PSYCHOTHERAPIST PERCEPTIONS OF BEHAVIORAL TREATMENTS FOR MDD AND CHRONIC UNIPOLAR DEPRESSION

MICHAEL J. BRANDT

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Mathematics / Statistics

State University of New York at Buffalo

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Dr. Jessica S. Ryan PhD, LPC

Supervising Faculty

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DEDICATION

The author of this work (and investigator for this study) would like to dedicate his effort within this research endeavor to all those who have struggled with depressive illness, but especially to those who have summoned the courage to take that step forward.

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ABSTRACT

Major depressive disorder (MDD) along with chronic unipolar depression present as a substantial, ongoing health challenge of the United States. It is estimated that more than 8 percent of Americans will encounter a severe depressive episode each year. This pervasive level of illness creates consequences extending beyond mental health concerns and into areas of negative public health indicators, economic loss and societal costs to individuals, families, and communities. Treatment models for depression, originating within primary care include prescribed antidepressants with behavioral treatment for cases seemingly resistant to that medication course. Approximately one-half million dedicated professionals across the United States currently offer professional psychotherapy treatments to those seeking relief from depression. Much as with antidepressants, the prevalent behavioral treatments utilized by psychotherapists to treat depression are sometimes effective and sometimes not. What is remarkable is that mechanisms of efficacy for these treatments toward improvement and for preservation of remission states are poorly understood. Research in the psychological literature presents as inconclusive. Enhanced understanding of mediative factors for prevalent psychotherapeutic interventions such as CBT and ACT could greatly benefit continued research as well as the development of more efficient models in diagnosis and clinical care.

The present study drew upon lessons learned from past research while employing qualitative analysis of the grounded theory type to assess the perceptions of psychotherapists to the prevalent treatment modalities that constitute their work processes. A codebook was developed as the genesis for a lexicon of behavioral treatment for depressive illness, and a theoretical model was devised capable of supporting the expression of this and other lexical data structures into the psychological research domain while in representation of the psychoanalytic process.

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CHAPTER 1

INTRODUCTION

Incidence of major depression within the United States over the past decade for adults had been estimated as occurring consistently at 8% through 2018 (cdc.gov, 2018). The events of the SARS-COV-2 pandemic and associated effects of lockdowns, along with social, financial and service constrictions evidenced exponential rises in rates of depressive illness, with one prominent study showing a three-fold increase (Ettman et al., 2020). At this juncture, and with partial abatement of pandemic woes, it remains undetermined whether a commensurate decrease in depressive illness will be tracked moving forward.

Major depressive disorder (MDD) is included in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) (APA, 2013). Coding is included for severity levels as well as for both partial and full remission. Also included as a separate diagnosis in DSM-5 is Persistent Depressive Disorder (Dysthymia), characterized by sporadic occurrence but not inclusive of mood-swing like behavior. It is important to note that the diagnostic information contained within DSM-5 for depressive illness is very granular. Mental health professionals as well as medical general practitioners (GPs) will at times utilize the descriptive, ‘unipolar depression’ to qualify most all varieties of depressive illness that are seriously debilitating but not bipolar in nature (even as ‘unipolar depression’ does not appear in the DSM-5).

The DSM-5 lists comorbidities of MDD including substance abuse, panic disorders, obsessive-compulsive disorder, anorexia nervosa, bulimia nervosa, and borderline personality disorder. The DSM-5 stresses that those suffering from Dysthymia are at higher risk for comorbidity of anxiety disorders as well as substance use disorders, and Cluster B (dramatic, emotional) and Cluster C (fearful, neurotic) personality disorders.

Although it would be accurate to state that individuals suffering from depression exhibit greater risk to self-harm or suicide on average, it is more precise to indicate that individuals battling depressive illness may exhibit strong suicidal ideation that can be detected through screening (on an individual basis) such that their susceptibility to self-harm might be evaluated and acted upon appropriately (Simon et al., 2016).

An estimated 21.0 million adults in the United States had at least one major depressive episode in year 2020, as related by nimh.nih.gov (2022). Depression increases medical morbidity and mortality. It also increases the likelihood of stroke, myocardial infarction and diabetes (Gaynes, 2018). Since depression inhibits and weakens the immune system, it increases the chance of infection and acute or chronic pain, as well as morbidity and mortality in acute care situations (Ghoneim & O'Hara, 2016).

The economic burden to the United States economy in terms of absenteeism, unemployment, lost productivity, and income from depressive illness for year 2018 was estimated to a staggering 326.2 billion USD (Greenberg et al., 2021). Remarkably, however, many provider networks in the U.S. estimate that two-thirds of all cases of major depression go undiagnosed, along with negative effects incurred with this forgoing of treatment (Williams et al., 2017).

The Path to Treatment for Major Depression

A characterization of treatment approach for depressive illness is provided by Cuijpers et al. (2019). This summary includes the qualification that the origination of most treatment (in western societies) occurs at primary care and in primary care facilities – and then is by virtue of that origination, medically-oriented. Therefore, the first option typically involves the cost-effective prescribing of an antidepressant medication. This scenario of treatment had also been

described by Kroenke (2002), and branded with the moniker, ‘Psychological Medicine’. Options for ‘behavioral interventions’ would exist if the patient showed resistance of depressive symptoms, either to the application of original or increasing doses of medication or simply with the passage of time.

Cuijpers (2018) explains that the challenges for improving efficacy for treatment outcomes include adaptions to the rigidity of the existing model while considering the unique needs of individual patients in terms of treatment resistance, placebo effects, and gaps in understanding for the efficacy of ‘behavioral treatments’ as options to medicinal interventions (or in combination with the medicinal). Note: It is within these junctures in the literature that the consumer/reader will begin to encounter the conflation of ‘behavioral intervention’ as well as ‘behavioral treatment’ to what more accurately should be referred to as ‘psychotherapy’ or ‘psychotherapeutic intervention’.

Behavioral Treatment / Psychotherapy for Depressive Illness

Cognitive Behavioral Therapy (CBT), originated and codified by Dr. Aaron T. Beck, has been the most widely-advocated and utilized therapeutic approach for the treatment of major depression in the United States and other western societies over multiple decades at this time. Its efficacy for the treatment of MDD and dysthymia is considered alongside other treatments by Cuijpers et al. (2010). The primary assumption of CBT is that dysfunctional thinking can be changed, and as a result, can lead to symptomatic relief and improvement in functioning (Craske, 2010, p. 49).

Drs. Steven C. Hayes and Stefan G. Hofmann discuss the employment of CBT, as well as the transition of the psychotherapeutic community to ‘third wave’ therapies, including Acceptance and Commitment Therapy (ACT) and others, describing these alternatives as options

of expanded range for processes of change – as opposed to direct competitors to CBT (Hayes & Hofmann, 2021). The goal of Acceptance and Commitment Therapy is the creation (in partnership with the patient) of 'psychological flexibility', inclusive of the ability to engage the present moment fully while accepting change but while remaining true to one's stated values (Hayes & Lillis, 2012, pp. 41-43).

Other approaches known to be employed by psychotherapists practicing in the United States and while treating patients with depressive illness include humanistic, experiential, or person-centered (HEP) therapies (Cain et al., 2016, p. 209; Greenberg & Watson, 2022); and psychodynamic therapies, sometimes qualified as 'short-term psychodynamic psychotherapy' (STPP) (Driessen et al., 2015).

Difficulties Encountered during Research for the Efficacy of Behavioral Treatments

Cuijpers (2018) elaborates that with each new option attempted on behalf of the patient exhibiting treatment -resistant depression, the success rate toward improvement and remission can be expected to be cut in half, with this expectation even less favorable upon selection of behavioral interventions. To add to the frustration incurred by providers, research inquiring into the efficacy of mechanisms involved in affecting change in the depressive state through employment of the behavioral intervention has shown to be inconclusive in terms of mediating factors.

An experimental study examining CBT and conducted by Burns and Spangler (2001) failed to uncover expected causal effects of changes in dysfunctional attitudes (DAs) along with changes in the depressive state. Kazdin (2007) cites studies recording CBT intervention with patients then demonstrating symptom change unexpectedly early in treatment and prior to DA strategies having fully been implemented. A phenomenon of 'differential activation' is

hypothesized by Beevers et al. (2007) , though without resolute conclusion, while attempting to explain that CBT patients responding to treatment typically show their strongest decrease in symptoms early on, followed by less dramatic change.

Steven Hayes and colleagues express aspirations for a research emphasis on mediation analysis to explain the moderation of illness from ACT interventions, while describing ACT as a unified intervention therapy for behavior change (Hayes et al., 2011). And Bramwell and Richardson (2018) express inexact conclusion of depressive outcome to defusion or value-based action components (attributing association but not causation).

EFT and Psychodynamic therapeutic approaches, by their very nature, are less-regimented and structured in their approaches, and then do not lend well to mediation-style analysis or other quantitative evaluative methods of incremental efficacy. It can be roughly asserted that it is known that these treatment modalities do demonstrate levels of success in alleviating symptomology of depression in some afflicted individuals, but the mechanisms whereby this change is affected is not quantified.

Statement of This Study's Focus and Direction

It is within these gaps of understanding for the efficacy of behavioral treatments employed by psychotherapists in treatment of MDD and chronic unipolar depression that the focus and direction of this study situates and proceeds. For one may readily assert that the present treatment model inclusive of antidepressant medications and behavioral treatments as needed, and describable by the label, 'Psychological Medicine', will continue to proliferate, with insurance and/or private pay reimbursement of services commensurate to these services and with these reimbursement resources being checked by any available outcome measure, i.e., symptomology relieved, and/or remission states preserved. But research into efficacy of

behavioral treatments will most certainly continue to be attempted because the path to greater efficiency of outcomes is desirable, from all of humanitarian, ethical, and financial perspectives. Researchers will certainly continue to attempt such work. Witness Hofheinz et al. (2020) mounting an extremely inventive quantitative study seeking to specify cognitive change while introducing elements of strong Bayesian posteriors into the mediation analysis; yet finding cognitive change to be general, rather than a specific mediator or mechanism for change.

One must laud this study from Hofheinz et al. (2020). The investigators imagine a problem space not previously conceived and operate within this alternative dimensional space in bold fashion. They define a comparison between likely alternative vectors of cognitive quantity (automatic thoughts vs. dysfunctional attitudes) and base their structural modeling on this new comparative paradigm. They do not pursue a previously-charted path to any great extent. They do not demonstrate what they intended to show, but they do produce significant alternative findings, covered in their discussion(s).

Perhaps what is needed then is more ‘thinking outside the box’. The questions that the present study then posed as preliminary inquiry were the following: ‘Has anyone ever asked the members of the psychotherapeutic community what their perceptions are as to why these interventions work (when they do)? And why they might provide efficacy toward improvement? And why they might aid remission?’ And if no party had ever thought to ask these questions of this pool of experts, then why not? A qualitative study of a grounded theory type seeking to reach the psychotherapeutic community - on their own terms, and while fully acknowledging and enlisting their expertise in a research effort – could potentially elicit information essential to the construction of elements and attributes of knowledge currently absent from the body of

knowledge applicable to the ongoing research into the efficacy of behavioral treatments. These questions did provide the genesis of focus and direction for the present research study.

Background and Need for this Research Study

The investigator for this study commenced the literature review encapsulated within Chapter 2, below. The finding most remarkable during this phase was that the question proposed above regarding the existence of a study seeking the perceptions of the psychotherapeutic community did not appear within the literature. There did not seem to be an incentive to conduct such a study - for reasons unknown. Mentors of the investigator did, however, assure that this might well be a quality objective if it could be managed. Plans were then made to attempt to execute a qualitative study of a grounded theory type enlisting the perceptions of professional psychotherapists regarding their work processes in treating Major Depressive Disorder (MDD) and chronic unipolar depression.

The Purpose of This Study

The purpose of this study was stated as the following, prior to embarking on its work processes: ‘Describe a theoretical structure for treatment selection and application of behavioral interventions to depressive illness directed onto the goals of improvement, remission, and preservation of remission state.’

It was intended that this statement of purpose would focus the intent of the study where its end purpose did logically situate, i.e., onto the research domain, as opposed to that of the clinical psychological domain.

Research Questions for this Study

The research questions utilized to support the study were also stated prior to embarking on its work processes and were designed to assuming the minimum possible of the

psychotherapeutic process that would be examined during the study. There was one central research question, along with three subordinate questions:

RQ0 (Central): What are the most efficacious behavioral therapies for the treatment of patients with MDD or chronic unipolar depression, as relates to goals of improvement, remission, and preservation of remission?

RQ1: What factors are perceived as contributive to improvement or remission in patients with MDD or chronic unipolar depression given application of specific treatment intervention?

RQ2: What factors are perceived as contributive to preservation of remission in patients with MDD or chronic unipolar depression given application of specific treatment intervention?

RQ3: What considerations are perceived as contributive to the selection of a treatment intervention for patients with MDD or chronic unipolar depression?

Significance to the Field

The potential significance to the fields of psychology and from this study will be of a contribution of terminology and knowledge applicable to the furtherance of understanding relating to the efficacy of behavioral interventions for the treatment of depressive illness and in the preservation of remission states. The study additionally seeks to combine this accumulated terminology and knowledge into a descriptive model capable of offering clarification to the psychotherapeutic process of treatment for depressive illness. As alluded to above, these contributions would primarily benefit the research domain.

A secondary level of significance to the fields of psychological science and to data science, generally, is expected to occur from the usage of an online survey instrument to collect data to a qualitative study of the grounded theory type. This represents a novel area of method and analysis.

Definitions/Terminology

Behavioral treatment, behavioral intervention. Processes of psychotherapists applied in treatment of depressive illness (including CBT, ACT, HEP, Psychodynamic processes, other) may be described herein as 'behavioral treatment' or 'behavioral interventions', in contradiction of some conventions of psychological theory, that could be taken to indicate treatments/applications influenced by behaviorist psychology and featuring the application of stimulus and reward, etc. Such (behaviorist) usage is strictly not intended. To the contrary, the usage of 'behavioral treatment' or 'behavioral intervention', here is in keeping with common parlance in the literature that by all appearances is an influence of non-psychological collaboration, inclusive of medicine and payor types, i.e., behavioral equating to NOT pharmacological.

Remission. An effort was made to standardize on the term, 'remission' in this document to connotate the trackable transition to an absence of symptomology (for this case, where a lack of depressive symptoms would be detected or where a score on a psychometric instrument would fall below a given agreed clinical threshold). Therefore, remission should be taken to be synonymous with 'recovery' and the state at which a patient 'discharge' would occur. The effective antonym of remission could be considered 'relapse'.

Limitations (forwarded)

Limitations for this study are fully featured in the 'Discussion' of Chapter 5. These assume a cumulative understanding of most of the prior chapter and so are ideally situated, there.

Ethical Considerations

The participant pool for this study were professional psychotherapists, eligible if holding a professional degree qualifying them for licensing in a state or region of the United States of

America and to treat patients using psychotherapeutic services. Participants were recruited based upon assessed possession of these qualifications and, if choosing to participate, were vetted for professional qualification prior to having data included in the study.

The privacy of potential participants was respected throughout. Potential participants were approached during recruitment according only to methods approved by the Institutional Review Board (IRB) of Tiffin University of Ohio, USA. If a participant expressed dissatisfaction with contact, that contact was immediately discontinued. All contact was professionally conducted and limited to the content of the study, only. The full contents of the IRB approval along with approval modifications are available at this study's web site, Brandt (2022), or by request from the study investigator or the Tiffin University IRB.

There were no patients as participants in this study. There was no patient information, nor Protected Health Information (PHI) collected. There were no considerations that would extend to the Health Information Portability and Accountability Act (HIPAA), should this study transition to accept public grant funds or interface with public health records of any kind in the future.

There were no recorded instances of participating psychotherapists providing information as study data that was inclusive of PHI. If that had been the case, or if future iterations of this study are conducted and that occurrence had been or would be observed by the investigator(s), then that data would be redacted in all study publications prior to dissemination/publication.

All study data, along with documentation on the study web site has been de-identified and/or dual-published for dissemination to publication, with only one special-view copy available to investigators/database administrators and IRB officials, and the general, redacted view selectively available for publication to academic purposes, conferences, etc. The academic and conference level views are secured and require logins for access (they are not public, nor

will they be at any time in the future). The investigator is in discussions with the Tiffin University IRB regarding matters of appropriate use at this juncture (dated 11/30/2022).

CHAPTER 2

REVIEW OF LITERATURE

While attempting to determine current behavioral treatment trends for depressive illness, more than one source type had been considered. Large data maintained by public health agencies and professional organizations tracks incidence of depressive disorders across populations but lacks granularity for treatment interventions applied. Alternatively, studies available within the literature examining current psychotherapeutic approach to treatment of Major Depressive Disorder (MDD) and chronic unipolar depression for adult patients in the United States are numerous, with most adopting a clinical trial format.

Perceptions of psychotherapeutic providers to the efficacy of the behavioral treatments employed for patients of depressive illness could be anticipated from studies associated with theory and application of these methodologies as well as from accounts of treatment and case studies of patients treated for depressive illness. Studies related to theory are numerous but must be carefully considered in relation to the perspective of the psychotherapeutic provider.

While research sources selected in regards to anticipated perceptions of providers can be expected to focus on specific treatment types, it could be assumed the professional psychotherapist addressing the needs of a patient suffering from depressive illness would not be constrained by a single approach, and may utilize aspects of more than one treatment as deemed optimal from patient indications.

Current Treatment Interventions for Depressive Illness

Efforts to establish norms for current treatment interventions rendered to patients with depression included searches of publicly available data. Inquiries to large data sources can provide aggregate incidence numbers for depressive illness broken down over demographic

indicators but not data points tracking specific behavioral interventions or outcome measures. The Proquest statistical abstract of the United States, Proquest (2020), provides age, sex and race information (but not treatment type). The National Mental Health Services Survey (N-MHSS), data, samhsa.gov (2022), is focused on location, facilities, availability of services and utilization of services. There is limited data available on maternal depression.

The National Institutes of Health (NIH) does not publish data collected specifically on depression. An informational page is offered relating to behavioral therapy without reference to types of treatment (nimh.nih.gov, n.d.). The primary contribution of the NIH toward research of depressive illness currently is through the Research Domain Criteria (RDoC) and focused on biological/genetic origins, see Woody and Gibb (2015) as example.

The National Alliance on Mental Illness (NAMI) offers strong advocacy through mental health professional affiliation. There is an informational page on psychotherapy featuring information on Cognitive Behavioral Therapy (CBT), as well as other treatment modalities (nami.org, n.d.). NAMI also maintains a members-only database, NAMI360. This study unfortunately does not have access to this database content nor knowledge of that content's meta structure.

While continuing to seek data exposing norms of behavioral treatments rendered to patients with depression, research studies exploring trends through meta-analyses were next considered.

Cuijpers et al. (2014) published a much-cited meta-analysis examining efficacies of psychotherapeutic treatments for depression across 92 studies (adult patients, United States and United Kingdom). The study found an overall added benefit averaging 14% of psychotherapy treatment as compared to control conditions and to a remission state. Important to note are the

heterogeniety of the included studies and the assessment instruments utilized, precluding more exacting analysis regarding persistence of remission. Most of the studies reported utilization of CBT, although other modalities were included (Acceptance and Commitment Therapy (ACT) was not).

A study comparing 12 weeks of CBT with ACT against indicators of declining levels of depression measured by the Beck Depression Inventory (BDI) was presented by Zettle et al. (2011). This study was the first to attempt mediation analysis (including session-by-session measurement) to mark incremental changes across patient visits for ACT patients on a Dysfunctional Attitudes Scale (DAS). The mediation analysis results did not prove significant, but the decline in the mean BDI scores across the length of the study in comparison to the CBT patients were significant and did show ACT as a comparable treatment.

Mediation analysis was also employed by Forman et al. (2011) while comparing CBT to ACT and with assessments of mediators and outcomes prior to each therapeutic session. This study concluded efficacy for both CBT and ACT and found expected mediators to be active (cognitive restructuring for CBT, cognitive defusion for ACT). One hypothesis of the study not demonstrated was that the focus of ACT on goal-directed behaviors and in conjunction with cognitive defusion would lead to greater levels of metacognitive awareness over those patients receiving CBT.

A comprehensive study comparing the efficacy of ACT to CBT as related to remission originated from Forman et al. (2012). This study included one hundred thirty-two depressed (or anxious) outpatients with 90 assessed posttreatment and 91 assessed at the 1.5-year mark. The study findings were that CBT provided evidence of more lasting effects toward remission states than ACT.

An article from Zettle (2015) provides a summary and interpretation of study data available at that time related to the efficacy of ACT for treatment of depression with significant overall positive outcome. Zettle references utilization of ACT treatment protocols at Veteran's Administration (VA) hospitals, with treatment outcomes comparable to those obtained from traditional CBT. He concludes with recommendations for a larger empirical base for ACT combined with analyses featuring elements of component analysis.

A German study compared CBT to ACT in a trial of inpatients of a psychiatric hospital with assessments post-treatment and at six-months using the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-I) (Samaan et al., 2021). The study found comparable favorable reductions of depressive symptoms between ACT and CBT treatments with stability over six months' time accompanied by corresponding improvements in life measures. It can be noted that interventions in this study were mixed between group encounters and one-on-one.

A combination mediation analysis and follow-up study from A-Tjak et al. (2021) defined specific criteria for validity (of mediation studies for behavioral therapies). It proceeded to indicate that the last prior study to meet those criteria was the effort from Forman et al. (2011) (see, above). Its mediation analysis then compared CBT with ACT based upon 'dysfunctional attitudes' for CBT and 'decentralized and experiential avoidance measurements' for ACT. This study indicated that the choice of therapies made by the provider and according to identified case type would represent an opportunity for further research. The study demonstrated efficacy to sustained recovery at the one-year mark for both CBT and ACT.

A meta-analytic study of the evidential value of ACT was conducted (Williams et al., 2022). These authors indicate that many of the RCTs examining the efficacy of ACT over the last 35 years have exhibited flaws, either low sample sizes/insufficient power, poor sampling

technique, poor methodology, or some combination of these factors. The resulting meta-scientific study here represents the result of the analysis of 55 studies meeting final criteria after meticulous examination and resulting in necessary exclusions. The meta-analysis resulting from comparative measures of ACT over several dimensions to multiple outcomes is summarized to indicate that ACT displays a lack of clear evidence for equivalency with or superiority to CBT. They conclude that providers as well as stakeholders in health care providing practices should seek to gain further confidence and awareness of ACT, along with assurance that the resources necessary for utilization (in terms of training, dissemination, and implementation) do not exceed those of other more proven therapeutic modalities.

