

## Perceptions of Depression among Never-Depressed and Recovered-Depressed People<sup>1</sup>

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*We assessed perceptions of the impact of depression among two groups of currently nondepressed adults (Beck Depression Inventory score  $\leq 9$ ). The recovered-depressed (RD) participants ( $n = 25$ ) had a history of major depressive disorder but had been recovered for at least 2 months since the most recent depressive episode. Never-depressed (ND) participants ( $n = 25$ ) had no history of major depressive disorder. Participants completed the Self-Appraisal Questionnaire (Coyne & Calarco, 1995) as an assessment of beliefs about the experience of having been depressed. RDs rated depression as having more severe aftereffects than did the NDs. They reported feeling more loss of energy, being a burden on others, need to hide depression symptoms, strength drawn from depression, need to maintain a balance in life, fear of relationships, fear of taking risks, fear of recurrence of depression, and sense of stigma. These results replicated the findings of Coyne and Calarco (1995) and extended them to a more fully recovered population. These perceptions are important to understand because a person's ideas about depression may influence treatment outcome and susceptibility to future episodes.*

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Understanding lay people's perceptions of depression is important for several reasons. How recovered depressed (RD) people perceive the experience of depression may influence how they structure their lives following an episode and how susceptible they will be to future episodes (Coyne & Calarco, 1995). For example, RDs may avoid taking risks in professional life or personal relationships for fear of becoming depressed and unable to meet those demands. By organizing their lives with a lack of involvement and social support, however, they may be making

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themselves more vulnerable to future episodes of depression (Coyne & Calarco, 1995).

In addition, beliefs that never-depressed (ND) lay people have about depression may affect the quality of support experienced by people suffering from depression. A good deal of research has focused on depressed people's often conflictual and distressed intimate relationships (e.g., Feldman & Gotlib, 1993), but less is known about their more casual, more numerous social ties with coworkers, neighbors, classmates, or simply fellow community residents. Research on interpersonal theories of depression suggests that even brief interactions can lead to depressed people's being rejected (Segrin & Abramson, 1994). Understanding such negative reactions may be facilitated by learning more about how lay people view depression. If one takes depression to be fairly similar to ordinary bouts of sad, depressed mood that nearly everyone experiences, and to be addressable effectively by engaging in commonsense self-help activities, one might react very differently to persistent signs of depression in an acquaintance or colleague than if one views depression as a devastating disease qualitatively distinct from ordinary experience and likely in need of professional treatment. This issue was vividly described by a participant in a focus group on depression reported by Coyne and Calarco (1995): "It's like telling somebody to snap out of cancer. . . . Even my dentist said 'You know [as he is drilling away], I get depressed sometimes, but it just doesn't last very long and I can snap out of it,' . . . and I would just like to drill him!" (p. 157).

Several studies have examined lay perceptions of depression. Research by Rippere (e.g., 1977, 1979, 1980) established that, on average, lay people have a detailed and reasonably accurate set of beliefs about depression, but there are individual differences in perceptions of depression. Having suffered a depressive episode oneself appears to be one correlate of these individual differences. For example, in one study (Furnham & Kuyken, 1991), participants who reported having been depressed rated interpersonal difficulties as more important in accounting for depression than did participants who had not been depressed.

In our study, we contrasted perceptions of depression among (a) a community sample of people who had recovered (for at least 2 months) from a major depressive episode and (b) a demographically similar group of people with no history of major depression. We asked both groups of participants about the impact of being depressed using the Self-Appraisal Questionnaire (SAQ) developed by Coyne and Calarco (1992) on the basis of focus group discussions with current and former depressed patients regarding their experiences of depression and its effects. The SAQ consists of nine subscales: having low energy, being a burden on others, hiding symptoms, perceived strengths from depression, balancing activities to avoid recurrence, sense of stigma, fear of future relationships, fear of taking risks, and fear of recurrence. Recovered depressed women differed significantly from women who had never been depressed on all SAQ subscales except the perception of having developed personal strengths from surviving depression (Coyne & Calarco, 1995). Many of the RDs remained in treatment at the time of the Coyne and Calarco (1995) investigation, and we examine in this study whether the effects would be obtained among (a) those with a longer period of recovery post-treatment, and (b) a sample including both men and women.

