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ARE WE FACING AN EPIDEMIC OF DEPRESSION? AN ETHNOGRAPHIC STUDY IN TWO PSYCHIATRIC OUTPATIENT CLINICS IN MILANO

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Al mio amico Maffo.

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Introduction – The need for a sociology of mental health

According to the Global Burden of Disease, depressive disorders are identified as the second most prevalent form of psychopathology of the century, affecting an estimated 280 million people or 3.8% of the global population in 2019 (Global Burden of Disease Collaborative Network, 2020). Their significant prevalence, only exceeded by anxiety disorders, has prompted the World Health Organization to categorize both depressive and anxiety disorders within the "Common Mental Health Disorders" classification. These conditions are notably widespread worldwide, frequently occur together (comorbidity), and significantly influence the moods and feelings of those affected, producing distress and disability (World Health Organization, 2017).

Depression increased by 10.5% between 2010 to 2019 (Global Burden of Disease Collaborative Network, 2020). Longitudinal studies confirm a rising prevalence of depression in the last decades of the 20th Century that led to the expression “epidemic of depression” (Hidaka, 2012). Moreover, depression found more and more space in both the scientific, political, and economic discourse, as well as in common sense. In the 1980s, depression entered the most used classifications of mental disorders and since then become more frequent in the public discussion (Horwitz & Wakefield, 2007). Recently, during the COVID-19 pandemic, we have learned about this constant reference to depression and mental distress. Depression seems to be a typical state of this era, and as such, it is necessary to understand why it has taken up so much space or has been granted so much space.

The concept of depression, rooted in history for over two thousand years (Coppo, 2005), has recently gained prominence in scientific, political, and economic discourse, as well as in common sense. By the 1980s, depression was formally incorporated into the most widely used classifications of mental disorders, leading to its increased prevalence in public discussion (Pignarre, 2012). As a result, depression has become increasingly prominent in common reasoning and public debates, emerging as a recognized "social problem”. Mainly studied by disciplines such as psychology and psychiatry, which aim to understand the etiology and development of this disorder in individuals, depression needs to be studied as a subject of investigation in sociology for the following reasons.

First, from a sociological perspective, individual experiences are embedded in wider dynamics, specifically social dynamics. Therefore, understanding personal distress necessitates

contextualizing it within its epoque (Mills, 1959). As sociologists, we can try to understand which are the structural basis for individual problems, as well as the social contexts in which is easier to find them. For example, the COVID-19 crisis has intensified the risk factors commonly linked to deteriorating mental health, such as financial insecurity, unemployment, and fear. Meanwhile, protective factors like social connection, employment, and educational engagement have significantly diminished (OECD, 2021).

Secondly, despite depression existing as a psychological condition characterized by low mood and loss of interest in everyday life, its classification as a disorder hinges upon a system of knowledge that recognizes it as psychopathological in a certain time and culture (O'Reilly and Lester, 2016).

Depression has become a dominant focus of discussion and inquiry in Western societies, dominating clinical practice, treatment modalities, and research in mental health. Great importance is given to this condition by scientific research and political agendas, as well as great are the interests of the pharmaceutical industry in the revenues by the treatment of this condition (Horwitz, 2010; Pignarre, 2012). As mentioned, the increasing awareness of this health issue has extended beyond academic and political realms, becoming integrated into everyday common-sense reasoning as a recognized "social problem." What was once typically viewed as an individual psychological disorder to be managed by medicine has now transformed into a widespread societal concern that requires collective attention and intervention.

Within this context, it is necessary to investigate the actual procedures of construction and definition of depression as a problem, examining how this form of distress became an object of inquiries and policies. The causes of social problems are not the social processes that determine them but the processes that define those conditions as problematic (Kitsuse & Spector, 1973). Studying depression as a social problem means taking into account its history, definition, the actors involved, the conflicts and resources in play (Caniglia and Recchi, 2018).

Therefore, recognizing the embedded nature of depression in social dynamics, we can address it through a sociological perspective. The use of the "sociological imagination" enables us to connect personal problems with public issues, providing awareness about the relationship between personal experience and the wider societal context (Mills, 1959). Through a sociological lens on depression, it becomes evident that the phenomenon is not solely rooted in psychological and biological factors. Societal influences play a significant role in the

development of mental distress. Within this framework, biological and psychological aspects, such as mood disorders, are integrated into social dynamics when considering how individuals, professionals, national healthcare systems, and society as a whole address this issue.

Psychiatric investigation and practices frequently prioritize individual aspects over social considerations, with biological perspectives concentrating solely on the brain, and psychological perspectives highlighting the influence of childhood adversities on mood regulation (Coppo, 2005). Conversely, comprehending mental health issues necessitates maintaining a focus firmly rooted in human reality, encompassing all the inherent complexities that arise from it (Maj, 2015). Within a biologically reductionist model of mental disorders, sociology has played a vital role in preserving the social dimension of psychiatry, showing since the beginning the importance of socioeconomic circumstances in the study of mental health (e.g. Durkheim and suicide, labelling theory, psychiatric social control, social constructionism of mental health problems) (Armstrong, 1986).

For those instead interested in the history or anthropology of mental disorders, two significant challenges emerge: from a biological perspective, the positivist temptation to reduce disorders to mere chemical processes; from a sociological perspective, the relativist temptation to disregard the biological dimension of humanity and dissolve the concreteness of pathology into the abstraction of purely social functions. These two inclinations ultimately represent a noteworthy aspect of the difficulty in assessing the social role of the notion of the psyche in our society. The disagreements on the causes, definitions, and treatments of pathologies, with their understandable uncertainties from a psychiatric standpoint, serve as indicators of the complex transformations undergone by the concept of personhood throughout modernity. Depression, furthermore, possesses its singularity: no prominent authors seem to have extensively studied it (Ehrenberg, 1997).

Coming to the specific topic of our research, which is depression, we recognize two perspectives for its social inquiry. The first perspective assesses social factors' relevance in the occurrence of depressive disorders. In this way, research explores which contexts, personal characteristics and socio-economic variables are associated with depression. While some factors are cultural, such as self-realization and the aim of success, others are structural, such as adversities and inequalities. The epidemic of depression, as well as the higher prevalence in Western and modernized countries, should be explained by these theories (Coppo, 2005; Ehrenberg, 1997; Horwitz and Wakefield, 2007).

The second perspective, conversely, does not take the existence of depression as a fixed entity but understands how collective and cultural mechanisms shape psychopathologies, highlighting the connections between the environment, representations and treatments adopted by human groups. This approach embraces the idea that the definition of diagnosis categories is a way to define what is normal and what is pathological (Crowe, 2000). Instead of a tool to detect an existing distress, diagnostic categories work in the other way around. Diagnosis is the active process of labelling the patient's experiences through an explicative category, defining its traits and development (Georgaca, 2013). In this sense, some authors claim that depression should be regarded as a culturally and historically situated phenomenon, giving attention to the way the distress is conceptualized and assessed in the general population (Coppo, 2005, Horwitz, 2010; Horwitz and Wakefield, 2007).

In this study, depression is approached as both a social problem and a medical category. The research explores various aspects of depression, including its determinants, theories on aetiology and treatment, and the diagnostic process. On one side, we employ a phenomenological approach to understand the social determinants of depressive symptoms through the narration conveyed by patients. Simultaneously, we consider how professionals interact with depression from a clinical perspective, in terms of representations concerning its nature and treatment. Through an integrated approach, the study seeks to gain a comprehensive understanding of depression, analysing its societal context and dynamics, and recognizing it as both a clinical reality and a discursive product.

The study addresses, more generally, the following research questions. Are we facing an epidemic of depression? What do we mean by depression? How is such an epidemic explained? What do professionals think about depression and its determinants? What social dynamics are involved in the emergence of depressive symptoms in patients? These questions are interconnected.

Each chapter allows us to address a specific question and lays the groundwork for the next one. We will begin with: Is there an epidemic of depression currently underway? This is the focus of the next chapter (Chapter 1). We will respond using statistics from various sources regarding the global prevalence of depression. Subsequently, a review of literature in sociology, anthropology, psychology and psychiatry will help us better understand how depression has been defined throughout history (Chapters 2 and 3). Also, some of these theories will help us explain what may have led to defining it as an epidemic (Chapter 4).

Theoretical explanations are sometimes insufficient to speculate on the relationships between the social context and the emergence of depressive symptoms. We will, therefore, interview mental health specialists to obtain an account of their practices and to understand how depression is represented at the discursive level (Chapter 6). Finally, we will also analyse the patient component through participant observation of clinical practices and an analysis of clinical documentation to understand which social needs and contexts are determining factors for the emergence of depressive disorders (Chapters 7 and 8). The methodology used for the empirical part of this research can be found in Chapter 5 and in the Appendix.

Part 1 - Theoretical Perspectives

Chapter 1 – An epidemic of depression? A closer look at global and local estimates of the prevalence of depressive and anxiety disorders

1 Introduction

Our journey to understand this epidemic of depression will begin by examining estimates of the prevalence of depressive disorders in both the global, European and Italian populations. This type of data has been seldom used in the last decades as proof of the existence of this epidemic by national and international institutions, primarily by the World Health Organization (WHO), to claim attention in public and scientific discourse about the necessity of interventions through healthcare intervention and research fundings.

We will show data from 2019 to 2022 from different sources, namely the Global Burden of Disease (GBD) by the World Health Organization, OECD reports on mental health and antidepressants consumption, Eurostat European Health Interview Survey (EHIS), data from Italian National Statistical Institute (Istat) and the Italian Ministry of Health (Ministero della Salute), and data from the Territorial Health Agency of the Metropolitan City of Milano (Azienda Territoriale Sanitaria (ATS) Città Metropolitana di Milano). Data show that depression and anxiety have different prevalences in the population's subset, according to gender, age class, income, education, and world region. However, data also show some contradictions and lack of consistency, which we will discuss in the chapter.

From this analysis, we can state that depressive disorders have been diagnosed more and more in the last decades. The term "epidemic" is justified by the high increase in prevalence assessed in the global population (Hidaka, 2012). Possible explanations have been posed for this increasing prevalence, mainly ascribed to two different groups. On one side, social processes brought the transformation of contemporary living conditions, directly affecting psychosocial well-being and increasing depressive symptoms. On the other side, depression is more assessed than in the past, and we can explain these differences through increased attention to mental health problems and well-being. Both accounts involve social processes. These explanations will be reviewed in Chapter 4.

We will end the chapter by questioning the conceptualization of depression used while assessing its prevalence in global and local data. We will provide methodological as well as historical and cultural evaluations of the concept used here. A wider review of the concept of

depression in psychiatric, psychological, and sociological literature, with its controversies and limitations, will be instead the topic of Chapters 2 and 3.

2 The global burden of disease and the common mental health disorders

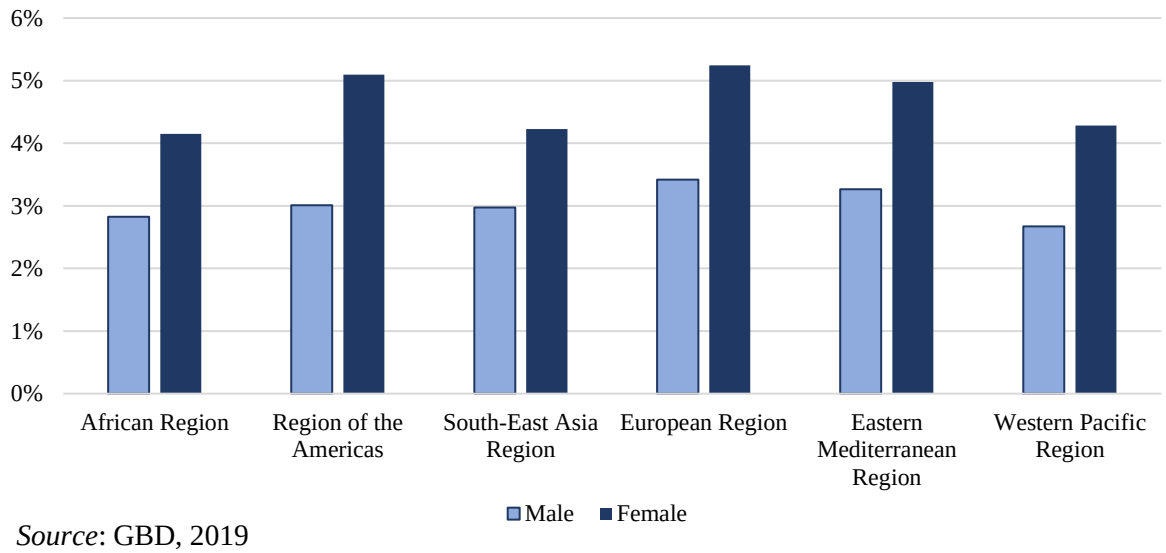
The World Health Organization (WHO) is the main global actor involved in the promotion of healthy lifestyles and conditions, defining the main health problems at the global and regional levels, and promoting programs that can coordinate a response to health emergencies (World Health Organization, 2023a). One of the goals of this institution – as well as other national and international health institutions – is to identify the main health problems that can affect people, understand their spread, and recognize their consequences and future scenarios. The organization promotes intervention work by identifying the individual, social, and structural determinants of mental health, and then intervening to reduce risks, build resilience, and establish supportive environments for mental health (World Health Organization, 2023b; 2023c). Now, we will present review data to gain insight into how depression is distributed worldwide.