A meta-analysis provided from Driessen et al. (2015) compared the efficacy of short-term psychodynamic psychotherapy (STPP) with other modalities for adult patients with depressive illness. The comparisons included CBT, but not ACT and utilized 54 studies, 33 of which were RCTs. Conclusions found no significant differences between STPP and other psychotherapies for treatment of MDD. This study, like that of A-Tjak et al. (2021), above, concludes a need for research focused on choice of therapies according to discreet patient presentation or case type.

A meta-analysis from Elliott et al. (2013) examined efficacy of humanistic-experiential (HEP) psychotherapies, finding equivalence of outcomes in 37 comparisons utilizing 23 studies (n = 755, HEP; n = 1,261, non-HEP (typically CBT), respectively). Four of these comparisons included patients of depression and showed support for the (more process-driven) modalities of emotion-focused therapy (EFT), with efficacy measures comparable to those of CBT.

A study protocol (ongoing) published by Rossberg et al. (2021) indicated an initial treatment phase of 28 weeks utilizing two groups (CBT and psychodynamic therapy (PDT)) with subsequent follow up investigations at one- and three-years post-treatment. The intent of this

novel study was to investigate and produce knowledge related to individual patient moderators and (effects upon) mediators of treatment efficacy.

A well-cited study from Shafran et al. (2009) investigating utilization of CBT in clinical settings as treatment for mental illness found that 69% of providers in the United States use this treatment only part time or in combination with other therapies to treat depressive illness. With the assumption in place that CBT is the most proven (and known efficacious therapy), the study ponders why further dissemination does not proceed. Conclusions include lack of training opportunities resulting in difficulties in measurement of quality outcomes and minimum procedural visit requirements. The study encourages CBT trials for the measurement of therapist effects.

Considerations for Treatment Efficacy

CBT as a treatment for depression was characterized by Lehner-Adam and Dudas (2012) as consisting of three pillars: a) building up daily activities, b) training social competencies, and c) cognitive techniques. In terms of c), these authors outline process components for identification of automatic thoughts and cognitive distortions prior to attempts at cognitive restructuring. Listed as a key component within latter stages of the CBT process is awareness and challenge of dysfunctional attitudes (DAs).

An experimental study examining CBT for adult patients of depression and anxiety and including a number of hypotheses centered around a core theoretical construct - challenging and replacing DAs - returned surprising results (Burns & Spangler, 2001). The authors reported that there did not appear to be any causal factors linking change in DAs with change in depression (or anxiety) at intake or at study termination (12 weeks). They attributed change to an unknown variable appearing to mediate dysfunctional attitudes, depression, and anxiety.

Kazdin (2007) enumerates various study findings showing patients receiving CBT treatments then indicating symptom change relatively early in treatment prior to DA strategies having been fully implemented. He concludes that '… perhaps we can state more confidently now than before that whatever may be the basis for changes with CT [cognitive therapy], it does not seem to be the cognitions as originally proposed' (pg. 8). Such assertions fuel the need for continuing research into the mechanisms for efficacy of CBT.

A concept of 'cognitive specificity' as distinct from 'cognitive mediation' for CBT is addressed by Garratt et al. (2007) while in review of the psychological literature. Garratt et al. (2007) conjecture the most direct way to test the specificity of CBT is in comparison to pharmacological interventions. They note that patients exposed to negative affect post treatment from either CBT or pharmacological exhibit stronger resilience post-CBT.

A study conducted by Beevers et al. (2007) utilizing 121 adult patients with MDD examined variables associated to severity of illness including family history and number and length of recurrence for depressive episodes. They cite the 'differential activation hypothesis' that depression is maintained by negatively biased information processing. Their findings - evidenced from CBT as well as family therapies for the included subjects – were that depressive symptoms usually showed their strongest decrease early on in treatment followed by less dramatic changes. Only levels of negative cognition were found to mediate an association between depression history and change during treatment, with prior repeated episodes of MDD resulting in higher levels of negative cognition.

A meta-analysis was performed by Cristea et al. (2015) to determine the effect of CBT on depression along with changes in dysfunctional attitudes. Findings from the inclusion of 26 studies were that CBT treatment for depression exerted a positive and robust association to

dysfunctional attitudes (DAs) and that DAs were strongly associated (but not causal) to depressive symptoms. There were no significant differences found between CBT and pharmacological therapies in effect on DAs.

Hayes et al. (2011) defined ACT as a unified model for behavior change linked to a strategy termed 'contextual behavior science'. They differentiated ACT from CBT most notably within its tendency to build psychological flexibility and resilience based on clarity of mind. The six processes of ACT were introduced (acceptance, defusion, the now, self, values, committed action). The authors also stressed aspirations for emphasis on mediation and moderation of illness within research applied to ACT interventions. They were careful not to portray ACT as a superior to CBT.

An RCT analysis from the Netherlands examining early effects of ACT on adult patients of depressive illness included measurements of depressive state (Center for Epidemiologic Studies Depression Scale (CES-D)), as well as measurements for anxiety, fatigue, and alcohol use before and after the two-month ACT intervention (Bohlmeijer et al., 2011). The study demonstrated statistically significant reductions in depressive symptomology over the course of the intervention and as compared to the control group, with reductions maintained at three month follow up.

ACT as a therapy for depression was examined by Bramwell and Richardson (2018) in a secondary study of data generated from (Richardson et al., 2018). Unlike the primary study that focused on outcomes, Bramwell and Richardson (2018) utilized repeated measures to indicate that changes in depressive outcome were associated to defusion and to values-based action components of the intervention.

The concept of cognitive defusion as related to psychological flexibility was explored by Bardeen and Fergus (2016), using a sample of 955 community adults assessed with standardized psychometric instrumentation. The resulting correlational analysis asserted positive associations of cognitive defusion as well as experiential avoidance for indicators of depressive illness.

Psychological flexibility was further explored as an interaction of component processes by Tyndall et al. (2020). These authors indicate psychological flexibility as relevant to functioning and resistance to impairment from depression, anxiety, and stress-related illnesses. They define psychological flexibility as composed of attributes reminiscent of the six ACT processes (acceptance, cognitive defusion, present-moment awareness, self-as-context, values clarification, committed action), and psychological inflexibility as attitudes opposed (experiential avoidance, cognitive fusion, self-as-content, lack of present-moment awareness, lack of values, lack of commitment to action). The latent class analysis performed using 955 subjects and standard psychometric instrumentation revealed aggregate composite profiles containing significance for all measured variables and separable into classes of high, medium, and low psychological flexibility.

Greenberg and Watson (2022) outlined recent contributions to ‘emotion-focused therapy’ (EFT) as a depression-specific derivative of client-centered therapy (CCT) or person-centered therapy (PCT). These authors stressed the need for the psychotherapist to assess the experiential level of the client in relation to their emotions, as well as ongoing levels of emotional arousal as indicators toward progress. Also stressed was the importance of the therapeutic relationship, or ‘working alliance’ - not only within the EFT process, but within all psychotherapeutic processes. Greenberg is a noted author on this topic, and has intoned in her writings that EFT for depression

includes support for emotional awareness, emotional regulation, and emotional transformation (Greenberg, 2017).

Considerations for Provider Perceptions

The 2019 document update from the UK's National Collaborating Centre for Mental Health (NICE) (2019), referenced strong indications to CBT for treatment of depression with applicability and cost effectiveness cited as advantages. Also warranting mention are interpersonal therapy (IPT) and couples therapy (neither receiving focus in this study), as well as behavioral activation (BA); 'counseling' (for individuals with 'subthreshold' or mild to moderate cases and/or refusing other treatments); and short-term psychodynamic therapy (for individuals of complex comorbidities, or with refractory cases or worsening of symptoms). The document concluded with overall recommendations for treatment plans designed according to observed moderators of condition, including severity ((NICE), 2019, pp. 291-299).

A group of authors from the Journal of Counselling and Psychotherapy Research reviewing NICE recommendations on psychotherapeutic approaches to depression concluded little, if any advantage to the selection of CBT over counseling approaches while delivered in supportive one-on-one environments (Barkham et al., 2017). This article is critical of the NICE advisement of counseling for less severe, subthreshold case symptomology. It is also critical of the vague specification of 'counseling' by NICE, while indicating that 'counseling' may include person-centered therapies as well as the short-term psychodynamic.

Cuijpers et al. (2019) delivered a study on the state of treatment for depression originating in primary care health settings. They cite studies indicating that many patients prefer behavioral treatments over medication and examined the outcomes of seven meta-analyses of treatment modalities for depressive illness. Conclusions are that combined treatment including

medication is generally more effective than approaches consisting of single intervention. The study also highlights opportunity for preventive application at the subthreshold levels of depressive illness in primary care.

Contrasts between ACT and BA were provided by (Kanter et al., 2006). These authors indicated that both ACT and BA operate from a behavioral-analytic perspective conceptualizing depression as a condition of avoidance, while then attempting to adjust behavioral positioning to mitigate such avoidance. Differentiation was offered from the standpoint of ACT definitions of avoidance as verbal and contingency/rule-based, with this opposed to the BA definitions of avoidance resulting from the loss of response-contingent positive reinforcement in situational contexts. Kanter et al. (2006) explained that both approaches focus on the same behaviors contributing to ongoing depression (e.g., oversleeping, overeating, rumination, substance abuse, others) in attempt to improve the patient condition.

Guidelines for the treatment of depression published by the Journal of American Psychiatry included support for CBT as efficacious and cost-effective, along with recommendations for IPT and ‘problem-solving’ therapy for specific cases, such as geriatric and special needs (Gelenberg et al., 2010). BA received mention as a ‘newly articulated behavioral intervention’ (in 2010). Psychodynamic therapies were addressed as multi-defined but not well-studied as related to efficacy in treatment of depressive illness. Not addressed were person-centered approaches or ACT. These authors detailed risk factors to recurrence of MDD including persistence of subthreshold symptoms, prior history and severity, age at onset, comorbid conditions (including medical), family history, ongoing stressors, negative cognitive style and sleep disturbance (Gelenberg et al., 2010, p. 58).

Norcross and Wampold (2011) intoned that a process of matching a psychotherapy to a disorder is incomplete and ineffective. They referenced the American Psychological Association's (APA) policies on evidence-based practice apa.org (2021), and encouraged providers to adapt or tailor psychotherapeutic approaches to patient characteristics in ways found to be demonstrably effective.

CBT for treatment of adult depression and as an intervention based from primary care was investigated by Santoft et al. (2019), using the results of 34 RCT studies. CBT was found to show a significant but small positive effect toward remission and as compared to treatment as usual (TAU). The study also found effects of similar magnitude to other treatments and treatment combinations, although data was not sufficient to explore the inter-relationships between putative moderators. Limitations also included a lack of specific clarity as to the professional qualifications of the provider delivering treatment for included cases.

López-López et al. (2019) conducted a components-level meta-analysis of 91 CBT studies with findings of short-term improvements in depression scores. This study did not find evidence for efficacy within described combinations of treatment components. There was no finding of superiority between face-to-face CBT over technology-delivered, although the authors advised caution with that finding in their limitations section. Other limitations cited were that most included studies utilized none (or limited) data related to follow-up, precluding analysis of longer-term effects.

Functional assessment was stressed as foundational in CBT cases and for utilization in treatment of depression (Grant, 2008). Aside from medical and family history, information gathered from the client will critically include their beliefs about their present difficulties as well as their goals and expectations from therapy. The CBT therapeutic process typically focuses on

building up positive daily activities, reinforcing social competencies and teaching of cognitive techniques, including challenging negative self-talk as well as the identification and transposition of cognitive distortions. Grant (2008, pp. 192-213) offered a case study of 'Paul', a 63 year-old married white male with a 40 year history of chronic and recurrent depression. The relationship of recurrent characteristics of depression as well as to cognitive-emotional mismatches leading to negative affect intrinsic to the condition were stressed for this patient. After construction of a case and biopsychosocial formulation, and development of the patient-provider relationship, the therapist introduced self-monitoring exercises using probing questions based on patient experiences. These examples were used to attempt to remodel cognitive processes as well as to build self-compassion. An emphasis was placed on assisting this patient to build identification and empathy for their own distress. Good outcomes in this case were achieved through a compassion-based approach along with intermittent follow-up.

A case study involving a 48 year old Arabic man, 'Farid', with history of psychiatric case in excess of one year following a suicide attempt, was presented by Corrie et al. (2016, pp. 107-126). For this severe case, the focus of formulation included a detailed understanding of the interaction between the cognitive, behavioral, emotional, attentional, physical, environmental, and interpersonal aspects of the patient's day-to-day life. His motivation with respect to his suicidal intent was explored, and a personal history was gathered with emphasis leading up to the cascade of events that led to his first encounters with depressive episodes. As with any patient of severe depression, Farid's applicability to the CBT intervention had to be assessed. Once this applicability was assured, therapy began with weekly activity scheduling and using the results of an activity log as the basis for therapeutic encounters. Significant progress was realized by Farid when he was able to identify the nature of his cognitive dysfunction and dissonance as a

counterpoint to the resilience being shown by his wife and daughters in response to his difficulties. In this way the CBT process was able to identify and assist in leveraging the unique aspects of a patient's experience to cognitive restructuring objectives. Farid made progress toward a recovery state and follow-up was arranged at two-month intervals.

Arnow and Post (2010, pp. 183-205) discussed depressive illness and its presentation as multidimensional with some patients experiencing episodes of major depression lasting two years or longer. Such severe cases often may involve consecutive interludes of dysthymia with exacerbations to more severe MDD, commonly referred to as 'double depression', also referenced by Klein et al. (2006). Arnow and Post stressed the importance of inter-personal, family and 'significant other' histories during such case assessments, while explicitly differentiating the client-therapist relationship from other kinds of relationships. These authors include the case study of 'John', a middle-aged white male, suffering chronic depression after perceived failures and shortcomings in early family life, academics, career, and romantic endeavors. John exhibited reluctance to the therapeutic relationship that had to be gradually dissipated through empathetic provider expression. Unfortunately, John did not reach a recovery point during the sessions that were allowed to him with the therapist, but strategies to address his problems were discussed and follow-up was scheduled.

The importance of 'collaborative empiricism' in CBT case management was explained by Dattilio and Hanna (2012). This desired state of analysis, originally identified by Aaron Beck, is outlined as essential to the therapeutic relationship for the discovery of automatic thoughts and underlying beliefs. Dattilio and Hanna (2012) explained that collaborative empiricism is what will allow the patient and therapist to explore dysfunctional thinking together in a confident manner, and to explore these thoughts in a partnership. These authors utilized an excerpt from a

case study to illustrate a collaboration involving a therapist asking a patient to take more exacting account of somatic symptoms the next time they would occur (such that these could be explored as detailed phenomena). The therapist offered the patient strategies to persist and manage such an episode should it occur. Collaborative empiricism is summarized as the therapeutic atmosphere that allows partnership of understanding patient experiences and allowing identifications of related emotions and possible distorted beliefs.

ACT was described by Strosahl et al. (2016) as a therapeutic approach derived of 'functional contextualism'. They described its methodologies as employing 'pragmatic truth', i.e., 'what is true is what works while (striving) to achieve a (shared) goal'. These authors intoned that these philosophical concepts are enabling of an overall ACT goal of building 'psychological flexibility' within the patient, guided by a framework of workability in his/her life (Strosahl et al., 2016, p. 33). Initial therapeutic goals would include the construction of a 'functional analysis case formulation', based on the patient's present life experiences along with goals for the future. Questions might include, 'What kind of life do you most deeply want to create and live?', and 'What are the psychological and/or environmental processes that have interfered?' A timeline of events is typically constructed. (Strosahl et al., 2016, p. 106). Also essential to ACT assessment is a values interview, typically utilizing an assessment instrument. The values interview, along with an understanding of patient experience, enable the ACT therapist to detect and attempt to counteract the 'siren songs' of suffering in depressive illness, fusion and experiential avoidance (Strosahl et al., 2016, p. 114). ACT seeks to assist the patient of depression in displacing fusion with defusion and experiential avoidance with being present.

According to Luoma et al. (2017, pp. 20-21), patients of depressive illness become susceptible to fusion based on verbal perceptions of expected events and on an overextension of

language to literality. A patient might use circular reasoning while stating that, ‘I stayed in bed because I was depressed,’ in response to a question on that behavior. These authors explained that fusion is enabled by language as an innate cognitive construct and is thus enmeshed with culturally-supported messages about the causal effect of private events, along with the need to control these events - typically through avoidance behaviors. Building patterns of ‘committed action’, according to the intervention processes of ACT, can influence the patient to gain self-efficacy by breaking the chain of experiential avoidance and moving forward toward valued life directions (Luoma et al., 2017, p. 239).

The case study of ‘Daniel’, a 44 year-old white male who had suffered from chronic depression with extreme sensitivity to criticism was presented by Cohen (2016). The author states that while he had seen the patient in psychoanalytic therapy for several years with progress made in understanding childhood determinants of difficulties, outcomes toward behavior transformation had not been realized. The decision to integrate techniques from ACT treatment structure began with ‘experiential learning’ along with the client’s choice of participation in exercises from an ACT workbook. Cohen (2016, pp. 15-21) devoted considerable time to attempting to orient his patient through ACT paradigms of ‘being present’, ‘mindfulness’, and ‘willingness’. The patient demonstrated remarkable tendencies not only toward elaborate cognitive mechanisms of fusion but towards referencing these activities with ruminations and orientation to past difficulties. The patient did not demonstrate overt avoidance behaviors, but avoidance of inter-personal relationship styles that connotated fear along with exposure of weaknesses/vulnerabilities. An ensuing period of patient resistance was followed by a breakthrough during which mindfulness exercises inclusive of meditation were mutually adopted

by the therapist and patient, leading first to decreased treatment resistance and then to apparent recovery and discharge with follow up (Cohen, 2016, p. 23).

Stephen J.F. Holland commented positively on Robert Cohen's published case study of 'Daniel' while opining that more psychoanalytically-informed therapists should consider employment of ACT to patients presenting as candidates for this therapeutic approach (Holland, 2016) (Note: Holland therein repeatedly referred to ACT as a form of 'cognitive behavioral therapy', which may be considered ambiguous from the terminology standpoint). Holland noted that psychoanalysts typically eschew ACT (or CBT, for that matter), based on neglect for transference/countertransference. He did point out, however, that all psychoanalysis as well as ACT (and CBT) benefit from mechanisms of identification for emotional affect with subsequent activation of these emotions. Holland went on to explain that ACT can provide the psychoanalyst with tools to target problem emotional states – such as those designed to enhance defusion. For the case of 'Daniel', this did involve his ability to create emotional distance from events. Mindfulness proved to be key in that objective – even as defusion represented the underlying progress point. Holland made additional conjectures that 'other' treatment modalities, such as CBT, might also be applicable in conjunction with the psychoanalytic approach, albeit without sufficient elaboration.

Elliott et al. (2013) described person-centered therapies within categorizations of 'humanistic' or 'experiential' and inclusive of person-centered therapy (PCT), gestalt therapy, emotion-focused therapy (EFT), and existential therapies. Elliott, et al. proceeded to describe all these under the wider categorization of 'humanistic-experiential' (HEP) psychotherapies. The 2013 meta-study referenced under the 'Current Treatment Interventions for Depressive Illness' level heading, above, compares and contrasts (some of) these approaches with other

psychotherapeutic modalities. Cain et al. (2016, pp. 95-105) discussed the humanistic-experiential contribution to psychotherapeutic research in terms of qualitative and grounded theory within conceptual analysis of patient-provider interactions. Within extractions from case interactions, there, these authors presented the style of interaction that exhibits the humanistic elicitation of emotional affect – with this in contrast to the conjectural path of psychoanalysis. Leading and open-ended questions are posed, while interludes of silence are interpreted as introspective zones along a path, as opposed to indicators of patient resistance to the therapeutic process. Offerings of silence from the humanistic psychotherapist are inserted to model introspection to the patient.

A case study of 'CG' was published as an example of psychodynamic therapy for depression (Skean, 2005). 'CG' presented as a graduate student in his late twenties fitting diagnosis for MDD and describing frustration, demoralization, and isolation after a difficult academic year resulting in his having been placed on probation. The patient complained of a tumultuous upbringing inclusive of domestic violence. The patient viewed the seeking of help as a shame-filled experience. The creation of the patient-provider trust relationship was used to enable the goal of insight-oriented reasoning that the patient himself had participated in the creation of his present difficulties – even while they seemed insurmountable to him in large part due to his life's history. The continuing goal was to assist the patient to navigate away from the difficulties and to gain new knowledge of himself in the process. The psychodynamic therapeutic process spanned this patient's confrontation of his worst fear, an eventual dismissal from his academic program, which challenged his sense of self, and led to the end of the therapeutic relationship. The patient resolved to seek treatment after relocation.

Plan analysis was presented as a topic of investigation by Kramer et al. (2022), and in relation to an opportunity to form an effective patient-provider relationship. These authors intone that plan analysis as a consideration of treatment in psychotherapy provides an idiographic focus enabling links between a patient's observed behaviors, experiences, and expressed or inferred intentions and goals. The authors provide a psychodynamic case study for, 'Sharon', a 22-year-old single woman suffering from recurrent depression. The plan formulated required conceptualizing the patient's primary internal conflicts. Behaviors deemed problematic were graphed and connected according to ad-hoc relational analysis. These behaviors then provided a top-down agenda for therapy sessions. The patient, Sharon, admitted to difficulties with controlling behaviors and fears of rejection from others as causal to these behaviors. Plan analysis proceeded according to the 'motive-oriented therapeutic relationship' (MOTR), requiring the patient to collaborate with the provider to select a starting behavior for dialogue and including reasons for those behaviors; and for that discussion to include the transposition of these reasons onto other behaviors, desirable or otherwise. It is hypothesized that the process related to the MOTR does facilitate the cohesiveness of the patient-provider relationship.