## METHOD

### Participants

The participants were 50 adults (25 RD and 25 ND) who had responded to newspaper advertisements. To be included in either group, participants needed to meet the following criteria: (a) currently nondepressed (Beck Depression Inventory of  $\leq 9$ , as recommended by Kendall, Hollon, Beck, Hammen, and Ingram, 1987); (b) no history of manic or hypomanic episodes; (c) no history of primary psychotic ideation, and no bizarre behavior or impaired mental status evident on the day of the study; (d) no current suicidality; (e) no substance abuse or dependence (other than nicotine dependence) in the previous 6 months; (f) no use of antidepressant medication or of psychotherapy for depression in the previous months; and (g) age at least 18 years.

ND participants had to meet two additional criteria: (a) no past major depressive episodes (MDE) and (b) no history of dysthymic disorder. RD participants had to meet three additional criteria: (a) positive history of major depressive disorder by DSM-IV (American Psychiatric Association, 1994) criteria; (b) experience of at least one MDE in the previous 3 years not precipitated and sustained by drug or organic factors; and (c) complete recovery from the most recent MDE (asymptomatic by SCID criteria) at least 2 months prior to the study. Requiring at least 2 months of asymptomatic functioning is consistent with the recommendation of the MacArthur Foundation Research Network on the Psychobiology of Depression (Frank et al., 1991) that at least 8 symptom-free weeks be considered a consensus definition of full recovery from an MDE.

Anxiety disorder diagnoses were recorded but not used as inclusion or exclusion criteria. Eight of the RD participants (32%) received DSM-IV anxiety diagnoses: 3 had social phobia, 2 panic disorder, 1 PTSD, and 2 both panic disorder with agoraphobia and past PTSD. Two of the ND participants (8%) received anxiety diagnoses, one with social phobia and one with panic disorder with agoraphobia.

### Measures

#### *Beck Depression Inventory*

The Beck Depression Inventory (BDI; Beck, Rush, Shaw, & Emery, 1979) is a self-report measure of current depressive symptom severity, with extensive evidence of high internal consistency and high convergent validity with independent interviewer ratings (Beck, Steer, & Garbin, 1988). As indicated earlier, participants in either group had to score  $\leq 9$  on the BDI to be included in the study.

#### *Inventory to Diagnose Depression—Lifetime*

The lifetime version of the Inventory to Diagnose Depression (IDD-L; Zimmerman & Coryell, 1987), a 22-item self-report measure designed to correspond to DSM-III depression criteria, was used for sample description purposes and to corroborate the RD/ND diagnoses we derived from structured interviews.

### *Beck Scale for Suicide Ideation*

The Beck Scale for Suicide Ideation (BSI; Beck, Steer, & Ranieri, 1988) is a 19-item self-report measure of suicidality that is highly correlated ( $>.90$ ) with clinical ratings of suicidal ideation (Beck, Steer, & Ranieri, 1988). The first five questions of this measure, which serve as an overview of suicidality, were used to screen out potentially suicidal people (i.e., anyone scoring above 0).

### *Structured Clinical Interview for DSM-IV*

Diagnoses were derived on the basis of relevant portions of the nonpatient edition of the Structured Clinical Interview for DSM-IV (SCID-I/NP; First, Gibbon, Spitzer, & Williams, 1995). Williams et al. (1992) reported adequate interrater reliability for major depression diagnoses based on an earlier version of the SCID. In our study, SCID interviews were conducted by clinical psychology PhD students under the supervision of a licensed psychologist (David A. F. Haaga) with experience using SCID protocols in research and the immediate direction of an advanced PhD candidate (Ari Solomon) with independent SCID-I training and certification and experience conducting SCIDs in several clinical trials. All SCID interviews were audiotaped to facilitate evaluation of interrater agreement. A randomly selected subset of 20 SCID audiotapes (40% of the total sample,  $n = 11$  RD,  $n = 9$  ND) were submitted to the supervising psychologist (David A. F. Haaga) for an independent diagnostic evaluation conducted without awareness of the original diagnosis. There was 100% agreement between these judgments.