The primary source used by WHO in recent years to assess the global prevalence of depression is the Global Burden of Disease (GBD) data. The Global Burden of Disease is a study carried out by a consortium of more than 3,000 researchers in more than 145 countries, to capture premature death and disability from more than 350 diseases and injuries in 204 countries, by age and sex, from 1990 to the present (Global Burden of Disease Collaborative Network, 2020). The last data available is from 2019, whose results were published in The Lancet in October 2020 (GBD 2019 Risk Factors Collaborators, 2019). The study is considered a reliable source by different national and international policymakers, such as the World Health Organization, that use this data for dissemination purposes as well as planning interventions (Mathers, 2020). Due to its reputation and availability, this source is well-used also in academic literature (Brhlikova, Pollock & Manners, 2011). We will start from these data to discuss the prevalence of depression in populations of different areas and personal characteristics.

2.1 GBD data: prevalence of depressive disorders in the global population

Data from the Global Burden of Disease show that depressive disorders[1] are the second most common psychopathology of the century, with 280 million people estimated to have these conditions in 2019, affecting 3.8% of the global population. The share of the population with depression ranges mostly between 1.8% and 6.7% in different countries (Global Burden of Disease Collaborative Network, 2020). However, as we can observe in Figure 1, the highest rate is reported in the European Region and the lowest in the Western Pacific Region and Africa. There is also a higher prevalence in women compared to men (globally 4.5% of the female population compared to 3.0% of the males).

Figure 1 - % people with depressive disorders, by sex (WHO Regions)



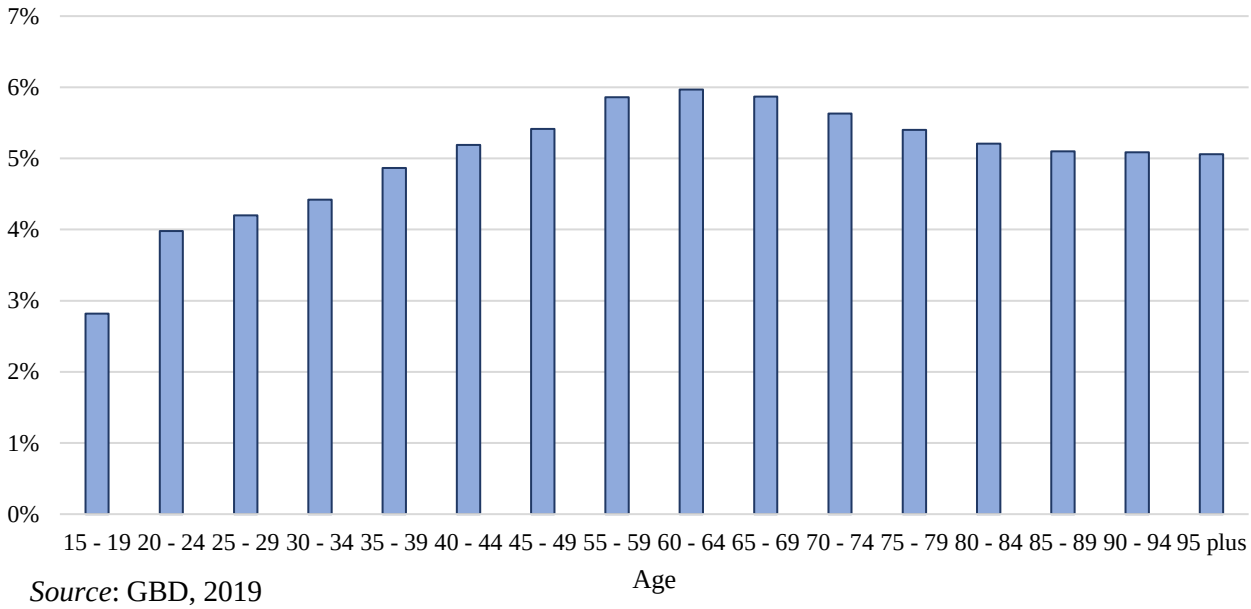
Source: GBD, 2019

Figure 2 shows the global prevalence of depressive disorders according to age. Depression prevalence increases for the whole life course and has its peak in the age class 60-64 years old. While age differences persist for all regions, the age peak can vary between them but generally comes around 60 years old (except for Region of the Americas in which depressive disorders

[1] The study considers with "depressive disorders" people affected by Major Depressive Disorder as well as by Dysthymia.

reach a peak between 45 and 49 years old and in Africa for people over 80 years old). Figure 1 shows the prevalence of depressive disorders by sex, according to WHO Regions.

Figure 2 - % people with depressive disorders per age (Global Population)



Source: GBD, 2019

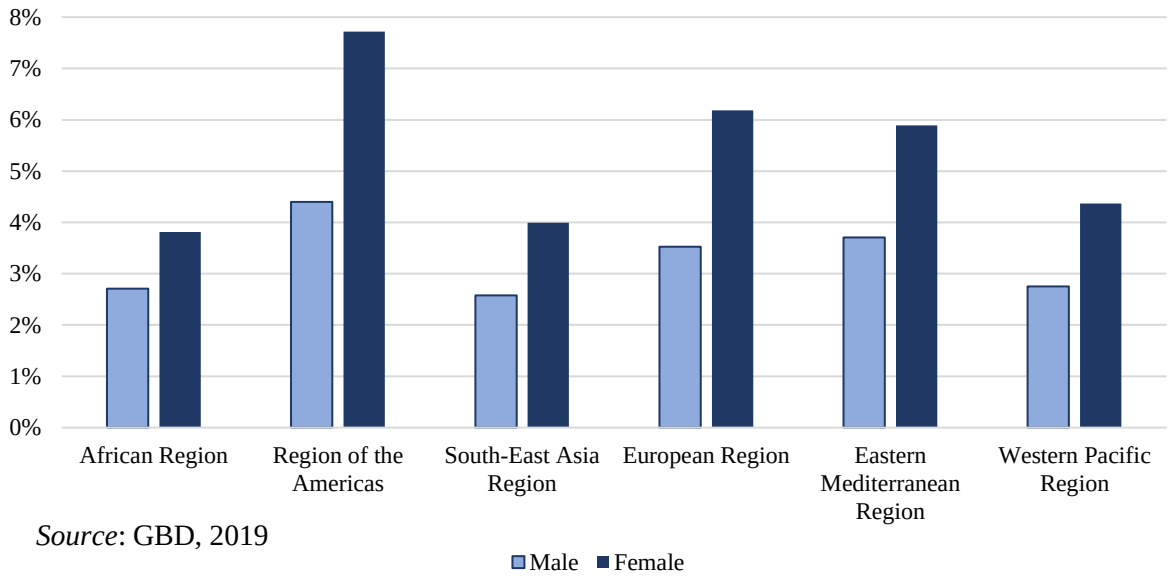
2.2 GBD data: prevalence of anxiety disorders in the global population

We want to show here some data about anxiety disorders as well, even if the research question is related to depressive disorders. The history of psychiatry demonstrates how the two syndromes have consistently been viewed as overlapping (Horwitz, 2010; Shorter, 2013a) and share similarities in terms of symptoms. They often co-occur and share pharmacological treatment options such as antidepressants and benzodiazepines (Belzer and Schneier, 2004; Kessler et al. 1996; Pollack, 2005).

In 2019, an estimated 301 million people worldwide suffered from anxiety disorders, surpassing even the number of people with depressive disorders. Around 4.1% of the global population is affected by this condition, with the range varying from 2.1% to 9.1% depending on the country (Global Burden of Disease Collaborative Network, 2020). The highest rates, according to WHO Regions, are in the Region of the Americas, and lower in Africa and the

South-East Asia regions (Figure 3). Analogous to depressive disorders, considering the global population there is a higher prevalence of people with anxiety disorders for the age class 40-44 years old, and for women (5.0%) compared to men (3.1%). However, the highest prevalence of people with anxiety disorders differs for age classes according to the different WHO Regions, with the peak between 15 and 29 years old in African, Eastern Mediterranean, European, and South East-Asia Regions, while for American and South-East Asia Regions between 40 and 49 years old. This implies that in certain regions, the condition predominantly affects younger generations, while in others, it predominantly affects middle-aged individuals[2].

Figure 3 - % people with anxiety disorders, by sex (WHO Regions)



Source: GBD, 2019

2.3 Common mental health problems and health loss

According to the data, depressive and anxiety disorders are the most common mental health disorders, with more than 580 million people affected by these two conditions (Global Burden of Disease Collaborative Network, 2020). Taking into consideration their high rates, the World Health Organization includes them in the category of "Common Mental Health Disorders". Both of these conditions are prevalent among the global population and are often encountered

[2] For this high heterogeneity in distribution, differently from what we did for depressive disorders, we will not show age class distributions for anxiety disorders.

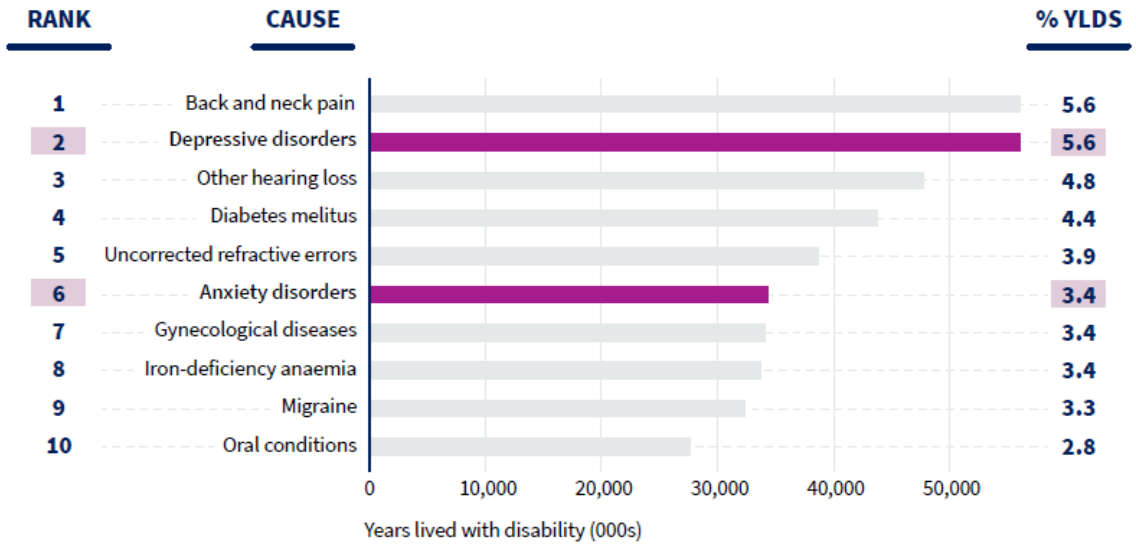
simultaneously, a phenomenon referred to as comorbidity (World Health Organization, 2017 and 2023b).

The attention from the World Health Organization is not related only to the spread of these conditions in the global population, but also due to the considerable losses in health and functioning. Global Burden of Disease estimated depressive disorders to be the second largest contributor to non-fatal health loss in 2019, with 46.86 million Years Lived with Disability worldwide, 5.5% of all YLD for any health conditions. It is specifically for young people that depression represents a significant cause of disability: for example, between 20-24 years old depressive disorders produce 8.7% of all the YLD (Global Burden of Disease Collaborative Network, 2020). In the general population, only one-third of the symptomatic cases follow a moderate-severe development (World Health Organization, 2017)[3].

Conversely, while anxiety disorders are more prevalent than depression, they affect people, with 28.68 million Year Lived with Disability (3.4% of all YLD), affecting more the younger generations, with 6.4% of all the YLD for the class age 15-19. Anxiety disorders represent the sixth largest contributor to non-fatal health loss in 2019 (Global Burden of Disease Collaborative Network, 2020). Figure 4 shows the top ten leading causes of disability for the global population in 2019. Common mental health conditions (highlighted bars) are in the top ten, demonstrating their importance for health loss in terms of years lived with disability.