Summary

Current studies existing within the psychological literature specific to behavioral interventions for MDD and related depressive illness may be utilized to demonstrate the predominant therapeutic approaches in the United States while simultaneously gaining assessments of comparative efficacy for these treatments, based on their included analyses. The predominant therapeutic approaches have been found to be those of Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT). Clinical trial studies included in this review also show support for other therapeutic models, including Humanistic, Experiential

and Patient-Centered Therapy (HEP) (alternatively labeled humanistic, Rogerian, Client-Centered Therapy (CCT) or Emotion-Focused Therapy (EFT)), as well as time-limited psychodynamic approaches.

Exploration of public health data sources as well as those freely available through professional organizations were found to supply aggregate data (along with service-related information) but evidenced a lack of granularity allowing discernment of treatment interventions applied for patients of depressive illness.

Studies related to the theory and application of behavioral interventions to depressive illness are numerous. Studies here were selected for relevance to perceptions of efficacy from psychotherapeutic providers. Key elements of theory for CBT, ACT, and HEP were uncovered for this purpose. This segment of the literature review provides evidence that much of the positive effect offered by these behavioral therapies to patients of depressive illness is not fully understood at present.

Literature further contributing to the understanding of psychotherapy provider perceptions was included from sources of advanced-level textbooks, training literature and clinical case studies. Accounts inclusive of literal perceptions and/or opinions of these providers toward the utility and efficacy of specific treatment modalities was not evident in the literature. It is coincidentally that same information that is sought by this study.

As stated in the introduction to this literature review, the professional psychotherapist addressing the needs of a patient suffering from depressive illness could be expected to utilize aspects of more than one treatment as deemed optimal from patient indications. Many of the included studies echoed this notion. There exists little dissension among advocates of these behavioral therapies, nor open claims of superiority for their advocated approach over any other.

CHAPTER 3

METHODS

The purpose of this study was to develop a theoretical structure for treatment selection and application of behavioral interventions to depressive illness directed onto the goals of improvement, remission, and preservation of remission state. A review of the psychological literature reveals a great deal of information attempting assessment of the efficacy of prevalent behavioral treatment modalities (including Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Humanistic, Experiential and Person-Based therapies (HEP)). A paucity of literature exists to suggest perceptions of the professionals choosing and administering these therapies according to patient indications and moderators.

This study utilized a qualitative design of a grounded theory type with establishment of participation through an online survey form. The online survey form included options for follow-up to participants enabling interview capabilities as well as extended question responses. The study coded and categorized data collected through surveys, interviews, and extended responses to determine perceptions of participating psychotherapists relating to the efficacy of behavioral treatments for MDD and chronic unipolar depression as related to goals of patient improvement, remission, and preservation of remission.

Setting

Much of the research interaction for this study took place within the structure provided from a dedicated web site, psytsurvey.online. This web site was constructed for purposes of enlisting and managing participant recruitment along with resulting study data. The informed consent for participation, along with the survey form utilized as an entry point into the study were published on psytsurvey.online and opened for initial data collection beginning 11/07/2022.

The study informed consent is included in Appendix A. The survey question set is included in Appendix B.

Participants permitting follow-up interviews were scheduled for these sessions, to enable either video conference or phone conversation – with scheduling negotiated via private survey form. Content for these interviews was based on initial survey responses. Participants were required to complete a secondary informed consent prior to follow-up interviews. (Note: As of 11/29/2022, none of the participants approached had completed a follow-up interview).

Participants permitting follow-up survey questions were sent a secondary private survey form based upon their initial survey responses. Secondary survey questions were based on initial participant survey responses. Participants were required to complete a secondary informed consent prior to follow-up survey questions. (Note: As of 11/29/2022, one of the participants approached had completed their follow-up private survey. This is mentioned further in Chapter 5, Discussion section).

Participants

Recruitment and selection of participants was conducted according to methodology prescribed for grounded theory research and involving a flexible process of 'theoretical sampling'. Theoretical sampling occurs concurrently with the extraction of themes from data as it is being collected and as core themes in the data suggest axial coding mechanisms (Creswell & Poth, 2018, pp. 82-90). Corbin and Strauss (2015, pp. 134-139) indicate that theoretical sampling represents a method unique to grounded theory research. They indicate that techniques of theoretical sampling are commonly employed with considerations for 'saturation' as a guideline, indicating that sampling proceeds for as long as possible while data is being analyzed and until there is no longer new information to uncover.

For the case of this study, the division of focus between behavioral modalities of Cognitive Behavioral Therapy (CBT), Acceptance and Commitment Therapy (ACT), or Humanistic, Experiential and Person-Based therapies (HEP), indicated a theoretical sampling approach serving to saturate categories of participant perceptions across three treatment modalities of focus (as well as possibly a 'other' fourth, depending on responses).

The study included professional psychotherapists practicing within the United States. Although this wide geographic allowance combined with concurrent modes for participant contact might be suggestive of wide participation, the window of opportunity for recruitment extended only from 11/07/2022 – 11/23/2022. The study therefore set a preliminary goal to achieve 20 – 30 participants contributing to analysis. That goal was in concert with sampling guidelines from Creswell and Poth (2018, pp. 158-160), while exercising techniques of 'maximum variation sampling' in pursuit of saturation.

Prior to participation cutoff and finalization to data collection and analysis, the recruitment effort produced a total of 20 participants selected for the analysis. These 20 participants led to the saturation of categories of perceptions within all the treatment modalities. Of the 20 participants, 12 initially agreed to (as a survey option) follow-up after the initial online survey response. However, at this time, the net yield from this follow-up response has been the single private survey response indicated, above. This aspect is further discussed in Chapter 5, Discussion section.

The study did not collect demographic data for participants indicating ethnic background, sex, age, or health status. This information was not expected to contribute to the analysis and nothing within the categorization, coding scheme, or subsequent analysis did indicate that such information might have been useful.

Materials

Materials – in the traditional sense of that which might be utilized as tools of an intervention – were not employed in this qualitative study measuring perceptions of psychotherapists. Information relating to the survey instrument, as well as to follow-up interviews and to secondary surveys is included in the next section.

This study did make use of the psytsurvey.online dedicated web site, programmed, published and maintained by the investigator. The site was maintained at https://liquidweb.com, with full support for backups and security oversite. The server runs on RHLinux 4.18.0 while using an Apache 2.4.54 web server. Survey forms are programmed using PHP 8.0.24, and the site's SQL database is MariaDB MySQL v. 10.5.17.

It was a goal of this study to proceed by electronic means. Email did provide the primary means of recruitment communication to participants, although some participants were alerted through messaging on social media platforms, predominantly twitter, https://twitter.com. In all such cases, any messaging subsequent to initial contact was by email, and through the investigator's Tiffin University email address, brandtmj@tiffin.edu.

Follow-up interviews were conducted according to the preference of the study participant and either by Zoom videoconference (https://zoom.us), Google videoconference (https://google.com), or by telephone. The investigator presented all three options without expressed preference. Any notes from follow-up interviews were transcribed within 24 hours after the interview and added to the study's database on the psytsurvey.online web server's database.

Measurement and Instruments

The study survey instrument (Appendix B) was a proprietary design specific to this study and not suggested by existing psychometric instruments. Its inclusion of open-ended questions allowing free-text input was intended to allow this survey instrument to serve with utility for collection of perceptual information in a non-naturalistic setting.

The survey's early revisions were circulated for feedback to selected academic psychotherapeutic professionals for input and were adjusted according to critiques returned to the investigator. The theoretical approach adopted in design of the survey instrument was one of a 'constructivist' approach to questioning – as opposed to an 'intensive interview' style (Charmaz, 2014, pp. 81-105).

The study attempted to elicit perceptions from psychotherapists from the perspective of an external observer to these processes, with this perspective not assuming professional knowledge directly applicable to the therapeutic interaction. In terms of the design of the survey instrument, as well as the content of follow-up interviews or follow-up questions, this perspective was maintained throughout to focus measurement onto perceptions of the therapeutic process independent of discernable levels of bias evident to the participants or translatable to the eventual analysis.

Procedure

The survey instrument described above was utilized as an initial point of entry as well as a collection instrument for qualitative data. Such a design approach could be considered unconventional but was employed for this study based upon considerations of time constraint as well as approachability to participants. The utilization of such non-naturalistic mechanisms

within qualitative research is not unprecedented, however, and an incidental discussion topic of this study involves the employment of this approach.

The study included professional psychotherapists practicing within the United States. Participants were vetted upon completion of the online survey instrument using the name and email information provided for purposes of informed consent, along with postal code provided in the survey, to ensure that their status as a professional and practicing psychotherapist was legitimate. Resulting participants had data selected for inclusion in analysis of the study based upon the content of the responses holding qualitative relevance to the questions asked. The description of the study included in the informed consent (Appendix A) did not make representations of inclusion of data in analysis based on completion of the online survey.

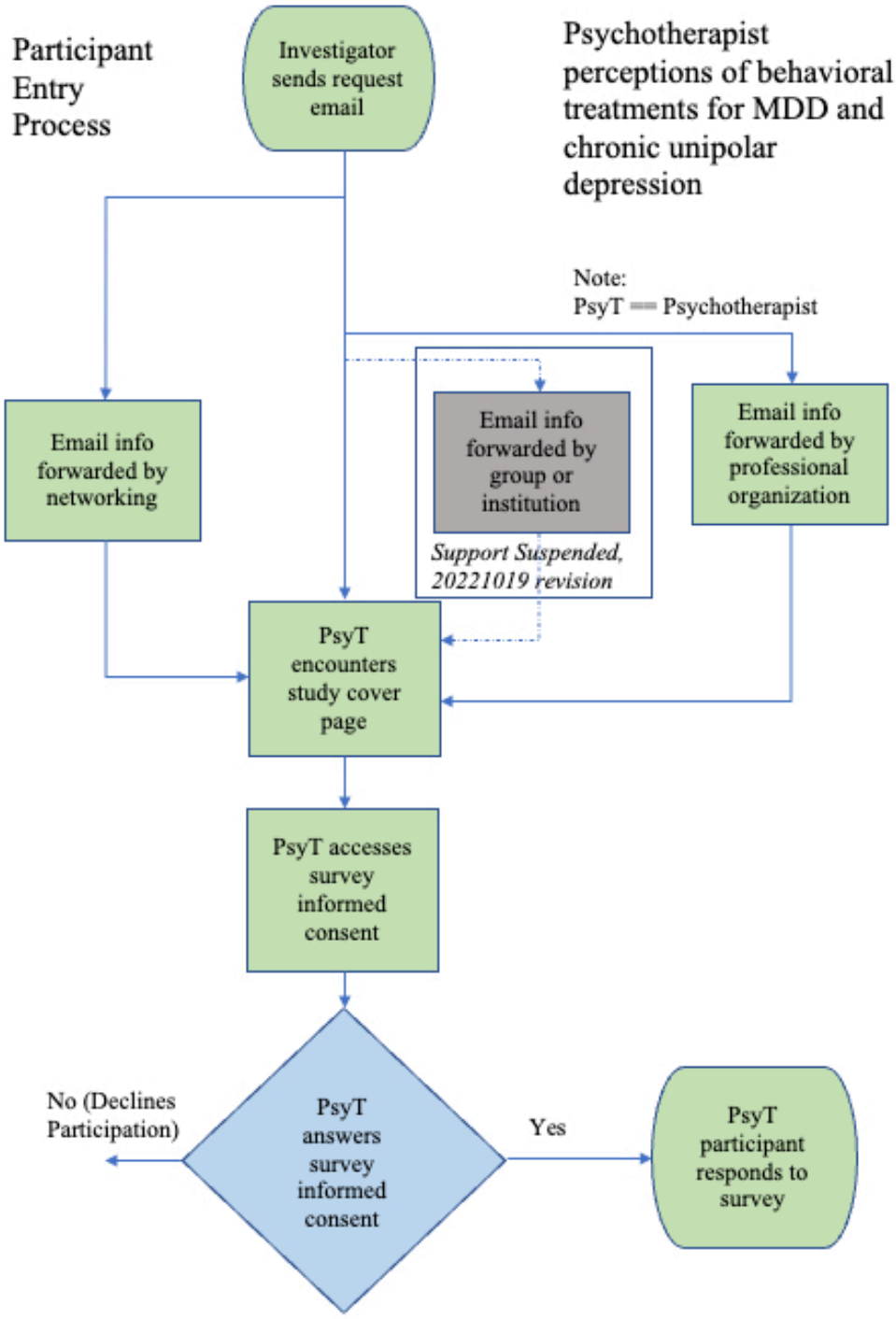
Participants delivering psychotherapeutic services from group or institutional practices were not utilized in this study. Conventions of informed consent for participation of such individuals and requiring (group or organizational) consent in writing prior to approval of the study resulted in such potential participants being not approved by the Tiffin University Institutional Review Board (10/21/2022). Participants for this study, therefore, are those delivering psychotherapeutic services from a private practice setting.

The initial contact requesting participation was made by means of an email from the investigator, Michael J. Brandt. This email was sent to one of two types of recruitment destinations:

1. Individual psychotherapy contacts for networking.
2. Professional organizations for contact to members.

A flowchart outlining participant entry is included, below:

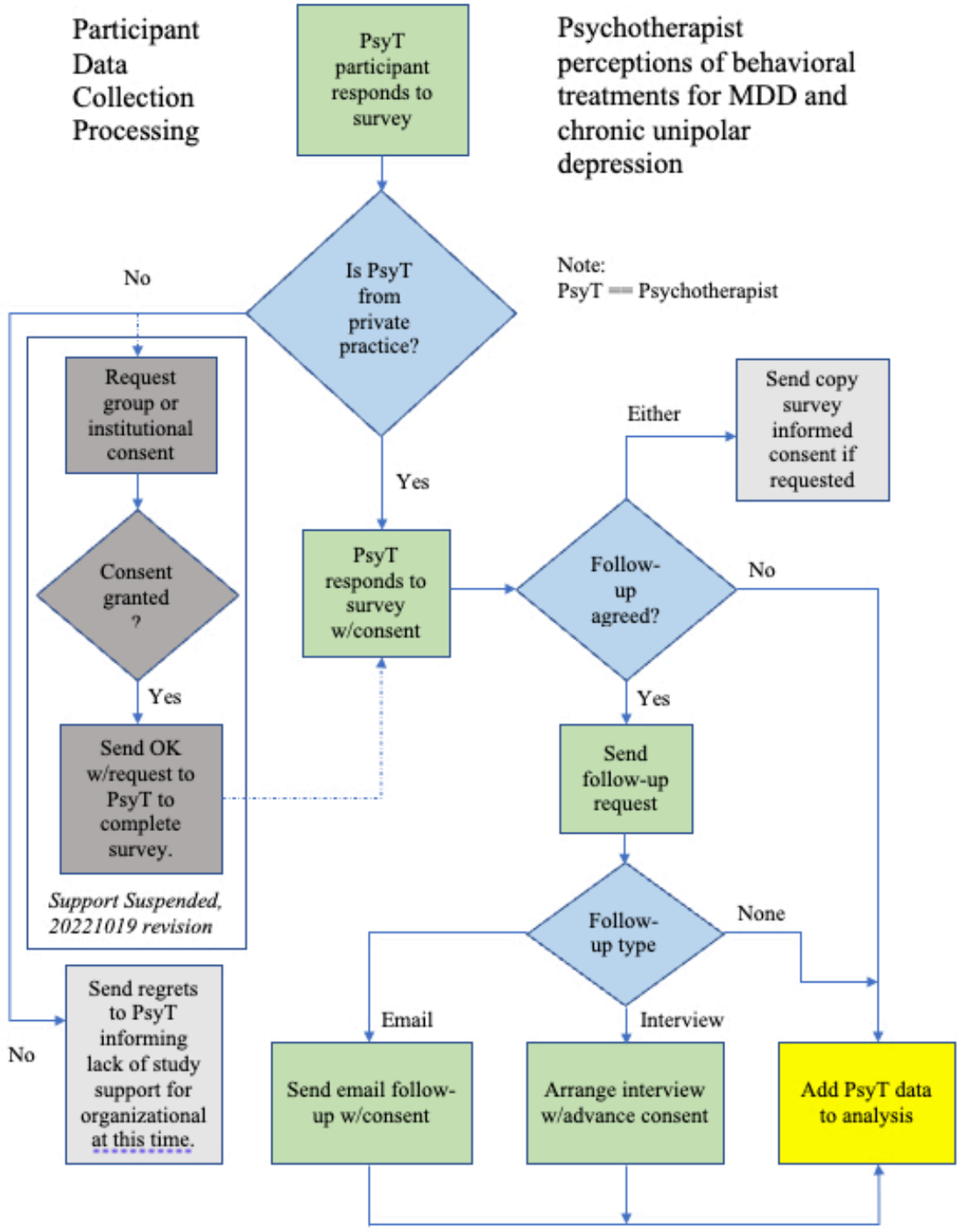
Figure 1



As evidenced in Figure 1, participants originated from one of two email routing paths but converged to the study cover page (on the psytsurvey.online site) and then passed through the survey informed consent as a condition of study entry.

A flowchart detailing the data collection process that ensued after study entry - inclusive of potential follow-up is included, below:

Figure 2



Records of all data transactions were recorded, and all data was preserved regardless of whether it is utilized in the study analysis. Utilization status was explicitly maintained within data storage. The study investigator attempted follow-up with all vetted participants submitting survey responses contributive to saturation in theoretical sampling and permitting a follow-up option upon survey submission.

Since most interaction occurred electronically and prompted by email or other messaging, scheduling considerations related to time of day were not significant. Follow-up interviews were arranged via email but were scheduled to the convenience of the participant.

Qualitative data collected from the survey instrument, as well as that from secondary follow-up surveys was assimilated within the SQL database on the psytsurvey.online web site server as it was collected. Additional qualitative data collected through follow-up interviews was added to the same SQL database. This practice was maintained for purposes of 1) A common study data repository, 2) A common data container capable of receiving scheduled daily backups, and, 3) A common data container receiving continual security oversite.

A log of recruitment and participant contact for the study during the period 11/7/2022 – 11/23/2022 was maintained upon the same psytsurvey.online web site server and was subject to the same backups and security oversite. Daily backups of analysis files performed offline were uploaded to the psytsurvey.online web site server and were also subject to backups and security oversite.

Data Analysis

Data analysis began as survey and follow-up data began to be accumulated on 11/10/2022. Qualitative data received in the form of survey responses were downloaded for categorization analysis on a workstation equipped with the ATLAS.ti software v22.2.0 (bld

3721) (atlasti.com, 2021). Data from new responses were combined to the existing analysis project array within the ATLAS.ti software and text was evaluated by the investigator/analyst while annotating its content with ‘memos’, i.e., records of ongoing analysis (Corbin & Strauss, 2015, pp. 106-119).

As critical amounts of data for definition of coding categories for participant perceptions were uncovered within treatment modalities of focus, coding maps were constructed, first preliminarily, and then resolutely, and according to a three-level, second-cycle grounded theory coding methodology described by Saldana (2021, pp. 301-319). This coding methodology included the following levels:

1. Focused coding (similar to open coding): Categorizing based on thematic or conceptual similarity.
2. Axial coding: Describing a focused category’s properties and dimensions while exploring how the categories might relate to each other.
3. Theoretical coding (also termed selective coding): Representing the discovery of central/core categories that illuminate the primary themes of the research.

Data analysis was applied continuously through 11/18/2022. Each iteration of analysis provided feedback to the process of theoretical sampling ongoing in participant recruitment (see ‘Participants’ and ‘Procedures’, above), and continuing in parallel with analysis. Each iteration of engagement in data analysis concluded with an upload of the ATLAS.ti analysis database to the psytsurvey.online web site server, in order to be subject to backups and security oversite.

Upon cutoff to data collection on 11/18/2022, the investigator/analyst applied the final versions of the coding schemes to the compendium of the study data, extracted (and ‘edited/scrubbed’ as necessary) quotations to be used in analysis and discussions phases, and

finalized the study data set as a preliminary step toward archival. The final ATLAS.ti analysis database was uploaded to the psytsurvey.online web site server.

CHAPTER 4

RESULTS AND FINDINGS

The survey form designed for purposes of the qualitative design was published online to the proprietary web site, psytsurvey.online, and was promoted to psychotherapy professionals across the Unites States via methodologies described in Chapter 3. Participants completing the informed consent (Appendix A) and then completing the online survey received a thank you message on the web page as the data that they entered was inserted into the web site's database for consideration to the study's analysis. As indicated in Chapter 3, the informed consent made no representations of inclusion of data to analysis based on this completion of the online survey.

Two other considerations did then apply. First, this study's approval did not allow inclusion of participants from group or institutional practices. For participants entering data at the web site and indicating such practice types, the electronic survey instrument collected brief information on their practice prior to display of an explanatory message indicating the inability to fully utilize their participation. These same participating individuals then did also receive a follow-up email message offering further explanation for this survey behavior (this tactic was well-received). Second, each remaining survey response was vetted based upon the information collected (firstname, lastname, email, at informed consent; professional degree, postal code, at beginning of survey) to check the validity of the response with respect to the qualification of the participant.

After these described participation and recruitment requirements were met, a sample set of 20 vetted professional psychotherapeutic practitioners were considered for analysis in the data set. All these 20 did report seeing patients within 'private practice'. Vetting processes served to confirm these assertions. This section will describe the attributes of the participants in this set as

well as the perceptions that they shared related to behavioral treatments for MDD and chronic unipolar depression.

Information About Participants and Their Practices

It was considered desirable to gather participants for this study from across professional designations capable of the application of psychotherapeutic modalities. The recruitment effort resulting in participation here fortuitously resulted in an equitable cross-section within the allowable online survey professional types. Table 1 displays the distribution according to allowable enumerated types.

Table 1

Participant professional type

Professional Degree	Participants
PhD/Psychiatry	0
MD/Psychiatry	0
PhD/PsyD/Psychology	7
LCSW/LCSW-R	1
LPCC/LPC	4
LMHC/LMHP/LMFT	4
MHNP/PMHNP	1
MS/MHC	2
other	1

Note: This data generated from online survey question 0.c (see Appendix B).

The lack of participation from psychiatric professionals, while unfortunate, might be predictable given the relatively small number of these individuals providing psychotherapeutic services within non-critical care environments. Aside from this (one) deficiency, the distribution achieved can be considered favorable, inclusive of significant representation of Doctor of Psychology participants. The single social worker is certainly indicative of the prohibition on

group and institutional participation for this study (without which that total may have been higher).

