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How Do Cognitive Therapists and Psychoanalysts Diagnose a Case of Depression? Clinical Inference Process and Diagnostic Hypotheses

¿Cómo terapeutas cognitivos y psicoanalistas diagnostican un caso de depresión? Proceso inferencial clínco e hipótesis diagnósticas

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ABSTRACT

The clinical inferential process is a central activity for clinical psychologists; however, there are no studies focusing on how Argentine clinical psychologists formulate diagnostic inferences in depression cases. Objective: The aim of this study is to understand how Argentine cognitive therapists and psychoanalysts-both senior and junior-formulate diagnostic hypotheses on the same patient with major depressive disorder. Method: A stimulus session was presented to 28 cognitive therapists and psychoanalysts-both senior and junior. Their clinical inferential production was classified and analyzed. Findings: Cognitive therapists considered depression in their presumptive diagnosis more frequently than psychoanalysts did. Psychoanalysts found the silence of the session more relevant than cognitive therapists to formulate their clinical inferences. Junior psychologists rated the patient's depression as more severe than senior psychologists. In general, the use of psychometric instruments, suicidal risk assessment, and consideration of medical history or affective episodes all seem to be lacking. Conclusions: These findings warn about the underdiagnoses and misevaluation of depression. Future studies are necessary to confirm these issues with a relevant mental disorder such as depression.

Keywords: Clinical inferential process, Diagnosis, Depression, Cognitive therapy, Psychoanalysis, Argentina.

RESUMEN

El proceso inferencial clínico es una actividad central de los psicólogos clínicos. Sin embargo, no existen suficientes estudios sobre cómo los psicólogos clínicos argentinos formulan inferencias diagnósticas sobre un caso con depresión. Objetivo: este estudio se propone entender cómo terapeutas cognitivos y psicoanalistas argentinos, de diferentes niveles de experiencia, formula hipótesis diagnósticas sobre el mismo paciente con un trastorno depresivo mayor. Método: una sesión esítmulo se presenta a 28 terapeutas cognitivos y psicoanalistas, senior y junior. Su producción clínica inferential se clasifica y analiza. Resultados: Los terapeutas cognitivos consideran a la depresión en sus diagnósticos presuntivos más que los psicoanalistas. Los psicoanalistas encuentra los silencios de la entrevista como más relevantes. Evaluando la gravedad, los psicólogos junior consideran que el caso presenta una mayor gravedad que los psicólogos senior. En general, se observa un escaso uso de herramientas psicométricas, evaluación del riesgo suicida y la consideración de aspectos médicos o historia de episodios afectivos. Conclusiones: Los hallazgos alertan sobre el subdiagnóstico y la subevaluación de la depresión. Más estudios son necesarios para confirmar estos problemas en una trastorno mental de alta relevancia como lo es la depresión.

Palabras clave: Proceso inferencial clínico, Diagnóstico, Depresión, Terapia cognitiva, Psicoanálisis, Argentina.

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Depressive disorders are considered a high-impact disease in the general population. In Buenos Aires, Argentina, according to a study involving 1,335 adults, "point-prevalence of probable current clinical depression (BDI[1] total score ≥13) was 20.0% overall" (Leiderman, Lolich, Vazquez, & Baldessarini, 2012, p. 1155). In Argentina, Chile, and Uruguay, based on a study of 7,524 participants, aged 35 to 74 years old, the overall prevalence of depression was 14.6% (95% CI: 2.6, 6.7) (Daray, Rubinstein, Gutierrez, Lanas, Mores Calandrelli, et al., 2017).

The World Health Organization estimates that depression affects 322 million people globally, which accounts for 4.4% of the world's population (WHO, 2018). Around 800,000 people commit suicide every year, and depression is one of the most critical mental disorders linked to suicide (WHO, 2018a). Depression "led to a global total of over 50 million Years Lived with Disability (YLD) in 2015" and is "the single largest contributor to non-fatal health loss (7.5% of all YLD)" (WHO, 2017, p. 15). Therefore, depression stands as one of the most critical challenges for mental health services and policies.

