitation, hallucination, paranoia, and



dementia (Berrios, 1988). In the earlier part of the 19th century, many physicians associated the term melancholia with a sort of general “madness” (Prichard, 1835). While some relationship between mania and melancholia was posited, the two were not believed to be polar opposites as depression and mania may be viewed today. States of *sadness* or *depression* could sometimes be found amongst the highly varied amalgam of symptoms contributing to melancholia, but they were not typically seen as the essential features of the illness until the latter portion of the century and the further development of diagnostic classification (Berrios, 1988).

One significant historical antecedent to modern depression and our current understanding of the term melancholia can be found within the advent of another term called “lypemia.” Although its use was predominantly limited to the countries of Spain and France, the clinical understanding of lypemia began to move 19th century understandings of melancholia towards what they are today. The expression lypemia was invented by Jean-Étienne Dominique Esquirol (1820), who suggested that lypemia was an illness presenting with delusions, but also with “sadness which is often debilitating and overwhelming” (pp. 151-152). Esquirol further went on to suggest that it was a form of suffering distinct from mania and dementia (Esquirol, 1820). This delineation seems to have begun pushing 19th century European physicians toward a more precise belief about what constituted melancholia, and eventually depression. The term did not last, however, as many practitioners in other parts of the industrialized world continued to prefer melancholia over the newer lypemia. This seems to have been partially due to the tendency at the time to frequently use both terms interchangeably. As this happened, the more longstanding melancholia outlasted the comparatively young lypemia, which eventually fell by the wayside of technical use (Berrios, 1988).

As the beginning of the 20th century drew nearer, the term *depression* was utilized more frequently, though a consistent understanding of what it meant remained unclear. In some cases, the terms depression and melancholia were both used by the same physician, or otherwise used interchangeably (Berrios, 1988). During the earlier portion of his career, Freud described a “periodic depression,” which he believed to be a particular kind of “anxious neurosis.” This illness could last for many months and involved a chronic period of anxiety attacks. He added that this kind of ailment tended to have a distinct connection to a “psychical trauma” (Freud, 1893). As these kinds of descriptors suggest, Freud believed this kind of depression to fit more closely with what might today be considered an anxiety disorder.

While highlighting this specific form of mental distress, he concurrently spoke of melancholia or “melancholia proper.” According to Freud (1917), this illness contained symptoms such as: feelings of worthlessness, loss of interest in things, difficulty sleeping, and loss of appetite. He also noted that someone experiencing melancholia would have a significant loss of self-respect (Freud, 1917). These kinds of symptoms closely resemble the diagnostic criteria typically associated with depression, or more specifically, major depressive disorder (APA, 2013). Freud’s use of both terms points to some of the ambiguity that existed in the late 19th century to the beginning of the 20th century. While he utilized a form of depression in his diagnostic classification, it meant something different than how we understand it today. Melancholia began to be understood as akin to modern day depression, but it was harbored in a different linguistic frame.

Surprisingly, the term depression would not reach greater widespread clinical use until the 1950s and 1960s. During this period of time, the first “antidepressants” were developed. Some scholars suggest that the diagnosis of depression may have come from the idea that those

who benefitted from antidepressants could subsequently be described as depressed.

Electroconvulsive therapy began to be used prior to the 1950s and 1960s, however, this procedure did not specifically label patients as depressed (Hirshbein, 2006). The diagnosis of depression was not listed in the first edition of the DSM (1952) and would not make its formal classificatory debut until DSM- III (APA, 1980).

The term depression had been used in more minor descriptive ways in the first two editions of the DSM, but it was not officially thought about as its own category of illness. In DSM-I, experiences consistent with a depression or melancholia were placed under one of three categories of psychotic disorders. In these cases, the disorder was believed to be primarily affective in nature, separating it from the “Schizophrenic” or “Paranoid” types (APA, 1952, p. 12). It was thought that sufferers would, at times, also have difficulties with reality testing, sometimes experiencing hallucinations or delusions as a part of their illness.

More broadly speaking, it was believed that depressive-like symptoms arose as a defense mechanism for managing an onset of anxiety (APA, 1952; Horwitz, Wakefield, & Lorenzo-Luaces, 2017). Much of this initial DSM conceptualization can be understood when taken in light of the prevailing theory and practice in the 1950s. Psychodynamic theory was dominating the clinical landscape, and many mental illnesses were considered against a frame of defense mechanisms and unconscious anxieties that were responsible for producing symptoms (Horwitz et al., 2017).

DSM-II continued to view depression as an experience categorized under and in connection to anxiety disorders. It spoke frequently of the role of “neuroses” and the belief that anxiety was the central feature of these disorders (APA, 1968). During the 1970s, debate and research intensified around the possibility that depressive disorders could exist as distinctly

separate from anxiety or psychosis. In response to this increase in debate, and despite a relative lack of evidence at the time, a new category was added. This change gave depressive disorders their own category in the DSM-III (APA, 1980; Horwitz et al., 2017).

In the current era, antidepressant medications often dominate the psychiatric landscape and represent a major biochemical intervention for the treatment of depression (Pratt et al., 2011). Much of the emphasis on the use of antidepressant medications is advanced by the medical model which suggests that there are distinct biological underpinnings for psychiatric disorders. This perspective is largely founded upon finding physiological brain pathways that are responsible for the depressive symptoms we observe (Callahan & Berrios, 2005). It also attributes depressive symptomology to a lack of neurotransmitters and/or the idea that a chemical imbalance is to blame for this kind of human suffering. The “Chemical Imbalance Theory” of depression originated around the same time as the advent of antidepressant medication and has remained a part of popular practice ever since (Callahan & Berrios, 2005).

Psychiatric practitioners continue to pursue findings consistent with this epistemology, despite a continuing lack of agreement regarding a specific biological pathway in the brain responsible for the symptoms of depression. Though there appears to be a lack of scientific evidence supporting the Chemical Imbalance Theory of depression, antidepressant medications continue to be widely proscribed. This may be partly due to the fact that, for many people, they produce a desirable reduction of symptoms (Callahan & Berrios, 2005).

### **Key Concepts**

**Mental disorder.** In order to understand what traditional diagnosis looks like in the mental health field, it may be necessary to examine some of the core components needed for a mental disorder to be present. According to the American Psychiatric Association (2013), the

DSM-5 states that, “A mental disorder is a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (p. 20). As stated by this definition of a mental disorder, dysfunction exists within an individual.

Despite the widespread use of the DSM as a clinical tool, and its laborious construction and development by the American Psychiatric Association (2013), much controversy remains regarding the mental disorders it describes (Demazeux & Singy, 2015; Ghaemi, 2014; Miller, Wolf, & Keane, 2014; Wakefield, 2013). Some of this controversy is concerned with the scientific underpinnings said to inform the DSM-5. The American Psychiatric Association (2013) has suggested that each mental disorder should have objective criteria which determine its presence within individuals. Statistical measures have been used to assign validity to the disorders and emphasize the importance of being able to detect the same disorder among many individuals who may be experiencing similar symptoms (APA, 2013).

As strong scientific validity is appended to mental disorders, the hope may be that they become viewed similarly to various medical diagnoses (Ghaemi, 2014). This style of scientific methodology stems from a post-positivist and/or modernist stance which claims that the world and the observer of the world can be separate. The primary notion is that as scientific empiricists engage with and observe the world, they can find objective truths that exist therein. Through careful scientific deliberation, the world can be understood as it is, and the actions of the observer will have little to no effect upon it (Creswell, 2007; Gergen, 2002; Gergen, 2009). The post-positivist approach often acts in a reductionistic fashion, seeking to take broad theoretical

concepts and break them into their narrower component parts as a means of better understanding their functionality (Creswell, 2007).

As previously mentioned in this paper, mental disorders are often believed to exist within individuals. This idea also has modernist roots and is maintained by the assumption that individual knowledge is essential for understanding psychological processes. Each individual is believed capable of rational, truth-bearing thought, which may be impeded by various kinds of mental dysfunction. As a person experiences dysfunction, they become less able to maintain objective truths about the world. The modernist view continues that language is used to communicate the rationality and truth each individual holds which may be scrutinized against the truths held by others' individual knowledge (Gergen, 2001).

**Social constructionism.** Social constructionism is a postmodern perspective within the field of psychology that rejects many of the previously held modernist views. It challenges the notion that individual knowledge exists, and that the external world is observable by individuals seeking to discern truth. Instead, it proposes that knowledge is shared between individuals in relationship with one another (Gergen, 2001; Gergen, 2009; Gergen et al., 2004). Much social construction takes place through a process called co-action, or coordinated action. As a person shares their thoughts or feelings with another person, a reaction of some sort is called for, and this reaction will continue to construct, for the other, how they understand the relationship. This process extends far beyond the relationship, however, and these patterns shape how we conceive of our world, and the subjective realities within (Gergen, 2009).

When two people are involved in a thoughtful discourse, they share meaning which is thought to be derived largely from culture and tradition. As each individual develops and grows, they learn the traditions of their local culture. During their lifetime, most individuals will meet

many people from different local cultures who hold a different understanding of reality. Upon this meeting, they may share their differing realities and through such processes, each individual's understanding of the world is shaped and reconstructed. In this sense, social constructionism offers a very relational view toward understanding psychological phenomena (Gergen, 2007; Gergen, 2009).