It was also considered desirable to attract participants from across diverse geographic regions if possible. Table 2 displays the distribution by state for participant primary practice. These locations were derived using the participant's practice postal code.

Table 2

Participant primary practice location

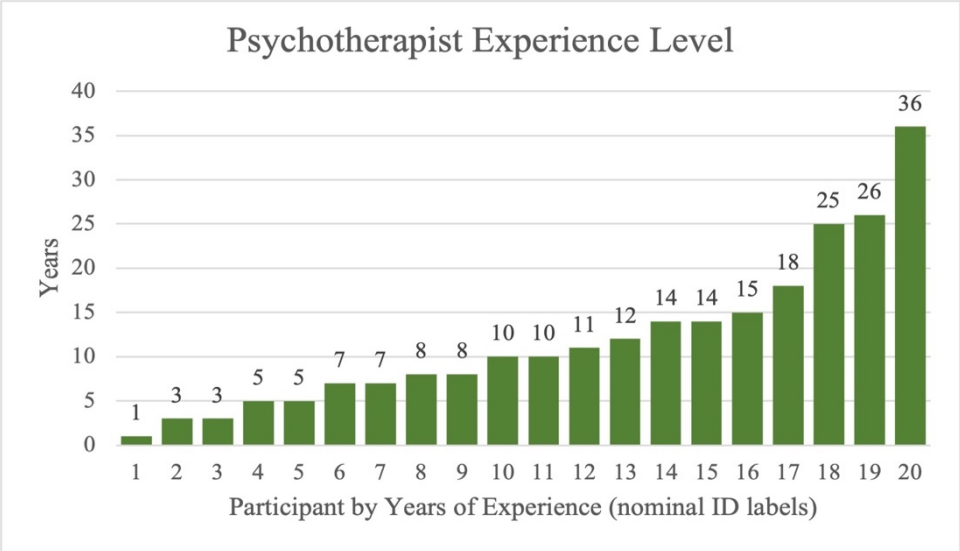
State (Location) of Practice	Participants
California	3
Colorado	2
Florida	1
Illinois	1
Indiana	1
Massachusetts	1
New York	3
Ohio	2
Pennsylvania	1
Texas	2
Washington	3

Note: This data generated from online survey question 0.e (see Appendix B).

The experience level of each participant was collected (in years practicing psychotherapy, total). A chart of these experience levels can be seen, below, in Figure 3, with participants arranged low-to-high according to experience and then assigned pseudo-id numbers, which will be utilized for purposes of subsequent explanation in results of this chapter.

Figure 3

Psychotherapist Participant Experience Level



Note: This data generated from online survey question 0.f (see Appendix B).

Please then note that subsequent descriptive statistics, along with thematic references of this chapter will maintain this relative assignment of 'pseudo-ids' for clarity across sections and outputs, i.e., the psychotherapist providers will continue to be individually identifiable by the nominal id number, above.

Participants reported their awareness of the online survey instrument such that effectiveness of recruitment efforts could be estimated for discussion purposes. Table 3, below, indicates reporting of these awareness types:

Table 3

Recruitment awareness

How did you hear about this survey?	Freq of Participants
Study investigator email or web message	18
Info from colleague (networking)	1
Other	2

Note: This data generated from online survey question 0.g (see Appendix B).

Information About Numbers of Patients and Visits

This study indicated to participants a requirement to track an approximate number of patients and patient visits they experienced each month within their practices for the conditions of MDD and unipolar depression. Figure 4, 5 display charts for patients/visits per month.

Figure 4

Patients Seen Monthly

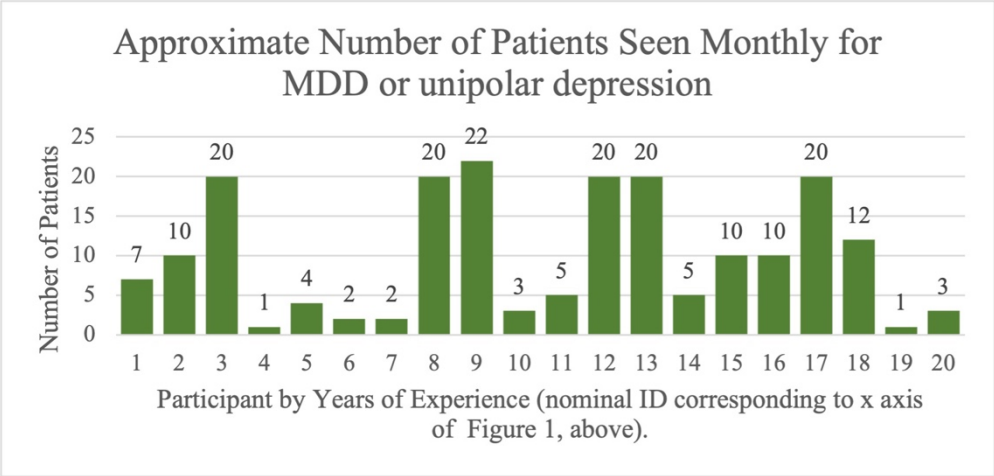
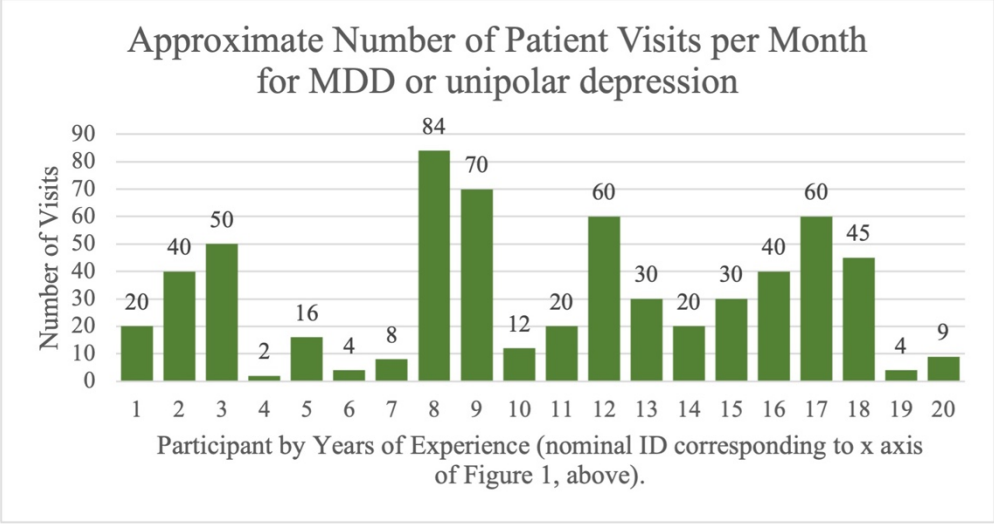


Figure 5

Patient Visits Monthly



Note: Figure 4 and Figure 5 generated from online survey questions 1a., 1b. (see Appendix B).

Information About Treatment Modalities for Patients with MDD or Chronic Unipolar Depression

Cognitive Behavioral Therapy (CBT)

This study's literature review had established CBT as prevalent for treatment of depressive illness (Cuijpers et al., 2014). Also discussed were the opportunities for further research cited from A-Tjak et al. (2021), and with respect to selection of appropriate treatment based on identified case type. The study from A-Tjak et al. (2021) differentiates CBT from other prevalent therapies based upon its identification and focus on dysfunctional attitudes, but stresses the need for data applicable to greater understanding of the mechanisms involved in the mediation of the disordered condition.

The participant sample from this study indicates endorsement of CBT as a treatment modality. Table 4, below, lists the results from the online survey:

Table 4

CBT Utilization from Participating Psychotherapists

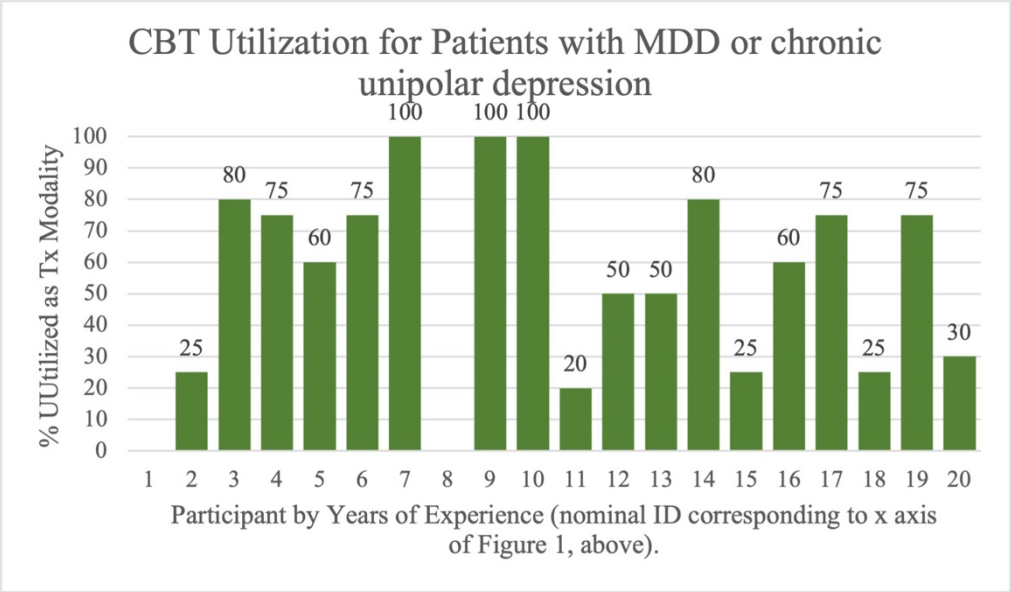
Do you use Cognitive Behavioral Therapy (CBT) as a treatment modality?	Yes (18/20)

Note: This data generated from online survey question 2ai. (see Appendix B).

Figure 6, below, indicates the percentage of utilization for CBT from those 18 participating psychotherapists employing this modality for patients with MDD or chronic unipolar depression.

Figure 6

CBT Utilization by Psychotherapist Participants



Note: This data generated from online survey question 2aii. (see Appendix B).

Thematic Analysis for Participant Responses (CBT)

Prevalent utilization of CBT for treatment of depressive illness as echoed within the responses of the participant sample resulted in remarkable levels of insight, evidenced within input to text questions 2aiii. – 2avi. (See Appendix B). Some participants offered responses exceeding hundreds of characters per question.

For treatment planning indications and moderators, some respondents stressed assessments or checks of physical health indicators as well as a check on medications. Most respondents indicated the need for requisite levels of awareness, engagement, and cognitive capacity, with negativity, dysfunctional and unhelpful thoughts a detriment important to the treatment planning. Respondent #6 adds: ‘Level of cognitive functioning, insight into automatic thoughts and the relationship between thoughts and feelings, patient willingness to participate

…'. The comments from the respondents indicate flexible opportunities for application to CBT, albeit those that must include careful considerations within the treatment planning approach.

Comorbidities are unsurprisingly dominated by anxiety considerations, but history of trauma as well as substance abuse and self-harm are common to the cited concerns. Participant #5 offers the following:

> '… intrusive and obsessive thoughts along with the presenting diagnoses. I feel that trauma is a core component that needs consideration regardless of diagnosis. A lot of the symptoms and experience I see with clients can be tied to traumatic events/experiences they have had …'

Other comorbid concerns are provided across the sample. Participant #10 enumerates the following: 'Anxiety, substance abuse, OCD, grief, PTSD, ADHD, personality disorders.'

Inquiry to the efficacy of CBT toward improvement and remission results in productive and diverse commentary - ranging from advocacy to more cautious perceptions advising consideration of patient characteristics: Participant #16 states, '… good (for CBT) but depends on individual client factors.' Many respondents indicate CBT utilization in combination with other treatments. Participant #9 intones, 'CBT alone hasn't been effective for my clients' improvement and remission rates, historically speaking. I'm almost always using another modality or training alongside CBT.'

There appears widespread consensus across the sample that CBT does aid remission. Participant #5 indicates that, 'I think it can help people to have tangible, actionable skills to utilize.' Participant #17 adds that, 'I find that it is largely effective in aiding persistence in remission.' The opinions are not unanimous, however, with Participant #18 favoring '… third-wave approaches like ACT or DBT when it comes to preventing relapses.'

Acceptance and Commitment Therapy (ACT)

This study's literature review had (also) established ACT as prevalent for treatment of depressive illness (Zettle et al., 2011). A-Tjak et al. (2021) provide differentiation to ACT from CBT based on its application of 'decentralized and experiential avoidance measurements'. Williams et al. (2022), additionally offer clarification on ACT, but with cautions inclusive of a lack of clear evidence for equivalency (or superiority) to CBT for treatment of depressive illness.

The participant sample from this study indicates endorsement of ACT as a treatment modality to a substantial degree (albeit somewhat less so than for CBT). Table 5, below, lists the results from the online survey:

Table 5

ACT Utilization from Participating Psychotherapists

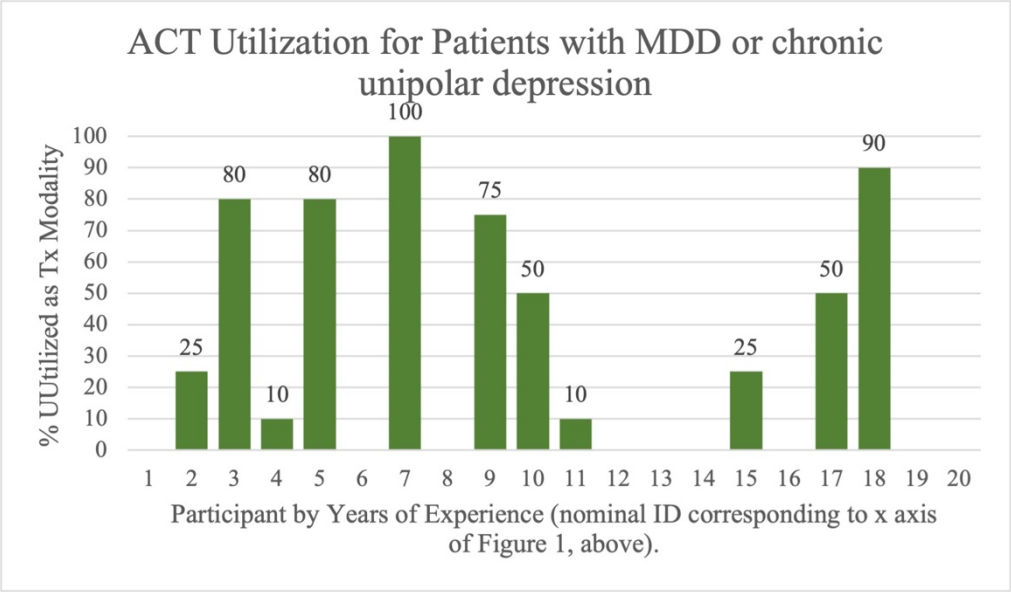
Do you utilize Acceptance and Commitment Therapy (ACT) as a treatment modality?	Yes (11/20)

Note: This data generated from online survey question 2bi. (see Appendix B).

Figure 7, below, indicates the percentage of utilization for ACT from those 11 participating psychotherapists employing this modality for patients with MDD or chronic unipolar depression.

Figure 7

ACT Utilization by Psychotherapist Participants



Note: This data generated from online survey question 2bii. (see Appendix B).

Thematic Analysis for Participant Responses (ACT)

Details concerning the utilization of ACT for treatment of depressive illness was echoed within the responses of the participant sample, resulting in levels of insight sufficient to saturate this category of analysis. This information was collected by text input questions 2biii. – 2bvi. (See Appendix B). The 11 participants indicating utilization of ACT offered varied input of significant length and quality.

With respect to treatment planning indications and moderators, participant emphasis shifted more strongly to the nature and severity of symptomology, along with the nature of intrusive and debilitating thoughts. A willingness to engage the therapeutic process is also stressed by more than one respondent. Participant #15 advises an indication for '… patient desire to feel better …,' but with a '… a demonstration of negative thought patterns …'.

Anxiety is (of course) typically cited as comorbid by respondents, along with trauma, but many additionally cite personality disorders as uniquely key while considering ACT as a treatment modality. Participant #9 lists '… difficulty with interpersonal roles …' while Participant #17 includes '… attachment wounds …'.

Efficacy to improvement and remission is perceived as accomplished through the application of the ACT treatment modalities through the '… normalization of thoughts …' (Participant #5). In contrast to responses for CBT, there is less consensus on the efficacy of ACT as a path to remission, with alternative emphasis on selective efficacy. Participant #2 elaborates:

> 'I believe that ACT works really well for some clients but can be difficult to apply for others. I tend to see that clients who lean into mindfulness have an easier time with ACT skills than those who prefer a more cognitive approach.'

A tendency to also advocate cautiously for ACT in terms of aiding persistence of remission is evidenced across the sample. Respondents voice agreement that skills acquired by the patient tend to aid remission but some voice concerns that remission states are not reliable for patients treated by ACT as a stand-alone therapy. Participant #5 advocates pairing ACT with mindfulness and Dialectical Behavioral Therapy (DBT) approaches, while Participant #11 cites utilization of ACT '… as an adjunct, in conjunction with psychodynamic/relational/emotion-focused work.'

Humanistic/Experiential/Person-centered therapies (HEP)

References of Chapter 2 include the meta-analysis from Elliott et al. (2013), finding equivalence in outcomes for HEP psychotherapies in treatment of depressive illness. That same section includes mention of emotion-focused therapy (EFT) as an alternative or accompanying treatment modality.

The participant sample from this study indicates substantial utilization of EFT therapies as treatments for depressive illness. Table 6, below, lists the results from the online survey:

Table 6

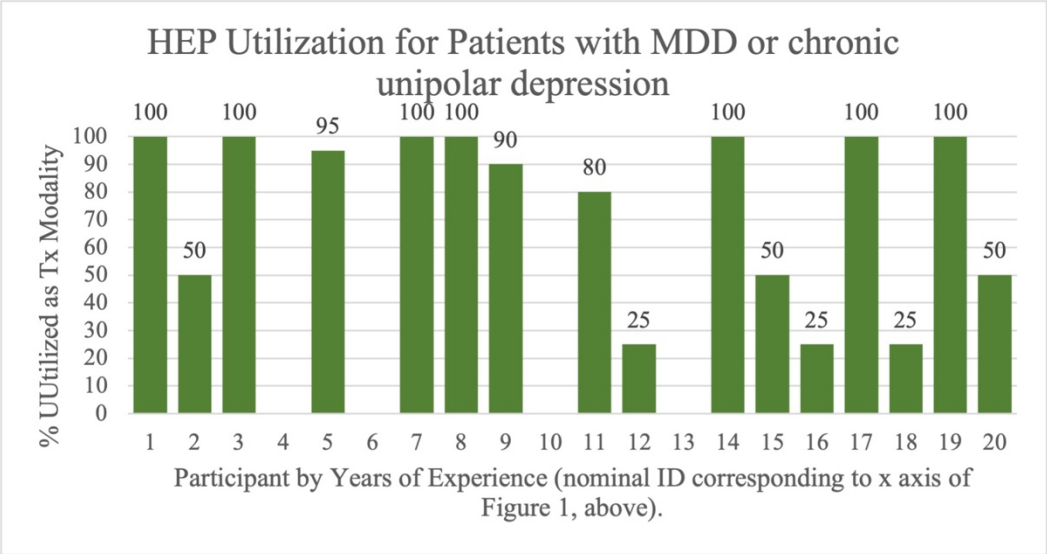
HEP Utilization from Participating Psychotherapists

Do you utilize Humanistic/Experiential/Person-centered therapies (HEP) as treatment modalities?	Yes (16/20)

Note: This data generated from online survey question 2ci. (see Appendix B).

Figure 8

HEP Utilization by Psychotherapist Participants



Note: This data generated from online survey question 2cii. (see Appendix B).

Figure 8, above, indicates the percentage of utilization for HEP from those 16 participating psychotherapists employing these modalities for patients with MDD or chronic unipolar depression.

Thematic Analysis for Participant Responses (HEP)

The level of employment of the Humanistic, Experiential and Person-centered therapeutic approaches reported was very significant in endorsement number (16/20), and also evidenced of several high percentages (7/20 participants utilizing these approaches for 100% of cases). These summary numbers lend significant insight to the prevalence of humanistic approaches within the landscape of treatment for depressive illness.

Within the context of treatment planning, considerations stressed by respondents are focused on issues pertinent to treatment delivery, with Participant #12 citing 'the therapeutic relationship', while Participant #16 stresses 'relational factors.' Respondents indicate a treatment planning focus on the patient's self-concept, with Participant #15 advising observations to '… low self-esteem; poor self-image; low social support; low self compassion; history of trauma'.

Comorbidites (once again) include anxiety, trauma, and substance abuse history, but respondents also include emphasis here for 'panic disorder(s)' (Participant #1), along with stress disorders. Participant #14 adds that, '… PTSD seem(s) to have a very strong impact on their self esteem and self worth.'

With respect to efficacy, respondents were universal and effusive in their endorsement of HEP methodologies, although some did caution that against sole reliance on these modalities. Participant # 9 indicates, 'It is not effective as a sole therapy,' while Participant #17 provides the qualification of '… most helpful with comorbid trauma of some sort.' The widespread support for these approaches in the sample, along with the descriptive nature of the responses should not

be minimized, however, especially when considering that this study's literature review did not reveal a wide body of evidentiary knowledge detailing study into efficacious effects for HEP with respect to treatment of depressive illness. Participant #1 opines:

> 'I believe a humanistic approach is highly effective for the treatment of MDD because it looks at the whole person and addresses factors that influence depression such as sleep, nutrition (gut health), and exercise. In addition, it provides a window into understanding the role(s) the client plays that is not in alignment with their true or authentic identity.'

An insightful set of perceptions related to the efficacy of HEP approaches are submitted by Participant #15, offering the following:

> 'HEP appears to be beneficial with most of my patients, particularly those who have not been in therapy before, have not had good therapeutic experiences, and those who don't have much social support. It is also beneficial for patients who have low opinions of themselves or who have difficulty expressing themselves for fear of judgement. It provides them with a forum to be able to be themselves and to verbalize or discuss things they may not have been otherwise. It can help them to feel supported and to see that someone will accept them without judging and that they are someone who matters.'