Although a debate revolves around the treatment of depression (Westen, Morrison, & Thompson-Brenner, 2004), a large body of outcome research and clinical recommendations focus on depression treatments (APA, 2010; NICE, 2018). However, it should be noted that, according to a study carried out in 21 countries, "only 16.5% [people] received minimally adequate treatment (22.4%, 11.4% and 3.7%, respectively, in high-, upper-middle-, and low-/lower-middle-income countries)" (Thornicroft, Chatterji, Evans-Lacko, Gruber, Sampson, & Aguilar-Gaxiola, 2017, p. 121). This shortfall in depression treatment has been attributed to lacking resources, a shortage of trained psychotherapists, and the social stigma associated with mental disorders (Mascayano, Armijo, & Yang, 2015).

Over the past 25 years, the so-called Operational Diagnostic Systems (ODS) have gained much traction in the field of mental health. The ODS hinge on the *Diagnostic and Statistical Manual of Mental Disorders*, fifth edition (DSM-5), and the *International Classification of Diseases*, 10th edition's section on mental and behavioral disorders (ICD-10) (WHO, 1992), the *Operationalized Psychodynamic Diagnosis*, second edition (OPD-2) (von der Tann, & OPD Task Force, 2008), and PDM-2 (Lingiardi & McWilliams, 2017). Resulting from a consensus among different theoretical perspectives, the ODS pay special attention to the empirical evidence available to establish the criteria for a diagnostic category.

From the perspective of these diagnostic manuals, depression is a multifaceted condition—that is to say, it involves psychological symptoms (e.g., low self-esteem, self-criticism, pessimism), biological symptoms (e.g., changes in appetite and sleep patterns), and social symptoms (e.g., isolation, passivity). Depressive disorder sub-types include the *chronic subtype* (dysthymic disorder and chronic major depressive disorder), the *recurrence subtype* (recurrent major depressive disorder), the *episodic subtype* (a unique episode of a major depressive disorder), and other forms not included in the ODS—such as *minor depression* and *depressive personality disorder*.

The diagnosis of depression is a process that involves the recognition and description of its characteristics-the subtypes-as well as the quantification of its severity (mild, moderate, or severe). Diagnostic instruments (e.g., screening) and tools to assess symptom intensity (e.g., scales, questionnaires, and inventories) have been designed to systematically support the diagnostic process and the planning of an appropriate intervention strategy, as well as selecting treatment targets and evaluating the efficacy and effectiveness of the therapy chosen (Nezu, McClure, & Nezu, 2016).

In the field of the psychological treatment of adult depression, according to Cuijpers (2017), there are 500 randomized clinical trials (RCTs). Among these studies, the efficacy of different types of treatment has been evaluated without significant differences, since "the effect sizes for these therapies range from g = 0.58 for non-directive counseling to g = 0.83 for problem-solving therapies" (Cuijpers, 2017, p. 9). Another considerable body of research has focused on the factors responsible for patients´ improvement (Norcross, & Lambert, 2018).

Factors that influence the results of psychotherapy may be largely divided into two main groups: (1) theory-specific factors, (i.e., specific interventions for each theoretical framework), and (2) factors common to all forms of psychotherapy (i.e., factors present in almost every psychotherapeutic treatment). In this second group, several studies have focused on the common factors that influence the results of psychotherapy, with Wampold (2015) noting the following: (a) Goal consensus/collaboration; (b) Empathy; (c) Alliance; (d) Positive regard/affirmation; (e) Therapist (naturalistic); (f) Congruence/genuineness; (g) Therapists (randomized controlled trials); (h) Cultural adaptation of evidence-based treatments; (i) Expectations. Within the study of therapists´ variables, a number of studies zero in on "the clinical inferential process" (Leibovich de Duarte, 2000, 2001, 2010; Roussos, Lissin, & Duarte, 2007; Rutsztein, 2005; Torricelli, 2006).