### *Self-Appraisal Questionnaire*

The Self-Appraisal Questionnaire (SAQ; Coyne & Calarco, 1992) is an 81-item self-report measure of perceptions of the experience of depression. This measure was developed from themes identified in a focus group on the effects of depression (Coyne & Calarco, 1995). Each item consists of a statement to which the participant indicates her or his extent of agreement on a 1 (strongly disagree) to 5 (strongly agree) Likert-type scale. Internal consistency of the nine SAQ subscales in our sample was high, with the exception of the "sense of stigma" subscale. In particular, Cronbach's alpha's were as follows: (1) lack of energy (.92); (2) sense of being a burden (.85); (3) need to hide symptoms (.85); (4) finding strengths in depression (.87); (5) needing to maintain a balance in life (.86); (6) reduced involvement in relationships (.87); (7) fear of taking risks (.89); (8) fear of recurrence (.84); and (9) sense of stigma (.58). These were generally similar to the reliability findings obtained by Coyne and Calarco (1995). We computed subscale scores as the mean item score on each subscale.

### *Semistructured Interview on Depression Experience*

Participants were asked about any previous academic or professional experience they may have had dealing with depression.

## Procedure

Participants took part in the study individually. After completion of informed consent, the BDI and the BSI were administered. Those scoring  $\leq 9$  on the BDI and 0 on the BSI (thus remaining eligible for the study) next completed the exclusionary portions of the SCID. Participants who were not excluded based on the SCID then completed the SAQ as well as several other measures not relevant to this report (Solomon, Haaga, Brody, Kirk, & Friedman, 1998). Finally, participants were interviewed regarding any past academic or professional experiences with depression, treatment history, and detailed histories of mood disturbances among the RD participants. At the end of this interview and testing session, participants were debriefed, offered low-cost therapy referrals if appropriate, and paid \$20 for their time.

## RESULTS

### Demographics, Depressive Symptoms, and Personal Experience

Descriptive data on demographics and depression variables are summarized in Table I. As intended, RD and ND groups were very similar demographically. Corroborating the SCID results used in group classification, the RD group reported much more severe depression in the past on the IDD-L ( $M = 41.48$ ) than did the ND participants ( $M = 12.67$ ). RD participants also obtained significantly higher scores on the BDI ( $M = 3.88$ ) than did the ND group ( $M = 2.04$ ). Although this is not ideal from the standpoint of clearly distinguishing effects of current vs. past depression, it should be noted that the RD average score is still well within the nondepressed range on the BDI.

A majority of participants (72%;  $n = 36$ ) reported no prior academic study of depression, and 84% ( $n = 42$ ) had no professional experience working with depression (e.g., conducting research, providing clinical services). Thus, the sample appears representative in terms of having largely a lay rather than professional/scholarly perspective on depression.

**Table I.** Demographics and Depression Data for Recovered-Depressed and Never-Depressed Participants

	RD ( $n = 25$ )	ND ( $n = 25$ )	$t(48)$	$p$
Demographics				
Age	37.28 (12.18)	40.04 (13.08)	.77	.44
Female (%)	76	76		
Caucasian (%)	76	76		
Depression history				
IDD-L	41.48 (12.00)	12.67 (10.55)	8.91	<.01
No. of Prior MDEs	Median = 3	—		
Current depressive symptoms (BDI)	3.88 (2.65)	2.04 (2.44)	2.55	.01

*Note:* Except as noted otherwise, numbers are means, with standard deviations in parentheses. IDD-L = Inventory to Diagnose Depression, Lifetime version; MDEs = major depressive episodes; BDI = Beck Depression Inventory; RD = recovered depressed; ND = never depressed.

### Self-Appraisal Questionnaire

There were no significant sex differences on any of the SAQ subscales. Also, the distribution of each variable was explored and found not to violate the assumption of normality. Accordingly, RD/ND comparisons were based on *t*-tests, and male and female participants were considered together in these analyses.

The RD group scored significantly higher than did the ND group on each of the nine subscales of the SAQ. That is, the RD participants reported feeling more loss of energy, sense of being a burden on others, need to hide depression symptoms, strength drawn from depression, need to maintain a balance in life, fear of relationships, fear of taking risks, fear of recurrence of depression, and sense of stigma (Table II). All of these subscale differences between groups were large, according to the effect-size conventions proposed by Cohen (1988) (see Table II), and all subscale differences remained significant in ANCOVA statistically controlling for current depressive symptoms (BDI) (see Table II).