From the social constructionist vantage point, language is the primary vehicle through which culture and knowledge are shared. As we grow and develop as individuals, we learn how to use language in a way that is consistent with the cultural values of the society we are from. In order to interact with others around us, who may also meet some of our most basic needs, we must learn to socialize in a way that will be valued. A person may choose to reject the cultural language values of the society they are from, but it is likely this will result in a decreased ability to cooperatively communicate knowledge and understanding with those around them (Gergen, 2009). For example, if an individual decides to discard their family conventions around language and begins describing the world in a way contrary to preferred understandings, communicative collaboration with family members may become strained. This may be seen in deeply political families, where one member chooses to adopt strong beliefs that run contrary to the political values of the family majority. As these patterns continue, interaction may become less fulfilling and the individual may find their family culture less nurturing and accepting (Gergen, 2009).

More broadly speaking, these communication difficulties can result in social justice issues. As the modernist view of clinical diagnosis has become the dominant view in American culture, other perspectives may be deemed unscientific, or inferior. This sets up the foundation for a clinical system in which the providers of "truth," the psychological scientists, determine what is "reality," while lay people are subjected to this view whether it resonates with their

personal subjective reality or not. This process may lead to the marginalization of those said to be lacking, or “abnormal,” within the dominant view (Gergen, Hoffman, & Anderson, 1996; Gergen et al., 2004).

As the powerful voice of the media spreads the dominant cultural knowledge of mental disorders, individuals may see themselves as possessing some form of deficiency. This mechanism may create a cycle in which lay people see themselves as lacking, with clinical providers being the only ones capable of repairing what is broken (Gergen et al., 1996). As this takes place, the dominant voice within society gains a significant amount of public control, while other societal voices are forced to relinquish the control they once had (Gergen et al., 2004).

Pragmatism is another major concept that supports the social constructionist perspective. As ideas of objective truth and accuracy are rejected, the value in different perspectives is derived not from the extent to which they represent one universal reality, but to the extent with which they have utility within a shared subjective reality (Gergen, 1994; Gergen, 2009; James 1907). For example, in the United States we have laws which instruct legal driving practices. Traffic lights direct us when to stop and when to proceed. Traffic lights do not reflect a universal reality about how driving is to be done best, but function within a cultural system that gives them purposeful utility. They serve to organize cars on the road, and as people share the socially constructed reality that traffic lights are necessary, a sense of order can be experienced while driving.

Diagnosis, as understood by the DSM, does meet some pragmatic ends. This can be seen in the efficient manner by which providers are sometimes able to use commonly understood diagnoses to conceptualize client cases for other professionals. Diagnoses can also be used for effective communication with insurance companies, who look to reimburse providers for their



services (APA, 2013; Ghaemi, 2014). The problem may not be that mainstream constructions of diagnosis lack utility, but that they may end up providing their utility to those with the most power within the mental health services field. If treatment is to be most beneficial for the clients receiving it, it seems essential that their conceptions of the dysfunction they are experiencing be given increased volume (Gergen et al., 2004).

### **Application to Clinical Psychology**

If the field of psychology is going to adopt a new understanding of diagnosis, it will be important for student clinicians be exposed to it. Theoretical models for clinical practice have grown, developed, and fallen out of mainstream practice since the beginning of psychotherapy as an established treatment. As this process takes place, student clinicians are trained and scrutinized for their ability to replicate a desired treatment model. In today's mental health training programs, there may be a lack of emphasis on the role of context in mental health treatment. Although many programs are discussing the role of context to some degree, this discussion is often relegated to a single class where it may not be a primary focus (Peterson, Vincent, & Fechter-Leggett, 2013).

As previously mentioned, personal knowledge and meaning are thought to be derived from the relationships people have with each other (Gergen, 2001; Gergen, 2009; Gergen et al., 2004). This means that in order to fully understand the clients we serve, it is essential that we understand the contexts from which they come. As this type of material is given priority throughout clinical training programs, student clinicians may also develop a respect for the subjectivity of knowledge. This may lead to a beneficial breakdown in the detrimental social hierarchy that has existed between the scientific community and those outside of it (Gergen, 1994; Gergen, 2002). As student clinicians become comfortable with the idea that all knowledge

is situated within a specific context, they may be less inclined to assert dominant mainstream views regarding diagnosis. This may empower the voices of the clients they serve and create restorative discourses in which clients can feel as though they have control over the treatment they receive, and the outcomes they can expect (Bohan, 1990).

**Intersection with social justice.** The concerns with our current diagnostic and epistemological trajectory relate to issues of social justice in the sense that they may create a detrimental hierarchy between different societal groups. Stated earlier were the notions that the modernist scientific establishment has produced views deemed to be objective realities of what is, with alternative views often being considered inferior (Gergen et al., 1996; Gergen et al., 2004). The current mainstream system of diagnosis was also described as providing a deficit model for understanding clients' presenting problems. This may create a cultural atmosphere in which lay people begin to see themselves as lacking, while treatment providers are seen as necessary for helping them to overcome their shortfalls (Gergen et al., 1996).

These can also be considered issues of social justice because they give volume to the voices of one population within society, while simultaneously silencing the voices of many others. Language is the vehicle by which this happens. The mental health field has adopted a pattern of "technologizing" (Gergen, 1994) terminology. This happens when terms such as *sadness*, *depression*, and *anxiety* are taken in by social scientists and made into technical concepts that are observed through experimentation and scientific inquiry. Once this happens, these concepts are assumed to be correctly understood by the scientists who have researched them, and only marginally understood by lay people who have not. In this way, language is used to differentiate between members of society who are believed to be informed, and those who are

not. This process may result in facilitating social hierarchy and potentiating oppression (Gergen, 1994).

The social constructionist perspective might suggest that increased importance be placed on the open dialogues shared between clients and clinicians. This may allow for a restorative atmosphere of polyvocality, in which individuals can explore a variety of constructions through which they can understand their difficulties. As a plethora of constructions are considered, the range of solutions increases (Gergen, 2009). Rather than suggesting that people suffer from illnesses like depression that involve a chemical imbalance which can only be treated through lifelong medication use (Leventhal & Antonuccio, 2009), clients can begin to entertain the idea that there may be a variety of effective ways to alleviate the pain they are experiencing. In this fashion, social constructionist dialogues likely offer clients a considerable amount of hope for the future.

As I transition from a review of past literature to an examination of the new research that was conducted, a couple of underlying questions are asked. First, “Is a predominately modernist theoretical orientation sufficient for bringing psychotherapeutic practice deep in the 21st century?” and secondly, “What might modern day psychotherapy gain from adopting a wider contextual lens toward our understanding of mental illness?” In attempting to derive some answers to these questions, an online survey was utilized that asked participants about their theoretical views. It compared these views with participants’ beliefs about diagnosis, depression, and the overarching model that dominates clinical practice, the medical model.

## **Method**

### **Study Design**

This study involved the use of an online survey to assess the theoretical beliefs of clinical and counseling psychology doctoral students. It also examined the views held by clinical psychologists who are currently practicing in the field, or who have practiced at some point during their careers. Specifically, the administered survey sought to assess these individuals' views regarding diagnosis, and the clinical benefits they perceive to be derived from the use of diagnosis. It also attempted to gather information about participants' conceptions of the diagnosis of depression and gave particular attention to their etiological and epistemological understandings of these kinds of illnesses. Additionally, it sought to discover participants' views about the diagnosis of depression as an objective or subjective construct. These views may inform whether or not major depressive disorder is viewed as an easily measurable phenomenon, or one that may exist outside the realm of quantification. The present study further attempted to understand whether participants view depression as something experienced in gradations by most people, or whether it is conceptualized as a unique experience for a minority of the population.

### **Participants**

I recruited potential participants for the study by sending an email to graduate psychology program directors, asking that they forward an invitation for participation to students and clinical psychology faculty. The students were graduate students in either clinical or counseling psychology programs who had begun seeing clients through clinical training experiences. The faculty participants had either their PhD or PsyD, but also needed to have practiced clinically at some point during their careers. The invitation included a link to the study survey so participants were able to access the questionnaire as easily as possible. In hopes of increasing participation

rates, program directors were asked to respond regarding their willingness to forward the survey request to members of their programs. This allowed for greater awareness of the number of potential participants.

The present study utilized a snowball sampling methodology for gathering participants. The study survey was sent via email to doctoral-level clinical psychologists with whom I am acquainted from my own clinical experience. As a part of this email, these psychologists were asked to participate in the survey and forward the email to other clinical psychologists known to them. Following this style of research methodology, the study survey made its way to a larger number of experienced doctoral-level participants.

In addition to seeking participants from these specific groups, I also sent my survey recruitment letter and link to psychologists and doctoral-level trainees connected to various professional organizations, such as APA and the NCSPP (National Council of Schools and Programs of Professional Psychology). Various college counseling centers across the country were also contacted for recruitment and participation.

All study participants had the option to enter a drawing to win a \$50 Amazon.com gift card after successful completion of the survey. For those participants interested, an additional and separate entry form was presented. This form asked these participants for contact information, and automatically entered them into the drawing. As a part of this process, confidentiality was maintained, and participants were not required to provide their names. This separate drawing entry form was not attached to survey responses which helped to ensure that questionnaire responses were kept confidential. This plan was designed to recruit participants from the population being sampled.

**Measure**

An online survey was utilized for data collection as a part of this study. During the process of survey development, licensed clinical psychologists, doctoral students in the field of clinical psychology, and clinical psychology faculty were consulted. The measure was made up of 45 total questions from six separate question categories. Fifteen of these questions covered participant demographic information and theoretical background. Four questions examined participants' views about the factors that contribute to our understanding of depression. Nine questions addressed participants' conceptions of the diagnosis of depression, including their beliefs regarding its etiology and their views about its existence as an objective or subjective phenomenon.