The clinical inferential process refers to a key task performed by psychotherapists: the formulation of hypotheses about their clinical cases (Wolitzky, 2007). This process is present from the beginning and informs every decision made by therapists at any given time: "It guides and shapes therapists' actions, such as the elaboration of clinical judgments, the formulation of a differential diagnosis, the establishment of long- and short-term therapeutic goals, and the development of therapeutic strategies" (Roussos, Lissin, & Duarte, 2007, p. 535). A clinical inference is a process of data transformation, an inferential-interpretative process that involves structural and personal schemes: "[It] involves not only a theoretical framework and clinical experience but also personality and cognitive style characteristics" (Leibovich de Duarte, 2010, p. 31). This process implies a complex inferential function that is necessary to understand another person´s experience. Based on these inferences, clinical professionals make a presumptive diagnosis and design a possible therapeutic plan. Knowing how clinicians make decisions

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in their daily practice leads to the study of their process to hypothesize a diagnosis.

There are empirical research studies that are focused on the therapist variable, the incidence of their therapeutic framework (Ablon & Jones, 2005; Eells & Lombart, 2003; Goldfried, Raue & Castonguay, 1998; Roussos, Lissin, & Duarte, 2007), and experience levels (Eells, Lombart, Kendjelic, Turner, & Lucas, 2005; Mayfield, Kardash, & Kivlighan, 1999). In one of the studies about the clinical inferential process, Rutsztein (2005) examined the clinical inferential process of Argentine psychotherapists with an eating disorder case, and Etchebarne (2013) did the same with a Generalized Anxiety Disorder case. To our knowledge, there are no published studies about the clinical inferential process of Argentine clinical psychologists dealing with a depressive disorder case. Regarding Argentine psychologists´ theoretical frameworks, a recent study has shown that the most common include psychoanalysis and cognitive therapy (Alonso, Gago, & Klinar, 2018; Dagfal, 2018; Korman, Viotti, & Garay, 2016).

This study aims to understand how Argentine clinical psychologists with two different theoretical frameworks—cognitive therapy and psychoanalysis—and two different experience levels-senior and junior-formulate diagnostic hypothesizes on the same clinical material of a patient with chronic major depressive disorder.

Method

The patient variable was controlled by using the same clinical material (the first session of a therapeutic treatment) as a stimulus. This stimulus session was used to study (a) similarities and differences between theoretical framework groups in the way they deal with clinical material and produce clinical inferences, and (b) similarities and differences between groups with dissimilar experience in the way they deal with clinical material and generate clinical conclusions.

Participants

Twenty-eight Argentine clinical psychologists with two different experience levels and two theoretical frameworks were recruited (see Table 1).

All the clinical psychologists work in clinical settings in Buenos Aires City, Argentina, with a psychoanalytical framework (n = 14) or a cognitive framework (n = 14). They have received training and supervision in renowned Argentine psychotherapeutic institutions. According to their experience level, they are senior psychotherapists (n = 14) and junior psychotherapists (n = 14) (see Table 2).

Materials

The materials include the stimulus session of a patient with depressive symptoms—audio- recorded and transcribed verbatim—and three questionnaires about several aspects of the clinical inferential process (see Table 3).

Table 1.
Senior and Junior Psychologists' Characteristics

	Junior (n = 14)	*Senior* (n = 14)
Theoretical framework		
Psychoanalysis	7	7
Cognitive therapy	7	7
Professional training		
Hospital	7	3
University postgraduate degree	6	2
Private institution	1	1
Combined [a]	0	8
Institutional setting		
Public hospital	11	0
Private institution	2	6
Private practice	1	4
Combined [b]	0	4

[a] Clinical psychologists who combined divers options (i.e., hospital training and postgraduate university degree).

[b] Clinical psychologists who combined divers options (i.e., working in a public hospital and a private institution).