[3] The Global Burden of Disease has four ways to consider health loss: 1) Deaths; 2) Years of Life Lost (YLL); 3) Years Lived with Disability (YLD) which is a measure of years lived with disability; 4) Disability-Adjusted Life Years (DALYs) that represents the number of years lost due to illness, disability, or early death. In our case, anxiety and depressive disorders are considered conditions that do not cause death directly. This means that the first two indicators (Deaths and YLL) do not apply to these conditions. Also, DALYs are calculated by summing the value obtained for the YLD with the value obtained with the YLL. This means that, as depression is not considered a direct cause of death, the value for DALYs will correspond exactly to the YLD value, as the value for YLL will be 0. This means that, according to these data, we can consider the Years Lived with Disability as the only measure accountable for assessing health loss.
Also, while the GBD data does not regard depressive disorders as potentially deadly conditions in the assessment of health loss, the World Psychiatric Association and the WHO consider them as associated with premature mortality for suicide (Herrman et al., 2019; World Health Organization, 2017).

Figure 4 – Top ten leading causes of global years lived with disability (YLDs), 2019



Source: World Health Organization, 2022

3 OECD Countries, Europe, Italy

We considered the Global Burden of Disease Study as it is the only source of data that covered all countries and regions in the world for many years. However, data about mental health disorders are generally available for different samples, covering global, regional, national, and subnational samples. We will present here some other data sources to provide closer insight into regions of interest for this study.

3.1 OECD Countries

A study by the Organisation for Economic Co-operation and Development (OECD) compares the prevalence of depression and anxiety symptoms before and after the beginning of the COVID-19 pandemic in OECD15 countries, using data from different national sources. According to data, before the COVID-19 pandemic, 7.5% of the population experienced

depression and related symptoms, but in 2020, this number rose to 21.9%. Likewise, anxiety and its symptoms increased from 12.3% before the pandemic to 24.6% in 2020 (OECD, 2021)[4].

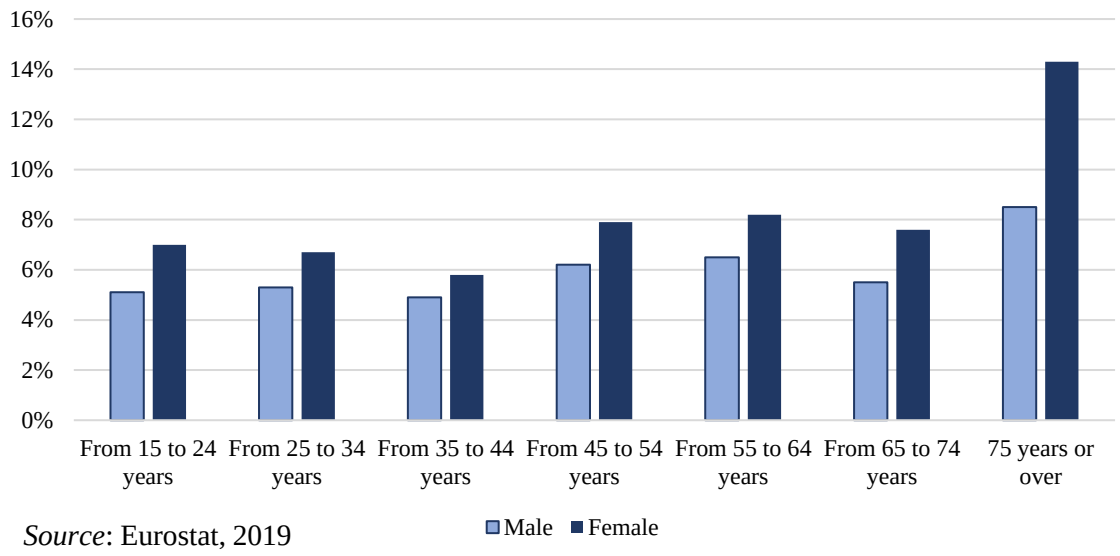
3.2 Europe

We previously showed some data about the European Region according to the Global Burden of Disease Study, which assessed depressive disorders in 4.4% of the population and 4.9% of anxiety disorders, more present in females than in the male population. Depressive disorders' prevalence is growing through the age class until age class 55-59 years old, while conversely, anxiety disorders are decreasing from age class 15-19 (Global Burden of Disease Collaborative Network, 2020)[5].

However, we possess additional data sources for Europe. The European Health Interview Survey is run by Eurostat in all European Union Member States about health status (including disability), health determinants (lifestyle) of the EU citizens and use of health care services and limitations in accessing it. These data cover the population from 15 years old and aim at a harmonized basis and with a high degree of comparability among nations (Eurostat, 2020). According to data, depressive symptoms occur in 7.0% of the population of the European Union, with a prevalence of 5.9% for the male population and 8.1% for the female population. The prevalence of depressive symptoms in the European Union population according to age class and sex is shown in Figure 5. Depressive symptoms' prevalence is 6% for the age class 15-24, increasing from 45 years old and doubling for the age class 75+ years old, reaching 12.0% (Eurostat, 2021).

[4] Prevalence before Covid-19 pandemic is calculated using different national sources collected between 2013 and 2020. OECD15 includes Australia, Austria, Belgium, Canada, Czech Republic, France, Italy, Japan, Korea, Mexico, New Zealand, Spain, Sweden, United Kingdom, United States.
[5] Prevalence for the European Union is 4.6% for depressive disorders and 5.8% for anxiety disorders (Global Burden of Disease Collaborative Network, 2020).

Figure 5 - % people with depressive symptoms, per age class and sex, European Union



Source: Eurostat, 2019

Depressive symptoms are more prevalent within the less educated and their prevalence decreases through the increasing of educational level (9.8% for people who have completed at *most* a *lower secondary education* compared to 4.6% for people with tertiary education - Odds Ratio: 2.13). In the same way, their prevalence is higher for the population with the lowest income and decreases while income is growing (11.5% for the population in the first income quintile compared to 4.2% for the population in the fifth income quintile – Odds Ratio: 2.76). The data shows a slightly higher prevalence of depression in urban areas, with a rate of 7.7%, as compared to towns, where it stands at 6.8%, and rural areas, where the prevalence is slightly lower at 6.3%.

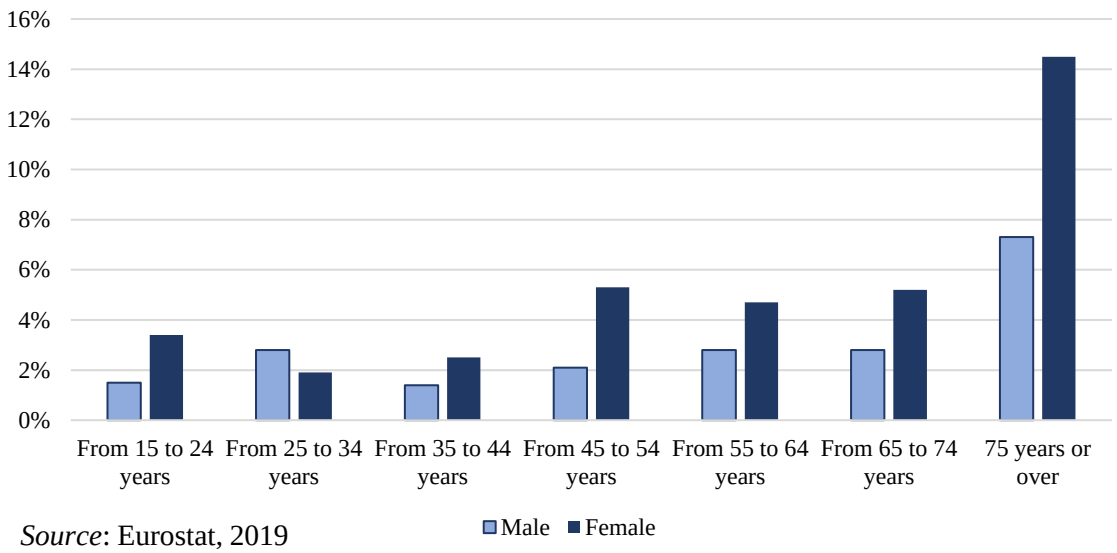
3.3 Italy

As our empirical study will take place in Italy, we can also briefly present some data regarding the prevalence of depressive and anxiety disorders in the Italian population. According to GBD data, depressive disorders are estimated to be 4.6% of the population, while anxiety disorders comprise 6.2%. As it happens for the European Region, depressive disorders are growing through the age class until the age class 55-59 years old, while conversely, anxiety disorders are decreasing from age class 15-19, and both disorders are more prevalent in females than in male population (Global Burden of Disease Collaborative Network, 2020).

According to OECD data, in Italy, the prevalence of depression and its symptoms increased from 5.5% of the population before the COVID-19 pandemic to 17.3% in 2020. In the same year, the prevalence of anxiety and related symptoms was 20.8%[6] (OECD, 2021).

According to Eurostat sources, the share of persons aged 15 and over reporting depressive symptoms was 4.2% in 2019 (5.5% for females and 2.8% for the male population). Depressive symptoms' prevalence increased through the life course, starting from 2.4% for the age class 15-24, increasing from 45 years old, and doubling after 75 years old, reaching 11.5% (Figure 6) (Eurostat, 2021).

Figure 6 - % people with depressive symptoms, per age class and sex, Italy



Source: Eurostat, 2019

Depressive symptoms are more prevalent within the less educated and prevalence decreases through the increasing of educational level (5.6% for people who have completed at *most* a *lower secondary education* compared to 2.5% for people with tertiary education - Odds Ratio: 2.24). The prevalence is higher for the population with the lowest income and decreases while income is growing (5.1% for the population in the first income quintile compared to 3.2% for the population in the fifth income quintile – Odds Ratio: 1.59). As it happens for the general

[6] No data available before 2020.

European Union population, the prevalence is inversely proportional to income, but in this case, the differences between income quintiles are smaller (Eurostat, 2021).

The Italian National Institute of Statistics (Istat), provided data concerning mental health in 2015, where depression is estimated to affect 2.8 million (5.4% of the people aged 15 and over). Depression is often associated with severe chronic anxiety: in 2015 7% of the population over the age of 14 suffered in the year of anxiety-depressive disorders. The prevalence of depression and anxiety disorders grows through age classes, with higher frequencies observed among women, those with lower levels of education, and individuals with lower incomes. These disorders are also more prevalent for those who perceive limitations in everyday activities and insufficient social support (Istat, 2018).

The Ministry of Health (Ministero della Salute) provides every year data on how many people were treated for mental health conditions by the public healthcare system. According to this source, in 2021 the amount of people treated for depression was 34.9 per 10,000 inhabitants (43.5 per 10,000 inhabitants for the female population vs 25.3 for the male population per 10,000 inhabitants). Depression represents the disorder with the second highest prevalence within these patients (22.0%), after schizophrenia and other psychosis, and it's also the disorder with the highest incidence for new public service users (Ministero della Salute, 2022). Still, these data do not represent the whole population but only account for those who were registered as patients in public healthcare services. Patients treated by private health professionals (such as psychiatrists, psychotherapists, counsellors, and other professionals), those whose symptoms are managed through medications provided by general practitioners or emergency rooms, and those whose symptoms go untreated are not included in these figures.

3.4 Lombardia and Milano Metropolitan Area

According to the Italian Ministry of Health, the number of people treated for depression in Lombardia was 39.0 per 10,000 inhabitants (49.1 per 10,000 inhabitants for the female population vs 28.4 for the male population per 10,000 inhabitants), values slightly higher than national estimates. Depression represents the disorder with the highest prevalence among these patients (25,4%), and it's also the disorder with the highest incidence among new service users (Ministero della Salute, 2022).

The Territorial Health Agency of the Metropolitan City of Milano (Azienda Territoriale Sanitaria (ATS) Città Metropolitana di Milano) reported a prevalence of mood disorders of 6.4

per 1,000 inhabitants (4.5 for men and 8.2 for women) in 2018. These data include both depressive and bipolar disorders and these are based on diagnoses made for patients who accessed public services (ATS della Città Metropolitana di Milano, 2021).

3.5 Antidepressant consumption

We can get some information about the extension of depressive disorders by looking at the use of antidepressant drugs. Although antidepressants aren't the exclusive treatment for depressive disorders, they serve as the primary pharmacological intervention for such conditions. Monitoring drug consumption is a common metric utilized to gauge the heightened attention towards diagnosing and managing the disorder across various contexts.

According to OECD data, the use of antidepressants increased by nearly two and a half times from 2000 to 2020 in 18 European countries, according to Organization for Economic Cooperation and Development (OECD) data. In 2000, the average antidepressant consumption across 18 European countries was 30.5 DDD (defined daily dose)[7] per 1,000 inhabitants, while in 2020 rose to 75.3 DDD, an increase of 146%.