Thus, even after a minimum of 2 months of complete recovery, RD participants depicted themselves as scarred in a number of ways by their experiences of depression. To provide another perspective on the enduring nature of these effects, we correlated time (in months) since the most recent depressive episode with SAQ subscale scores within the RD subsample. None of these nine correlations was significant (*r*s from  $-.25$  to  $.30$ ), suggesting that the impact of major depression may be relatively stable even after clinical recovery.

#### Single and Multiepisode RDs

The 18 RD participants who had more than one previous episode were then compared to the 7 RD participants who had reported only one episode in order

**Table II.** Self-Appraisal Questionnaire Subscale Scores for Recovered-Depressed and Never-Depressed Participants

Subscale <sup>a</sup>	RD ( <i>n</i> = 25)	ND ( <i>n</i> = 25)	<i>t</i> ( <i>df</i> )	<i>d</i>	<i>F</i> (1,47) controlling BDI
	<i>M</i> ( <i>SD</i> )	<i>M</i> ( <i>SD</i> )			
Energy	3.86 (.59)	1.84 (.81)	10.14 (48)	2.85	83.99
Burden	2.73 (.77)	1.51 (.56)	6.33 (48)	1.81	30.99
Hide	2.78 (.74)	1.84 (.65)	4.79 (48)	1.34	16.14
Strength	4.01 (.94)	3.09 (.90)	3.53 (48)	1.00	13.43
Balance	2.83 (.72)	1.66 (.54)	6.51 (48)	1.83	32.61
Relationships	2.00 (.64)	1.27 (.39)	4.88 (39.4)	1.38	17.05
Risk	2.19 (.71)	1.31 (.46)	5.19 (40.8)	1.47	18.76
Recurrence	2.53 (.51)	1.51 (.44)	7.62 (48)	2.17	44.53
Stigma	2.29 (.93)	1.47 (.50)	3.93 (36.9)	1.11	13.57

Note: *d* = Cohen's *d* [by convention, .20 = small, .50 = medium, and .80 = large effect size (Cohen, 1988)]. All *t*-tests in this table were significant at .01 level. *F*-tests are ANCOVA controlling for Beck Depression Inventory, and all *F*s in this table are significant at the .001 level.

<sup>a</sup>Energy = lack of energy subscale of the Self-Appraisal Questionnaire (SAQ); Burden = fear of being a burden subscale; Hide = need to hide symptoms subscale; Strength = strength from depression subscale; Balance = need to find a balance in life subscale; Relationships = fear of relationships subscale; Risk = fear of taking risks subscale; Recurrence = fear of recurrence subscale; Stigma = stigma associated with depression subscale.

to assess whether a chronic, recurrent depression might be associated with different perceptions. The only significant difference was that the single-episode RD participants expressed significantly less fear of recurrence ( $M = 2.13, SD = .40$ ) than did the multiple-episode RD subgroup ( $M = 2.69, SD = .47$ ),  $t(23) = 2.81, p = .01$ . On all other SAQ subscales, the two subgroups did not differ significantly.

### *Anxiety Disorder Comorbidity*

To explore the possibility that the experience of depression would be different for those with comorbid anxiety disorders, we compared SAQ subscale scores among RD participants with any current or past anxiety disorder and those with no history of an anxiety disorder (Table III). These two subgroups did not differ significantly on any SAQ subscales, and in most cases the absolute value of mean differences was very small.

## DISCUSSION

Two groups of currently nondepressed people—one group with a history of major depression (RD) and one group without (ND)—responded to questions about the phenomenology of depression. The RD group significantly exceeded the ND group on all subscales of the SAQ, indicating a perception of depression as a more debilitating experience with a more sizable impact on self-conceptions.