Table 2.
Professionals' Age, Gender, and Clinical Experience

	Age (years old)	Gender		Clinical Experience
		Female	Male	
Juniors (n = 14)	M = 28.35; SD = 2.46	11	3	M = 2.71; SD = 1.22
Seniors (n = 14)	M = 50.42; SD = 4.76	9	5	M = 23.57; SD = 2.82

Table 3.
Materials

Stimulus session audio-recording
Stimulus session verbatim transcript
Psychotherapeutic Resources Used Questionnaire
Diagnostic Inferences and Treatment Planning Questionnaire
List of Psychotherapeutic Goals

Audio-Recorded Stimulus Session. The stimulus session presented to the psychotherapists was selected according to the following criteria: It was the first audio-recorded interview session of a patient with depressive symptoms. The session had to feature a few interventions by the interviewing psychotherapist and no theoretical jargon. Two independent expert clinicians—one psychoanalyst and one cognitive therapist—checked the patient's diagnosis. To avoid bias, the experts were prevented from determining the interviewing psychotherapists' clinical framework . The stimulus session was the first interview of a 58-year-old childless widow, with chronic depressive symptoms; she was retired and had a middle-income and intermediate educational background. The patient meets the DSM-IV criteria for Chronic Major Depressive Disorder according to the MINI. The severity of her depressive symptoms was measured with Beck Depression Inventory, second edition (Ahnberg, Dobson, & Dozois,1998), and the score was DBI-2 = 21. The patient was not receiving psychopharmacological treatment at the moment of the interview. The interview lasted 44 minutes.

The *Verbatim* Transcript of the Stimulus Session. It was *a verbatim* transcript according to the guidelines set forth by Mergenthaler and Stinson (1992). The complete transcription consisted of 6,159 words.

Psychotherapeutic Resources Questionnaire. It includes 16 questions about the participants' clinical inferential production and the words or sentences they considered relevant in the *verbatim* transcript. Nine items are Likert-scale questions (e.g., "How much do you trust inferences?"; "How much attention did you pay to the silences, the emotional mood, or the content of the session?"); five items are open questions (e.g., "What is your presumptive diagnosis?"), and two items are yes-no questions (e.g., "Do you consider your inferences as speculations?").

Diagnostic Inferences and Treatment Planning Questionnaire. This questionnaire was designed to elicit different aspects of the participants' clinical inferences that could not be obtained while they were listening to the audio-recording and reading a *verbatim* transcript of the stimulus session. It consists of seven items about diagnosis and treatment (e.g., "In your opinion, how severe is the clinical case that you have listened to?", "How long a treatment would you recommend for this patient?").

List of Psychotherapeutic Goals. It is a list of common psychotherapeutic goals, and participating psychotherapists had to select the five most important ones in their clinical practice (e.g., the ability to deal effectively with problematic issues; strengthening self-esteem; symptom mitigation). It refers to the psychotherapeutic goals in their general clinical practice and not only specifically to the stimulus session; at the end of the list, the participants were able to add other goals freely.

Procedures

Study participants took the following steps to formulate their clinical inferences. They were asked to underline what they considered relevant in the printed transcript while listening to the audio-recording of the stimulus session. Whenever possible, they were asked to freely express their inferences, hypotheses, ideas, questions, or comments about the stimulus session. When a psychologist wanted to say something, the audio-reproduction of the stimulus session was stopped, and the participating psychologist´s statement was recorded. Finally, participants were asked to complete (1) the Psychotherapeutic Resources Used Questionnaire, (2) the Psychotherapeutic Goals List, and (3) the Diagnostic Inferences and Treatment Planning Questionnaire.

Data Analysis

Participating clinical psychologists' inferential statements were transcribed *verbatim*, and two independent judges classified the clinical inferences, using the classification devised by Leibovich de Duarte et al. (2001) (see Table 4). The judges were doctoral-level psychologists, and their doctoral dissertations also addressed clinical inferential process issues. The inter-judge agreement was evaluated using the kappa test, and the score was 715.

Table 4.
Clinical Inference Content Classification

Interpersonal: The way the patient relates to peers, family, and others.
Intrapsychic: The patient's internal world.
Family situation: The structure and functioning of the patient's family.
Etiological: The origin or cause of the patient's current mental disorder.
Diagnostic: The diagnostic category made on the patient's symptoms.
Prognostic: The future course of the disorder or the treatment results.
Feasibility: Considerations associated with the possibility of starting treatment.
Developmental: The vital cycle that the patient is currently undergoing.
Psychotherapy relationship: Considerations concerning the role of the psychotherapist, the patient, and their relationship.