Between 2010 and 2020, the increase in 24 OECD countries whose data are available, antidepressant consumption increased by 44%. In the same period, Italian consumption increased only by 14%, confirming itself as one of the countries that has the lowest use of antidepressants in the group (44 DDD every 1000 inhabitants). Between 2019 and 2021, there was an increase of 10% or more in consumption of antidepressant drugs in the 14 OECD countries for which data is available. However, as the earlier figures show, there has been a steady increase in the consumption of antidepressants consumption over the last 20 years, so the recent rise cannot necessarily be attributed to the pandemic (Yanatma, 2023).

National estimates by the Italian Ministry of Health confirm this data, showing the consumption of antidepressants in 2021 was 44.2 DDD for every 1,000 inhabitants, representing 85.1% of the pharmaceutical treatments provided for patients of public structures. For the Lombardia region, it is estimated consumption of 42.3 DDD per 1,000 inhabitants (Ministero della Salute, 2022).

[7] Defined Daily Dose (DDD): The assumed average maintenance dose per day for a drug used for its main indication in adults (World Health Organization, 2023e).

The Italian Pharmaceutical Agency (Agenzia Italiana del Farmaco, AIFA) estimated the national consumption of antidepressants as 44,6 DDD per 1,000 inhabitants in 2021, which increased by 2.4% compared to the previous year and with an average annual increase of 1.9% since 2014 (Agenzia Italiana del Farmaco, 2022).

4 The epidemic of depression. Possible explanations

4.1 Is the epidemic real?

We have shown the prevalence of depressive and anxiety disorders for different samples in different areas of the world. While data points differ from different sources, what we can certainly say is that the number of people diagnosed as depressed increased over the last decades. Specifically, according to GBD data, depressive disorder prevalence increased by 13.6% in the last 30 years (from 3.31% to 3.76% between 1990 and 2019) and by 10.5% in the last 10 years (from 3.59% to 3.76% between 2010 and 2019) (Global Burden of Disease Collaborative Network, 2020). According to Eurostat, values in the European Union grew by 7.7% in five years (from 6.5% to 7% between 2014 and 2019) (Eurostat, 2021). OECD data shows that depression increased through the start of the COVID-19 pandemic (OECD, 2021) and data about the consumption of drugs see the use of antidepressants as more than doubled in the last 20 years for OECD Countries (Yanatma, 2023).

How can we explain the rise in the prevalence of depressive disorders? Can we consider these changes as relevant? This prompts a critical examination of whether this phenomenon can be defined as an epidemic and an exploration of the rationale behind its current prominence in public discourse.

Many epidemiological studies, in different subnational samples, assessed the increase of depressive symptoms over time. Longitudinal studies confirm a rising prevalence of depression in the last decades of the 20th Century that led to the expression “epidemic of depression” (Hidaka, 2012). In the opposite position, some other authors claim that, although the crude number of cases increased, we cannot talk about an epidemic of depression, as this growth is explained by the population growth and changing of the age structure, as the prevalence of depressive disorders increases through life course (Baxter et al., 2014). Similarly, the World Health Organization (2017) stated that the growing percentages from 2000 to 2015 naturally followed the ageing of the world population, especially in lower-income countries, but then

changing its position after the COVID-19 pandemic, raising concerns about the rise of about 25–27% in depression and anxiety in the first year of the pandemic its consequences (World Health Organization, 2022). Finally, others believe that more than a real depression epidemic we are facing an epidemic of the use of antidepressants (Summerfield, 2006),

Which conclusions can we draw from this? It seems like the claim of an "epidemic" of depression comes mostly from how it is given attention to this issue. Most of the authors presented in this dissertation believe in an increase in depressive disorders prevalence and are not explaining it through the ageing explanation. In the same way, the most recent epidemiological reports, presented in the first part of this chapter, claim the importance of taking into account this growing prevalence and its consequences. We can believe that something is happening in terms of the increase of depressive disorders prevalence in the adult population, at a global level.

4.2 Two sets of (sociological) explanations for the epidemic of depression

So, what kind of explanations have been given to prove this epidemic by social scientists? Many authors consider the rise of depressive disorders as something that belongs to our é*poque*, at least from the 1980's. According to these authors, the possibility of being diagnosed as depressed mainly increased within the last four decades, while it was almost non-existent before that. This reflects a bigger phenomenon that took place in the last forty years and that implies a change in the way we think about psychiatric problems and in general individuals' *self* in Western societies. We can delineate two sets of explanations from social sciences literature that explain the epidemic of depression.

On one side, we have the ones who try to identify the social conditions and processes that brought about the increase in the prevalence of depressive disorders. Depression is considered the typical *disorder of late modernity* (Ehrenberg, 1997; Grippaldi, 2021), and some processes bound to modernization are responsible for the occurrence of these disorders. Specifically, high levels of competitiveness and individualization in modern capitalist contexts have the effect of increasing the demand for self-realization. The emergence of depressive symptoms is the consequence of the inability to reach high standards of oneself (Ehrenberg, 1997; Han, 2015). Together with this, western societies have seen secularization processes and the deterioration of social cohesion, which are considered to be protective factors against symptoms that can arise when experiencing losses and adverse events (Coppo, 2005).

Another group of scholars says that, instead of occurring more frequently, depression is nowadays more diagnosed all over the world. The increase in depressive disorders is mostly the consequence of evolutions and changes in psychiatric discipline. Data on the prevalence and the epidemic of depression shown so far are proof that scientists, institutions, and, the media are *measuring* depression, more than proving an actual increase in the phenomenon. The rise of depressive disorders' prevalence is a direct effect of the increased attention from different actors (Pignarre, 2012).

The new-born discourse on depression emerged with the introduction of its diagnostic category in DSM-III (1980), exported from the USA to other global contexts, substituting already existing local knowledge on psychopathology (the so-called "Americanisation of psychiatry") (Watters, 2010). The advent of the diagnostic category is the result of the psychiatric discipline's need to have a classification of mental distress, hampered by the extremely diverse theoretical approaches to the nature of diseases. The lack of consensus about how to classify mental disorders was overcome with the DSM-III, with the introduction of standardized methods of measurement and evaluation of psychiatric disorders (Shorter, 2013b).

Furthermore, the importance given to depression came as a result of the deinstitutionalization of asylums and the advent of pharmacological treatment for psychiatric disorders. Once psychosis and schizophrenia are no longer the main interest of psychiatry, and patients can be dismissed, psychiatric research is interested more in common mental health problems, widely present in the outpatient population (Ehrenberg, 1997; Grippaldi, 2021; Horwitz and Wakefield, 2007).

Finally, while some scholars see the increase in diagnosis as a consequence of better assessment instruments, others think that this is to be attributed to the misclassification of common sadness or other syndromes such as depression (Horwitz and Wakefield, 2007). The disorder is also something recently spread through media, professional, and public discourse as the disorder can typically describe these times and people's distress (Ehrenberg, 1997; Pignarre, 2012).

To sum up, the *social change explanation* sees the increase in depression as a consequence of social change. In contrast, the *diagnostic explanation* sees it as the consequence of discursive practice related to mental health and the *self*. In both cases, the importance of *context* emerges as fundamental. Chapter 4 will be dedicated to this issue.

5 Assessing the data quality of data on depression

While discussing the prevalence of depression in different populations, we should take into account some issues related to the way data are collected and the measurements involved. As the reader might have noticed in the data shown so far, there are similarities and dissimilarities between the prevalence of depressive disorders in different sources. We will now try to describe why this is possible and reflect on its implications.

5.1 Depressive symptoms vs depressive syndromes

Data presented in this chapter refer to different disorders. GBD data show the prevalence of depressive disorders (including Major Depressive Disorders and Dysthymia), OECD data show depression and symptoms of depression, and Eurostat data show depressive symptoms. Data about Italy is related to depression and mood disorders. All those measures do not represent the same phenomenon. We can briefly explain why.

Depressive symptoms are the constitutive parts of a syndrome, in this case, depression (or depressive disorders if we consider the definition by the DSM-V-TR (American Psychiatric Association, 2022). This means that the symptoms are not essentially part of depressive disorders but can be only singular symptoms or part of other syndromes. In this way, we expect a higher prevalence when talking about depressive symptoms compared to disorders. For mood disorders, this category includes also bipolar disorders and can lead to a discussion about the idea that depression and bipolar disorder could be or could not be part of the same syndrome[8].

Finally, sometimes data on the consumption of antidepressants are generally used to prove the increase of depressive disorders in the population, while this actually cannot be done. Data on the consumption represent the consumption itself and we cannot say if its increase is related to an actual increase in disorders. Data on the use of antidepressants are widely different in OECD data and do not reflect the prevalence of depressive disorders in countries (Global Burden of Disease Collaborative Network, 2020; Yanatma, 2023)[9].

[8] For a debate about this topic, see Horwitz and Wakefield, 2007.
[9] Antidepressants are not used only for the treatment of depression, but also for other psychiatric syndromes as well “off label” for other non-psychiatric disorders (Kessler et al. 1996; Pollack, 2005)

As we noted so far, there are some differences in the way depression can be represented according to the different data sources. This depends on the way a concept is measured. This moves us to debate the data quality of the sources presented previously.

5.2 Measuring depression

Data shown so far use a definition of depression that comes from the main used definitions of depression as psychopathology: the ICD-10 (World Health Organization, 2004) and the DSM-5 (American Psychiatric Association, 2013)[10]. In both sources, depression is intended as the experience of a depressed mood, loss of pleasure, or loss of interest in activities for two weeks or more. However, only Eurostat and Istat sources provide accountable measures based specifically on whole the set of symptoms defined by the DSM-5, taken from the Brief Patient Health Questionnaire, Depression Module (PHQ-9)[11] (Eurostat, 2020).

As we saw before, if we compare the GBD dataset with the Eurostat one we obtain different prevalence of depressive disorders in European Countries. This can be explained by the fact that we are accounting for different phenomena (depressive disorders vs depressive symptoms), and because Eurostat data have a standardized way to measure depression, while GBD data haven't.

5.3 Is the Global Burden of Disease data reliable?

We can now assess the quality of the data collected by the Global Burden of Diseases and other estimates of depression. The analysis shows some problems regarding 1) the unavailability of metadata; 2) the incomparability of national estimates; 3) the different outcomes for the variable of depressive disorders.

1) The unavailability of metadata: As said, GBD recently became one of the most used sources to quantify phenomena related to health. The purpose of the data collection made by the Global Burden of Diseases is to provide an estimation of the different causes of death and disability worldwide, giving insights into the prevalence of illnesses in different countries and territories (Global Burden of Disease Collaborative Network, 2020). Specifically, the GBD collects

[10] As data refer to 2019, it has been used the ICD-10 and the DSM-5, while it is now available the eleventh version of the manual, ICD-11 (World Health Organization, 2023d) and a revised version of DSM, DSM-5-TR (American Psychiatric Association, 2022).
[11] The definition and symptoms of DSM-5-TR (American Psychiatric Association, 2022) will be presented in Chapter 2.

multiple sources and through the use of statistical modelling, produces estimates for more than 350 illnesses. While the type of data that we can use is the result of this modelling, we do not have direct access to the original data and its related information, such as sample sizes, sample methods, response rates, and measures used. In this sense, without metadata that can provide us with information on the measure used, we cannot evaluate the quality of data.

2) The uncertainties of estimates: The Global Burden of Diseases is the only recent study that collects data for all countries in the world, and it is used to evaluate the prevalence of depression in different areas. However, as Brhlikova, Pollock & Manners (2011) suggest, prevalence rates are estimates, resulting from the statistical modelling of a multitude of data, and should not be treated as "facts". The uncertainties of these estimates can be very high. For instance, while we do not have evaluations on the uncertainties of data regarding the prevalence of depression, the GBD study reports that the estimated YLD for depression may vary by about ±54.8% (World Health Organization, 2020).

3) Different outcomes for the same variable: comparing data by GBD with data collected by WHO through the Global Dementia Observatory (World Health Organization, 2018) for 2015, we can observe different estimates for depressive prevalence, correlating with about 0.58. Both reports collect data from multiple sources and standardize them. Data on prevalence are based on estimates, that might not be accurate, and this can lead to different outcomes for the same variable.

These three motivations lead us to suggest taking GBD data's prevalence carefully, as data are built on estimates with some degrees of uncertainty. Comparisons between countries can be hampered by these problems, so we cannot say precisely if depression is more prevalent in some areas than in others. The same considerations can be applied while using OECD prevalence, as data is built by merging different sources.