With respect to the support of remission states, respondents are not as committal as with efficacy to improvement and remission, itself. Participant #19 intones 'I think it's not as effective for remission, but for returning to therapy if needed.' Participant #18 offers that HEP modalities '… can be useful in cases of less severe depression.' And Participant #15 replies that '… HEP can help a person to become better at expressing themselves or less fearful of doing so. It can help them have more positive views of themselves.'

The high utilization percentages indicated across 16 of 20 participants would then indicate widespread acceptance of the application of HEP modality application toward the treatment of depressive illness, while comments would position is as either a first choice for selected patients or as a consistently applied adjunctive therapeutic approach.

Other Treatment Methodologies Utilized

The online survey anticipated that psychotherapists might employ a variety of other treatment methodologies while addressing the needs of their patients presenting with depressive illness. The literature review for this study references Shafran et al. (2009), with finding that 69% of the providers in the United States utilize CBT, but only part-time or in combination with other therapies. Rossberg et al. (2021) conducted a study examining a treatment phase of 28 weeks combining CBT with psychodynamic approaches.

The participant sample from this study indicates varied utilization of alternative therapies as treatments for depressive illness. Table 7, below, lists the results from the online survey:

Table 7

Utilization of Other Treatment Methodologies from Participating Psychotherapists

Other methodology utilized (if any)?	Yes (5/20)

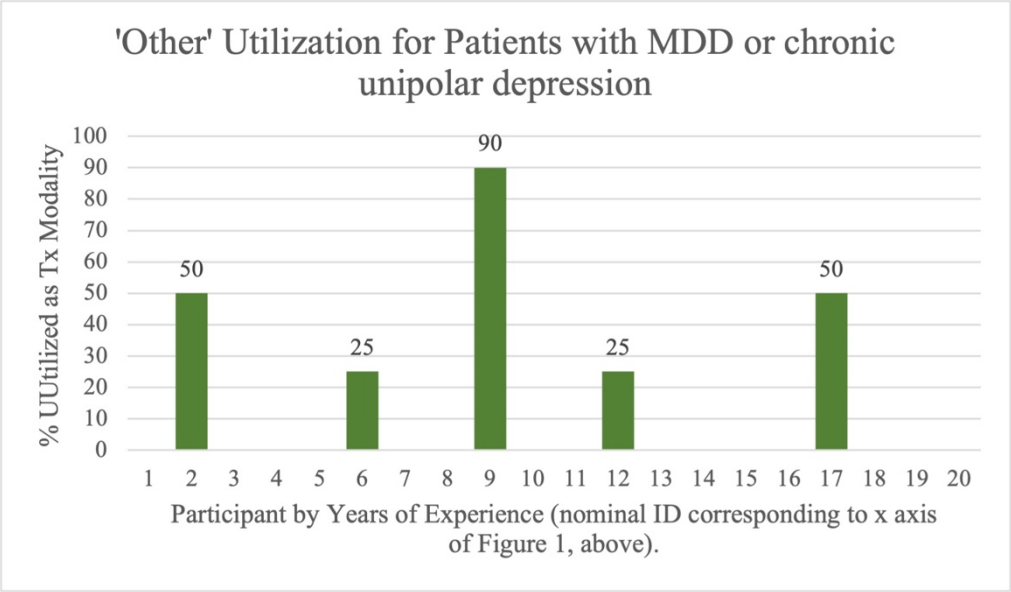
Participant Id	Tx Modality Specified
2	Shame informed treatment
6	Mindfulness training
9	Dialectical Behavior Therapy
12	Psychodynamic
18	EMDR and Parts work/Ego State work

Note: This data generated from online survey question 2di. (see Appendix B).

Figure 9, below, indicates the percentage of utilization for these other methodologies from those 5 participating psychotherapists employing these modalities for patients with MDD or chronic unipolar depression.

Figure 9

Other Treatment Utilization by Psychotherapist Participants



Note: This data generated from online survey question 2dii. (see Appendix B).

Thematic Analysis for Participant Responses (Other Treatment)

5 of 20 participants indicated applications of other treatment methodologies utilized in their practices as interventions to MDD or chronic unipolar depression. Accompanying perceptions related to the application of these modalities were offered by all of these 5 participants.

Participant #2 indicated utilization of 'Shame informed treatment' for 50% of cases covered by the online survey (i.e., MDD and chronic unipolar depression). This treatment intervention, not generally well-known, is explained by Ng (2020) to originate in Eastern therapeutic traditions and to involve the 'reframing' of harmful shame states internalized by a patient, to enable the ability to move forward into a liberated state, unencumbered by self-limitation. Participant #2 indicates a choice of treatment planning for this modality while observing '… comparison to others, negative self perception, negative core beliefs, (and)

avoidance.' Participant #2 is a staunch advocate for this modality (indicating relative percentages of utilization 25/25/50/50 CBT/ACT/HEP/Other (Shame informed)). Participant #2 offers the following in commentary:

> 'This is the most helpful treatment modality I've found. My clients tend to overall improve as they build positive self-regard and self-compassion because they start to accept themselves fully.'

Participant #6 reports utilization of 'mindfulness' approaches for approximately 25% of patient cases covered by the online survey. This participant elucidates the rationale for inclusion while indicating treatment planning concerns for '… patients being willing to pay attention to thoughts and feelings, practice sitting quietly, etc.' Participant #6 does not portray a 'mindfulness' approach as anything but adjunctive, indicating that '… it can be somewhat helpful …' but '… I don't see mindfulness alone as enough to support remission.'

Participant #9 provides resounding endorsement for Dialectical Behavioral Therapy (DBT) and estimates their utilization at approximately 90% of cases covered by the online survey. DBT is utilized widely as an alternative to other cognitive behavioral therapies, typically for cases involving comorbidities of personality disorders. Although its theory and application falls outside the scope of this study, it might be indicated that quantitative meta-analyses examining the efficacy of DBT for cases of depressive illness (and similar to those cited in the Chapter 2 Literature Review for the interventions included in the online survey) have been published. Panos et al. (2014) offer indications of efficacy utilizing DBT for treatment of depression in specialized populations of patients and as compared to treatment as usual (TAU) (the Panos study focuses on patients presenting comorbidly with Borderline Personality Disorder (BPD)). Participant #9 advocates for DBT while treatment planning and observing '… emotion

dysregulation …' as key. They indicate '… suicide ideation …' as a comorbidity, and intone 'I think DBT is incredibly effective.'

A psychodynamic approach is included for approximately 25% of applicable cases by Participant #12 while indicating that 'Level of insight, life experiences, (and) a desire to go into more depth in therapy …' can be important while assessing a patient with depressive illness. Although some advocates for psychodynamic approaches tend to be vociferous in support for the psychodynamic (commensurate with background in psychoanalytic training), Participant #12 rather pragmatically describes the efficacy of the psychodynamic modalities within their practice for patients of depressive illness to be 'moderate'.

Participant #17 describes utilization of Eye Movement Desensitization and Reprocessing (EMDR) intervention, along with 'Ego State' work as intrinsic to approximately 50% of their work with patient cases covered by the online survey. A study out of the UK finds efficacy for EMDR in treatment of long-term depressive illness (not a clinical trial but a quasi-experiment) (Wood et al., 2018). Although the theory and application of EMDR is beyond the scope of this study, it is known to be utilized a great deal for patients comorbid of panic disorders and PTSD. The principal investigator of this study did note a significant percentage of psychotherapists treating depressive illness and claiming to utilize EMDR within their practices during recruitment phases for this study. Participant #17 indicates that EMDR can be '… used with CBT and HEP approaches,' and that they find the efficacy to be high both for improvement to remission and sustainability of the remission state.

One participant (#7) reported on the positive effects of ketamine therapy. This participant's responses to other phases of the online survey were entirely valid within the scope of behavioral treatments, but commentary on ketamine were ignored for purposes of this study

(they are noted here, however, for any reader that may access the participant online survey entry items separately). It is additionally noteworthy that this survey respondent did not report being a psychiatrist or medical doctor, but was vetted as a licensed psychotherapist, so most assuredly was referring to infusion services that their patients were referred into.

Information About Follow-up for Patients with Major Depressive Disorder (MDD) or Chronic Unipolar Depression

The online survey elicited information from psychotherapist participants relating to follow-up for patients after discharge from treatment. The results from survey questions related to follow-up are displayed in Table 8, below:

Table 8

Follow-up Options Available After Discharge from Treatment

Does your practice provide follow-up after discharge for these patients?	Yes (12/20)

Follow-up Type	Frequency
Email/text	7
Telephone	1
other	4
other consideration	1

Note: This data generated from online survey questions 3a., 3b. (see Appendix B).

Analysis of Participant Perceptions Regarding Patient Follow-up

A majority of twelve respondents reporting practices featuring follow-up with patients post-discharge offered full-featured commentary for perceptions on these services. Participant #3 (whose practice follow up by email/text) offered that '… it seems to be effective, as long as I am talking about discharge with them and planning it several weeks ahead of time at least.' Participant #14 (email/text) indicates follow-up as protective from '… a common experience (of)

suffering … of being alone. I find that follow up assists with that.' Participant #7 (other) provides the novel practice approach of '… tapered visits through 1 years after completing treatment … (this) would be my recommendation for improvement.' More than one respondent alludes to reminders. Participant #2, includes that '… sometimes our clients forget that these skills can be utilized a million different ways and a little nudge to adjust how they address stressors is usually all that they need.' Also, Participant #2 advises that '… management of remission could be improved with short sessions designed to tackle everyday stressors after treatment.'

Participant #'s 15 and 18 both inform that they do not conduct follow up but do always advise patients of an 'open-door' policy post-discharge. Participant #8 responds that discharge and follow-up is too cumbersome at present and would prefer upload into a 'cohesive, national medical system (that) could allow better tracking/follow up.'

Secondary Coding and Analysis

The responses of the twenty participants considered within this chapter resulted in the analysis above, inclusive of a 'focused coding approach'. This approach resulted in the generation of a thematic analysis 'codebook' (Appendix D). This codebook was then utilized for more in-depth analysis across the larger expanse of online survey responses while considering this study's research questions. This secondary phase of analysis consisting of 'axial coding' was engaged, suggested by the study's research questions while in conjunction with the processes observed via the responses to the online survey.

The predominant thematic concept providing focus and pivot to the grounded theory aims of the analysis at this secondary juncture would be that consistent tendency of individual participant psychotherapists to integrate treatment modalities at the patient level. This integration

is perhaps best evidenced within the analyses above while summing approximations for percentages of treatment modalities applied from participant to participant. In virtually every case, these percentages sum to greater than 100%. It was intentional that the online survey instrument would not enforce a restriction, here, as it is naturally intuitive that this percentage would be greater (across each participant's patient family). This then could lead to the logical assumption that each psychotherapist is combining therapies – while indicating within their perceptions/comments that they are (in fact) doing so to the full benefit of patients presenting with MDD or chronic unipolar depression.

Therefore, the natural progression of secondary coding and analysis (utilizing an axial approach) would be to coalesce the observations from the individual treatment modalities onto patterns more closely resembling an integrative vision of the psychotherapist provider. This secondary analysis proceeds below utilizing diagrammatic forms.

Treatment Planning Considerations for Patients with MDD or Chronic Unipolar Depression

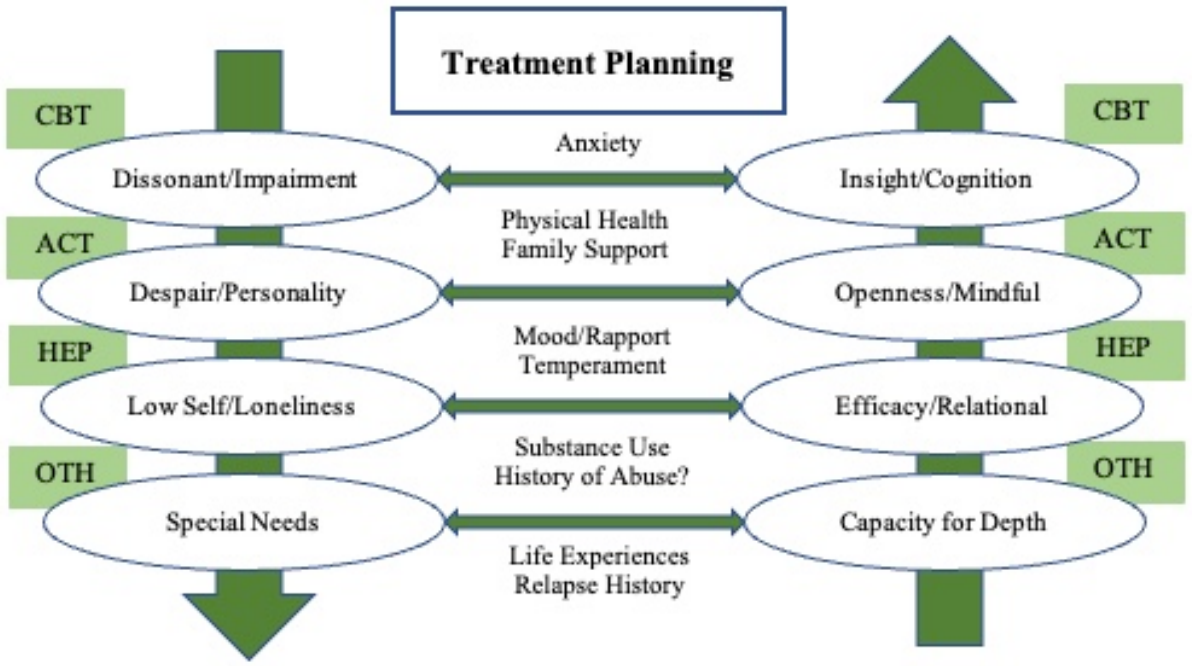
Coalescence of thematic elements gathered during observation of the psychotherapeutic process utilizing the online survey instrument and in terms of treatment planning were engaged using the codebook generated (Appendix D). A resulting diagram appears below in Figure 10.

One might note from this diagram a variety of visual conventions adopted as follows: 1) Treatment methodologies included within this study have been assembled at the left and right margins as for concurrent consideration and as may be appropriate to a given patient's needs, 2) A down arrow-grouped assemblage of ovals adjacent to (light green) treatment tabs indicate less favorable considerations, 3) The middle region lists concerns that are found to be common to all treatment planning scenarios for MDD and chronic unipolar depression, regardless of treatment modality, and in no particular order, and 4) An up arrow-grouped assemblage of ovals adjacent

to (light green) treatment tabs indicate more favorable considerations to take into consideration during the treatment planning process.

Figure 10

Treatment Planning Analysis from the Psychotherapist Perceptual View



Note: This phasic view was generated utilizing the study codebook of Appendix D.

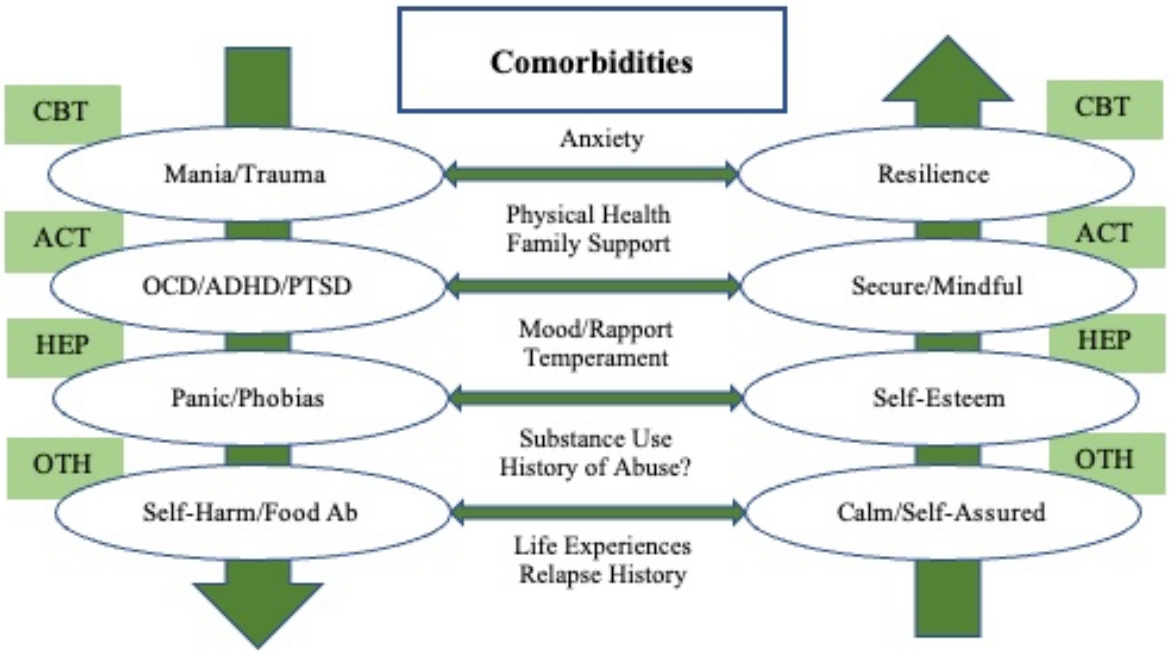
The secondary analysis for treatment planning is intended to offer an overview of that which has been extracted and conditioned as a benefit of the codebook and resulting axial coding analysis. It is not intended to represent a 'one size fits all' depiction for a treatment planning process of the psychotherapeutic professional, but a 'phasic' page derived from treatment planning terminology. Such an aspiration would not be in keeping with the axiology of this study, nor appropriate to the simple observation that can be noted from the tables and figures above. Not all psychotherapists utilize all methodologies or theoretical approaches to their patients. This assertion applies but (then) is not limited to treatment planning considerations.

Comorbidity Considerations for Patients with MDD or Chronic Unipolar Depression

In similar fashion to that employed for treatment planning, Figure 11, below displays coalescence of thematic elements gathered during observation of the psychotherapeutic process utilizing the online survey instrument and in terms of perceptions related to comorbid conditions. This figure follows like conventions to those of Figure 10.

Figure 11

Comorbidity Analysis from the Psychotherapist Perceptual View



Note: This phasic view was generated utilizing the study codebook of Appendix D.

Figure 11 notably includes identical attributes down the middle region of the diagram to that of Figure 10. This is to reinforce that these considerations have been perceived by psychotherapists as constants of clinical practice for patients presenting with MDD or chronic unipolar depression. As stated above with respect to the treatment planning diagram, Figure 11 is not intended as a ‘one size fits all’ depiction of the psychotherapeutic perception of comorbidity

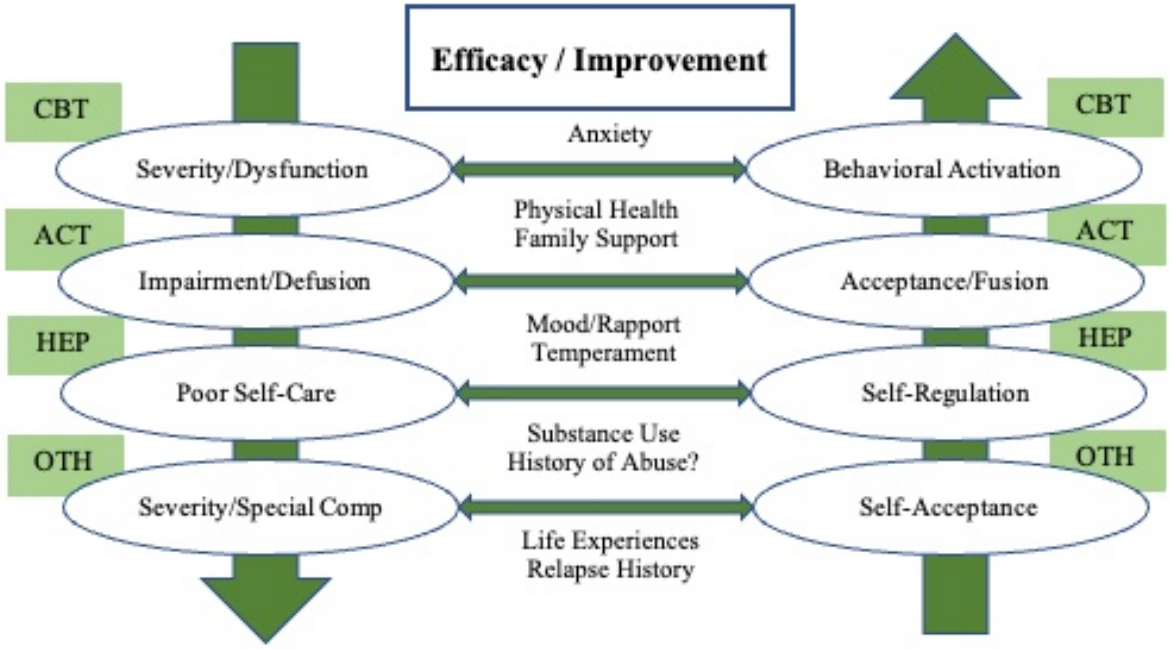
assessment but rather, a phasic page of available perceptual options derived from the community – a subset of perceptions generated from the axial analysis.

Treatment Efficacy Considerations for Patients with MDD or Chronic Unipolar Depression

In like fashion to that employed above, Figure 12, below displays coalescence of thematic elements gathered during observation of the psychotherapeutic process utilizing the online survey instrument and in terms of perceptions related to treatment efficacy to improvement and towards remission. This figure follows like conventions to those of Figures 10 and 11.

Figure 12

Efficacy to Improvement Analysis from the Psychotherapist Perceptual View



Note: This phasic view was generated utilizing the study codebook of Appendix D.