Nonparametric statistical tests were used. The Pearson chi-square test was used to analyze associations between qualitative variables. The Mann-Whitney Test was used to calculate the comparisons between two groups and the Kruskal-Wallis Test was used for comparisons among the four groups.

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Ethical issues

The total safeguard of professional secrecy regarding the patient's identity, as well as the identity of the psychotherapist who conducted the stimulus session and that of the participants was guaranteed. All the participants gave their informed consent.

Results

Twenty-two out of 28 clinical psychologists formulated clinical inferences within the first 5 minutes of the stimulus session. Half of the first 22 clinical inferences were diagnostic inferences. Examples of first diagnostic clinical inferences follow:

> "The patient says that she is depressed, that she had two previous episodes, one with the loss of her mother, and that she had not received psychotherapy before. Also, there is something that I don't understand, because she then begins to say 'I, in analysis', then I don´t understand if it is something personal or if she received therapy afterwards or if she was taking some medicine. I don't know, but, so far, this is a question I have. And then, the interpretation she makes of her discomfort, that it is due to being over-protected, excited about life, and that life, later on, turned out to be different. Up to here, that is all." (Senior cognitive therapist, time 1' 24", *verbatim* transcript line 17).

> "In what the woman is narrating, there is time compression—as if everything had happened all at once. We don't know if a month or a year has gone by. Here, when she is asked how long she has felt this way, I thought it was when she (her mother) had died. Because if she tells you that it has been a year, I say to myself, 'Well, this woman has been in pathological grief for a very long time.' The reference she made to her mother already involves a matter of loss, that she wept inconsolably when the little dog died. One might think that there is a depressive focus beyond the death issue. I would have asked her how long ago her mother had died because, if she had died two months before, it was logical for her to be in pain. I suspect that her parents must have been elderly people, because of the difference in age with her older sister. If she was born at 40 (when her mother was forty), the patient´s age is not stated, one prepares oneself for the death of very elderly parents rather than of young parents." (Senior psychoanalyst, session time: 3' 33", *verbatim* transcript line 35).

Among the other 11 clinical psychologists who did not formulate diagnostic inferences during the first 5 minutes, the diagnostic inferences emerged later or at the end, when they were asked directly about their presumptive diagnosis.

Descriptive Number of Diagnostic Clinical Inferences among Groups

During the whole stimulus session, the participating clinical psychologists formulated 456 clinical inferences in all. According to the classification of the independent judges that took part in the analysis, 87 clinical inferences were diagnostic inferences (see Table 5). There are no significant differences between groups. Examples of diagnostic inferences follow:

> "Now, she is shifting towards what made her feel good, what, at one point, she could name, and then she goes back, again and again, to this complaining litany that depressive people usually have, referring all the time to what is wrong and what she lacks." (Junior cognitive therapist, session time 23' 25", *verbatim* transcript line 274).

> "She speaks of a dream that she commented on before. She says that, when she wakes up, she looks for her husband because she thinks that her husband is by her side. And there are times when she wakes up in the morning and turns in bed and finds that empty place. And this tends to occur very often. I think that, four years after her husband´s death, her grief process should have already finished. However, for this woman, it seems that it has not finished yet." (Junior psychoanalyst, session time: 34' 37", *verbatim* transcript line 401).

Table 5.
Number of Diagnostic and Other Clinical Inferences

	Cognitive Therapists		Psychoanalysts		Total
	Junior (n = 7)	*Senior* (n = 7)	*Junior* (n = 7)	*Senior* (n = 7)	
Diagnostic inferences	41	12	11	21	87
Other clinical inferences	86	108	67	108	369

Relevant Fragments

Regarding the underlying relevant fragments of the stimulus session *verbatim* transcript, there were no significant differences among the participating groups. As shown in Figure 1, this can be seen in most of the underlined lines of the transcript. According to ANOVA, there is no significant difference between the groups. The differences between the groups emerge when the content of the inferences is considered.