An additional eight questions inquired about participants' views surrounding clinical diagnosis. These questions specifically sought to examine their views regarding its utility, both in terms of professional communication with those in the mental health related fields, and as a part of therapeutic interactions with clients. Four further questions asked about people's views in terms of the medical model, which is the dominate model of treatment in the United States. Finally, five questions explored participants' professional practice, and their experience using diagnosis. This section also briefly examined participants' experience treating the diagnosis of depression. The survey questions were asked through the use of Likert-type response choices (See Appendix C for survey items).

**Procedure**

In order to begin the data gathering process, a request for research participation was emailed to program directors both in clinical psychology and counseling psychology doctoral programs. A similarly crafted email was sent to the clinical psychologists that I have come in

contact with during my pre-doctoral practicum experiences. This same process was followed when contacting directors of college counseling centers and psychologists associated with professional organizations. Program directors and other psychologists willing to forward the participation request received further information about the study, and a link to the electronic measure. The measure was hosted by SurveyMonkey.com. Participants who opted to be involved in the study were directed to a webpage describing and requesting their informed consent. As a part of this page, participants learned about the goals of the present study and were informed of any possible benefits and risks of participating. Those willing to provide their informed consent were guided to the first page of the survey. In total, the survey should have taken approximately 15 to 20 minutes to complete. Survey responses remained anonymous and confidential throughout the duration of data collection and analysis. Data was gathered for several weeks, until the desired number of participants was reached. Later analysis was conducted using the SPSS statistical analysis program.

### **Statistical Analysis**

A working hypothesis for this study was that therapists from particular theoretical backgrounds would have tendencies to view depression as more or less socially constructed (Hypothesis 1a). Those who viewed depression as a more socially constructed phenomenon would also view it as a less useful diagnosis than those therapists who view it as a more objective biological illness (Hypothesis 1b). As depression was believed to be more closely akin to a medical illness, it would be increasingly viewed as a vital component in understanding the client's symptoms. The more depression was understood as a socially constructed concept, the less valuable the diagnosis may become as it represents one subjective view among many for describing human experience. The null hypothesis within this proposition was that there is no

relationship between a person's theoretical understanding of diagnosis and their views of it as useful.

Analysis of variance, correlational statistics, and paired samples t-tests were utilized for examining Hypothesis 1a and 1b. This involved assessing possible relationships between participants' views of depression as more social constructed, view of diagnosis as useful, and their theoretical model of choice. Statistical crosstabulations were examined for benefit through the large amount of data collected, while preliminarily identifying meaningful results. In this analysis, the independent variable was a person's theoretical model of choice. The dependent variable was the person's conceptualization of its usefulness, and their view of it as more socially constructed than biological. These questions represented working Hypothesis 1.

Another working hypothesis was that clinicians who tend to view diagnosis and depression through a more social constructionist lens would likely view the medical model as decreasingly helpful (Hypothesis 2). To test this hypothesis, crosstabulations were used to search through data more efficiently. Paired-samples t-tests were performed to discover the relationship between views of diagnosis as useful, the view of depression as more socially developed, and the view of the medical model as appropriate for psychological understanding. In these t-tests, the independent variable was a view of depression as more socially developed. Dependent variables were the view of diagnosis as useful, and the view of the medical model as preferable.

Through examination of interesting statistical frequencies, participants' views were also compared to the diathesis stress model. These types of participants may view depression as an objective psychological illness but hold the perspective that it is approximately equal parts biological and social (Hypothesis 3). Comparison of these frequencies provided information about whether a diathesis-stress perspective remains a dominant context of clinical practice, or



whether there is a significant variation in the degree to which clinicians adhere to this kind of model.

Statistical analysis involved the comparison of views between seasoned clinicians and clinician-in-training. This analysis offered insights into the impacts of having worked in the field of mental health for an extended period, compared to those who are relatively new to the field. These findings created further hypotheses about the impact of having attended graduate school in the more distant past versus currently engaging in this kind of study. This might provide indication of whether clinical graduate programs have begun offering students different perspectives toward mental health treatment than they might have in the past (Hypothesis 4). Analysis of these data involved the calculations of correlation coefficients to examine the relationship between seasoned clinicians and social views of depression, as well as a correlation coefficient looking at the relationship between clinicians-in-training and their views of diagnosis as socially constructed or useful. It also included the use of one-way analysis of variance comparisons to explore statistical significance of the data.

It was also informative to compare data frequencies between the demographic information collected, and the individual questions asked. For example, did clinicians from particular parts of the country tend to adhere to particular theoretical views more often than those from other parts of the country (Hypothesis 5a)? It was further interesting to compare the frequencies of participants from particular parts of the country and their views about the medical model (Hypothesis 5b). In concluding analysis of the data, other demographic areas were compared to survey questions with the hope of identifying interesting connections and relationships.

Each of the questions developed for the survey had the potential to highlight interesting information about currently practicing clinicians, and their theoretical views towards diagnosis and the treatment of depression. This information provided introductory insights into clinicians' views towards the medical model, and how they are utilizing tools such as the DSM, or diagnosis. Overall, this survey information supplied valuable information about the current epistemologies guiding practitioners in the modern era. These findings told us something about our relationship to past understandings of diagnosis and depression, while informing us of what the future may hold for clinical practice.

## Results

### Descriptive Statistics

**Race and gender.** The research sample included a total of 101 participants ( $N = 101$ ) with 82 identifying as female (82%), 18 identifying as male (18%), and one participant identifying as gender non-binary (1%). Of these participants, 6% identified as Asian or Asian American; 8% identified as Black/African American; 8% identified as Latino/Hispanic, or Latinx; 81% identified as White; 6% identified as Bi-racial; and one participant identified their race or nationality as “international” (1%). Participants could select multiple racial or ethnic identities when completing the survey.

**Age, sexual orientation, and relationship status.** The mean participant age was 33 ( $SD = 10.9$ ,  $N = 100$ ), with a maximum of 76, and a minimum of 22. Of peripheral interest, 75% of participants identified as heterosexual, 2% as gay, 5% as lesbian, 14% as bi-sexual, 3% as pansexual, and 1% as queer ( $N = 97$ ). In reporting on their marital status, 23% of study participants indicated that they were currently single, 38% said they were in a committed relationship, 37% said they were married, and 2% said they were divorced ( $N = 99$ ).

**Educational experience, specialty track of training, and graduation.** Participants were asked about their “Highest Degree Earned at Present” ( $N=100$ ). Of this data it was found that 14% had acquired their bachelors, 57% had acquired their masters, 10% had earned a PhD, and 19% had earned their PsyD. One participant in the study had also acquired their JD. Participants were also asked about the “Highest Degree they were Anticipating.” About 20% of respondents reported that they were anticipating their PhD to be their highest degree, while the remaining 80% felt that a PsyD would be the highest degree they earned. Six participants opted not to answer this question. Approximately 89% indicated attending clinical psychology programs, while 11% reported coming from counseling psychology programs.

For the purposes of conducting later comparisons, respondents were also asked whether they had come from specialty training tracks in psychology. About 23% of respondents reported a child specialty, 37% reported an adult specialty, 44% indicated a more generalist track, 11% endorsed a health specialty track, 7% reported a community track, 12% reported background training in neuropsychology, and 9% reported specialty training in forensic psychology. Some participants also expressed other areas of specialty training including specific areas like, *College Counseling, Military, Latino/Bilingual, Couples and Families, and School Psychology*. Participants could endorse multiple areas of specialty when completing the survey.

Figure 1 displays the years that participants finished/were expecting to finish their doctoral programs ( $N=98$ ). For people who have already graduated, this included a year in the past, while for current trainees it meant a year in the future. The majority of participants expected to graduate between the years 2018 and 2022. These participants made up approximately 72% of those surveyed. This also indicates that the majority of participants were likely still in training.

Of the participants that were still in their graduate programs ( $N=72$ ), approximately 7%

were in their 1st year; 15% in their 2nd year; 21% in their 3rd year; 32% in their 4th year; 18% in their 5th year; and 7% in their 6th year. From the group of participants who had graduated in the past ( $N=28$ ), about 93% were still practicing clinically in some capacity, while the other 7% had practiced at some point in the past.

**Theoretical orientation.** Figure 2 displays participants identifications in terms of theoretical orientation. Participants could select multiple orientations to accommodate the reality that many, if not most clinicians, consider themselves to fit somewhere within a broader integrative category (Goodyear et al., 2016; Jaimes, Larose-Hébert, & Moreau, 2015; Norcross & Prochaska, 1982).

### **Hypothesis 1a**

As a means of exploring relationships between participants' theoretical orientations and their views of depression as social constructed (Hypothesis 1a), related survey questions were statistically analyzed in comparison to theoretical orientation data. For the purposes of analyzing this data, participants who indicated an adherence to multiple orientations were grouped as "integrative" while participants who indicated only one orientation were grouped as solely within that orientation category. Approximately 68% of participants identified as integrative, 16% as Cognitive-Behavioral (CBT), 11% as psychodynamic, 3% as behavioral, and 2% as humanistic ( $N=100$ ). This pattern appears largely consistent with data from other research (Goodyear et al., 2016).

The first question examined was Question 2, "In the majority of cases, I find that the development of depression is due to the suffering constructed between people." Analysis of variance showed no statistical significance between participant theoretical orientation and participant response to question 2  $F(4, 93) = .695, p = .597$ . Question 3 ("In the majority of cases

I find that the development of depression is defined by individual cultures”) was also compared to theoretical orientation, but similarly, did not show any statistical significance  $F(4, 93) = .874$ ,  $p = .483$ .