One will note the persistence of the middle region attributes, these representing perceptions of psychotherapists observed ubiquitous across all considerations and for all

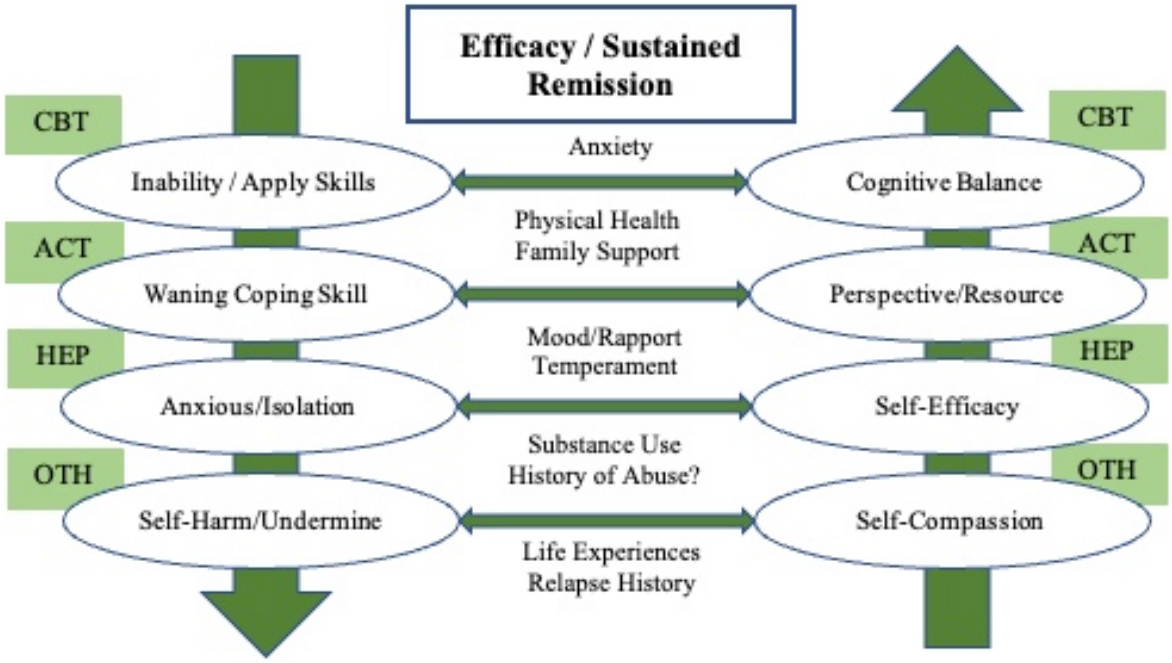
dimensions of process. One might also begin to interpret translation across chronologic process dimensions of the psychotherapeutic process and as expressed from perceptions.

Efficacy in Remission Considerations for Patients with MDD or Chronic Unipolar Depression

In like fashion to that employed above, Figure 13, below displays coalescence of thematic elements gathered during observation of the psychotherapeutic process utilizing the online survey instrument and in terms of perceptions related to treatment efficacy in remission. This figure follows like conventions to those of Figures 10, 11, and 12.

Figure 13

Efficacy in Remission Analysis from the Psychotherapist Perceptual View



Note: This phasic view was generated utilizing the study codebook of Appendix D.

Once again, the persistence of the middle region attributes are evident indicating that according to interpretation of psychotherapist perceptions, all these factors remain for patients after discharge, and even as they were upon initial patient presentation.

Validity of Analysis

As noted in Chapter 3, this study set a preliminary goal to achieve 20 – 30 participants contributing to analysis. That goal was in concert with sampling guidelines from Creswell and Poth (2018, pp. 158-160), while exercising techniques of 'maximum variation sampling' in pursuit of saturation of categories. There is ample reason upon completion of analysis phases depicted in this chapter to assert that validity was achieved – not only within the context of the 20 participants gathered and then vetted, but also as can be detected by the saturation of treatment categories across online survey question types.

Acceptance of the online survey format could be generally asserted favorable within the scope of qualitative content and via the liberal style of input response volunteered by participants. There does remain, however, concerns related to the unusual use of an online survey for the execution of grounded theory analysis and as a departure from the 'naturalistic setting' of interaction that might occur with interviews. This aspect as related to validity of findings (and as related to the novel nature of this research study) will be discussed further in Chapter 5.

Still pending at this juncture are follow-up options engaged by participants in the form of interviews or private surveys based on initial responses (due to recruitment and participation time constraint windows), and with these features of the methodology as attempts to offer more full-featured dimensions to the grounded theory analysis within the spirit of triangulation of qualitative content (Cho & Lee, 2014). A small number of these follow-ups are anticipated to be completed and then to be included as an amendment to this analysis section prior to final draft.

Conclusions of Results and Findings

Results are presented in this chapter from the axiological perspective of the investigator while adopting the role of an observer not assuming professional knowledge or credentials within clinical psychology or its processes. The online survey instrument had been developed during research appropriate to formulation of open-ended questions intended to elicit responses appropriate to expose the process of psychotherapist participants. This online survey was then reviewed with individuals that were professionals within that field (one being the faculty advisor for this research study).

The analysis presented in this Chapter 4 exposes descriptive statistics for the psychotherapist participants intended to advise of the appropriateness of the qualitative sample and then delivers qualitative analysis on two levels: First, a focused coding approached, utilized to categorize responses based upon the open-ended question structure of the online survey was engaged, while developing thematic contents and developing the contents of the study's codebook (Appendix D). Second, a process-oriented phase, suggested by the tendencies of the psychotherapist participants to position their acquired skill sets to the characteristics of their patients was engaged. Axial coding techniques utilizing the acquired codebook were employed to construct phasic process figures serving to illustrate the interaction of coded components while transcending the focus away from individual treatment methodologies. A third and theoretical transformation to this same qualitative data will provide content to Chapter 5 and the discussion of findings constituting a theoretical structure.

CHAPTER 5

DISCUSSION

The purpose of this study was to describe a theoretical structure for treatment selection and application of behavioral interventions by psychotherapists to patients with MDD or chronic unipolar depression and directed to goals of improvement, remission, and preservation of the remission state. The study employed a grounded theory design within a unique online survey format, featuring open-ended questions designed to elicit perceptions of psychotherapists relating to their work processes and the effectiveness of treatments employed during this work to the goals enumerated above.

Both the level of participant response, as well as the quality of the responses (as mentioned in Chapter 4) were better than adequate for purposes of the study and its thematic analyses, even as both key study factors had represented study design concerns. The quality of online survey responses was found to be sufficient for thematic analysis with capability of the generation of a codebook of terminology and subsequent secondary analysis utilizing axial coding techniques.

Discussion below will include key findings of the analysis of the previous chapter, along with presentation of a theoretical model describing the work processes of the psychotherapeutic community while conducting treatment for MDD and chronic unipolar depression. This theoretical model may provide utility in the research domain as basis for more concise investigation of the efficacy of behavioral interventions to depressive illness. It also may serve as a template for the development of similar models of treatment processes in mental health service from perceptual data gathered of therapeutic service providers for alternative conditions of mental illness.

The Composition of the Study Sample

Aside from the observations of Chapter 4 that were related to the sample of the 20 participants, and in consideration of professional designation, primary practice location, experience level, and reported source of study recruitment awareness, it bears mention that neither any ensuing analysis nor discussion of perceptual data will attempt inference based on any of these descriptive variables. The perceptions of all participants therefore are deemed equivalent in value.

A rationale for this approach might be supported through consideration of the landscape of delivery within psychotherapeutic services in the United States. Table 9 lists 2021 statistics for ‘Mental Health Workers’ in the United States compiled by the Bureau of Labor Statistics (bls.gov, 2022). While the titles included do not precisely correspond to the professional designations utilized as qualifiers in the present study, the table does reveal insight to the substantial numbers and qualification diversity for individuals providing mental health services inclusive of those professionals that could have participated in a study of the current type. Some percentage of the approximate one-half million therapists counted in the BLS estimate may not include depressive illness in their covered services, but the recruitment phase of this study served to indicate that inclusion of treatment for adult depression by psychotherapists did constitute a high percentage of the psychotherapeutic professions.

Table 9

US Bureau of Labor Statistics Estimates for Mental Health Worker Professions, 2021

Professional Designation	Estimated Number
Psychiatrists	25,520
Clinical and counseling psychologist	58,100
Mental health and substance abuse social workers	113,810
Substance abuse, behavioral disorder, and mental health counselors	310,880

Note: This data referenced from listings at bls.gov (2022).

Additional support for an integrated sample of professional designations resulted during recruitment for this study, while encountering numerous group practices, and then taking the opportunity to quickly peruse their provider makeup, typically composed of one or two psychologists along with other designations of a slightly higher frequency (such as Licensed Professional Counselor, Licensed Mental Health Counselor, or Licensed Clinical Social Worker). Elsewhere, the researcher can utilize an example of an institutional mental health practice at the University at Buffalo, buffalo.edu (2022), inclusive of clinical psychologists, along with staff psychiatrists, licensed mental health counselors, licensed social workers, graduate assistants, and interns.

It is the expectation that (not only) within group environments but also within psychotherapeutic communities of geographic areas, that collaboration (inclusive of educational opportunity) and across professional boundaries is commonplace. Patients then may benefit from the services of more than one provider as resolution to their case is sought. Referrals across professional boundaries would also be expected to occur.

The psychotherapeutic community in the United States, then is large and both diverse and diffuse. The analysis of Chapter 4 did reveal, however, remarkable levels of insight originating from participants of all professional levels. All these factors would indicate that a consideration

of a sample heterogeneous of professional designations was a valid choice for the present research study.

An Observed Holistic Approach to Psychotherapeutic Practice

The first notable finding unanimously evident across participants in the sample was the practice of integration of treatment modalities according to both patient presentation and those available within that provider's training and experience. The evidence of this finding abounds: Participant #11 includes, '… I primarily use CBT as an adjunct, and for patients with less capacity for dynamic/emotion-focused work…'. Participant #5 indicates of ACT that, 'I have seen this approach be quite effective when paired with mindfulness based approaches and DBT.' As indicated in Chapter 4 in 'Other Treatment Methodologies Utilized', psychotherapists additionally may seek opportunities to integrate novel treatment modalities or emerging approaches to existing modalities for the benefit of their patients.

This observed phenomenon of integration could be taken as an assumed aspect of psychotherapeutic practice but it should be considered fundamental within the assessment of the process as described by this study, as the psychological research literature exhibit analyses intent on the examination of efficacy only from the perspective of theoretical definitions for discreet treatment modalities (A-Tjak et al., 2021; Cuijpers et al., 2014; Elliott et al., 2013; Zettle et al., 2011).

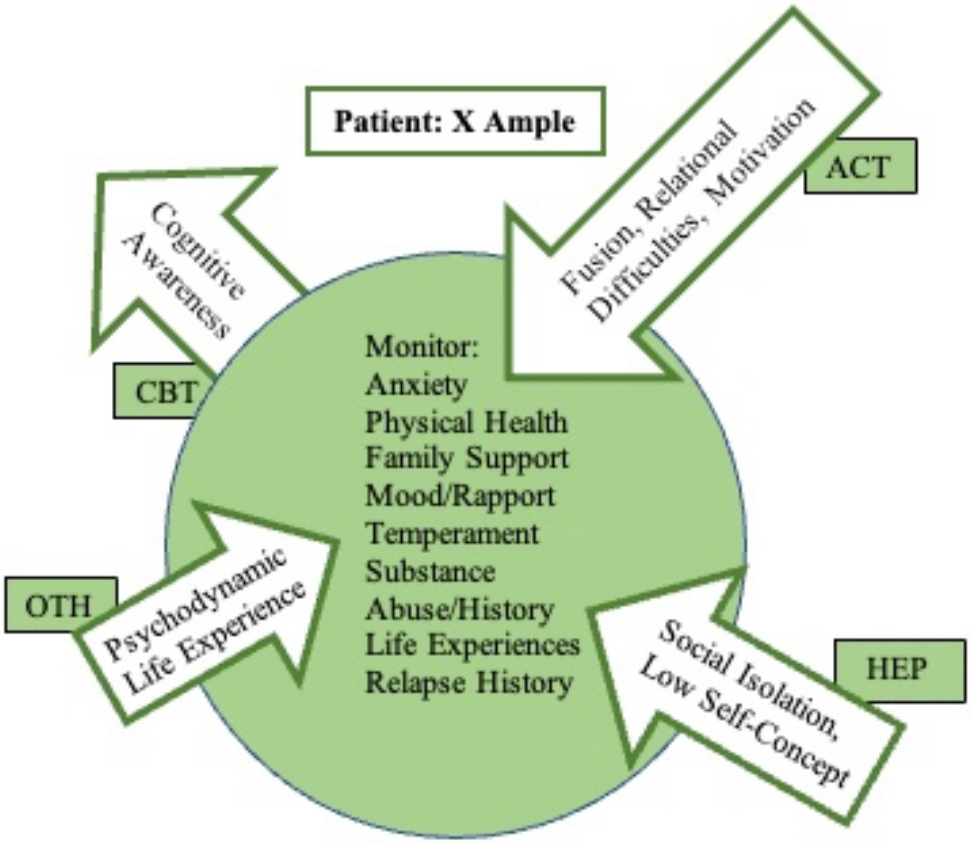
Formulation of a Theoretical Structure: The Transvector Model

The sections containing Figures 10, 11, 12, and 13 of Chapter 4, along with their associated analyses and derived from axial coding technique provide coalescence of thematic elements gathered at the level of treatment modality and then mapped onto core considerations of treatment planning, comorbidities, efficacy toward improvement of condition, and efficacy toward preservation of remission after treatment, respectively. The axial coding resulting in these 'phasic' mappings was enabled by the codebook developed during the primary analysis - using techniques of focused coding. This codebook then provided a lexicon for the specification and assignment of attributes onto the treatment modalities at this phasic level.

A theoretical structure for treatment selection and application of behavioral interventions could then be managed through a re-conformation of Figures 10 – 13 into a visual model featuring utility of demonstration for time process as well as the display of relative magnitudes of patient presentation articulating selected treatment vectors. These vectors would be categorized by the treatment modalities but would be rotated in space by the re-conformation. They would be described (once again) by the terminology of the lexicon provided by the codebook. An example of such a re-conformation is provided below in Figure 14.

Figure 14

Transvector Rendering of a Patient Presentation at the Treatment Planning Stage



Notes: 1) Vector arrows are associated with prevalent treatment modalities. Terms associate to those modalities are those existing within the lexicon.
2) Vector arrow size indicates the magnitude of effects while direction indicates positive or negative attribution onto patient condition.
3) Patient attributes for monitoring and centrally listed are considered universal across patient populations and constants of consideration within the patient case.

The re-conformation attained and serving to expedite the theoretical model of this study is then referred to as a 'transvector', with the associated model to assume the label, 'Transvector Model for Psychotherapeutic Practice'.

Note while examining Figure 14 (along with the descriptive notes) that the transvector is designed to 1) Enable a conception of patient status as described by the lexicon of terminology

combining to act along the vectors of treatment modalities, and 2) Transform over time in representation of observed effect as the patient progresses through treatment.

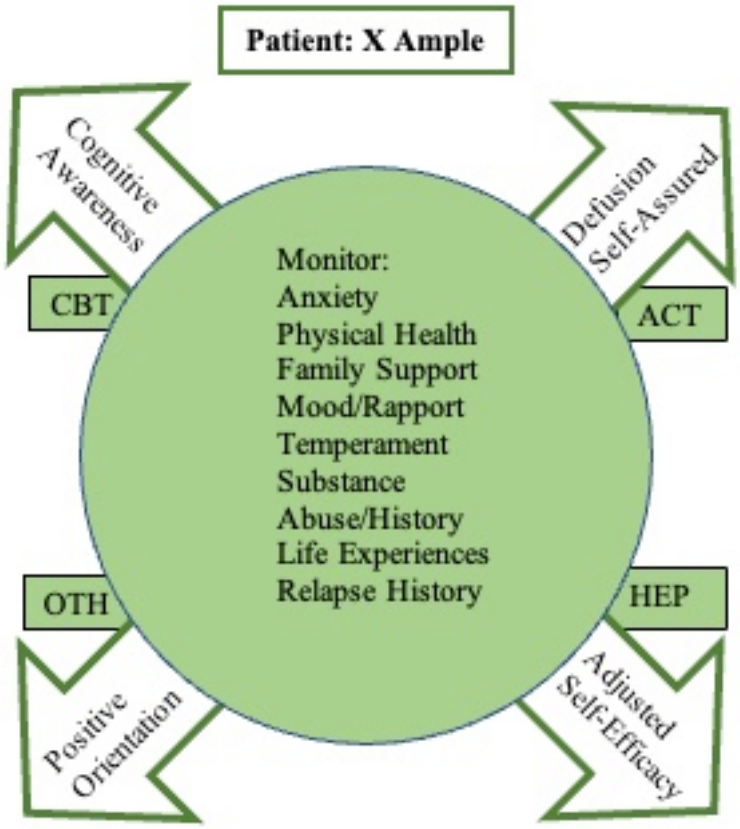
For the example patient with case rendered in Figure 14 and existing at the treatment planning stage, observations have indicated strengths of cognitive awareness, while the patient's needs of greatest magnitude evidence as processes of cognitive fusion, relational difficulties, and poor motivation. Although the diagram does not indicate relative levels for the attributes listed centrally, it should be assumed that these have been charted and considered as components of the treatment plan.

The likely course of action in terms of treatment, then might be application of sessions for Acceptance and Commitment Therapy (ACT), along with integration of a Humanistic or Person-Centered therapeutic approach. Equally important would be a de-emphasis on CBT as an option unless indicators for this modality were to present more strongly as the case proceeded.

As well-planned treatment progresses and the patient's depressive illness condition improves with hopes for a remission state, the visual state of the transvector would be expected to change accordingly. For the case of the example patient, the magnitude of the vector directed inward, and indicative of ACT modalities would be expected to decrease. 'Fusion' would eventually be replaced by 'Defusion', and 'Relational Difficulties' could be replaced by 'Social Adjustment' or the equivalent. As the remission state became imminent, the vector should indeed reverse its orientation. A patient near a remission state for depressive illness would then display a transvector rendering quite like that depicted in Figure 15, below:

Figure 15:

Transvector Rendering of a Patient Case Approaching a Remission State



Notes: 1) All vectors are directed outward and are associated with protective qualifiers.
2) Patient states for monitoring and centrally listed are considered universal across patient populations and remain as constants of consideration after discharge and into remission.

The transvector of Figure 15 displays an equilibrium of patient orientation to their outside environment as indicated by vectors now associated with protective qualifiers, gained through the benefits of behavioral treatment and cognitive activation. Importantly, and as indicated in the notes to Figure 15, the states for monitoring listed centrally continue to exist as constants of consideration moving forward.

Utility for the Transvector Model

This discussion does not conceptualize the course of psychotherapeutic treatment to be indicated by the Transvector Model. To the contrary, this model has been illuminated by the processes of that treatment via grounded theory analysis of the perceptions of those psychotherapists that were participants of this study. They are the experts of their process. The acceptance of their perceptions as the basis of the analysis and of the products of that analysis is fundamental to an understanding of the utility of the resulting model.

The purpose of the study was to develop a theoretical structure of the psychotherapeutic process. The rationale for doing so was indicated by gaps in the research literature indicating a lack of scientific understanding for the efficacy of that process. What was evident from a review of the body of the psychological literature was that the efficacy of prevalent behavioral treatments utilized for MDD and chronic unipolar depression – and most prominently CBT and ACT – demonstrated as inconclusive in terms of mediation effects.

The present study finds sufficient grounds to reason that past efforts may have demonstrated as inconclusive based on mistaken assumptions. While contrasting current findings back to studies employing mediation analysis in search of the cognitive origins of efficacy (A-Tjak et al., 2021; Beevers et al., 2007; Cuijpers et al., 2014; Forman et al., 2011; Zettle et al., 2011), this study concludes that mistaken assumptions might fall into one (or both) of two categories: 1) There is no way to isolate a patient as a ‘CBT’ or an ‘ACT’ patient suitable to the execution of a clinical trial utilizing these modalities, as patients suffering from depressive illness express indications across multiple domains aside from those addressed theoretically by the independent modalities, and 2) There is (perhaps) no way to isolate a clinical environment while addressing the authentic treatment needs of a patient suffering from depressive illness in

such a way that would certify the patient has been treated by CBT or ACT as some independent and ‘sterile’ vector of intervention.

Also pertinent to this level of conjecture would be the high prevalence of utilization observed for HEP modalities within the sample of the present study but with a commensurate lack of accounting for these approaches in the psychological research literature. While considering the oft-cited phenomenon of patients exhibiting improvement in depressive symptomology and in excess of that which can be predicted by cognitive improvement, (see A-Tjak et al. (2021); (Forman et al., 2011)), such studies do not consider effects of an HEP-like approach, either intentional to the therapy or otherwise (Elliott et al., 2013). Such a factor could well be significant toward unexpected improvement, with patients responding to little more than an influx of compassion and the chance to interact with an individual capable of understanding their dilemmas and life struggles. The investigator then echoes the five-word response from Participant #19 to the online survey question gathering perceptions of what are important indications and moderators for treatment planning with respect to HEP? The response is ‘They are a human being.’

The utility for this Transvector Model would then be within the research domain, while providing a more articulate definition of process upon which to base quantitative analyses in search of outcome measures. This definition of process begins with the terminology generated from the grounded theory analysis and then passed from the codebook into the lexicon. The resulting lexicon, specific to the entirety of treatment options for a mental health condition – in this case MDD and chronic unipolar depression – then acts as a proper language set (of sorts). Private practice mental health providers, group practice providers, and institutional providers all utilize dialects of this lexicon according to their featured sets of treatment modalities. Some even

opt for an infusion of ‘slang’, with the adoption of novel or emerging treatment options, such as that alluded in Chapter 4 from Participant #97 integrating ‘shame-informed treatment’, this of Eastern origins.

The lexicon can then be described as the collective language of the psychotherapeutic community in terms of the mental health condition under consideration. What it is not is an ontology. This is to state that it is not precise in nature as an ontology might require, but fluid and capable of evolution as is any product of natural language. Ontological conventions of terminology might be useful in describing the lexicon, however, and (in particular) at the technical level and within documentation.

As the terminology of the lexicon would develop and become more full-featured, it could be envisioned that quantitative analysis based on that terminology and then more closely approximating the actual psychotherapeutic process for the treatment of depressive illness could be attempted with goals of determining efficacy in outcomes.

A possible benefit past that juncture could be the development of clinical systems supporting treatment planning, progress notes, referrals, and financials (billing including insurance) and based on the integrated approach supported by the lexicon and visualizations of patient progress states supported by the Transvector Model.