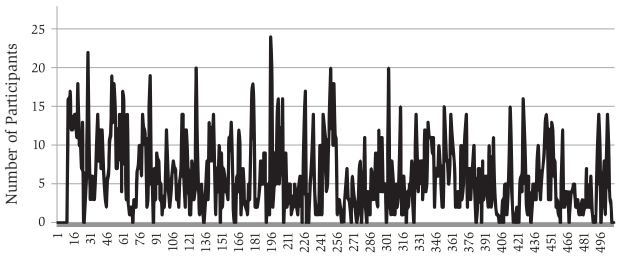


Figure 1. Underlined lines in the stimulus session verbatim transcript

Differences Found, According to Clinical Psychologists' Clinical Framework

Twenty-six out of 28 clinical psychologists formulated a presumptive diagnosis. Ten cognitive therapists and four psychoanalysts considered depression in their presumptive diagnosis, $X2(1, N = 28) = 11.63$, $p < .05$. A depressive syndrome was considered alone or with a cluster C personality disorder. Nine psychoanalysts and three cognitive therapists did not consider depression in their presumptive diagnosis. Two clinical psychologists did not formulate a presumptive diagnosis (see Table 6).

Table 6.
Number and Type of Presumptive Diagnoses

	Cognitive Therapists		Psychoanalysts		Total
	Junior ($n = 7$)	*Senior* ($n = 7$)	*Junior* ($n = 7$)	*Senior* ($n = 7$)	
Depression alone or with type-C personality disorder	5	5	2	2	14
Neurosis	-	-	3	3	6
Bereavement	-	1	1	1	3
Psychosis	1	-	-	1	2
Personality disorder	-	1	-	-	1
None	1	-	-	1	2

Note. According to DSM-5, Cluster-C Personality Disorders include avoidant, dependant, and obsessive-compulsive personality disorders (APA, 2013).

During the interview, the cognitive therapists focused more than the psychoanalysts on their emotional reaction to the stimulus session, $U = 44$, $p = .01$, $r = .49$, while the psychoanalysts focused more than the cognitive therapists on the silences in the session, $U = 49.5$, $p = .022$, $r = .43$.

As regards the general practice of psychotherapy, the use of psychometric instruments was more common among cognitive therapists than psychoanalysts, $X2(1, N = 28) = 9.95$, $p < .01$.

Cognitive therapists choose "solving problems effectively" as a psychotherapeutic goal more often than psychoanalysts, $X2$ $(1, N = 28) = 7.33$, $p < .01$.

Differences Found, According to Clinical Psychologists' Experience Level

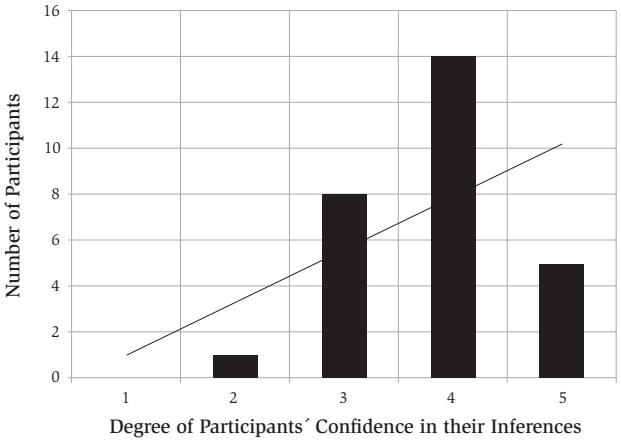
Senior cognitive therapists and psychoanalysts considered the content of the session to formulate their clinical inferences more than junior cognitive therapists and psychoanalysts, $U = 52$, $p = .018$, $r = .45$. Junior cognitive therapists and psychoanalysts more than senior cognitive therapists and psychoanalysts considered the need to know the patient's demographic data, $U = 54.5$, $p = .035$, $r = .4$, and life history data, $U = 53$, $p = .028$, $r = .41$, to formulate their clinical inferences.