Question 12 (“my understanding of depression is significantly impacted by my cultural upbringing”) was also analyzed against the theoretical orientation data, but no significant mean differences were found with this comparison either  $F(4, 91) = 2.18$ ,  $p = .077$ . Despite this lack of significance, a Tukey HSD post-hoc analysis was conducted to explore this lower p-value. As a part of this post-hoc analysis a statistically significant relationship between the psychodynamic and humanistic orientations was found when compared to question 12 ( $SD = .7$ ),  $p = .044$ . While significant at the .05 level, this finding may represent an intriguing relationship. Problematically, the present study did not have enough participants identifying solely as psychodynamic or humanistic to give this lower p-value the meaning it might otherwise have.

Finally, survey Question 13 (“my understanding of depression has been significantly shaped by my graduate school education”) was also compared with theoretical orientation, to examine whether significant differences would be found between orientation and the construction of clinician’s understanding of depression through graduate school. Again, no significant differences were found  $F(4, 91) = 1.37$ ,  $p = .250$ . In sum, this means that for Hypothesis 1a, the null hypothesis cannot be rejected, and it must instead be concluded based on the current data, that there may not be any statistically significant relationship between theoretical orientation and one’s conception of depression as socially constructed.

Although no statistical significances were found between these variables, it is interesting to note that across theoretical orientations, approximately 68% of participants agreed that “depression is due to the suffering constructed between people” (Question 2;  $SD = .86$ ,  $M = 3.5$ ).

Nearly 69% of respondents also agreed that “depression is defined by individual cultures” (Question 3;  $SD = .91, M = 3.5$ ). About 70% also agreed with the idea that “my understanding of depression is significantly impacted by my cultural upbringing” (Question 12;  $SD = .93, M = 3.6$ ). Finally, about 83% of participants believed that their understanding of depression was shaped by their “graduate school education” (Question 13;  $SD = .9, M = 4$ ).

### **Hypothesis 1b**

A statistical crosstabulation was used to explore meaningful correlational relationships between survey questions related to Hypothesis 1b. A significant positive correlation was found between the belief that “... depression is defined by individual cultures” (Question 3) and “diagnosis is useful... to create a story of client’s suffering” (Question 19), Pearson’s  $r(98) = .29, p = .004$ . While this represents a statistically weak correlation, a significant relationship between these variables might be considered somewhat intuitive. Survey results also revealed a weak positive relationship between the belief that “depression is defined by individual cultures” (Question 3) and that “diagnosis is useful for conceptualizing client cases” (Question 15),  $r(94) = .26, p = .01$ . This may mean that many clinicians recognize the impact of culture on the development of depression and they also see the value of clinical diagnosis for treatment purposes. About 69% of participants agreed and strongly agreed with the former question in this comparison ( $SD = .92, M = 3.6$ ), while approximately 81% agreed and strongly agreed with the latter ( $SD = .93, M = 3.9$ ).

A weak-to-moderate positive correlation was found between participant views to the statements “my understanding of depression has been significantly shaped by my graduate school education” (Question 13) and “diagnosis is useful for easing communication between mental health professionals” (Question 14;  $r(94) = .40, p < .001$ ). This finding is statistically

significant and unlikely to be found due to chance. While correlational data do not provide a causal explanation, this relationship may make sense if clinicians are developing a shared understanding of depression in graduate school, and then using this for simplifying communications in clinical practice.

A paired samples t-test was also used to explore relationships between Questions 2 (“In the majority of cases, I find that the development of depression is due to the suffering constructed between people”) and Question 27 (“If I had the option I would prefer to assign people diagnoses”). Responses to these questions were found to be statistically significant, with scores to Question 2 ( $M = 3.57$ ,  $SD = .85$ ) being significantly higher than scores on Question 27 ( $M = 2.5$ ,  $SD = .97$ ),  $t(93) = 7.3$ ,  $p < .001$ ,  $d = 0.76$ . This data also represents a medium to large effect size.

Question 3 was also compared to Question 27 using a paired samples t-test, and significant differences were found in these data as well, with scores from Question 3 ( $M = 3.57$ ,  $SD = .90$ ) being significantly higher than scores to Question 27 ( $M = 2.5$ ,  $SD = .97$ ),  $t(93) = 8.9$ ,  $p < .001$ ,  $d = .92$ . This suggests that there is a meaningful relationship between participant beliefs in depression as a culturally defined concept and their low clinical desires to assign diagnoses. Overall, the majority of participants (69%) agreed with Question 3 and disagreed with question 27 (59%). Interestingly, while participants largely believed that depression is defined by individual cultures (Question 3;  $M = 3.6$ ,  $SD = .90$ ), they also saw a benefit in using diagnoses for developing treatment interventions (Question 16;  $M = 4.0$ ,  $SD = .83$ ),  $t(93) = -3.26$ ,  $p = .002$ ,  $d = -0.38$ .

In sum, data from Hypothesis 1 and Hypothesis 1b reveal that while theoretical orientation does not seem to be a major factor influencing participant views of depression as

socially constructed, participants across all theoretical orientations seemed to strongly endorse a social constructionist/post-modern perspective when thinking about depression. Much of this constructed narrative of depression seems to be acquired as trainees are in graduate school and are learning about how members of the clinical psychology field communicate about the illness. In assessing how this narrative is being used in clinical practice, the majority of clinicians seemed to feel that diagnosis has a worthwhile value for conceptualization but may not be a useful narrative to specifically assign to clients when meeting with them.

### **Hypothesis 2**

Hypothesis 2 analysis involved continuing to look at those questions relevant to conceptualizations of depression as socially constructed, while comparing them with the survey questions related to the medical model. A statistical crosstabulation was again used to begin exploring collected data to determine where significant relationships between questions existed. One unexpected finding was found in the relationship between Question 1 ( $M = 2.4, SD = .96$ ; “In the majority of cases, I find that the development of depression is due to biological illness”) and Question 22 ( $M = 2.9, SD = 1.1$ ; “Mental disorders can be best understood as akin to medical illnesses”). Approximately 70% of participants disagreed with the idea that the development of depression is due to biological illness, but they were overall more divided about whether they saw it as “akin to a medical illness,” with about 45% disagreeing, 36% agreeing, and 19% feeling uncertain. A paired t-test revealed a strong statistically significant relationship between these questions as well,  $t(94) = -3.77, p < .001, d = 0.40$ , suggesting that the null hypothesis can be rejected. It is unlikely that these data findings are due to chance. A different hypothesis may instead be supported. This hypothesis is that while participants generally do not



think depression is due to biological illness, they tend to be more comfortable thinking of it as being related to medical illness.

A t-test also showed a relationship between Question 22 ( $M = 2.9$ ,  $SD = 1.1$ ; “Mental disorders can be best understood as akin to medical illnesses”) and Question 8 ( $M = 2.4$ ,  $SD = 1.1$ ; “The DSM-5 diagnosis of depression fully captures the experience of those who suffer from it”),  $t(94) = 3.99$ ,  $p < .001$ ,  $d = 0.38$ . Participants predominantly disagreed with both of these questions, and these data show that a weak-to-moderate effect size can be noticed between variables. Of further interest was participants’ endorsement of question 11 (“I believe that depression is a subjective experience that is difficult to measure quantitatively”) and their previously mentioned differences in how comfortable they were with thinking about depression as akin to medical illnesses (Question 22). About 70% of respondents agreed with Question 11 ( $M = 3.6$ ,  $SD = .92$ ), with significant results existing between these data also  $t(94) = -3.92$ ,  $p < .001$ ,  $d = 0.43$ . This further supports the notion that participants viewed depression as a heavily subjective experience, while still recognizing a value in likening it to different medical experiences.

In continuing to thoroughly explore data related to Hypothesis 2, Question 24 (“In psychotherapeutic practice, the clinician understands an objective truth about how mental health can be achieved”) was found to be significantly related to Question 3 (“In the majority of cases, I find that depression is defined by individual cultures”). Approximately 66% of participants disagreed with Question 24 ( $M = 2.3$ ,  $SD = 1.1$ ) while nearly 70% of respondents agreed with Question 3 ( $M = 3.6$ ,  $SD = .92$ ),  $t(94) = -9.73$ ,  $p < .001$ ,  $d = 1.03$ . This represents a somewhat surprising set of data as it would appear that the majority of respondents did not believe in a clinician holding objective truth, but instead appeared to give more weight to the impact of

culture. The effect size for these data is also quite strong, and so the relationship between these questions may be more meaningful than previously thought. These figures gain greater interest when responses to Question 25 (“In psychotherapeutic practice, the client and therapist construct a subjective reality of how mental health may be achieved”) are considered. About 91% of respondents agreed with this question ( $M = 4.1$ ,  $SD = .74$ ), further emphasizing the subjective nature of clinical work.

The ability to measure a person’s experience of depression is often connected to a medical model of understanding, and so Question 25 ( $M = 4.1$ ,  $SD = .74$ ) was compared with Question 10 ( $M = 2.5$ ,  $SD = .97$ ; “I believe depression is an objective illness easily measured by quantitative scales”). Data between these questions were significant  $t(94) = -11.80$ ,  $p < .001$ ,  $d = 1.20$ , with about 65% of people disagreeing with the idea that depression is easily measured by quantitative scales.

To conclude examination of Hypothesis 2, Questions 20 ( $M = 2.6$ ,  $SD = 1.1$ ; “It is important for clients to agree with the diagnoses I give them”) and Question 23 ( $M = 2.3$ ,  $SD = .91$ ; “In psychotherapeutic practice, it is necessary to have a doctor-patient hierarchy”) were compared. Statistically significant results  $t(93) = 2.50$ ,  $p = .014$ ,  $d = .20$  showed a small effect size, where about 53% of people disagreed with Question 20, 29% agreed, and 18% were uncertain. Approximately 70% of participants disagreed with Question 23, with about 15% in agreement, and 15% feeling uncertain. These numbers indicate that participants did not tend to see a strong value in the doctor-patient hierarchy in psychotherapeutic treatment but tend to be more diversified in their beliefs about whether clients need to agree with assigned diagnoses.