As a summary to this section, it is important to note that this abstraction of perceptual data herein coined as the Transvector Model for Psychotherapeutic Practice is not an invention of theory, but more concisely a translational product generated of grounded theory research into a therapeutic process – one resulting from inquiry that up until this juncture had neither been considered nor clarified in the psychological literature.

Limitations of the Current Study and Resulting Model

The primary limitation for the current study was that of available time and resources as compared to the scope and depth of the research effort. In terms of recruitment and participation, a window of opportunity was scheduled between 11/07/2022 and 11/23/2022 resulting in the requisite 20 vetted participants by 11/18/2022 and utilized for the analysis and discussion contained in this study document (Chapters 4 and 5). The study may have benefitted from a larger pool, and additional participants did (in fact) continue to accumulate through 11/23/2022.

In terms of resources, the sole investigator participated not only in all phases of design, implementation, documentation, and related collaboration, but was also the sole designer and constructor of the study website, intended and believed to be intrinsic to the success of this research study effort. The study website afforded publishing and promotion of a professional online survey instrument capable of generating participation from the psychotherapeutic community that would have been highly unlikely had the investigator opted for survey publishing using SurveyMonkey or Google Forms. Additionally, the proprietary study web site afforded security of study data inclusive of administrative access along with continuous monitoring of site access and monitoring of daily backups, all necessary to the protection of study data and study informed consent information. The proprietary study site will remain active and secured for purposes of dissemination of study information. Information about this study as well as that related to recruitment and participation, etc. may be found there (for secured users granted appropriate access levels by the investigator) (Brandt, 2022).

Limitations of study resources could then extend onto the qualitative grounded theory analysis, in its scope and/or quality. Fortunately, this study did benefit from the employment (by the investigator) of the Atlas.ti software and toolset atlasti.com (2021), to benefit this analysis

and production of the study's codebook within a very limited window of opportunity (less than 4 available days). Within context, the resulting codebook could be deemed to serve the study's intent, results, and discussion quite well.

Limitations of this study related to its adoption of an online survey format as a primary collection instrument for participant perceptions and for grounded theory research and analysis presents as an estimable topic. Within the context of options available to the investigator of this study and within the very limited time frame available for its design, implementation, documentation, and presentation, a traditional and 'naturalistic' methodology consisting of interviews across a varied sample and geographic area would not have been feasible. Other factors had been considered, including but not limited to (past) experience of the investigator; these involving the hesitancy of heavily engaged professionals to reserve time in their schedules to the devotion of participation in academic research projects. An online survey instrument was arrived upon as the initial entry point to the study as well as the likely means for the predominance of data collection. Limitations incurred from this design decision proved to be largely unrealized. Further discussion of this aspect of the study is explored in the section, 'Survey Utilization for Grounded Theory Analysis', below.

A final area of discussion in terms of limitation was incurred by this study and related to the IRB approval prohibition of participation from psychotherapists originating from group or institutional practices. While there did exist well-articulated policy reasons for this prohibition as applied to the present study and considerations for informed consent, its effect had two predominant limitations: 1) It both inhibited and complicated recruitment efforts by dramatically reducing the potential participant pool, and 2) It coincidentally (and most assuredly) inhibited the codebook and resultant lexicon based on the effects of the potential participant pool on

theoretical sampling. The sum effects of this limitation could be difficult to estimate, but there had been a reference made (in Chapter 4) to the participation of a single social worker in the present study. The gathering of perceptions from this single social worker could be contrasted with the high percentage of this profession evidenced to be active in mental health delivery from the descriptive statistics presented in Table 9, above.

Future Directions for this Research and for the Transvector Model

There would exist two groupings of future direction for subsequent iterations of this study. The investigator does express confidence in the validity of the findings and in the utility of the theoretical model now coined the Transvector Model of Psychotherapeutic Practice. Owing to the limitations incurred and listed above, however, the findings should be considered preliminary at this time. Therefore, the first grouping for future direction would be in mitigation of limitations. The second grouping for future direction would be in anticipation of continued success and with continuing iterations of the study methodology along with associated endorsement of the Transvector Model.

Overcoming Limitations in Future Direction

The current study, when considered as a ‘pilot’ and in conjunction with the voluminous organization of materials assembled at the encompassing website, psytsurvey.online, Brandt (2022), may enable opportunity within alternative research environments for more full-featured iterations, with these potentially enabled of institutional/organizational support or funding. Support would be envisioned as constituting either 1) Institutional aquiescence to the dissemination of the study materials across that institution’s mental health delivery infrastructure, or 2) Organizational promotion of the study iteration’s intent, such that recruitment efforts might enjoy distribution lists along with confidence of buy-in associated with

organizational trust. Neither of these amenities were possible given the strictures of the present study and its tight time constraints but could now be attainable goals given demonstrable success within this endeavor.

Co-investigators inclusive of Ph.D. level researchers with credentials in clinical psychology could be key with respect to grant writing and in pursuit of funding enabling a more full-featured research staff envisioned in providing upgrades to the methodology. The technical skill of the current investigator combined with design methods and existing inroads to dissemination of this product could make a partnership endeavor enticing to such individuals in the academic research domain.

A recognition of the compendium of limitations enumerated above of course should be compared back to the numbers of individuals estimated to be providing psychotherapeutic services in the United States (Table 9), with conclusion that validity of the operational elements of the Transvector Model can only be estimated and assured with continuing iterations of this study involving larger samples, and with these samples covering alternative areas of psychotherapeutic practice, group and institutional practices most notably included. While it might seem unlikely that substantial deviations within elements of the lexicon would deviate from private practice to group practice types, it would also seem unreasonable to expect consistency across the board, and especially to witness only small variations from an initial sample of 20 participants derived from private practice. The inductive logical practices associated with grounded theory analysis, specifically, and qualitative analysis, generally, dictate successive iterations across larger and more diverse samples for this study and its theoretical elements to fully assert validity.

Future Directions Manifested in Successive Iterations

The Transvector Model of Psychotherapeutic Practice could most benefit in the short term from critique of experienced research professionals in the clinical psychology domains. Such critique, short of what might be expected of refereed journal review, could enable consideration for modification benefitting the methodology and the model as a result. Access to this level of experience could best be obtained through participation at academic or organizational conferences.

After modifications considered and then applied to the methodology and the model, the onus would move on successive iterations with focus on building a perceptual database suitable for large scale data mining in demonstration and development of the full lexicon of the therapeutic practice type.

Note that the inclusion of institutional and organizational practice groups in addition to ‘private practice’ psychotherapists would introduce new cross-sections of data for analysis. It is envisioned within the context of the resulting data dictionary that these varying practice types would not be treated as alternative ‘dimensions’ so much as sectional aspects of the data.

Funding of future iterations of these studies could enable staffing inclusive not only of support individuals but also data coders providing teamwork in the development of the finest codebook possible and then resulting in the lexicon fully representative of the process associated to the current mental health condition. It would be anticipated that as the database grew, that coding efforts executed by teams of human researchers would be replicated using machine learning, i.e., Natural Language Processing/Understanding (NLP/NLU). The storage database would transition from the current relational MariaDB to a graph container, most assuredly MongoDB or some variant of the same.

Machine learning as applied to qualitative analysis with applications to mental health data of large scale ('big data') represents as an emerging area of research in the psychological sciences, one combining clinical psychology, cognitive psychology research and computer science. A number of research scientists attempting big data efforts can be located publishing in and around conference efforts similar to MindCare (Cipresso et al., 2018). For an effort such as that envisioned of the Transvector Model of Psychotherapeutic Practice – and for the singular mental health condition of depressive illness, a database container representing even a modest percentage of the estimated one-half million psychotherapists administering services would occupy terabytes of data and would quickly overwhelm the efforts of any coding staff assembled of non-machine origins.

For future iterations of the Transvector Model, it then can be envisioned that the methodology and resulting models could be retooled within parallel studies for alternative mental health conditions also attended to by psychotherapeutic professionals. These individuals, having now shown both the willingness and the eloquence necessary to express perceptions capable of generating a process lexicon, could be further enlisted to describe other essential therapeutic process. Input as to the most likely candidates of malady for such parallel research studies would consider known complexity along with abundance of existing knowledge of that disease state. Within a somewhat counterintuitive scope, the phenomenon of the mechanisms for improvement toward remission of depressive illness being less understood distinguished this disease state as an ideal candidate for the treatment of this study – and as one most likely to benefit from such efforts moving forward.

For all mental health conditions covered by research employing the Transvector Model architecture, development of the related architecture toward a multilingual and multicultural

platform would (and should) be an imperative. Fortunately, these variety of objectives often present more orderly within the context of computer and web-aided products than within more traditional studies, although the translation of key communication elements such as the online survey would have to experience development including the participation of native readers/speakers of the target language(s) and culture(s) that is/are targeted for deployment within the current iteration(s).

Survey Utilization for Grounded Theory Analysis

As briefly discussed in the limitations section, above, there had been concerns during study design phases over the employment of an online survey instrument as both the initial entry point to the study as well as the likely means for the predominance of data collection. These concerns were alluded to in Chapter 3, and in terms of methodology, wherein the online survey design was detailed and described as including options for participant follow-up enabling of more detailed study response.

Regarding the design concern that participants would respond to the open-ended questions featured on the online survey with short and non-descriptive answers not rich in perceptive quality, such variety of concern arrived in the data largely as unfounded. Participants were found to engage the questions to great extent across the breadth of the survey, with many responses to individual questions from participants constituting hundreds of characters over multiple sentences and paragraph form. The raw data is available for perusal on this study's web site in clickable html format (Brandt, 2022).

Of interest to this section of inquiry would be the length of time that 20 participants spent responding to the entirety of the survey, from start to finish. This length of time, in terms of summary statistics is included in Table 10, below.

Table 10

Summary of Length of Time Spent Completing the Online Survey Instrument (minutes)

Low	5
High	52
Mean	16
Std Dev	12

Note: Response time in minutes.

Within recruitment messaging sent to prospective participants via email (see this study's web site, Brandt (2022)), length of initial participation was predicted to require '5 – 10 minutes, depending on your level of involvement in the topic'. The web page would have timed out for any individuals vacating the survey for longer than 4 – 5 minutes, resulting in a cancelled participation attempt, so longer recorded interludes of participation should be considered as legitimate interaction approximate to such length (with average of 16 minutes).

It is additionally worth noting that approximately 50% of individuals that approached the online survey instrument did not follow through on participation. The phenomenon provides both opportunity for reflection on the design of the online survey instrument as well as opportunity for improvements in deployment methodology. The deployment of the online survey could only be ethically managed as a 'public' survey, i.e., one not gathering any information about the prospective participant prior to their agreeing to informed consent. Therefore, the study did not benefit from any information regarding these 50% of individuals except the fact that they did 'hit' the page and then did (for some unknown reason) result in a cancelled participation attempt.

One theory for cancelled participation attempts likely holding significant weight does relate to hesitancy and trust. The most significant percentage of vetted participation in the study was generated from an exploratory email approach to psychotherapists found through exhaustive online searching mechanisms – and not via networking through known contacts or organizational

affiliations as had been anticipated might be the case. Therefore, the percentage of participation as a ratio of approach from these exploratory contacts and post-vetting ended at approximately 4%. Surely, an email received from a person claiming to be a graduate student and seeking participation in a research study would have a difficult time engendering trust capable of generating participation at a more significant percentage, no matter how well-worded that email. The messages employed by this study did not enjoy institutional nor organizational endorsement in any official capacity. Additionally, when a participant did take 'a leap of faith' based on the wording of the email and then follow the supplied link to the online survey, they were then confronted by a lengthy informed consent message, along with a request for personal information, full name, and a repeat iteration of their email – albeit limited information that the requestor already had, but personal information, nonetheless. It is believed that this is the point at which many potential participants aborted their (still) potential participation.

One interesting interlude resulted as a psychiatrist from California took advantage of the information in the recruitment email to direct insightful questions about the nature of the research back to the investigator. The same potential participant also asked whether the research was featured on the university's website in any way (to which the investigator had to respond that it was unfortunately not). The investigator was able to, however, supply the prospective participant with a feature that Tiffin University had posted earlier in 2022 on the investigator himself ((go.tiffin.edu, 2022)) and that did serve to instill some level of trust whereby this individual did decide to participate two days later (although too late to qualify for the analysis included, here). This participant then sent a very gracious email to the investigator thanking the study team for the quality of their work and apologizing but explaining that they had been

guarded after receiving the email and wanted to ensure that it wasn't part of some elaborate scam or hoax.

Other emails received from participants as well as interested parties wishing the investigating team well were too numerous to count and to enumerate here, but it bears mention that these messages were extremely encouraging in concurrence with what presented as an extremely arduous effort. Psychotherapists seemed to be intrigued as well as appreciative of the intent of the research, inclusive of the notion that their perceptions held intrinsic value to unlocking research capabilities not presently available.

There was a single prospective participant originating from networking channels that had been recruited in part via a phone conversation and had assured their inclusion but did not evidence within the sample. This participant would have provided value as a Ph.D. psychologist with considerable experience in the counseling areas but did also present as technically-inhibited during the brief phone conversation. It is theorized that 'tech inhibition' may have played a role in an eventual decision not to participate (although this is only conjecture). This observation is included here, as perception that value could be added to future iterations of this study if staffing could be secured that would allow potential participants to simply opt for a call-in as an alternative to the online survey instrument, with a friendly voice on the other end of the call talking them through the question set.

Another amenity not requiring of a great deal of funding but requiring of additional programming time – and one that will be considered – would be a short linked optional video positioned on the entry page for the online survey. This video could explain question types as well as efficient methods of passage through the questions. Techniques of survey navigation that many take for granted, such as the effect of mandatory questions, tend to alienate other users,

and a short video could greatly alleviate any such alienation, particularly if this video was available as a 'hot tip' of sorts throughout the survey experience.

There was only one potential participant hailing from the State of Florida that expressed technical difficulties with the online survey. The investigator traded emails with this individual over the course of two days' time and (after apologizing for the difficulty) and gathering some information related to the potential participant's access attempts, determined that the individual had likely loaded an extension or spyware extension on their iPhone that was interfering with the proper functionality of the device. No other participants or potential participants reported problems with the web site or online survey, regardless of platform or device, computer or mobile handheld/phone.

Online Survey Options for Additional Study Follow-up

An effort to offer additional options to the online survey as the predominant data collection instrument and in pursuit of data quality for grounded theory analysis resulted in the inclusion of solicitation at survey's end and for acquiescence to additional follow-up for user input. Of the 20 vetted participants considered within the analyses of this study, 12 answered affirmatively to the Yes/No question, 'I agree to receive follow-up to my survey responses. I understand this follow-up will be immediately discontinued on request.' Follow-up emails sent offering these 12 participants a choice of A) A Zoom interview, B) A Google interview, C) A Phone interview, D) A follow-up private survey based on original survey responses, or E) My original response was unintended, or I have changed my mind, please do not contact me further. The results of follow-up emails to these 12 affirmative responses resulted in 7 non-responses to the follow-up email (at this time), 2 responses indicating choice E (no further contact), 2 responses requesting D) a follow-up private survey (both forwarded, one of which has been

completed at this juncture), and 1 response requesting C) a follow-up phone call (a scheduling form has been forwarded which has not been completed at this juncture). The summary, therefore, is of one completed follow-up response at this juncture.

The single follow-up response proved very instructive to the technique of additional follow-up included within the survey instrument. It was limited by design to three questions and was pushed out to the user with a separate informed consent as outlined in the study proposal approved by the IRB. The three questions and answers are included in their entirety (but without the informed consent section) for Participant #15 in Appendix E.

Although this follow-up was the only one received at the time of this documentation (additional follow-ups may be completed prior to the final draft), it does provide ample indication for value-added within the methodology of the online-survey instrument, as well as to its applicability within grounded theory analysis. The follow-up response received from Participant #15 could be argued to emulate some of the best features of a 'naturalistic' interview process, albeit with electronic-only contact and over significant geographic distance.

Additional level of insight that can be gained based on follow-up questions is perceived to be significant. Participant #15 was very engaged within initial survey responses and then did provide excellent opportunity for the presentation of follow-up. The third question (see Appendix E) relating to this study's discussion finding indicating unexpected prevalence for HEP treatment modalities was especially revealing and contributive to support conjecture of the Transvector Model.

Also, important as related to this demonstration of follow-up capabilities of the online survey instrument would be that Participant #15 stressed in email correspondence related to selection of the 'private survey' option for follow up that this option was most amenable based

on their busy schedule and the convenience that it would afford to that schedule. The investigator packaged the follow-up questions, sent off the private survey and scheduled a weeks' time window allowable for a response.

If future iterations of this study were planned, automation to follow-up services would be desired to allow as much of these such responses as possible. But the investigator(s) would have to be cognizant of the human labor involved and requiring of insight necessary to pose insightful questions based on original responses, i.e., such services are not simply a dilemma involving the addition of technical automation.

Based on the findings described in this section and demonstrative of a 'live test' for the online survey employed for this study onto an application of qualitative analysis of a grounded theory variety, this discussion concludes success for this novel approach and precedent that may be added to the small amount of application that could be located in the research literature (Currie, 2009; Gunnarsdottir & Bjornsdottir, 2003).

The investigator of this study considers the success of the online survey instrument with respect to this study to be significant not only for reasons of precedent in the literature but in order that feasibility for iterations of this study inclusive of scalability concerns might be deemed to be within a high probability of success. The inclusion in this study of varied professional levels as well as a wide geographical area of sampling would indicate the requirement for such high probability.

Conclusions

This research study, 'Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression', was undertaken as an academic endeavor, a Capstone project in partial fulfillment of requirements to a Master of Science degree for the investigator, Michael J.

Brandt. Although it was never portrayed otherwise, it was, from its very inception, planned, scheduled, designed, and conducted to the greatest extent possible to emulate the constraints and approaches that might typify a ‘real-world’ research study occurring out of a leading United States research university environment. Intrinsic to this approach and posture were the programming of the web site and the careful planning of all related messaging, whether contained within email communication or otherwise.

What the investigator was most careful to additionally maintain apart from this level of professionalism – and to buttress the chances for success of the study – was the axiological perspective of an educated but distanced observer to the psychotherapeutic process. This investigator sought this perspective from day one of the study, (in particular) within the careful wording of all language adopted on the study website but especially within the wording of every question contained of the online survey. The desired perception was to be that of the research scientist conducting a careful and measured assessment of a process that he did not share levels of expertise within.

This axiology was also necessary as the study moved into the analysis phases. Analysis of process according to accepted standards of grounded theory and for the generation of a theoretical model that might benefit future research (and possibly also clinical system tools) is certainly a worthy objective of the psychological scientist that possesses certifiable qualification as a research scientist. Inference into the motivations of the psychotherapists for their process decisions as based on patient indications or interactions, however, would be inappropriate. The requisite level of expertise would not be shared and the resulting inference would then be invalid.

This investigator hereby does certify that prior to completing this discussion, they have reviewed the history of conduct, data, and documentation associated to the study and is confident that the proper perspective had been maintained throughout the course of the study.

It will be important that this axiological view will be maintained throughout all future contact related to this study, communication related to its contents, as well as its possible future iterations, and products that may be derived from its initiative; be these offshoots of the research variety or clinical system products. This axiological view as a philosophical beacon would serve well all future investigative partners that do not hold Ph.D. level credentials in clinical psychological sciences.

The Transvector Model of Psychotherapeutic Practice, then, will be hereafter described as a research construct, and any clinical system products resulting from this research construct would emerge after proof of validity for this construct as demonstrated across subsequent iterations and/or resultant quantitative research, and along with the possibility of subsequent acceptability testing within pilot clinical environments and in conjunction with clinical psychology partners.

The strength of the Transvector Model of Psychotherapeutic Practice is perceived by this investigator to lie in the opportunity that it affords to a holistic description of the treatment process for the interventions utilized against MDD and chronic unipolar depression, codified with an accompanying lexicon, and applicable across the various communities of psychotherapists treating the mental health condition of MDD and chronic unipolar depression. It is a construct uniquely devised by the psychotherapy communities themselves. What the investigator in the role of research scientist provides within the context of this model could best be conceptualized as services of organization, collectivization, and a repository for terminology,

this then applicable to the research domain, and hopefully then applicable back to the clinical systems domain.

The investigator would invite the comment of interested consumers of this research and in particular research scientists and clinical psychologists offering criticism or insight based on this effort. It is only through collective efforts involving both clinicians and researchers that depressive illness is better understood, more effectively treated, and then tracked to a lesser prevalence with levels of higher sustained remission within our societies. Thank you, all.

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Appendix A: Study Informed Consent
Project Title: Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression
Project ID Number: 10102201
Investigator: Michael J Brandt, MS Psych
Informed Consent

INTRODUCTION:

'Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression' is a study that seeks to gather perceptions of professional psychotherapists relating to their application of behavioral interventions to the treatment of adult patients with depressive illness.

The purpose of this form is to provide you as a prospective research participant with information that will inform your decision as to whether to answer 'Yes' or 'No' in terms of your willingness to participate in this research. The form will additionally serve to record the consent of those that choose a response of 'Yes'.

RESEARCHERS:
Michael J. Brandt
Graduate Student MS Psychology
Department of Behavioral and Social Sciences
Tiffin University
155 Miami St., Tiffin OH, 44883
Phone: 716-202-8811
brandtmj@tiffin.edu

Dr. Jessica S. Ryan PhD, LPC
Supervising Faculty
Department of Behavioral and Social Sciences
Tiffin University
155 Miami St., Tiffin OH, 44883
Phone: 251-509-5100
ryanje@tiffin.edu

DESCRIPTION OF RESEARCH STUDY:

This research study seeks to gather perceptions of professional psychotherapists relating to their application of behavioral interventions to the treatment of adult patients with Major Depressive Disorder (MDD) or chronic unipolar depression. Of interest are the types of behavioral treatments utilized in your practice along with your insights relating to patient indications, moderators, and comorbidities relevant to treatment planning. Also of interest is the efficacy of these treatments with respect to patient improvement, remission, and patient persistence in remission.

The survey accessed through this consent contains some questions that are open-ended and enabling text input. Your participation could require 5 to 10 minutes (or longer, depending on your level of engagement in the topic). The question submission includes a voluntary option

to offer additional feedback on request of selected participants exhibiting perceptions relevant to the ensuing analysis.