For the most part, our results replicate those of Coyne and Calarco (1995). One exception is that we found RD people to score higher than the ND group in finding strength from the experience of surviving depression, a comparison that

**Table III.** Self-Appraisal Questionnaire Subscale Scores for Recovered-Depressed Participants with or without Anxiety Comorbidity

Subscale <sup>a</sup>	RD/Anxiety	RD/No Anxiety diagnosis	<i>t</i> (22)	<i>p</i>
	( <i>n</i> = 8) <i>M</i> ( <i>SD</i> )	( <i>n</i> = 16) <i>M</i> ( <i>SD</i> )		
Energy	3.70 (.44)	3.94 (.67)	.91	.38
Burden	2.82 (.83)	2.68 (.79)	.41	.69
Hide	3.04 (.83)	2.63 (.70)	1.24	.23
Strength	4.05 (1.07)	4.04 (.92)	.03	.98
Balance	3.17 (.68)	2.63 (.70)	1.83	.08
Relationships	2.07 (.72)	1.86 (.48)	.83	.42
Risk	2.28 (.75)	2.06 (.65)	.75	.46
Recurrence	2.77 (.50)	2.39 (.49)	1.79	.09
Stigma	2.50 (.87)	2.08 (.87)	1.11	.28

<sup>a</sup>Energy = lack of energy subscale of the Self-Appraisal Questionnaire; Burden = fear of being a burden subscale; Hide = need to hide symptoms subscale; Strength = strength from depression subscale; Balance = need to find a balance in life subscale; Relationships = fear of relationships subscale; Risk = fear of taking risks subscale; Recurrence = fear of recurrence subscale; Stigma = stigma associated with depression subscale.

was nonsignificant in Coyne and Calarco (1995) and that merits additional evaluation in future research.

Our findings extended Coyne and Calarco's conclusions to support the idea that having an MDE is associated with different perceptions of the experience of depression, even after full recovery. This difference in perception was evident even though our RD participants had been fully recovered for at least 2 months; also, perceptions of depression were not correlated with length of time since the most recent episode. Taken together, these findings suggest that the impact of depression on self-conceptions is part of long-term remission, not just transient adjustment. Consistent with this conclusion, a study (Coyne, Gallo, Klinkman, & Calarco, 1998) published after we completed our research also obtained significant differences on a shortened version of the SAQ between fully recovered, RD people and ND people.

To our knowledge, ours is the first study to compare the experience and aftereffects of depression among RD people with and without an anxiety diagnosis. We found no significant differences between these subgroups of RD people, but conclusions must be tentative, given our small sample sizes for this comparison and should be evaluated further in future research. Likewise, future research might also do well to evaluate gender differences in more detail, taking into consideration both gender of respondent and gender of the depressed person on whom perceptions are based. We found no significant gender differences on the SAQ, but had only a small subsample of men, rendering these findings tentative.

Also in need of further study is the issue of whether individual differences in perceptions of the impact and experience of depression affect susceptibility to future episodes. Some of these perceptions may be important to target in depression treatment to prevent future relapse. For example, the fact that RD people report fear of relationships may be a factor that contributes to their increased risk for future depressive episodes because they have limited their social support network (Coyne & Calarco, 1995). In addition, people may become more susceptible to future depression because their fears of becoming depressed again may cause them to interpret certain symptoms in a catastrophic way, which could snowball into a depressive episode (for example, they have trouble falling asleep and interpret this as a sure sign of depression, which makes them even more depressed) (Coyne & Calarco, 1995). Successfully targeting such interpretations in treatment may be a particularly important mechanism of reducing "depression about depression" (Teasdale, 1985) and thereby achieving positive outcomes (Fennell & Teasdale, 1987).

Finally, future research could also extend our findings by asking ND people about their perceptions of the experience of depression *as they relate to those who have suffered major depression*. It is possible, for instance, that ND people regard their own bouts of sad and depressed mood as relatively mild and as successfully "treatable," by watching television or going to a basketball game with a friend, but nevertheless realize that the experience is different for the clinically depressed. The aggravating feature of the insensitive dentist discussed by Coyne and Calarco's (1995) focus group participant (quoted in the introductory paragraphs) is not so much that his own periods of depression were minor and transient,

but that he appeared to be glibly projecting such an experience onto the depressed patient as well. Research on such vicarious-experience appraisals might shed additional light on the social context of depression. Such measures might also prove informative in individual-differences research on the impact of vicarious experiences of depression (e.g., having a relative or friend who experiences a depressive episode) or as dependent measures for evaluating public information campaigns about depression.

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