Overall, participants did tend to strongly endorse ideas consistent with a social constructionist mindset, however, they did not necessarily view the medical model as

decreasingly helpful. When thinking about their work, they often disagreed with significant components of a traditionally considered medical model, such as doctor-patient hierarchy, biological origins to identified depressive illness, and the ability to objectively measure facets of depressive experience. Despite the decreased belief and/or value seen amongst these factors, participants did more often feel that comparing mental disorders to medical illnesses can be a good way to think about them.

### **Hypothesis 3**

Statistical crosstabulation was again used to begin sorting out survey question data that appeared relevant and meaningful from data that were not. Hypothesis 3 is concerned with examining trends and beliefs related to the diathesis-stress model. Survey questions inquiring about the factors contributing to depression were explored in comparison to relevant questions asking about specific views of depression. It should be noted that while the present study collected information relevant to a broad understanding of the diathesis-stress model, it did not look at discrete variables that may play mediating roles in how a person's diathesis and stress lead specifically to a diagnosis of depression.

Of particular interest to Hypothesis 3 was Question 1, which specifically asked about whether participants thought depression was due to biological illness. As seen when thinking about Hypothesis 2, the majority of participants disagreed with Question 1 ( $M = 2.4$ ,  $SD = .96$ ). When analyzed with Question 4 ( $M = 3.6$ ,  $SD = 1.03$ ; "In the majority of cases, I find that the development of depression is related to a person's developmental upbringing"), the results were found to be significant  $t(97) = -8.89$ ,  $p < .001$ ,  $d = .90$ . Cohen's  $d$  shows a strong effect size and indicates that the differences between these means may be particularly meaningful.

Approximately 68% of participants agreed with Question 4, with about 18% in disagreement.

This data gives weight to the idea that clinicians seem to prioritize the significance of culture and individual upbringing over one's genetic biology when thinking about the etiology of depression.

Interestingly, Question 9 ("The presence of depression is a result of societal oppression") was found to be significantly related to Question 1 and Question 2 when utilizing a one-way ANOVA for comparing Question 9 with Questions 1–4. About 51% of respondents agreed with Question 9, with 24% in disagreement, and 25% feeling uncertain. This may show that there is a general lack of consensus about whether societal oppression plays a role, but about half of participants thought it did. Significance with Question 1 was found at the .05 level  $F(4, 91) = 2.66, p = .037$ , while its significance with Question 2 was at the .001 level  $F(4, 91) = 7.55, p < .001$ . This information shows that while participants generally did not feel that biological illness plays a primary role in the development of depression (Question 1), they were more concerned with the roles of societal oppression (Question 9) and the suffering constructed between people (Question 2).

Results informing Hypothesis 3 are further aided by responses to Question 10 and Question 11, which have been previously described. With 65% of clinicians disagreeing with the idea that depression is an "objective illness" that is "easily measured by quantitative scales" and 70% of clinicians agreeing that it is instead more "subjective," it would appear that a significant majority of participants might question whether specific components of a diathesis-stress formulation could realistically be measured in an objective way that would satisfy a modernist/naturalist epistemology.

Consistent with themes discovered within previous hypothesis data, participants strongly prioritized the role of culture, socialization, and society over genetics and biology, when thinking about depression. While most clinicians are likely to agree with a biopsychosocial lens, broadly

speaking, they seem not to view one's biology as a major factor contributing to the development of depression. In congruence with a diathesis-stress model, they may recognize that particular people are more likely to develop mental illness over others, based on their unique individual make-up, but they might be more inclined to consider personal social factors that influence the composition of one's diathesis.

#### **Hypothesis 4**

Hypothesis 4 aims to look at whether there might be significant differences between participants who had graduated with their doctoral degree, and those who were still doctoral program trainees. Table 2 shows the frequencies of participants who were graduated or not graduated when broken down by their identified theoretical orientations.

Graduated and non-graduated participant data were also compared to questions from the "Factors Contributing to Depression" portion of the survey. Analysis of variance revealed significant variance between the means when compared to Question 3 ("In the majority of cases I find that the development of depression is defined by individual cultures")  $F(1, 96) = 4.20, p = .043$ . Based on mean scores, respondents who had not yet graduated with their doctoral degrees ( $M = 3.7, SD = 0.87$ ) agreed more with Question 3 than those who had graduated ( $M = 3.3, SD = 0.97$ ). While interesting, it should be noted that the number of participants identifying as "graduated" represented a much smaller sample size, and so this increases the likelihood of a type 1 error when considering the null hypothesis.

Analysis of variance and correlational comparisons were also used to examine graduated and non-graduated views related to other survey questions from "views about depression," "views about diagnosis," "views about the medical model," and "questions about professional practice," but no other statistically significant data were found. Based on the data collected as a

part of this research, graduated and non-graduated clinicians were statistically consistent in their views with the exception of Question 3.

While the present study only minimally explored the ways in which views about depression and diagnosis may be changing over time amongst clinical psychologists, it is interesting to consider the possibility that newer members of the field are more focused on culture than past generations. These sorts of findings likely also speak to the impact that clinical and counseling psychology graduate programs are having on their students. If data show that much of a clinician's understanding of depression is shaped by graduate school training (Question 13), then it is logical to conclude that these programs have likely changed their curriculum over time to reflect new ways of understanding diagnoses and mental illness. If connected to intervention, this may also change the way these illnesses are being treated.

### **Hypothesis 5**

Hypothesis 5 sought to explore differences in where participants completed their doctoral programs, and the theoretical orientations that they had adopted. Table 3 provides a crosstabulation of the frequencies of participants from various portions of the United States when compared to their theoretical orientations. "Northwest" was not originally included on the survey, however, it was added as a part of analysis to accommodate respondents who responded as "other" and identified their program location more specifically. Analysis of variance was conducted to examine the theoretical orientation variable with the program location variable, however, no statistically significant data were found,  $F(4, 95) = 1.01, p = .402$ . It is possible that this statistical outcome is based on some of the collected sample sizes. As the crosstabulation in Table 3 shows, there were nearly double the number of participants who had attended programs in the northeast when compared to the other groups. There were only three respondents

specifically stating they had attended programs in the northwest, and there were no participants who had attended programs in Canada. The majority of participants also fit into the “integrative” category, with very few saying they were only utilizing one theoretical model.

In combing through other collected data for significant findings, an interesting relationship was discovered between participants who had or were seeking PhD’s and those who were seeking or currently had PsyD’s. Analysis of variance revealed that those participants whose highest sought degree was a PsyD ( $M = 3.7, SD = 0.77$ ) agreed more with Question 2 (“In the majority of cases, I find that the development of depression is due to the suffering constructed between people”) than those whose highest degree sought was a PhD ( $M = 3.1, SD = 1.02$ ),  $F(1, 90) = 7.44, p = .008$ .

In conclusion, it may be that the location of one’s graduate program does not lead to significant changes in the theoretical orientations selected. This might suggest a strong consistency in what constitutes a doctoral program in psychology across the country. It is also possible that differences that do exist between programs around the country were not detected within the survey administered. Other research focusing on different variables, or more discrete portions of the same variables might detect subtle changes in how clinical or counseling psychology is being taught. From the current research, there exists a possibility that clinicians seeking or graduating with PsyD degrees may be more inclined to endorse social constructionist views than those with PhD degrees. This could be something further explored in other research.

### **Limitations, Discussion, and Suggestions for Future Research**

#### **Limitations**

Several important limitations should be noted when considering the data and discussion section below. Of foundational importance to this research is the question of whether a

quantitative form of data collection and analysis is appropriate in the context of the underlying assumptions proposed. In fact, a very related statement was queried to participants in the survey, “I believe that depression is an objective illness easily measured by quantitative scales.” One might naturally assume that given the emphasis on social constructionism and relevant principles, a qualitative inquiry would have been selected. Contrary to this intuition, post-modernist thinking and/or constructivist lenses do not assert themselves against quantitative inquiry, but they often recognize that the quantitative questions they propose are deeply seated in lay and professional contexts that value the construction of narrative through numbers and statistical analytics (Hernández, 2015).

Like the quantitative criticalist approach (Stage & Wells, 2014), the current research has consistently proceeded with the recognition that quantitative analysis can be effectively utilized for measuring discrepancies and inequities, can be applied for the purposes of challenging the status quo, and can be employed for studying people and institutions within the contexts from which they are derived (Hernández, 2015). Rather than critiquing quantitative methods as “good” or “bad” for having developed out of a post-positivist paradigm, a constructionist approach might instead see quantitative tools as narratives to further a broader narrative.

A second limitation of this research involved the data collected from certain subgroups of the sampled population. The theoretical orientation groups varied in size, with small sample sizes considering themselves to be solely humanistic or behavioral in orientation. The ability of the present research to speak about theoretical orientation differences within the sample remained small due to the comparatively minute representation of people from these groups. Future research desiring to make more substantial comparisons of this type might utilize different strategies for gathering data from psychologists who only adhere to one theoretical orientation.



Consideration might also be brought to the percentage of participants who had already completed their doctorates. While not a number too small to analyze meaningfully, the majority of the data in this study came from people in the process of finishing their degrees. It is possible that question data became skewed based on the more prominent voice of those in training over those who had completed their degrees. It is possible that a study conducted solely with those holding doctorates in clinical or counseling psychology might produce different results.