RISKS AND BENEFITS:

Risks: If you decide to participate in this research study, and if questions contained cause you to reflect upon personal experiences or opinions, then you may encounter risk of identification of negative thoughts or feelings related to unpleasant past or present experiences. Therefore, there is a remote chance that consideration of these questions could make you feel anxious or ill at ease. If this were to occur, you may stop participating at any time with no penalty whatsoever. The researchers above would also be willing to provide the names and contact for local counseling (or substance abuse assessment and treatment services as necessary), should you decide that this might be helpful. Educational information would also be provided upon request.

Note: You or your medical insurance may be billed for such services if you would require counseling or other treatment. No other counseling, medical treatment, nor financial compensation for injury from participation in this research survey is provisioned, promised, nor implied.

The researchers attempt to reduce the risks to all participants by assuring the privacy of your participation and the confidentiality of your responses. The researchers have also designed the survey (as alluded to, above) such that any uncomfortable with their participation may discontinue their participation at any time prior to completion. As with any research, there is some possibility that you may be subject to risks that have not yet been identified.

Benefits: The primary benefit of participation in this research would be an increased awareness to perceptions of the efficacy for behavioral treatments that are utilized for patients with MDD or chronic unipolar depression. A secondary benefit to the participant would be the knowledge that they may be assisting the furtherance of research intended to benefit the psychotherapeutic community as well as the patients that they serve.

COST AND PAYMENTS:

The researchers want your decision about participation in this study to be absolutely voluntary. As such, they are unable to offer any payment nor other compensation for participation aside from thanking you for your assistance, should you be able to participate.

NEW INFORMATION:

Should the researchers uncover new information during the course of this study that would benefit you personally, they will do their best to share it back to you. Should they uncover new information that would reasonably change your decision to participate, then they will be obligated to get back to you in order that you might reconsider your decision.

CONFIDENTIALITY:

The researchers will take "all reasonable steps" to keep private information, such as questionnaire data confidential. The data from this survey will be removed from common digital storage after the study collection date, 12/03/2022, has passed. This survey form WILL NOT collect private personal information on you based on your participation.

This informed consent form will ask for and will require a full name (first, last, mi) and email for identification of informed consent and to be used for vetting purposes of professional

credential (and only by the investigator). Identification information will not be used to any extent beyond these limited purposes and will not be used for any purposes within the study.

Confidentiality will be maintained to the limits of the law. Confidentiality may not be maintained if you indicate that you may do harm to yourself or are placing yourself in an immediate harmful situation - or if you may do/have done harm to others. In cases where one is thought to pose an imminent risk of harm, the appropriate health care providers and/or authorities may be contacted/enlisted.

All responses collected in this research will be analyzed in aggregate form, and no names will be linked to the analysis. Consent forms are separated and not linked to identifying information.

Your confidentiality will be maintained to the degree permitted by the technology used, thus no guarantees can be made regarding the electronic interception of data sent using the internet, web-based or wireless services and protocols, and/or by any third parties, but every attempt will be made to safeguard your data as well as the data of all other participants.

WITHDRAWAL PRIVILEGE:

It is OK for you to say NO. Even if you answer YES initially, you may stop participation at any juncture during the survey and withdraw. Your decision will not affect your relationship with Tiffin University, nor with these researchers, nor with any future research studies, either at Tiffin University or elsewhere. Withdrawal will not incur a loss of benefits to which you might otherwise be entitled.

Taking part in this research is entirely voluntary, and up to you. You are attesting that you have read this form (or that you have had it read to you), and that you are satisfied that you understand its contents, and that you also understand the research study, and understand its risks and benefits. The researchers should have herein answered any such questions that you might have had regarding this research study. If you have further questions at a later date, then the researchers listed will be happy to answer these.

If at anytime you feel that you were pressured to participate, or if you have questions at this time that were not answered here, please then call the Faculty Supervisor for this study, Dr. Jessica S. Ryan, at 251-509-5100, or by email, ryanje@tiffin.edu, with these specific concerns and they will assist you as
soon as possible.

IMPORTANT:

By moving forward to the next section, you are giving your consent to participate in this research study, 'Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression', but you can withdraw from that participation at any time ...

INVESTIGATORS' STATEMENT:

I hereby certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws and promise compliance. I have answered the subject's questions (or offered the same) and have then encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed (or am now digitally obtaining) signature on this consent form.

If you wish to know more about this research project, please call the Faculty Supervisor for this project, Dr. Jessica S. Ryan, at 251-509-5100. If you have questions about Tiffin University's rules for research, please contact Dr. Jonathan Appel, Director Institutional Review Board (IRB), Tiffin University (Tel. 419.448.3285 or email appelj@tiffin.edu).

Appendix B Online Survey Layout

Project Title: Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression
Project ID Number: 10102201
Investigator: Michael J Brandt, MS Psych

Section 0: Information about your psychotherapy practice …

0a. What type is your home practice?	List Select	See choices, 0a.
0b. What is your group or institution?	List Select (appear if 0a not 'Priv. Pr.')	See choices, 0b.
0c. What is your professional degree?	List Select	See choices, 0c.
0d. Name of educational institution (university/college).	Text Entry (optional)	50 char
0e. In what postal code is your home practice located?	Text Entry	U.S. Zipcode format
0f. Years practicing psychotherapy (total)?	Text Entry	Integer Number
0g. How did you hear about this survey?	List Select	See choices, 0g.

Section 1: Information about treatment of patients presenting w/ Major depressive disorder (MDD) or chronic unipolar depression …

1a. Approximately how many patients do you see for these conditions monthly?	Text Entry	Integer Number
1b. Approximately how many visits from these patients does this sum to, monthly?	Text Entry	Integer Number

Section 2: Information about treatment modalities for patients w/ Major depressive disorder (MDD) or chronic unipolar depression …

2ai. Do you utilize Cognitive Behavioral Therapy (CBT) as a treatment modality?	Yes/No	
2aii. Approximate percentage CBT is utilized for these patients?	Text Entry	Percentage 0 - 100
2aiii. What patient indications and moderators are most important within tx planning for these patients? (CBT)	Text Entry	Block <= 1000 char
2aiv. What patient comorbidities are most important within tx planning for these patients? (CBT)	Text Entry	Block <= 1000 char
2av. What are your perceptions of the efficacy of CBT to improvement and remission for these patients?	Text Entry	Block <= 1000 char
2avi. What are your perceptions of the efficacy of CBT to aiding persistence in remission?	Text Entry	Block <= 1000 char

2bi. Do you utilize Acceptance and Commitment Therapy (ACT) as a treatment modality?	Yes/No	
2bii. Approximate percentage ACT utilized for these patients?	Text Entry	Percentage 0 - 100
2biii. What patient indications and moderators are most important within tx planning for these patients? (ACT)	Text Entry	Block <= 1000 char
2biv. What patient comorbidities are most important within tx planning for these patients? (ACT)	Text Entry	Block <= 1000 char
2bv. What are your perceptions of the efficacy of ACT to improvement and remission for these patients?	Text Entry	Block <= 1000 char
2bvi. What are your perceptions of the efficacy of ACT to aiding persistence in remission?	Text Entry	Block <= 1000 char

2ci. Do you utilize Humanistic/Experiential/Person-centered therapies (HEP) as treatment modalities?	Yes/No	
2cii. Approximate percentage HEP utilized for these patients?	Text Entry	Percentage 0 - 100
2ciii. What patient indications and moderators are most important within tx planning for these patients? (HEP)	Text Entry	Block <= 1000 char
2civ Percentage 0 - 100. What patient comorbidities are most important within tx planning for these patients? (HEP)	Text Entry	Block <= 1000 char
2cv. What are your perceptions of the efficacy of HEP to improvement and remission for these patients?	Text Entry	Block <= 1000 char
2cvi. What are your perceptions of the efficacy of HEP to aiding persistence in remission?	Text Entry	Block <= 1000 char

2di. Other methodology utilized (if any)?	Yes/No	
2dii. Approximate percentage (other methodology) utilized for these patients?	Text Entry	Percentage 0 - 100
2diii. What patient indications and moderators are most important within tx planning for these patients? (other)	Text Entry	Block <= 1000 char
2div. What patient comorbidities are most important within tx planning for these patients? (other)	Text Entry	Block <= 1000 char
2dv. What are your perceptions of the efficacy of this other modality to improvement and remission for these patients?	Text Entry	Block <= 1000 char
2dvi. What are your perceptions of the efficacy of this other modality to aiding persistence in remission?	Text Entry	Block <= 1000 char

Section 3: Information about follow-up for patients w/ Major depressive disorder (MDD) or chronic unipolar depression …

3a. Does your practice provide follow-up after discharge for these patients?	Yes/No	
3b. If so, through what form is this follow-up achieved?	List Select	See choices, 3b.
3c. If other, please specify.	Text Entry	20 char
3d. What are your perceptions relating to discharge and follow-up for these patients? How could management of remission be improved?	Text Entry	Block <= 1000 char

Section 4: Submission Confirmation (on completion of questions):
Thank you for completing this survey supplying data to the study, 'Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression.' The survey responses entered will be analyzed for purposes of providing insight into the work of the psychotherapeutic community treating depressive illness.
Please indicate your level of willingness below to receive follow-up regarding your survey responses. The investigator of this study will be attempting to clarify a select sample of responses gathered to aid the ongoing analysis through additional correspondence – and by permission granted, below. Additional correspondence would be strictly limited to survey data entered. Confidentiality will be maintained as outlined within the consent agreement. Email follow-up would be from brandtmj@tiffin.edu (Michael J Brandt, investigator).

☐ Yes, I agree to receive follow-up to my survey responses. I understand this follow-up will be immediately discontinued on request.
☐ No, I do not wish to be contacted after this survey submission.

☐ Please send a copy of this survey's 'consent to participate' to my email, for my records.

Submit

List Select Choices:
Q 0a. { Private Practice, Group Practice, Institutional Setting (Hospital/University) }
Q 0b. List choices are populated according to group or institutional requests sent or consent requests from respondents.
Q 0c. { PhD/Psychiatry, MD/Psychiatry, PhD/PsyD/Psychology, LCSW/LCSW-R, LMHC/LMHP, MHNP/PMHNP, MS/MHC, other }
Q 0g. { Study investigator email, Info from colleague (networking), Info from my professional organization }
Q 3b. { Letter/Mailer, Telephone, Email/Text, other }

Notes on survey presentation:

While attempting to gain participation of professionals in the psychotherapeutic fields, the investigator for this study will attempt an online survey presentation as professional and as concise as possible. One key element of this goal can be achieved through employment of 'expert system-like' features within the survey presentation, i.e., the presentation only of those questions that are logically pertinent according to previous answers. As an example, if the participant would respond in the affirmative that they employ Cognitive Behavioral Therapy (CBT), but not other treatment modalities, then they would only experience the subsequent block of questions requesting their perceptions of CBT – and not questions focused on any other treatments. Another aspiration will be to center focus on questions such that the total collection of survey questions does not detract from the current question focus.

The presentation of effective online surveys has developed as a distinct science of recent years and it is an aspiration of this study to present the survey detailed here in as effective a manner as possible while enlisting principles of best practice available in relevant literature (Baatard, 2012).

Baatard, G. (2012). A technical guide to effective and accessible web surveys. *Electronic journal of business research methods*, *10*(2), 101.

Appendix C Study IRB Approval

Project Title: Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression
Project ID Number: 10102201
Investigator: Michael J Brandt, MS Psych

Date Application Received by IRB: ____10/5/22___
Additional Action Required Before Approval____YES_____ _____Completed Date__10/21.22_____

TIFFIN
UNIVERSITY

Tiffin University Institutional Review Board (IRB) Feedback/Approval Form

Project Title: Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression

Project ID Number: 10102201

Researcher/Student name: Michael J. Brandt
Supervising Professor's name: Jessica Ryan. PhD

Your project has been:

☐ Denied
X Approved ***for non-organizational subjects***

Note: this approval is timed limited and set to expire: 12/31/22

Date: 10/21/22
IRB Chair Signature

Any changes and/or extensions to this project must be reported in writing to the IRB Director (change form on IRB website).

Appendix D: Qualitative Analysis Codebook

Project Title: Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression
Project ID Number: 10102201
Investigator: Michael J Brandt, MS Psych

No.	Code	Initial Search Type
1	acceptance	sentence
2	ACT OR Acceptance and commit OR Acceptance and commit	exact
3	aftercare	sentence
4	anxiety	sentence
5	attachment	sentence
6	ADHD OR Attention OR attention	exact
7	ASD OR Autistic OR autistic OR Autism OR autism	exact
8	beliefs OR Beliefs OR belief OR Belief OR believe OR Believe OR belief system OR Belief system	exact
9	blocking OR suppress	words
10	CBT OR Cognitive behavior OR cognitive behavior	exact
11	cognitive OR cognition	sentence
12	cope	sentence
13	defusion	words
14	DBT OR Dialectical OR dialectical	

No.	Code	Initial Search Type
15	developmental OR development	sentence
16	diagnosis	sentence
17	discharge OR discharge plan	words
18	dissonant OR dissonance OR disordered OR discordant OR dysfunctional OR unhelpful	words
19	dysregulate	words
20	EMDR OR Parts work OR Parts-work OR parts work OR parts-work OR Ego state OR Ego-state OR ego state OR ego-state	exact
21	environment	sentence
22	guilt	words
23	HEP OR Experiential OR experiential OR Emotion focus OR Emotion-focus OR emotion focus OR emotion-focus OR Person focus OR person focus OR Person-focus OR person-focus OR Humanistic OR humanistic	exact
24	holistic	sentence
25	hypochondria	words
26	interpersonal OR family OR relationship	words
27	life experience OR Life experience	exact

No.	Code	Initial Search Type
28	loneliness OR lonely OR isolation OR disconnection	words
29	mediate (no inflection, all) OR mediation	words
30	medication OR Medication OR medications OR Medications OR meds OR Meds OR prescription OR Prescription OR rx OR RX OR Rx	exact
31	medical condition OR Medical condition OR med condition OR Med condition	exact
32	memories OR rumination	words
33	mindfulness OR Mindfulness	exact
34	mood OR temperament OR disposition	words
35	negativity OR despondence OR despair	words
36	OCD OR ocd OR obsession OR Obsession OR obsessive OR Obsessive	exact
37	pain OR Pain OR chronic pain OR Chronic pain	exact
38	personality	words
39	phobia	words

No.	Code	Initial Search Type
40	prevention OR preventative OR protective	words
41	psychodynamic OR Psychodynamic OR psychoanalysis OR Psychoanalysis	exact
42	PTSD OR ptsd	exact
43	rapport OR collaborate	words
44	readiness OR willingness	words
45	regulate OR cope	sentence
46	relapse OR recurrence	sentence
47	remission OR recovery	sentence
48	risk assess OR Risk assess OR risk assessment OR Risk assessment OR evaluation OR Evaluation OR eval OR Eval	exact
49	self-care OR self care OR Self-care OR Self care	exact
50	self-harm OR self harm OR Self-harm OR Self harm OR suicide OR Suicide	exact

No.	Code	Initial Search Type
51	self-perception OR self perception OR Self-perception OR Self perception OR self-image OR self image OR Self-image OR Self image OR self-esteem OR self esteem OR Self-esteem OR Self esteem OR identity OR Identity	exact
52	self-regulate OR self regulate OR Self-regulate OR Self regulate	exact
53	shame	sentence
54	shame-informed OR Shame-informed OR shame informed OR Shame informed	exact
55	social OR community	sentence
56	stress	sentence
57	substance abuse OR Substance abuse OR addiction OR Addiction OR alcohol OR Alcohol	exact
58	symptom	sentence
59	trauma (no inflect)	sentence
60	transferance (no inflection)	words

No.	Code	Initial Search Type
61	tx plan OR Tx Plan OR Tx plan OR treatment plan OR Treatment Plan OR Treatment plan OR Tx Planning OR Tx planning OR Treatment Planning OR Treatment planning OR treatment planning	exact
62	wellness (no inflect, all) OR health OR sleep OR nutrition OR exercise	word

Appendix E: Private Survey Response, Participant #15, Completed 11/23/2022 12:12 p.m. EST

Project Title: Psychotherapist perceptions of behavioral treatments for MDD and chronic unipolar depression
Project ID Number: 10102201
Investigator: Michael J Brandt, MS Psych

Follow-up Question #1 Based on ACT Efficacy to Improvement and Remission

ACT for Improvement / Remission

Dr. [redacted], you distinguished uniquely among the psychotherapists participating in our research study while offering your perception on ACT and while reflecting on the importance of 'values'. You intoned, '... when patients can come to better understand their values and how they have or have not been living in accordance with them, they can learn to apply this to their lives and decrease their depressive symptoms ...' Would you comment further on protective effect of an individual's recognition and identification with their values as relates to resilience against stress and anxiety? As you expound on values, may I additionally ask whether you believe there are any character traits that could rival an individual's identification with their values with respect to the building of strength and resiliency - and to protection from depressive illness? Thank you.
Your answer:

Everyone has values of some kind, but many would have difficulty articulating them beyond generic things like "family" or "friends". ACT helps to get patients to think about and to clarify their values on a deeper level than most people do otherwise. When people are depressed, anxious, etc. they often see ways in which they have not been living in accordance with their values, whereas ACT proposes that this can be a source of suffering or something that contributes to it. And further, behaving in ways that aligns with our values is likely to lead to less suffering, including relief from depression. Therapy can help a client to learn about these concepts, to identify ways they might follow their values (or follow them more), and begin taking steps to do that. When we are following our values we are likely to feel more confident and less stressed or anxious. For example, if we value quiet time alone or quality time with a partner, we might take action to ensure that we have that time and we might set boundaries in order to protect that time. Doing the aforementioned is good self-care and increases resilience to stress and anxiety. As for your second question, I am certain that value identification, etc. is not the only way to build strength and resiliency. That is just a theory I identify with and that I have found useful with clients. I suppose there could be character traits that would be beneficial to have or develop, such as creativity. Being creative might allow for one to see things from different perspectives or in unique ways. This might also lend itself well to being good at problem solving or at developing a variety of positive coping skills.

Follow-up Question #2 Based on HEP Treatment Planning Process

HEP Treatment Planning

This question heading might be a bit misleading (my apologies), given an interpretation that you would not be tx planning strictly HEP, per se, so much as including HEP technique, but the follow-up question would be: You had included that HEP would be an important consideration for the patient presenting with 'low self-esteem; poor self-image; low social support; low self-compassion; history of trauma'. Could we build upon (or transition from) the theme of the first follow-up to indicate which core values in the patient tend to typically lag in these cases and then to benefit the most from a humanistic or person-centered approach, especially early on in treatment?
Your answer:

Ok, so if I am understanding what you are asking, I could give examples of core values that could be lagging that could be influencing a person's mood and leading to depression. One example is integrity. Most people would like to say they have integrity, but it's true that many people are not integrous when it comes to what they believe or value and then how they behave. This is true with cognitive dissonance, as the person notices or senses a disparity and they feel badly because of it. In many cases depressed patients feel like 'hypocrites' because they believe one thing yet their behavior contradicts it. For example, they say they love their partner, respect them, value them, and wouldn't want to hurt them, yet they have been having affairs. Many people feel guilty about this and it is a source of suffering for them. I have worked with several clients in this exact situation. Most of the time no one knows and they don't believe they have anyone they can talk to about it, most of all their partner. Many say they 'hate' themselves or they are 'terrible' for what they have done or are doing. These clients in particular need empathy, unconditional positive regard, and so on in order to feel comfortable saying these things aloud, to trust the therapeutic process, and to not feel judged by the therapist. Only then can they feel safe enough to engage in treatment and benefit. Further, a large part of the work I do with clients is getting to their values and how they are or are not following them, and helping them to develop the strength or courage to take actions that could help them to feel better. In this case that may be ending any outside relationships, disclosing to their partner, and being willing to accept that their partner may or may not want to remain in or work on their relationship.

Follow-up Question #3 Based on HEP Aiding / Assisting Remission

HEP Assisting Remission

You instruct in a very compassionate manner regarding strengths aiding the remission strength and while talking about HEP, thank you, Sir. You include, that individuals might well '... have more positive views of themselves and they can then either find more support in their lives or they can be less fearful of showing others who they are ...'. This is extremely well-placed in our modern societies (I hope you do not mind me saying so). The very extensive literature review conducted for our study uncovered little in the psychology peer-reviewed journals - and not substantially more in the texts - discussing the direct use of humanistic/experiential/person-centered therapeutic approaches specifically for the treatment of depressive illness. CBT and ACT are not only discussed (and focused upon) at length, but clinical trials quantitatively comparing their efficacy abound. What might be your perspective on why HEP techniques receive relatively less attention in the research

literature? Could this be that they are perceived as less regimented/scientific in many ways? Are HEP techniques perceived that differently in the psychotherapeutic community than in the research community? The preliminary findings of the present research study would indicate this phenomena to (in fact) be the case. Thank you.
Your answer:

You are exactly right. CBT in particular tends to be preferred because it is more structured and more measurable. I think by its very nature it makes it easier to study, particularly in a quantitative way. Insurance companies like CBT because it has wide application and is typically shorter, thus cheaper for them. HEP is certainly seen as less regimented and less scientific, but I don't know that people in the psychotherapeutic community believe it to be less valid. As insurance companies have a bias toward CBT and expect therapists to be able to articulate goals and treatment plans, and they are often unwilling to keep paying for longer-term treatment, particularly if progress can't be easily quantified, I believe the therapeutic community has responded to this by favoring CBT or at least being sure to include it in treatment. Some graduate programs have a primary therapeutic orientation (i.e. CBT), so students who apply there likely have this preference already, and then this represents the bulk of their training while there, so they likely go on to specialize in that orientation. I also think some therapists want to be seen as practicing something more scientific and measurable than psychotherapy has been, so they may have a preference for things like CBT or they may develop that preference over time. Most therapists I am aware of do not strictly practice one type of therapy, even if they do have one primary orientation. In my opinion HEP has a lot of value in therapy, particularly for clients like I mentioned before, but also because it helps you to develop rapport with clients, it helps them to feel safe, and it helps them to feel comfortable opening up and engaging in the process of therapy. It might be hard to connect with some clients or to get them to feel supported and understood in therapy if you were practicing CBT alone, so HEP in particular is a good thing to integrate into any other approaches you are using.