5.4 Depression: A Discussion on the Concept

Data rely on a definition of depression that comes from the DSM-5-TR (American Psychiatric Association, 2022). However, what is defined in psychiatry as "depression" cannot be taken for granted. We'll now discuss the concept of depression from a historical, cultural, and practical perspective.

From a historical perspective, the concept of depression has ancient roots. Since the Greeks, melancholia was understood as a condition of depressed humour and body complaints that was ascribed to an excess of black bile. The concept developed throughout history until the beginning of the XIX Century, when melancholia became an interest of newborn psychiatry (Coppo, 2005) The contemporary concept used in psychiatry to define depression is quite recent. As said, one of the most used definitions of depression by the medical and psychiatric communities comes from the Diagnostic and Statistical Manual of Mental Disorders, from 1952 defines the nosology of mental disorders in Western societies. The diagnosis of depressive disorders appeared for the first time with the third edition of the DSM in 1980 (Horwitz and Wakefield, 2007).

Mental disorders should therefore be considered in the specific cultural milieu where they are defined. While we can take into account the existence of conditions of low mood that could become dysfunctional, and that this type of condition can affect every human being, what is called “depression” is a specific way of defining this dysfunction. As we previously showed how the appearance of the diagnostic category of depression took place quite recently, we should also consider that the context in which it emerged was the Western one. The redefinition of the concept came as a response from the American Psychiatric Association to provide a symptom-based classification and a more standardized way to address diagnosis for any possible mental distress, cutting broad entities that were continuous with normality to categorical diseases (Mayes and Horwitz, 2005). Several factors, including changing norms of psychiatric classification, professional and political advantage, and economic organization and marketing led to the introduction of the Major Depressive Disorder in DSM-III by the American Psychiatric Association the definition in 1980 (Horwitz, 2010; Pignarre, 2012).

Nevertheless, the definition provided by the DSM is produced by the American Psychiatric Association, mainly created to define mental distress in the United States of America population. The exportation of USA diagnostic criteria to other contexts, specifically those “culturally far”, produces an “Americanisation” of mental disorders (Wykes and Callard, 2010). In this way, statistics on depression are based on a Western idea of mood disorders, and might not reflect the way some cultures experience low mood and grief. Some cultures do not know the concept of depression in the way Western societies intend it. Both symptomatologies, as well as linguistic categories used to define these dysfunctional experiences of worthlessness and low mood, depend on the culture of provenience.

Following this path, this cultural problem also affects the way depression is assessed and measured: DSM-5-TR criteria appear to be too much bounded to the Western countries that can detect a lower prevalence in non-Western territories. Cross-cultural differences in rates of depressive disorders are attributable to the fact that various depressive symptoms, not included in the DSM framework but relevant in some cultures, are unlikely to be identified (Chang et al., 2008; Haroz et al., 2017). While GBD data shows the prevalence of depression all over the world, we cannot affirm that this disease happens to be present all over the world and with the same characteristics.

These considerations regarding the way depression is conceptualized show many weaknesses in taking into account the previous estimates. These problems are related to an epistemological vision of mental health problems that pretend to exacerbate them from their cultural, social, and historical context. In this way, the possible explanations for the heterogeneous prevalence of depression in different areas can be ascribed to different ways to understand and diagnose it. Chapters 2 and 3 will be dedicated to a conceptual discussion about depression, retracing its history and discussing its definitions according to different professionals, schools, and contexts.

6 Conclusion: towards the use of a constructive approach to mental distress

6.1 Why we do say that the epidemic is real

This chapter gave a panoramic view of depressive disorders' prevalence around the globe. We used the most recent data sources about health statistics, recognized by both the scientific community, as well as by national and international policymakers, as sources to assess the increasing prevalence of depressive disorders. Again, we have reasons to believe that depressive diagnosis is increasing, and something is happening both for reasons concerning modernization and cultural changes as well as by the changing of the norms of classification, and the exportation of Western psychiatry to other contexts.

In any case, what we want to point out here is that regardless of the existence or not of the epidemic as a real and concerning problem for all age classes in any part of the world, the epidemic can be considered real as it is reported and narrated in this way. As stated in the introduction, the causes of social problems are not the social processes that determine them but the processes that define those conditions as problematic (Caniglia and Recchi, 2018; Kitsuse

& Spector 1973). Something, indeed, changed through the last decades in terms of scientific and public awareness about depression, with implications in terms of diagnosis, measurement, treatment practices, and policies, as well as in common sense. We cannot overlook the possibility of an epidemic without examining the discursive aspects surrounding depression as a social problem.

Through the analysis of the data from the Global Burden of Disease, we found that estimates of depression in different areas of the world lack consistency. The higher rates in the Western part of the world are more likely to depend on the higher propensity to be diagnosed in these contexts. The problems in measuring depression put us in the position to draw some considerations about the way this mental distress can be studied. Specifically, we will discuss how depression should be conceived as a socially constructed phenomenon. In the next chapters, we will try to understand the epidemic of depression in a wider and more complex way, both understanding it theoretically as well as through empirical methods. The understanding of the epidemic of depression will be posed no longer through the assessment of the numerical presence of depressive patients, but conversely through the understanding of the discourses, representations, practices, social contexts, and factors involved in that. The empirical chapters will try to give an account of what is depression today from a sociological standpoint, providing a case study in two psychiatric facilities in the city of Milano.

6.2 A constructivist approach to mental health

The positivistic idea of depression used by psychology, medicine as well and social sciences tends to decontextualize the phenomenon, stripping social and psychological factors from their background context, and treating it as a distinct object (Thomas and Bracken, 2004). Conversely, the concept of depression is historically, culturally, and practically situated. The study of depression needs a situated approach and a constructivist approach to mental distress can help in this direction. But what does this mean to use a constructive approach?

Constructivism is an epistemological perspective that provides a reflexive understanding of knowledge, continuously questioning itself and the way knowledge is achieved (Hacking, 1999). Within a constructivist approach, there is no reality independent from the observer and their way of understanding it. Without falling into complete relativism, a constructive approach moves the focus of the research from objects to processes, from facts to common meanings.

Using a constructionist approach to mental health problems means that, if a psychological condition characterized by low mood and loss of interest in everyday life exists, the way it is addressed as an illness depends on the fact that a community of practices developed a system of knowledge that recognize it as psychopathological. So, while there are situations of extreme suffering and distress for patients, the fact that those conditions are considered as something pathological and abnormal cannot be taken for granted because it depends on the way it is conceptualized by a specific scientific community, in a certain time and culture (O'Reilly and Lester, 2016). A "real" part of the phenomenon (the distress) corresponds to a "constructed" part of the phenomenon (Hacking, 1999), and we can only observe and measure the latter.

Secondly, it is also necessary to investigate everyday practices that bring depression to be a socially constructed phenomenon. Specifically, practitioners' assessments are the situations where the diagnosis is made, and where a patient "becomes depressed", where his or her symptoms are now defined through a diagnostic label, also determining the type of treatment that will be followed. From a sociological perspective, that highlights the contingent socially produced character of categories of mental distress and professional practices associated, diagnostic categories are not taken for granted but instead topic of investigation (Georgaca, 2013; O'Reilly and Lester, 2016). This approach aims to examine how these systems of knowledge and practice have come to take their current form, how they are accomplished in practice, and finally the consequences for mental health institutions and people with distress.

Finally, we posited that depression is considered a social problem, with the growing interest of both scholars and political institutions. Specifically, following Kitsuse and Spector (1973), the causes of social problems are not the social processes that determine the condition but the processes that define the condition as problematic. However, it is necessary to investigate the actual procedures of construction and definition of distress as a problem, examining how this individual mood distress became an object of inquiries and policies. It is although necessary to consider the complex interplay between social forces, medical practice, and individual experiences in the construction of diagnosis and treatment of disorders (Brown, 1995). In this sense, a constructionist approach can be the key to further research in this direction.

Chapter 2 – The concept of depression: historical paths and diagnostic categories

1 Introduction

Defining depression is harder than it seems. The previous chapter was useful to point out how talking about depression could be controversial first of all for the definition of depression itself. At the basis of this chapter, there is the necessity to define what is depression. As we saw in the previous chapter, epidemiological studies define depression in most cases using the DSM-5-TR or the ICD-11 standards. While these definitions are the most used by the international research community, specified by the American Psychiatric Association and the World Health Organization, some criticisms occur in their use, both in clinical work as well in epidemiology.

What does "depression" mean and what are its characteristics? Are there different types of depressive disorders? Did depression always exist? How was conceptualized during centuries and how it is considered nowadays? This chapter is intended to answer all these questions.

The discussion on data in the previous chapter points out how different ways of conceptualizing depression can affect the way we think and measure it. Mental disorders categories and their nature are still objects of discussion in the psychiatric discipline, and this can affect the quality of the research obtained through a standardized definition of them. This dissertation, instead, will explore some of the main possible definitions and then regard them as possible tools of analysis for the empirical chapter. The definition of depression that we propose is inductively produced, instead of deductively taken from literature, and the empirical chapters (Chapters 6, 7, and 8) will be testing these definitions using data obtained from clinical practice.

The chapter will be useful to provide all the tools to understand the empirical material, as well as theories on the epidemic of depression. The literature used, as mentioned, comes from different disciplines, as we cannot exclude any of these theories to explain the multifactorial aspects of this mental disorder. We also define a brief history of the concept to better understand nowadays standpoints.

2 Brief history of the definition of depression

2.1 Melancholia: black bile and deadly sins

The history of depression is based on more than two thousand years of knowledge in Europe. While depression changed its shape through the centuries, it has always been a condition recognized by medicine, discussing its causes and boundaries, and most importantly when recognizing the condition as something pathological compared to ordinary responses to life events. Depression is perhaps the most easily recognizable psychiatric disorder throughout history. From the oldest medical texts of ancient Greece to the current DSM, profound sadness and its variations – despair, sorrow, dejection, dismay, desolation, anxiety, discouragement – often recur as essential traits of depressive disorder, along with related symptoms such as loss of appetite, insomnia, irritability, restlessness, feelings of despair or worthlessness, suicidal ideation and attempts, fear of death (Horwitz and Wakefield, 2007).

The term "melancholia" has its roots in ancient Greek medicine and philosophy, particularly in the teachings of Hippocrates, who was a prominent figure in the history of medicine. Hippocrates proposed the theory of the four humours, which were believed to be the fundamental bodily fluids that influenced a person's psychophysical attitudes, namely blood, phlegm, yellow bile, and black bile.

Melancholia was considered the condition attributed to an excess of black bile. The melancholic type of person was recognized to have specific personal traits, characterized by symptoms of deep sadness and a pessimistic outlook but also introspections and realism. We can recognize, throughout the history of depression until the XIX century, the ambivalence between wisdom and madness that characterized the condition of melancholia. Melancholia is never fully madness because, unlike the fool, the melancholic does not lose his intellect and understanding of reality. On the contrary, the melancholic, introvert, and calm, can have a clear vision of reality, even better than non-melancholics (Coppo, 2005).

Before proceeding with this brief history of depression, it's essential to consider that our current conceptualization of depression as a disorder, predominantly addressed by medicine and psychology, identifying it as a medical and dysfunctional condition, is relatively recent. Before the classical age, reason and madness were still together and interacting (Foucault, 1965). We still find a similar tradition both in Freudian psychoanalysis, where the melancholic is the one who can see reality better than others (Freud, 1917) and in the traditional conception of

melancholic in Japanese culture, “utsushô”, considered a nonpathological - indeed, a respected - way of being. These persons are considered serious, diligent, and thoughtful and express great concern for the welfare of other individuals and society as a whole. The person affected by utsushô was not considered sick and did not necessarily seek a cure for his symptoms (Kitanaka, 2012; Watters, 2010). The ambivalence of the melancholic disappeared with the advent of the diagnostic category of depression, while still resisting in this culture.

Coming to medieval times, melancholia is still an object of inquiry. However, the element of guiltiness and the risk of sloth appear. Melancholia is considered associated with sloth, one of the seven deadly sins. Melancholia starts being understood through a religious perspective (Barbagli, 2009).

2.2 Neurasthenia: nerves, unconscious and modern conditions

In the 18th century, the established humoral theory of melancholia faced growing challenges from emerging explanations linking distress to the operations of the brain and nerves. Subsequently, in the 19th century, the concept of neurasthenia emerged. Pioneered by American neurologist George Miller Beard in the late 1860s, neurasthenia was rooted in the belief that the escalating demands of modern civilization placed an undue burden on the nervous system, resulting in a wide array of both physical and psychological symptoms. These symptoms, ranging from fatigue and anxiety to muscle aches, sleep disturbances, and various somatic complaints, often exhibited a vague and variable nature from person to person.