Another potential limitation may be found in examining other demographic variables. The current study sample was predominantly white and female. If it is known that culture plays a significant role in one's conception of mental health and/or depression, then a more diverse sample might produce different results based on greater variation in participants' cultural backgrounds.

Whenever a survey is constructed, the process and procedure of its development and analysis will likely also lead to limitations. In this study, a noteworthy limitation may be found in the way in which participants were asked about their theoretical orientations. Participants were asked to endorse specific theoretical orientations often thought to represent the major paradigms guiding the field of clinical psychology. Some participants may have selected one orientation feeling that the survey was looking for their primary orientation. There was no integrative option in the survey administered, and the integrative category was introduced for the purposes of data analysis. Based on this, it is possible that some of the participants only selecting one orientation, may actually utilize multiple orientations in their work. Participants could select multiple orientations but were not explicitly instructed to do so.

## Discussion

The current research attempted to examine relationships between therapist factors as compared to views about diagnosis, depression, and the medical model. Hypothesis 1a was unable to be confirmed and the current data did not support a meaningful relationship between theoretical orientation and views about depression as being more or less socially constructed. The current research was surprising, however, in that the majority of clinicians surveyed agreed with a variety of clinical sentiments closely connected to a social constructionist lens. This appeared to be across theoretical orientations, however as noted previously, there were very few participants identifying solely with one specific orientation. Most respondents appeared to fit more comfortably within a broad “integrative” lens.

While far from clear with the present data, these findings may represent a significant shift among psychologists toward a post-modern understanding of diagnosis, mental health, and clinical practice. Many clinicians may continue to identify within the theoretical orientation categories laid down over the past hundred years, but practice within these orientations in a way that is much more in line with a social constructionist lens than they might realize. This likely speaks to the role of narrative in understanding everything from day-to-day functioning in our personal lives, to the scientific realm where we develop labels and categories for simplifying communications between professionals (Bruner, 1990).

Based on the collected data, the importance of graduate school education was also emphasized as the majority of participants felt that their understanding of depression was shaped by their graduate education. While unremarkably intuitive on the surface, this kind of finding serves as a reminder that if conceptions of diagnosis and depression exist within a social/cultural epistemology, it is imperative that these professional narratives are carefully constructed by

those with clinical power, so that those without the same power do not experience increased suffering (Gergen et al., 1996). Efforts of this nature would do much to assist clinical psychology in advancing its interests in social justice.

Only a portion of Hypothesis 1b could be confirmed in the present study, and this was connected to the finding that clinicians in this survey sample seemed to believe that depression is largely socially constructed. In fact, the number of respondents believing depression to be predominantly a biological illness was so small, that meaningful statistics could not be conducted with such a sample. This finding is surprising considering the greater mental health field's attempt to use medical technologies for identifying mental illness at the biological level (Calhoun & Sui, 2016; Goodkind et al., 2015; Madan et al., 2017; Maher & Maher, 1994), however, it may be less surprising when the survey sample is considered. It may be expected that clinical psychologists, and psychologists-in-training would have a greater focus on social and cultural factors of mental illness, given their role and the interventions they utilize. If this research were done with more medicalized professionals in the mental health field, the present data might have looked significantly different.

Questions related to Hypothesis 1b further provided interesting results regarding how clinicians tend to use diagnosis in clinical practice. As mentioned earlier in this paper, pragmatism plays a key role in social constructionist views, and so the practical use of diagnosis was investigated. Findings seemed to reinforce previously discussed notions of diagnosis as a clinical tool between professionals and insurance companies, while being seen as less applicable for clients. The majority of participants perceived diagnosis to be useful for clinical procedures like conceptualization, easing communication between mental health professionals, and planning interventions, although they preferred not to actually assign these diagnoses to individuals.

While potentially beneficial in the sense that this practice might spare clients from a detrimental label that negatively shifts their perceptions of self, another potential danger may be created. If therapists are having conversations about client functioning that are entirely constructed between the therapist and his/her colleagues or scientific literature, then a disconnect has been created. This disconnect would exist between the therapist's understanding of the client's mental health and subsequent healing, and the client's understanding of their own mental health and paths to healing. This pattern may cause the clinical work to suffer as shared understandings are sacrificed for incongruence and epistemological differences in the therapeutic relationship (Duncan & Miller, 2000).

While other explanatory factors may play a role in the relationships between these variables, it would appear that the role of diagnosis may be changing in clinical practice. The sample of individuals and their unique training backgrounds need to be considered, however, among psychologists it would seem that diagnosis has been utilized predominantly as clinical shorthand for simplifying clinical practices. If so, this would represent a significant change from the use of diagnosis in generations past, where it may have been much more common for clients to receive a specific diagnosis from a psychologist and then carry that label with them post-session/treatment. Existent research does suggest that a gradual trend toward greater discretion with diagnostic disclosure is being utilized by a variety of mental health provider types (Schulze, 2007).

Hypothesis 2 findings raised interesting questions about present conceptualizations of diagnosis and depression as well. The majority of participants did not think that depression was primarily a biological illness, but they did think it appropriate to view it as akin to medical illnesses. One can only wonder about exactly why this might be, but several interesting

possibilities may arise. One idea may take us back to the influence of narrative on clinical thinking. It is possible that their perceived value in likening depression to medical illnesses may come from the ability to communicate broadly about mental illnesses, with populations that are less familiar with the complexities of the diagnostic narrative. Clinicians who do choose to disclose client diagnoses may have an easier time saying that depression is similar to “breaking your arm,” rather than having to explain the complicated constructive process that has led to the diagnosis of depression, or the fact that mental illnesses exist in a much more subjective realm than medical illnesses that allow for greater objective scrutiny.

It may also be hypothesized that viewing depression or mental illness as “akin to medical illnesses” provides the long-term connection psychology has desired with the medical field, or even the natural science fields before that (Hatfield, 2002; Laungani, 2004). As clinical psychology and mental health practices have found their way into the “Health Sciences” family, it helps to look and sound similar to our health science siblings, so that people do not begin to question the relationship. Significant questioning of this sort would impact the funding available for mental health resources, and it might complicate the ways in which a lay public receiving mental health treatment would view or respect the work being done (Laungani, 2004).

Findings further elucidate current conceptions of the DSM-5. It would appear that while clinicians broadly see value in the use of diagnosis for specific clinical purposes, they do not see the DSM-5 diagnosis of depression as wholly descriptive of depressed clients’ experiences. In many ways this may be connected to previously discussed findings, where clinicians saw the diagnosis of depression as part of a deeper cultural construct, where socialization and relationships are believed to play significant roles. If culture, relationships, and social experiences provide the most fertile ground for the development of depressive experiences, then

it would seem unlikely that a single universally applied diagnosis could represent these people well.

This may also be a circumstance where similar research with our medical colleagues might produce different results. If the current research were done with psychiatrists, primary care physicians, or nurses for example, one might expect to see significantly different endorsements of the surveyed questions. In a specifically medicalized environment where diagnosis is even more likely to dictate a course of treatment, it might not be surprising to find mental health diagnoses being thought of as proportionally more similar to medical diagnoses.

Findings related to Hypotheses 2 and 3 also inform discussion of how measurable depression is believed to be. Within medical or diathesis stress models, there is added emphasis on one's ability to measure experiences like depression. According to the current research, participants largely felt that depression could not be easily measured by quantitative scales. Again, one must be careful about generalizations significantly beyond the parsimonious information provided in the data, but based on the current findings, it is reasonable to wonder what the collected data might mean. It may be that clinicians are using the variety of objective or semi-objective measures that exist for measuring depression but hold a deeper belief that those measures can provide only a portion of the overall picture. It could also mean that clinicians are utilizing such measures of client depression for other reasons altogether, as directed by professional organizations or companies. This would likely create some diversity in clinical settings where such measures are used, potentially influencing narratives of how clients' depression is understood. Other possibilities also exist but will be left for exploration in other research and other papers.

Early suppositions of this research regarding the subjective nature of psychotherapy also appeared to be confirmed in the current research, with about two thirds of participants denying the idea that clinicians hold an objective truth about how to achieve mental health. Pair this with the surprising 91% of people who believed in the subjective construction of realities taking place in psychotherapy, and a strong post-modern picture begins to emerge. Among members of the clinical psychology field, this kind of finding may make sense, however, it is sharply contrasted with lay cultural beliefs supposing that mental health providers will have a clear formula for how to achieve mental before meeting with a client (Furnham, Pereira, & Rawles, 2001; Furnham & Wardley, 1990).

The Hypothesis 5 finding indicating potential differences between PsyD and PhD participants may also feed into this discussion. As stated before, other variables may be at work, and generalizations should be taken lightly given their departure from specifically what the data suggest. With this in mind, one might wonder whether the emphasis on clinical work within PsyD programs is more likely to lead to a constructionist viewpoint than the more research-oriented PhD programs. Might there be greater respect for a modernist scientific approach if one is asked to focus more time and energy on conducting research in this way? The current research provided only the beginnings of an inquiry into potential differences, but they would be interesting to explore further in other studies.

Continuing discussion of the therapeutic relationship in psychotherapy, clinicians tended not think a doctor-patient hierarchy was necessary but were mixed in the extent to which they felt that clients should agree with diagnoses they provide. At the outset, hypotheses about this finding could appear contradictory. For instance, the question may arise, "How can the doctor-patient hierarchy not matter, but then a client's acceptance of a clinician provided

diagnosis does matter?” These two ideas might seem incompatible when given the recognition that providing a diagnosis for a client supports an implicit hierarchy. Alternatively, clinicians valuing diagnostic agreement between therapist and client might be viewing this as greater opportunity for alignment in the therapeutic relationship, with some (hopefully) concurrent discussion of what the diagnosis means and whether it seems accurate to the client’s experience.