When it comes to rating severity, junior cognitive therapists and psychoanalysts considered that the patient had a more severe problem as compared to the one senior cognitive therapists and psychoanalysts found, $U = 49$, $p = .009$, $r = .49$.

Junior cognitive therapists considered the "reduction of symptoms" as a psychotherapeutic goal in their general practice more than junior psychoanalysts, $X2(1, N = 28) = 5.6$, $p < .05$.

Similarities Found among Participants' Groups

It seems that all clinical psychologists participating in this study took into account the following aspects of the session to formulate their clinical inferences: the emotional tone, the content, and the patient's assumptions or attributions. Additionally, 19 participants (5 junior cognitive therapists, 3 junior psychoanalysts, 5 senior cognitive therapists, and 6 senior psychoanalysts) reported having a high or a very high level of confidence in their clinical inferences (see Figure 2).



The Likert scale of participants´ confidence in their variables follows: 1 = Very low, 2 = Low, 3 = Average, 4 = High, 5 = Very high.

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One junior cognitive therapist found it necessary to include the suicide risk assessment. No participating clinical psychologist mentioned medical problems or history of emotional episodes as information required to formulate a diagnosis.

Discussion

The period of time before the first clinical inferences surfaced was very brief and very similar to the time observed by Leibovich de Duarte (2010) and Leibovich de Duarte et al. (2001). Twenty-two clinical inferences were made within the first 5 minutes of listening to the stimulus session, and only half of these first clinical inferences were diagnostic hypotheses. Among the other half of clinical psychologists, the diagnostic hypotheses emerged later on or at the end, when they were asked directly about their presumptive diagnosis. When it came to listening to a patient with depression at a stimulus session, the clinical psychologists who participated in this study formulated early clinical inferences, but they were cautious and did not arrive quickly at a diagnostic hypothesis. When they were asked about their presumptive diagnosis, 14 participating clinical psychologists took into account the patient's depressive issue in the stimulus session to make their possible diagnosis. This finding warns about underdiagnosis and the difficulty in detecting depression (Valdes, Contreras, Romero, Medina, Norero, Dussaillant, et al., 2006). As mentioned above, the experts diagnosed the stimulus session case as depression, and within this sample, cognitive therapists considered depression more often than psychoanalysts. This result might be moderated if we consider the content of some clinical inferences among the psychoanalysts who diagnosed neurosis and the number of participants. Thus, we should be cautious before jumping to conclusions about this issue. Another consideration is that, as cognitive therapy and depression have been linked since Aaron Beck´s first studies were published, cognitive therapists may be likely to consider a depression diagnosis more often. Additionally, cognitive therapy for depression is currently one of the most studied psychological treatments (Cuijpers, 2017). However, this issue requires more research to confirm this difference with larger samples.

Almost every junior cognitive therapist mentioned the depression diagnosis in their first diagnostic inferences. It is interesting to point out the coincidence with Torricelli´s study (2006) involving psychiatric residents, where she showed the possibilities these professionals focused on before formulating a diagnosis. The similarity between junior cognitive therapists and psychiatric residents supports Wampold's (2001) notion about the medical model of psychotherapy within the cognitive therapy field. Nonetheless, four psychoanalysts diagnosed depression, and not all of them focused on neurosis. The clinical psychologists who diagnosed depression did not make any remarks on the characteristics of depressive symptoms. While the stimulus session patient mentioned having depressive symptoms for several years, study participants did not consider the chronic course. Instead, the personality disorder comorbid with depression refers to the persistent pattern of symptoms along her life span.

Asked to choose between different options in the questionnaire, cognitive therapists paid more attention than psychoanalysts to the effect of the stimulus session on themselves, which is an interesting finding, since cognitive therapy does not focus on this issue while training psychotherapists. It could be a characteristic of cognitive therapy in Argentina (Korman et al., 2015), but more research is necessary on this issue.