Neurasthenia is intrinsically tied to the rapid pace of modern life, especially within industrialized societies. It encapsulates a distinctly modern malaise, arising from apprehensions linked to the rapid advancements of the era—industrialization and the sprawling metropolises it engendered. Neurasthenia embodies the nervous facet of industrial fatigue and achieved considerable recognition in the late 19th and early 20th centuries (Ehrenberg, 1997).

Previously, doctors and social scientists of the 18th century reported as well what was called “the English malady”, an epidemic of neurotic symptoms such as anxiety, low mood, hypochondria, low energy, and physical complaints associated with increasing and worrying suicide rates in the English population, then spreading all around Europe (Barbagli, 2009). The explanations given for the advent of this malady are recognized in the societal conditions of that epoque. The explanations given by numerous texts published between the end of the 19th century and the beginning of the 20th century are all imbued with the perception of a changing

world: life in large cities, increasingly elegant and frenetic, sparks a new appreciation for sensory pleasures and aesthetic refinements, a taste that was previously beyond the reach of the bourgeoisie and the middle classes. These social strata end up being influenced by new interpretative models of self and the world: the concept of "nerves" makes its appearance in medicine and culture, providing an entirely novel representation of the human being, both more instinctive and reflective. This entails a shift in the perception of oneself and one's suffering (Ehrenberg, 1997).

Neurasthenia can be considered, so to speak, the first fashionable illness. The idea that societal life can lead to illness begins to take hold. "Fatigue" and not sloth is the cause of the "disorders of the will." Hence, the notion of an exogenous factor emerges, referring to something that originates from the outside and, consequently, brings about an internal transformation (Ehrenberg, 1997). Among others, Durkheim recognized the increase in suicide rates and in general in these neurasthenic conditions to the increased anomie and social disintegration (Durkheim, 1897). Society was, once again, recognized as the source of distress, affecting directly the nerves. Today, we have different accounts of what happened hundreds of years ago. Durkheim explanation is widely recognized in sociological discipline, and similar accounts see cultural shift through the advent of Protestantism, new educational models, and individualism, as well as the introduction of Cartesian dualism in the recognition of mind problems affecting the body (Murphy, 1978) as the epidemic of the English malady. Nevertheless, Barbagli's (2009) further investigation identifies the diminishing influence of cultural taboos surrounding suicide as the primary factor behind the rise in suicidal behaviours from the 17th century. This cultural shift has consequently captured the interest of social scientists, among them Durkheim.

With the advent of psychoanalysis, the cause of distress is no longer attributed to nerve inflammation, but rather to the unconscious. The causes of distress are identified within the mind and no longer in the body. Charcot will introduce this shift. In contrast to prevailing beliefs, he sees neurasthenia as a common element among both the working classes and intellectual professions, as it results from a series of traumas. Neurasthenia is a disorder with somatic features, not vice versa. Nevertheless, the relationship between the individual and the outside context is finally taken into account (Ehrenberg, 1997).

2.3 Depressive disorders: The standardized DSM definitions

At the beginning of 1900, psychiatrists recognized the presence of many symptoms connected to neuroses, malaise, and sadness in the so-called “stress tradition” (Horwitz, 2010). Then, the term "depression" first appeared in Europe around 1920, as a result of a lengthy process in which, in the early 1900s, the evolution of the concept of melancholy became intertwined with neuropsychiatric notions surrounding neurasthenia (Coppo, 2010).

The defining aspect for the psychiatric diagnosis of depression in the 20th century is the emergence of psychiatric discipline and the establishment of psychiatric disorder classifications in medical manuals in the Western world. The first version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) edited by the American Psychiatric Association (1952) came a few years after WW2 Technical Medical Bulletin, for the US Army and revising the sixth edition of World Health Organization’s International Classification of Diseases (ICD-6) (Shorter, 2013b). Five versions of the DSM came out since then, the last one is the DMS-5-TR (American Psychiatric Association, 2022), a text revision of the DSM-5 of 2013 (American Psychiatric Association, 2013).

However, to see the introduction of the “Depressive Disorders” in the DSM we have to wait for the third version of the manual. The contemporary concept used in psychiatry is quite recent, appearing for the first time with the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1980 (American Psychiatric Association, 1980). Nowadays, the diagnostic criteria mostly used come from the fifth edition of the DSM (American Psychiatric Association, 2013)[12] and International Classification of Diseases (ICD-11) (World Health Organization, 2023d)[13]. In this manual, the American Psychiatric Association outlined some precise criteria to make a diagnosis of Major Depressive Disorder.

Depressive disorders include Disruptive Mood Dysregulation Disorder, Major Depressive Disorder (including Major Depressive Episode), Persistent Depressive Disorder, Premenstrual Dysphoric Disorder, Substance/Medication-Induced Depressive Disorder, Depressive Disorder Due to Another Medical Condition, Other Specified Depressive Disorder, and Unspecified Depressive Disorder. To give an example, we show the criteria for a diagnosis of Major Depressive Disorder, the most “iconic” one.

[12] Revised in 2022 but without significant differences for this group of disorders
[13] Originally published in 2019.

For Major Depressive Disorder, an individual must be experiencing five or more symptoms during the same two-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure.

1. Depressed mood most of the day, nearly every day.
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
3. Significant weight loss or weight gain, or decrease or increase in appetite nearly every day.
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day.
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death, recurrent suicidal ideation, or a suicide attempt.

To receive a diagnosis of depression, these symptoms must cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must also not be a result of substance abuse or another medical condition (American Psychiatric Association, 2022)[14].

The common feature of all the disorders in the category of "Depressive Disorders" is the presence of sad, empty, or irritable mood, accompanied by related changes that significantly affect the individual's capacity to function (e.g., somatic and cognitive changes in major depressive disorder and persistent depressive disorder). What differs among them are issues of duration, timing, or presumed aetiology. For instance, Persistent Depressive Disorder, once called Dysthymia, has prolonged but less severe symptoms compared to Major Depressive Disorder. Disruptive Mood Dysregulation Disorder is instead a specific condition for children or adolescents in which the patient experiences ongoing irritability, anger, and frequent, intense temper outbursts. Premenstrual Dysphoric Disorder is a condition whose symptoms appear related to menstrual cycle. All the other conditions, in the end, are related to

[14] The most recent DSM-5-TR definition (2022) do not differ much from the original definition of the DSM-III (1980) and the consequent DSM-IV (1994). However, in the two previous editions the symptoms should appear during the same two-weeks period for at least two months, while in the following DSM-V the specification of two months disappears. Also, the "bereavement exclusion" for the previous edition exclude the diagnosis of Major Depressive Disorder for the ones who are experiencing bereavement, which disappear in DSM-V.

substance/medication or other medical conditions or are unspecified (American Psychiatric Association, 2022). Also, conversely to Kraepelin's phenomenological psychiatry of the end of the XIX century, which defined maniac-depressive psychosis as a single entity that included disorders that could involve both manic and depressive symptoms, nowadays definitions are dividing the two categories as Bipolar Disorders and Depressive Disorders. Mania and related symptoms are then typical for other types of disorders and excluded from the diagnoses of Depressive Disorders.

Similar criteria to the DSM-5-TR are adopted also by the World Health Organization's International Classification of Diseases (ICD-11) (World Health Organization, 2023d). The most relevant characteristics of the two definitions are low mood and lack of interest in doing activities. These types of conditions are considered dysfunctional, lasting more than two weeks, and different from sadness and bereavement.

2.4 The hegemony of DSM classification

The 60's and 70's were turbulent decades for psychiatry. The discipline was under attack both from inside and outside the medical profession. Inside, the profession was divided into numerous theoretical schools, and different clinicians shared a few propositions about the nature of psychiatric disorders. The psychoanalytical theory, which dominated the disciplines for decades, was tackled by the rise of biological psychiatry and research-oriented psychiatrists who insisted that the discipline needed to expand scientific research on mental disorders. Then, the necessity to increase diagnostic reliability among clinicians, and more clearly demarcate different mental disorders. At the time, the DSM-II's reliability was low, because not all its users were equally familiar with the disorders and because definitions of some of the disorders included untestable assumptions about their causes. Psychiatric legitimacy was also questioned from outside the discipline. Anti-psychiatric movement, inspired by philosophical and social research statements regarding psychiatric practices as tools for social control, was questioning the discipline itself and its assumptions (Mayes and Horwitz, 2005; Horwitz and Wakefield, 2007).

Furthermore, psychiatric diagnoses were under attack from many quarters. Third parties, both private and public, funded the majority of medical care. The incomprehensible unconscious entities of the DSM-II and the erosion of psychiatry's medical legitimacy did not provide a solid basis for insurance reimbursement. Considering the theoretical fragmentation of

psychiatry, its diagnostic unreliability, and anti-psychiatric criticism, not only the scientific status of psychiatry was at risk, but also its legitimacy as a medical speciality. Moreover, the necessity of pharmaceutical companies to market their products to treat specific diseases required a clear definition of diagnostic categories (Mayes and Horwitz, 2005; Horwitz and Wakefield, 2007; Pignarre, 2012).

In the early 1980s, the third edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-III) transformed the theory and practice of mental health not only in the United States but also on a global scale. Mental disorders evolved from being broadly defined entities in a continuum with normality to becoming categorized as symptom-based diseases. The pivotal feature of the new manual lies in its adoption of categorical, symptom-centred diagnoses for delineating mental disorders. The DSM-III represented a fundamental shift by introducing a model that equated observable and quantifiable symptoms with the presence of diseases. This symptom-focused approach provided psychiatry with a standardized means of assessment (Meyes and Horwitz, 2005; Horwitz and Wakefield, 2007).

This standardization proved advantageous for an hegemonic subset of psychiatric discipline on several fronts. It empowered research-oriented psychiatrists, a relatively small yet highly influential faction within the field, enabling them to measure mental disorders in a consistent and replicable manner. Additionally, it supressed the objections of critics from the prior system, who argued that mental disorders couldn't be objectively defined. For clinicians, who constituted the majority of the psychiatric profession, the new diagnostic framework validated their efforts in treating bona fide diseases and, crucially, enabled them to secure reimbursement from third-party insurers. Because the manual defined disorders solely based on symptoms, irrespective of underlying causes, it remained agnostic to theoretical orientations, making it accessible to clinicians from all perspectives (Meyes and Horwitz, 2005). The symptom-based manual also met the needs of pharmaceutical companies to have specific categories of disorders to be treated with their products (Meyes and Horwitz, 2005; Pignarre, 2012).

Researchers developed the new manual according to a phenomenological “neo-kraepelian approach”. Rather than focusing on any underlying psychological causes for mental disorders, like Freud and psychoanalysis were used to do, Kraepelin stressed classifying them according to their unique symptoms, course of development, and eventual outcome. However, the DSM-III editor committee’s approach fundamentally diverged from Kraepelin's as it largely set aside

issues related to the course, context, and duration, relying solely on symptom profiles (Horwitz and Wakefield, 2007).

As the history of DSM shows, there has always been the principle of authority applied to the decisions on DSM classifications. The editors had a lot of power in deciding both the approach used and the type of disorders included (Shorter, 2013b). The editor of DSM-III, the psychiatrist Robert Spitzer, took the opportunity to create a new diagnostic system that reflected the previous decades of reflection on how to make psychiatry more scientific. The new diagnostic manual was intended to be used by doctors from many different schools of thought. The explicit symptom lists of the DSM-III not only improved reliability but were also "theoretically neutral," in the sense that they did not presuppose any particular theory regarding the cause of psychopathology, whether it be psychoanalytic, biological, or from another school. The new criteria were "descriptive" rather than "etiological," and eliminated any reference to presumed psychodynamic causes of a disorder (Horwitz and Wakefield, 2007). This represented a break with the psychoanalytical approach that dominated DSM-I and DSM-II because psychoanalysis has no interest in symptoms but it’s concentrated on intrapsychic conflicts. From DSM-III we can see the opposite, fine attention to symptoms and no theoretical reflection beyond. Neuroses have been medicalized, becoming distress entities (Shorter, 2013b). The DSM-III emerged as a political rather than a scientific document, arising in response to ideological and theoretical conflicts within the field of psychiatry. The shift to a symptom-based diagnosis in the new paradigm wasn't driven by any advancement in psychiatric knowledge but rather produced standardization in psychiatric diagnoses. The advent of DSM-III marked a significant milestone, as it provided psychiatrists, psychologists, social workers, and counsellors with a shared language to delineate mental disorders (Meyes and Horwitz, 2005; Pignarre, 2012).