The presented research also inquired about participants’ views related to societal oppression and the development of depression. Approximately one out of every two participants believed that the etiology of depression is significantly impacted by the oppression that exists in society. This finding may not seem surprising to many within the mental health community, who often have a heightened focus on the role of oppression in the development of mental illness (Barker, 2015; Hunn & Craig, 2009; Neitzke, 2016).

This kind of finding does depart in some ways from the longstanding medical model that has guided mental health treatment over the last hundred years. In many ways, the present research harkens back to early questions of “nature” and “nurture” and arguments about which factor matters more in development, mental health, or other psychologically related questions. Many early psychologists, psychiatrists, researchers, medical doctors and the like almost certainly had an awareness of how both are implicated in mental health issues, however, the avenue by which they conceptualized problems and proscribed treatment have unquestionably changed. The current research identified a portion of this change as seen in connection to Hypothesis 4. Doctoral students in clinical and counseling psychology believed that culture plays a role in the development of depression to a greater extent than their already graduated seniors.

If a significant portion of the etiology of depression is now viewed as seated within a broader cultural lens, with recognition of oppression as a precipitant for this suffering, then



future psychotherapeutic treatment may begin to look a lot different than it has in past. It may spend less time attempting to uncover secrets hidden away deep in the psyche or in chemical mechanisms of action, while spending more time exploring cultural beliefs, values, injustices, and subjugations that have led a person to feel disconnected from a meaningful group in their life. A broad application of many different therapeutic narratives will likely continue to be used, but we may at least have a glimpse of the future of mental health treatment as we witness these sorts of changes.

The bottom line, at least from a social constructionist lens, is not that one view or perspective is *better* than the other, but that changes in perspective have pragmatic impacts on the way things are done (Gergen, 1994; Gergen et al., 1996). Treatment efficacy hinges on these pragmatic impacts and the outcomes that are produced by the mental health work being done. It is also very pragmatic to recognize that creating change within an individual is generally going to be a great deal easier than creating changes in a society. In this light the mental health professional must consider, “What are positive changes I can help this individual make within himself or herself, despite knowing that the culture from which they come is at least partially responsible for their suffering?” This kind of question does not adopt a deficit model, suggesting that the individual is “disordered,” but holds onto the idea that individuals can be empowered, strengthened, and taught skills to cope with a world often experienced as unfair. This may build autonomy and individuality in ways that support greater mental health and well-being (Finfgeld, 2004).

### **Suggestions for Future Research**

Future research might consider the further exploration of factors related to theoretical orientation and the ways psychotherapy is delivered. In connection to the research presented in

this paper, it might examine the ways in which diagnostic practices differ between clinicians based on their orientations. Understanding these facets of clinical psychology practice might provide meaningful insights into how treatment differs between providers, and the role that diagnosis plays, if any.

Future research might also pose similar questions to mental health practitioners in psychiatry, primary care, and social work disciplines. If the field of clinical psychology is to continue moving in a direction similar to medical practice, then it would be important to understand similarities and differences between how professionals are thinking about diagnoses. This would likely ease collaborative care between these providers and create greater coherence in the narratives provided to patients/clients. Based on the current research, it may be hypothesized that psychiatrists would be more inclined to view depression through a biological lens than psychologists.

Another area for continuing research involves the use of diathesis-stress, and its relationship to epigenetics. As previously stated, the diathesis-stress model attempts to include both biological and social/environmental factors that contribute to the development of mental illness. Research in epigenetics enlightens us to the idea that social/environmental variables can change a person's DNA, leading to changes in gene expression and subsequent hereditary endowment (Barker, 2018). This kind of research might further highlight the ways in which a person's diathesis is shaped by social/cultural factors, and how these factors influence not only a person's reaction to stress in the present, but how also their individual response is shaped by different environmental factors from their ancestors' past.

New research might seek to further understand the ways in which diagnostic practices are being used in the therapy room with clients, and within clinical settings. This research might

create new understanding for treatment delivery and the role that diagnosis plays. For instance, if clinicians are primarily using diagnosis to communicate among themselves and to insurance companies, it may be helpful to reformat how they are designed so that their practical use may be consistent. It may also be helpful for research to examine some of these roles further, so that new ways of communicating with insurance companies are constructed, so that clients are not forced into a diagnostic category for the purposes of having their treatment covered.

Finally, the field of clinical psychology might be aided by new studies exploring the benefits of post-modern psychotherapy. The current research would seem to suggest that the majority of clinicians hold beliefs consistent with a post-modern view; however, it is clear that many other areas of the field remain firmly entrenched in modernist domains. While it is possible that modern and post-modern practice can operate together, knowledge and awareness of how this is being done would seem paramount. This might allow for the benefits of each perspective to be reinforced and supported, while the weaknesses are mindfully avoided.

In order to construct the most effective research, the most beneficial treatments, and the most egalitarian relationships, it is necessary to examine not only where the field currently is, but where it has been. The further we move chronologically from our roots, the more likely we are to forget their importance. A strong clinical psychology profession will require all of the meaningful narratives from the past to build the most meaningful mental health reality for tomorrow.

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Appendix A  
Recruitment Letter

Hello, my name is Chris Johnson and I'm interested in collecting survey data from doctoral-level clinicians who are currently practicing, or who have practiced clinically at some point in their careers. I am also interested in collecting data from current doctoral-level students in either clinical or counseling psychology programs, who have begun treating clients as a part of a practicum, internship, or other training experience. This brief survey is a part of my doctoral dissertation research at Antioch University New England.

This survey is anonymous and will require you to answer questions about your theoretical orientation and views surrounding the etiology of depression. It will also include questions about your views related to clinical diagnosis and the medical model of treatment. The survey will conclude by asking questions about your use of diagnoses in clinical practice. As a way of thanking you for your time, you will have the opportunity to enter a drawing for a \$50 Amazon.com gift card. Please click the link below to continue to further information about the study, the informed consent form, and/or to begin participating.

<https://www.surveymonkey.com/r/WTVT9NR>

Thank you! I greatly appreciate your consideration.

Appendix B  
Informed Consent

Dear Prospective Participant,

This survey attempts to gather information from psychologists who are currently in clinical practice, and those who have practiced at some point during their careers. It also seeks information from psychologists-in-training. It seeks to examine your views regarding the use of diagnosis and will ask you about your specific perceptions regarding the diagnosis of depression. This survey is also interested in your thoughts on the medical model and will include questions to that effect.

Your responses will assist in providing information about the use of diagnostic conceptualization in the 21st century, while adding knowledge to the existing scholarly literature on how various theoretical models influence clinical practice.

There are minimal, if any, risks from participating. Your identity will be completely anonymous and confidential. You will not be asked for your name, and all demographic information collected will be reported as aggregated information. No personally identifiable information will be associated with your responses to any reports of these data. This survey will take approximately 30 minutes to complete.

This survey is part of my dissertation research at Antioch University New England in the Psy.D. in Clinical Psychology program. The study results may be included in future presentations and publications.

At the end of the survey you will have the opportunity to enter a drawing to win a \$50 Amazon gift card. To enter, you need only submit an email address to be contacted at should your entrance be drawn. Email addresses will be kept entirely separate from survey data and cannot be used to connect individuals to their survey responses.

Your participation is voluntary, and you may decide to discontinue the survey at any time. If you do fill out the survey, you may leave any questions blank, but I ask that you answer as many questions as you can. If you should have any questions about the survey, please email me at (redacted).

This project has been approved by the Institutional Review Board at Antioch University New England. If you have any questions about your rights as a research participant, please contact Dr. Kevin Lyness at 603-283-2149. You may also contact AUNE interim provost, Dr. Barbara Andrews by email at [bandrews@antioch.edu](mailto:bandrews@antioch.edu) or by phone at 603-283-2436.

I have read and understood the above information. By clicking “Next” below, I am indicating that I have read and understood this consent form and agree to participate in this research study.

Please print a copy of this page for your records.

Thank you for your participation!

Chris Johnson, M.S.

Appendix C  
Survey

Do you agree to participate?

- Yes  
No

**Demographic and Program Information**

Gender?  Male  Female  Transgender  
 Other (please specify): \_\_\_\_\_

Race/ethnicity? (select all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Native Hawaiian or Pacific Islander |
| <input type="checkbox"/> Asian/ Asian American         | <input type="checkbox"/> White                               |
| <input type="checkbox"/> Black or African American     | <input type="checkbox"/> Biracial                            |
| <input type="checkbox"/> Latino/Hispanic/Latinx        | <input type="checkbox"/> Other (please specify): _____       |

Age? \_\_\_\_\_

Sexual Orientation?  Heterosexual  Gay  Lesbian  Pansexual  
 Bisexual  Asexual Other: \_\_\_\_\_

Marital Status?  Single  In a committed relationship  Married  
 Divorced  Widowed

Highest degree earned at present:  Bachelor's  Master's  PhD  
 PsyD  Other (please specify): \_\_\_\_\_

Highest degree anticipated:  Bachelor's  Master's  PhD  
 PsyD  Other (please specify): \_\_\_\_\_

Type of Graduate Program Attended:  Clinical  Counseling

Training Track of Specialty (select multiple if needed):  Child  Adult  
 General  Health  Community  
 Neuropsychology  Other (please specify): \_\_\_\_\_

Have you already graduated with your doctoral degree? Yes \_\_\_\_\_ No \_\_\_\_\_

If No:

Current Year of Study in Graduate Program:  1st  2nd  3rd  
 4th  5th  6th  7th  8th or later

If Yes:

Are you a clinician currently in clinical practice, or a clinician who has practiced in the past?