The participating psychoanalysts considered "the silences in the session" more often than cognitive therapists in their inferential formulation. Still, there were no clinical inferences based on the effect of silences during the stimulus session on participants.

The junior clinical psychologists considered that the stimulus session patient had more severe symptoms than what the senior ones found. The less experienced psychologists may have overestimated the patient´s symptoms. However, another option is also possible: the more experienced psychologists may have underestimated the severity of the symptoms.

Based on the question about these professionals' general clinical practice, not only about the stimulus session, we noticed that the use of psychometric instruments is widespread among cognitive therapists but not as much among psychoanalysts. This finding is similar to the results of Rutsztein´s study on eating disorders (2005)—another study conducted in Argentina with a sample of psychoanalysts and cognitive therapists. Yet, the use of psychometric instruments proved quite restricted in terms of diversity, since the only one mentioned by the cognitive therapists in this study was Beck´s Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). It should also be noted that this question does not refer to the depressive problems of the patient in the stimulus session but to psychologists´ clinical practice in general.

When asked about another aspect of their practice, junior clinical psychologists more than their senior counterparts focused on the "reduction of symptoms" as a psychotherapeutic goal, regardless of their theoretical framework. This finding is closely related to the growing tendency to emphasize symptom reduction over other psychotherapeutic goals. Future studies with larger samples should focus on the relationship between this feature and the changes in psychotherapy in Argentina (Korman et al., 2016).

As an open and flexible attitude is an essential trait for effective psychotherapists (Beutler et al., 2004), it is relevant to consider the fact that the participants, in general, showed a high level of confidence in their clinical inferences. On the one hand, this confidence may prove necessary in certain situations, such as an emergency or when working with high-risk behavior. On the other, if clinical psychologists are too confident in their clinical inferences, then it may prove difficult for them to change their hypotheses. Among others, the hypothesis-testing

approach developed by Persons and Tompkins (2007) and Gambrill's (2005) critical thinking model of can be taken into account when supervising and training clinical psychologists.

Even though the experts did not consider suicidal risk as a possibility in this case, they found it pertinent to do a suicide risk assessment. It is interesting to point out that, except for one junior cognitive therapist, all other participating clinical psychologists did not mention the suicide risk assessment. On this crucial clinical aspect of depressive patients, participants seemed not to follow current recommendations and international consensus standards (APA, 2010; NICE, 2018). This attitude matches other findings in Argentina regarding the gap between clinical practice and the consensus in the treatment of mental disorders (Garay, Donatti, & Fabrissin, 2018).

The differences between junior and senior clinical psychologists regarding the severity of the stimulus case point to the need to have assessment instruments that are used by psychologists. This, coupled with the limited use of clinical assessment tools, suggests the need to encourage greater communication among psychological evaluation specialists and clinical psychologists to build a collaboration that favors a proper analysis of depressive issues and treatment outcomes. It is also necessary to know if this is a general practice problem and, if so, to emphasize the evaluation and detection of suicide risk in the population affected by depression during psychologists' training and supervision. The promotion of interdisciplinary work is also relevant to address this issue.

The results of this study show how important it is to know what clinical psychologists do in their clinical practice to include specific instruments in their training and supervision, as well as in university syllabuses and health policies. Thus, we could generate and disseminate the necessary instruments for the assistance of the population affected by depressive disorders. By establishing how clinical psychologists formulate their diagnostic hypotheses, it is possible to design and implement better training strategies. Further development is required to promote a more effective practice and better psychotherapeutic assistance for the population affected by depressive disorders.

This study focused on the clinical inferential process as a therapeutic variable in the diagnosis of depression, an essential aspect of detection and psychological treatment of depression, a predominant mental disorder. The conclusions presented in this study should be considered with caution because this study features a number of limitations, including a non-probabilistic intentional sample. This methodological decision, which is coherent with the aims of this study, restricts the generality of its findings to the local community of clinical psychologists involved in the assistance of depressive issues.

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NOTA

[1]BDI: Beck Depression Inventory scores (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961).