Speaking of depression, the advent of DSM-III with its nosological-descriptive approach introduced Depressive Disorders as a specific category of disorders, mainly defined by a group of symptoms, with specific criteria and duration. No other specifications regarding causes or aetiology are included, as the manual follows an a-theoretical approach, that can fit any theoretical vision regarding distress. With the introduction of DSM-III, depression lost completely its representation as an “illness of the soul” elaborated throughout history. Depression has become instead more and more a specific medical condition, categorized like any physical illness with a diagnostic category, and become a competence of modern medicine.

Diagnostic and Statistical Manual's definitions are edited by the American Psychiatric Association, whose intent is to define diagnostic criteria for all possible mental disorders. The manual was initially constructed through the use of epidemiological data regarding the US population, and every commission is composed of US psychiatrists (Ehrenberg, 1997; Horwitz and Wakefield, 2007). While this would suggest that the manual reflects the mental health problems of the US population, this classification is used more and more all around the world, and not only in Western countries. As said, the ICD-11 (World Health Organization, 2023d) as well as the previous edition are mainly following DSM standards. Then, diagnostic criteria were also exported all over the world, regardless of different cultures and disorders' epidemiology (Watters, 2010). Depression, whose traits were defined through the Western way of experiencing distress, is now a condition recognized with the same criteria all over the world.

3 The diagnosis of depression

3.1 Is depression a disease or a disorder?

In medicine, the classification of diseases is needed to produce theory and medical models to verify. Later, the classification is useful to diagnose and later treat individual illness. But, while in medicine the classification of illnesses is built on indisputable aetiological theories, on a "naturalistic" basis, psychiatry has to do with phenomena whose causes are not determined yet. In this way, it is hard to define precise and mutually exclusive categories. Nevertheless, psychiatry's need to have a classification of mental distress was hampered by the extremely diverse theoretical approaches to the nature of the disease that different psychiatrists had at the time.

As medicine solidified its position as a science, the call for diagnostic criteria became inseparable from treatment protocols. The same evolution occurred in psychiatry. Back in the golden era of psychoanalysis, spanning from the late 19th century to the mid-20th century, the diagnosis wasn't the focal point. To align itself with the realm of medical science, psychiatry needed to formulate an analogous epidemiological framework for categorizing mental disorders, referred to as "nosology" (Shorter, 2013).

The DSM III played a crucial role in resolving the lack of consensus surrounding the classification of mental disorders. This consensus regarding the diversity and complexity of mental distress was achieved through the use of standardized methodologies, creating artificial

constructs that don't exist *per se*. Given that specialists often hold different and opposing views on the observed phenomena, the approach adopted from the DSM-III is deemed "atheoretical" – it's non-causal but purely descriptive, offering no explanations about the aetiology of the illness. This absence of rigid theories allows psychiatrists with neuro-biological perspectives and those with psychodynamic approaches to find common ground and reconcile in defining these mental issues (Horwitz and Wakefield, 2007; Shorter, 2013b).

However, it's important to recognize that the diagnoses made according to the norms outlined in the DSM should be viewed through a probabilistic lens. Their application in clinical settings should be approached with caution. Symptoms are clustered together not necessarily because we possess a clear understanding of their causes and the underlying nature of distress, but rather because they've been grouped via factor analysis. Consequently, we cannot assert that depression constitutes a disease, given the absence of a comprehensive theory regarding its origins and progression; instead, it is more accurately described as a disorder. These conditions represent syndromes that are rooted in probabilities (Coppo, 2005)[15].

3.2 Psychiatric diagnosis: categorical vs dimensional

From the DSM-III on, the manual is conceived to standardize previously subjective diagnoses. However, arises a fundamental ambiguity of the DSM: The categorical approach, more likely to be appropriate for research purposes, finds application not only in academic investigations but also in practical clinical settings (Ehrenberg, 1997). With the advent of DSM-III, diagnosis shifted from a bottom-up approach, which relied on a detailed patient life history, to a top-down approach based on symptom checklists, with the risk to confine medical practice to the mere recognition of syndromes. The DSM definitions of mental disorders can be likened to an inverted pyramid, where symptoms determine who should be considered mentally disturbed, standing as sole small points upon which the validity of the entire pyramid rests (Coppo, 2005; Horwitz and Wakefield, 2007).

Are psychiatric disorders truly distinct entities, or are they simply varying degrees of one or more continuums? Some experts question the notion of disorders as separate entities and instead propose categorizing mental disorders along a spectrum (Shorter, 2013b). This debate emerged before the release of DSM-5, as both scholars and professionals raised concerns about the challenges in delineating disorders within DSM categories. Many specialists view the

[15] More about the distinction between distress, disorder and disease can be found in Chapter 5, paragraph 5.

classification system as ineffective and not reflective of reality. Discontinuity fails to capture the true nature of a spectrum of disorders. Consequently, clinicians think beyond predefined categories because they encounter patients who don't neatly fit into these classifications relying on a multitude of information sources and not just symptom-checking to make diagnoses (Wykes and Callard, 2010).

Regardless of the many critics, DSM-5 maintained a categorical organization of mental disorders. Psychiatrists involved in the fifth edition of the manual protested that was premature to shift to a dimensional approach, that there wasn't strong evidence on dimensional scales proposed, and that psychiatrists did not have enough experience on how to diagnose patients dimensionally. The proposal was also unpopular for patient groups, who fought to have their condition as a visible brand, and health insurance that asked for precise diagnostic categories to cover reimbursements (Adam, 2013). Expressing discontent with this choice, the U.S. National Institute of Mental Health (NIMH), led by its director Thomas Insel, is endeavouring to construct a fresh framework for categorizing mental disorders. This reclassification will depart from the conventional 'categories', instead focusing on dimensions and their intricate link to corresponding neural pathways (Insel, 2013). Will this signify a departure from the DSM approach, opting with unwavering resolve to amplify the organicist inclination that has significantly shaped the underlying philosophy of numerous statistical manuals since the third edition in 1980? At the moment, the last edition of DSM (2022) is still sticking on a categorical vision.

3.3 The Psychiatric Diagnosis: Pros and Cons

The presence of established diagnostic categories and a consensus around them is crucial for several reasons: it helps patients comprehend their conditions; aids professionals in offering clear diagnostic criteria for mental distress and facilitates mutual understanding in inpatient treatment; and offers a framework for classifying mental distress in epidemiological research and healthcare administration (Coppo, 2005).

In particular, having a defined diagnosis can bring positive outcomes for the patient. It serves as a starting point for discussing potential treatments, determines access to social support and publicly funded therapies or benefits, and provides a sense of relief for the patient, who can now understand and identify the cause behind their symptoms. However, on the contrary, diagnosis leads to the medicalization of certain behavioural patterns, contributes to societal

stigma, and establishes a rigid framework for addressing the issue, potentially leaving little room for alternative approaches (Wykes and Callard, 2010).

It's important to consider how diagnoses shape the discussions around psychopathology, influencing both professionals and patients along with their families. On the professional side, the DSM discourse regarding psychological distress shapes the knowledge of experts in the field. Power dynamics are inherent in these discussions, as they claim to possess the most authoritative "scientific" knowledge. Any other discourse about mental distress is often dismissed in favour of accepting the idea of psychiatric diagnosis. Subsequently, patients and their families adopt medical terminology in their everyday discussions about their condition, symptoms, and distress (Crowe, 2000). In other cases, patients and families are directly involved in the recognition of a specific condition as pathological (Brown, 1995). Concerns about the labelling process through psychiatric diagnosis for patients have been present since Erving Goffman's groundbreaking work on stigma and psychiatric diagnosis (Goffman, 1961; 1963). Labelling individuals as mentally disturbed can lead to stigma, which is an attribute of a person that can trigger negative reactions from those around them due to existing stereotypes (Sjöström, 2017).

From a constructionist perspective, the diagnosis is set during practitioners' assessments, when the patient "becomes depressed". Diagnosis is not an act of discovery of a pre-existing entity lying inside the sufferer but an active process of transforming the patient's experiences in a diagnostic category as an explanation. From a sociological perspective, that highlights the contingent socially produced character of categories of mental distress and the professional practices associated, diagnostic categories should not be taken for granted but instead be a topic of investigation (O'Reilly and Lester, 2016).

Psychiatric diagnosis can bring into being the very phenomena and self-attributions that they purport to describe, as they produce responses from individuals, that attach meaning to behaviours and feelings and play an important role in shaping and embodying psychiatric diagnosis. People who are experiencing psychiatric symptoms are categorized through a psychiatric diagnostic category and are then identifying themselves through the category. Then, the actions and the identity of the person categorized, as well as the way to experience and understand the symptoms, are then influenced by the category attributed (Hacking, 2008; 2013). For example, if a patient is diagnosed as depressed, the patient knows that their

symptoms can be ascribed to the condition of being depressed, and see themselves and their recent life experiences as the ones of a depressed person.

3.4 Depression: Normal vs Pathological Condition

While depression demands serious attention, depression is a mood disorder influencing behaviour and demeanour without impacting logical reasoning. Individuals with depression should not be labelled as "crazy" if we define sanity by the capacity to perceive and comprehend reality accurately. So, if this condition is so common, how does psychiatry's manual consider depression as a pathological condition? The discourse regarding normality is quite complex. While the term "normality" itself, represents the centre of a statistical distribution, the high prevalence of depressive disorders makes this distinction based on frequency insufficient.

According to Horwitz (2008a), alongside the statistical perspective of normality, we can consider a normative perspective, based on social expectations, and an evolutionary perspective, based on adaptive functions. Horwitz and Wakefield (2007) propose that the distinction between normality and a pathological condition lies in the failure of a biologically functioning, referred to as dysfunction. Pathological is the sadness coming from a "harmful dysfunction" (Wakefield, 1992), wherein harmful refers to the failure of a mental mechanism to perform a natural function of sadness for losses for which it was designed by evolution. Therefore, 'contextuality' plays a crucial role in determining whether a depressive response is appropriate or not. This concept differentiates between normal sadness and pathological sadness, two broad categories that exhibit similar symptoms[16].

In general, the DSM classifications discursively define what 'normality' is compared to what is 'pathological' (Crowe, 2000). The manual determines pathological conditions as the ones whose symptoms "cause clinically significant distress or impairment in social, occupational, or other important areas of functioning" (American Psychiatric Association, 2022; pp:142). The criteria of functional impairment is considered relevant to recognize if a patient needs psychiatric treatment or not.

[16] We will delve deeper into this topic in the next chapter, where we will introduce various theoretical perspectives related to evolutionary biology and what constitutes a "normal" response. We'll also discuss the distinction between reactive and endogenous depression.

In the end, we should remember that the uniqueness of psychiatry lies in its integration of soul illnesses with medicine. Unlike other branches of medicine, psychiatry necessarily deal with moral issues, intersecting with problems that were once within the realms of religion and morality (Foucault, 1965; Pignarre, 2012). The transformation of moral entities, which the individual masters, into bodily and medical entities, over which the person is mastered, depression is no longer a sin against faith or violations of divine law but rather an affliction that compromises the subject's freedom (Ehrenberg, 1997).

3.5 The Diagnosis of Depression

The term commonly used today for depression often serves a dual purpose. It can be used to describe a specific diagnostic category, generally Major Depressive Disorder, or, more commonly, to indicate one of the symptoms of MDD, which is the depressed mood. However, a depressed mood can be a symptom of many other psychiatric conditions, as well as other medical conditions or due to substance consumption. Distinguishing between symptoms related to depression and those stemming from other conditions is crucial. Psychiatrists achieve this through "differential diagnosis," a method that aids in discerning between psychiatric and non-psychiatric conditions (American Psychiatric Association, 2022).

Given the vagueness and the extremely different conditions that can be included in this diagnosis, depression became a widely used category to describe many conditions once mostly related to the psychoanalytical category of neurotic disorders. Once considered a rare condition involving mainly severe cases of inpatients of psychiatric hospitals, now includes the breadbasket of common psychic and somatic complaints associated with the “stress tradition” (Horwitz, 2010). In this manner, within this broadly inclusive category, individuals who embrace the label of "depressed" find meaning in their suffering and potential remedies, namely psychopharmacological and psychotherapeutic treatments. Those experiencing depression can become part of a collective, identifying themselves as a "we", obtaining an identity, a purpose, and a viewpoint on the condition. Nevertheless, it's important to remember that what is presented as a disorder, framed as something inherent, is constructed, and generated through a technical and cultural process (Coppo, 2005).

3.6 Diagnostic process, assessment tests and scales

A psychiatric interview, also known as a mental health assessment or evaluation, is conducted by a mental health professional to gather information about a person's mental health, emotional

state, thoughts, behaviours, and overall well-being. In psychiatric syndromes, there are no physical markers that can be used to assess the presence of a disorder. The assessment is done through a face-to-face interaction, where the psychiatrist asks the patient questions regarding their life and symptoms, as well as social and occupational functioning. Also, can observe behaviour, appearance, speech and communication, mood and affect, thought processes, perception, cognition, insight, and judgment. Diagnosis is in this way something assessed through interaction, and it relies on the ability of the doctor to identify symptoms through what is observable and what is narrated by the patient. It happens that psychiatrists set a different diagnosis for the same patient, as they recognize the syndrome differently.