Currently Practicing \_\_\_\_\_ Practiced in the Past \_\_\_\_\_

Year of graduation from program (or anticipated year): \_\_\_\_\_

Where is/was your program located?: \_\_\_\_\_ USA (Midwest) \_\_\_\_\_ USA (Northeast)  
 \_\_\_\_\_ USA (South) \_\_\_\_\_ USA (West) \_\_\_\_\_ Canada

How would you primarily describe your views from a theoretical stand point?

Psychodynamic \_\_\_\_\_

Humanistic \_\_\_\_\_

Existential \_\_\_\_\_

Behavioral \_\_\_\_\_

Cognitive-behavioral \_\_\_\_\_

Constructivist \_\_\_\_\_

Interpersonal \_\_\_\_\_

Other \_\_\_\_\_

### **Views about Factors Contributing to Depression**

Please indicate the extent to which you agree or disagree with the statements below discussing the factors contributing to the diagnosis of depression.

1. In the majority of cases, I find that the development of depression is due to biological illness.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

2. In the majority of cases, I find that the development of depression is due to the suffering constructed between people.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

3. In the majority of cases, I find that depression is defined by individual cultures.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

4. In the majority of cases, I find that the development of depression is related to a person's developmental upbringing.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

**Views about Depression**

*Please indicate the extent to which you agree or disagree with the following statements regarding the diagnosis of depression.*

5. Depression is a universal phenomenon, presenting itself similarly in people around the world.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

6. Depression is made up of symptoms that everyone experiences at some point during their lifetime.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

7. Depression is made up of symptoms that only a certain percentage of the population will experience during their lifetime.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

8. The DSM-5 diagnosis of depression fully captures the experience of those who suffer from it.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

9. The presence of depression is a result of societal oppression.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

10. I believe depression is an objective illness easily measured by quantitative scales.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

11. I believe depression is a subjective experience that is difficult to measure quantitatively.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

12. My understanding of depression is significantly impacted by my cultural upbringing.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

13. My understanding of depression has been significantly shaped by my graduate school education.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

**Views about Diagnosis**

*Please indicate the extent to which you agree or disagree with the following statements regarding diagnosis.*

14. Diagnosis is useful for easing communication between mental health professionals.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

15. Diagnosis is useful for conceptualizing client cases.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

16. Diagnosis is useful for developing treatment interventions.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

17. Diagnosis is useful for completing billing procedures with insurance companies.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

18. Diagnosis is useful for providing clients with a language for understanding their suffering.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

19. Diagnosis is useful for helping clients to create a story of their suffering.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

20. It is important for clients to agree with the diagnosis I give them.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

21. It is unimportant for clients to agree with the diagnosis I give them.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

### **Views about the Medical Model**

*Please answer the following questions regarding your views on the medical model of understanding psychological illness and using diagnosis.*

22. Mental disorders can be best understood as akin to medical illnesses.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

23. In psychotherapeutic practice, it is necessary to have a doctor-patient hierarchy.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

24. In psychotherapeutic practice, the clinician understands an objective truth about how mental health can be achieved.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

25. In psychotherapeutic practice, the client and therapist construct a subjective reality of how mental health may be achieved.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

**Questions about Professional Practice**

*Please answer the following questions regarding your professional experience of using diagnosis.*

26. I discuss the diagnoses I give with the client's I give them to.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

27. If I had the option I would prefer to assign people diagnoses.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

28. In my clinical work I have found diagnosis to be useful.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

29. Most clients have their own understanding of their depression that doesn't match the DSM-5 criteria.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

30. Most clients have an understanding of their depression that matches the DSM-5 criteria well.

Strongly Disagree\_\_ Disagree\_\_\_ Uncertain\_\_\_ Agree\_\_\_ Strongly Agree\_\_\_

Table 1

*Survey Questions*

Topics	Questions
Factors Contributing to Development of Depression	<p>Q1. In the majority of cases, I find that the development of depression is due to biological illness.</p> <p>Q2. In the majority of cases, I find that the development of depression is due to the suffering constructed between people.</p> <p>Q3. In the majority of cases, I find that depression is defined by individual cultures.</p> <p>Q4. In the majority of cases, I find that the development of depression is related to a person’s developmental upbringing.</p>
Conceptions of Depression	<p>Q5. Depression is a universal phenomenon, presenting itself similarly in people around the world.</p> <p>Q6. Depression is made up of symptoms that everyone experiences at some point during their lifetime.</p> <p>Q7. Depression is made up of symptoms that only a certain percentage of the population will experience during their lifetime.</p> <p>Q8. The DSM-5 diagnosis of depression fully captures the experience of those who suffer from it.</p> <p>Q9. The presence of depression is a result of societal oppression.</p> <p>Q10. I believe that depression is an objective illness easily measured by quantitative scales.</p> <p>Q11. I believe that depression is a subjective experience that is difficult to measure quantitatively.</p> <p>Q12. My understanding of depression is significantly impacted by my cultural upbringing.</p> <p>Q13. My understanding of depression has been significantly shaped by my graduate school education.</p>
Views of Diagnosis	<p>Q14. Diagnosis is useful for easing communication between mental health professionals.</p> <p>Q15. Diagnosis is useful for conceptualizing client cases.</p> <p>Q16. Diagnosis is useful for developing treatment interventions.</p> <p>Q17. Diagnosis is useful for completing billing procedures with insurance companies.</p> <p>Q18. Diagnosis is useful for providing clients with a language for understanding their suffering.</p>

<p>Views about Medical Model</p>	<p>Q19. Diagnosis is useful for helping clients to create a story of their suffering.</p> <p>Q20. It is important for clients to agree with the diagnosis I give them.</p> <p>Q21. It is unimportant for clients to agree with the diagnosis I give them.</p> <p>Q22. Mental disorders can be best understood as akin to medical illnesses.</p> <p>Q23. In psychotherapeutic practice, it is necessary to have a doctor patient hierarchy.</p> <p>Q24. In psychotherapeutic practice, the clinician understands an objective truth about how mental health can be achieved.</p> <p>Q25. In psychotherapeutic practice, the client and therapist construct a subjective reality of how mental health may be achieved.</p>
<p>Professional Practice</p>	<p>Q26. I discuss the diagnoses I give with the clients I give them to.</p> <p>Q27. If I had the option I would prefer to assign people diagnoses.</p> <p>Q28. In my clinical work I have found diagnosis to be useful.</p> <p>Q29. Most clients have their own understanding of their depression that doesn't match the DSM-5 criteria.</p> <p>Q30. Most clients have an understanding of their depression that matches the DSM-5 criteria well.</p>

Table 2

*Theoretical Orientation Comparison with Current Graduation Status*

		Theoretical Orientation					Total
		Psychodynamic	Humanistic	Behavioral	CBT	Integrative	
Have you already	Yes	3	0	0	2	23	28
graduated with	No	8	2	3	14	45	72
your doctoral							
degree?							
Total		11	2	3	16	68	100

Table 3

*Program Location Comparison with Theoretical Orientation*


---

		Theoretical Orientation					
		Psychodynamic	Humanistic	Behavioral	CBT	Integrative	Total
Where is/was	USA (Midwest)	1	1	1	6	8	17
your program	USA (Northeast)	8	1	0	2	29	40
located?	USA (South)	0	0	0	4	16	20
	USA (West)	2	0	2	3	13	20
	USA	0	0	0	1	2	3
	(Northwest)						
	Total	11	2	3	16	68	100

---



Figure 1

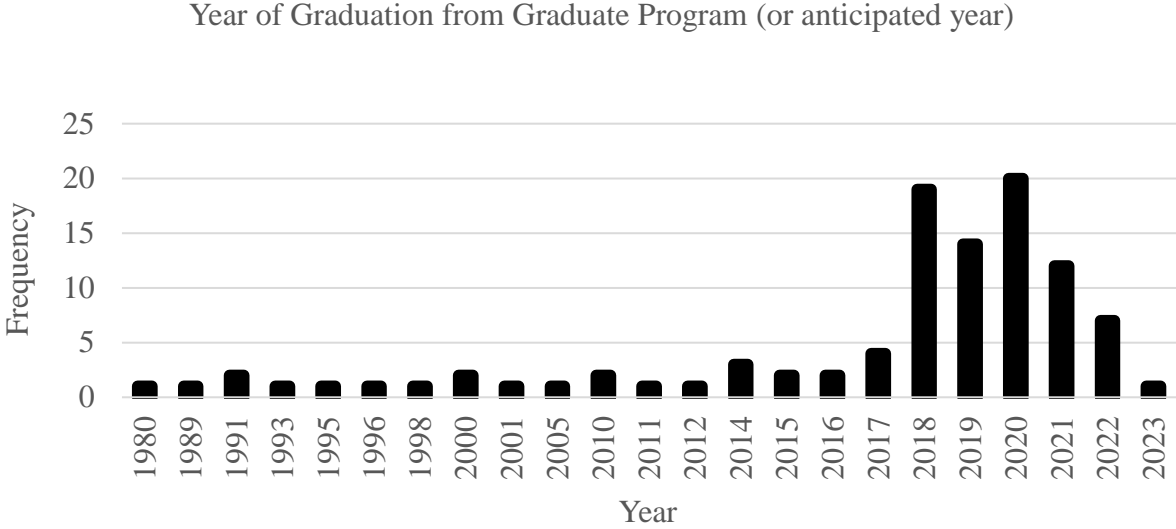


Figure 2