As said, the DSM-5 criteria intend to provide both diagnostic criteria for professional use as well as a classification tool for epidemiological studies. Many scales have been built for this purpose, according to these criteria, that can be used by health professionals to assess the presence of a depressive syndrome, as well as for research purposes. A review found that between 1918 and 2006 more than 280 measurement scales were published to assess depression, also revealing a trend of a growing presence of new scales (Santor, Gregus and Welch, 2006). The American Psychiatric Association (2021) recognize as valid diagnostic tools only some of them[17]. These assessment tests are structured or semi-structured interviews, which are self-administered or administered by clinicians to assess if the patient could be or not diagnosed as depressed. The answers given by the patient are coded into scores, and the final score is used by clinicians to determine if the patient is depressed and what is the severity of the depression. From the administration of these Depression Assessment Instruments we obtain a score of depressive symptoms in patients, these scales can be also used to gather data about depression. Through the analysis of the data collected in samples, both for depressed

[17] Specifically, for the whole lifespan, the Depression Assessment Instruments recognized are: the Beck Depression Inventory (BDI) (Beck et al., 1961), the Center for Epidemiologic Studies Depression Scale (CES-D) (Radloff, 1977), the EQ-5D (The EuroQol Group, 1990), the Hamilton Depression Rating Scale (HAM-D) (Hamilton, 1960), the Montgomery-Åsberg Depression Rating Scale (MADRS) (Montgomery and Åsberg, (1979), Social Problem-Solving Inventory-Revised (SPSI-RTM) (D'Zurilla, and Nezu, 1990). For the adult population the American Psychiatric Association suggests the Beck Hopelessness Scale (Beck et al., 1974), the Quick Inventory of Depressive Symptomatology-Self-Report (QIDS-SR) (Rush et al., 2003), the Patient Health Questionnaire (PHQ-9) (Kroenke et al., 1999), the Reminiscence Functions Scale (RFS) (Webster, 1993), the Short Form Health Survey (SF-36) (Ware and Sherbourne, 1992), the Social Adjustment Scale-Self Report (SAS-SR) (Weissman and Bothwell, 1976), the Social Functioning Questionnaire (SFQ) (Tyrer et al., 2005). For children and adolescents, the officially recognized scales are the Behavior Assessment System for Children (BASC) (Merenda, 1996), the Child Behavior Checklist (CBCL) (Achenbach, 1978), the Children's Depression Inventory (CDI) (Kovacs, 1985), the Children's Depression Rating Scale (CDRS) (Poznanski et al., 1979), while for the older adults we have the Geriatric Depression Scale (GDS) (Yesavage et al., 1982) and the Life Satisfaction Index (Neugarten et al., 1961).

patients as well as for the general population, the researcher tried to find associations between the presence of this condition and other variables.

In scientific research, although a lot of scales are available, only a small number of them are widely used. For instance, BDI, HRSD, and CES-D appear to be the most used in the literature (Fried, 2017; Santor, Gregus and Welch, 2006). Also, Santor, Gregus and Welch (2006) report that most of the studies are drawn on only six scales, and five out of six between the ones that the American Psychiatric Association consider validated. Specifically, BDI and HAM-D were used in 42% of basic science studies and 63% of treatment outcomes studies. This means that most of the epidemiological research uses scales that reflect the criteria defined by the DSM-5-TR (American Psychiatric Association, 2022).

Finally, we should take into account the practical use of the diagnostic category of depression in assessments. Research showed that psychiatric diagnoses result not only from institutionalized procedures but also from implicit skills, practical knowledge and commonsense reasoning (Palmer, 2000; Roca-Cuberes, 2008). Surveys addressed to psychologists and psychiatrists in different countries showed that up to 50-70% of them use depression rating scales, while others rely only on their professional experience (Lee et al., 2010, Zimmerman, 2020)[18].

However, some critics have addressed the use of scales to assess depression. First, as said, the number of scales to assess the same concept is quite high. This implies that scales differ in content, and as a result, the type of phenomenon measured varies, with low rates of overlapping and accordance between them (Fried, 2017; Santor, Gregus and Welch, 2006; Snaith, 1993). Second, while some scales are considered to be valid and reliable because they have been tested across different populations (American Psychiatric Association, 2021), others question their ability to assess depression (Bagny et al., 2004), specifically in non-western contexts (Chang et al. 2007).

4 Depressive symptoms and other syndromes

For completeness, to better understand later what emerges from the fieldwork, we present three groups of syndromes (Adjustment Disorders, Anxiety Disorders, and Personality Disorders)

[18] We should be cautious on using this information, as it may vary between different countries and contexts. For instance, fieldwork observations explained in Chapter 6 will show how none of the professionals observed ever used scales or assessment tests during interviews.

that share, completely or partially, their symptomatology with depressive disorders. As previously stated, the complexity of psychiatric syndromes sometimes makes it insufficient to use a categorical approach or to confidently determine the exact nature of the issue without overlapping with other closely related syndromes. The syndromes presented here are the ones that, both in the literature and from empirical observations, are most commonly intersected with depressive syndromes, and sometimes diagnosed or co-diagnosed with other depressive disorders.

4.1 Adjustment Disorders

DSM-V-TR addresses the topic of stress responses through the diagnostic category of Adjustment Disorders. Adjustment Disorders are psychiatric conditions characterized by an excessive and disproportionate emotional or behavioural reaction to a stressful or life-changing event, with the emergence of depressive or anxiety symptoms (American Psychiatric Association, 2022). According to some authors, conditions that may appear as anxiety and depressive disorders are, in reality, adjustment disorders, making this disorder more common than Major Depressive Disorder (Casey, 2009). The way this disorder is understood fails to differentiate it from normal adaptive stress responses and distinguishes it from other common disorders such as major depression or anxiety disorders. The flaws in the Adjustment Disorder category are so evident that researchers and epidemiologists have not shown much interest, given the limited number of research studies (Casey, 2009; Horwitz and Wakefield, 2007).

The problem here is determining when symptoms stemming from the reaction to an event should be considered appertaining to an adjustment disorder or, conversely, represent a depressive episode. We will not provide a definitive answer to this question since professional perspectives can vary, and diagnosing the same condition alternatively as depression or as an adjustment disorder[19].

4.2 Anxiety disorders

According to DSM-5-TR, Anxiety Disorders include disorders that share features of excessive fear and anxiety and related behavioural disturbances, including Separation Anxiety Disorder, Selective Mutism, Specific Phobia, Social Anxiety Disorder, Panic Disorder, Agoraphobia, Generalized Anxiety Disorder, Substance/Medication-Induced Anxiety Disorder, Anxiety

[19] This will be evident also while presenting fieldwork data.

Disorder Due to Another Medical Condition, Other Specified Anxiety Disorder and Unspecified Anxiety Disorder (American Psychiatric Association, 2022).

Anxiety and depression have some commonalities in what concern the history of their categorization, symptomatology and treatment. In the period between the 1970s and 1990s, a confluence of factors led to a shift in categorizing those issues and symptoms once categorized as anxiety into the category of depression (Horwitz, 2010)[20]. Despite the presence of specific categories, today anxiety is sometimes considered part of the depressive spectrum, further evidenced by the use of terms like "anxious-depressive" in clinical environments. Anxiety has remained more closely tied to the concept of a symptom, even more so than depression. Also, even considering the existence of anxiolytics, anxiety disorders respond better to treatment with antidepressants. For both anxiety and depressive symptoms, the use of antidepressants and anxiolytics work, making their distinction less relevant (Ehrenberg, 1997).

The discovery of modern anxiolytics did not lead to the emergence of a recognizable condition or syndrome akin to depressive neuropathies, such as an "anxiopathy." The term "depressed" as a pathological condition regarding an individual is way more used compared to the same use of the word "anxious". Also, as we demonstrated in the previous chapter, anxiety disorders are the predominant psychopathological form in the population, but we are not hearing of any "epidemic of anxiety"[21].

In this dissertation, we will consider some patients exhibiting anxious symptoms, even if our focus will always be on depression. Beyond the just mentioned connections between the two groups of syndromes, diagnostic and treatment aspects are often intertwined in terms of care practices, as we will demonstrate later on. However, literature and discourse regarding psychopathology are primarily, perhaps overly, restricted to depression.

4.3 Personality disorders

Personality represents the way of thinking, feeling and behaving that makes a person unique and different from others. An individual's personality is influenced by experiences, environment (surroundings, life situations) and inherited characteristics and it is stable over

[20] This, according to Horwitz (2010) is one of the reasons that can explain the "epidemic of depression". Further details on the author's theory are presented in Chapter 4.
[21] In any case, we have reasons to believe that sooner or later this condition will also be discussed in epidemic terms.

time. Personality disorders represent ways of thinking, feeling and behaving that deviate from the expectations of the culture, cause distress or problems functioning. The pattern of experience and behaviour usually begins by late adolescence or early adulthood and causes distress or problems in functioning. Without treatment, personality disorders can be long-lasting.

The reason why personality disorders are bound to depressive disorders, as well as other psychiatric disorders, is simple. Personality is constituting the persona itself, on which other mental health conditions are posed. Until DSM-IV-TR (American Psychiatric Association, 2000), clinical diagnosis was posed on five axes, on which mental health and substance disorders are posed on Axis I, personality disorders on Axis II, general medical conditions on Axis III, psychosocial and environmental problems on Axis IV, and the global assessment of functioning on Axis V. Following this distinction, we can see how personality disorders are on a lower level on which other mental health disorders (e.g. depression in this case) can be posed.

There are ten specific types of personality disorders in the DSM-5-TR, classified into three different clusters: Cluster A (Paranoid, Schizoid, and Schizotypal Personality Disorders), Cluster B (Antisocial, Borderline, Histrionic, and Narcissistic Personality Disorders), and Cluster C (Avoidant, Dependent, and Obsessive-Compulsive Personality Disorders) (American Psychiatric Association, 2022). For our dissertation, patients considered were sometimes classified in Cluster B Personality Disorders, more often Borderline, Histrionic and Narcissistic, and others in Cluster B as Dependent Personality Disorder. Some patients were considered just as affected by personality disorders, without specification.

Personality also needs to be taken into account, from a sociological perspective, when we consider how societal conditions are shaping the individuals themselves, their aspirations, and their ways of living and experiencing life in general. This is specifically true regarding narcissistic discourses about the self and the realization of individuals, that nowadays are more and more present and normalized in contemporary western societies and enhance distress (Gabbard, 2014), considered by some authors as a main problem in the advent of the epidemic of depression (Ehrenberg, 1997; Han, 2015).

5 Conclusions

Social scientists inclined towards a neo-positivist approach tend to argue against subjecting the categorical definitions of the DSM to sociological inquiry, citing their perceived futility. The diagnostic categories of the DSM form the basis of epidemiological research on psychiatric syndromes, portraying psychiatry as a science with criteria that are considered indisputable, and undisputed within their ranks, except by a few dissenting enemies of science. The history of the phenomenon is also to demonstrate how this does not align with the truth. Psychiatry and psychology present themselves as internally fragmented sciences from a theoretical standpoint, and the current definitions of psychiatric disorders are the result of a historical process, a compromise that aimed to remove any discussion of their causes. In this way, many different perspectives continue to coexist and define conflicting viewpoints. As we will show in the next chapters, the mental health professionals who participated in this study themselves are aware that what is defined by the manual is something incapable of fully defining such a complex phenomenon, ineffective in clinical practice.

The chapter emphasizes the importance of not treating depression as an unchangeable condition but to explore how cultural and collective processes influence our perceptions and interactions with psychopathologies. This analytical approach not only offers new perspectives on our conceptions of normality and pathology but also highlights the deeply social nature that distinguishes the normal from the pathological. It's understandable to note the proliferation of discussions about "depression," even when often referring to a type of generic distress that intersects with other types of psychological and social issues. The category of depressive disorder is often too vague and suffers from an "epistemic fallacy" to the point where it can encompass a heterogeneous range of conditions. This, indeed, explains its media and epidemiological success (Caponi, 2009).

The idea of depression that we proposed here is inductively produced by considering the history and the various definitions, instead of deductively taken from psychiatric literature. As sociologists, it is not our role to set the boundaries of a concept concerning psychiatric symptomatology. Instead, the aim of sociology is often to reveal its inconsistencies and observe its practices.

Chapter 3 - Exploring Diverse Theoretical Perspectives on Depression: Insights from Biology, Psychology, Psychiatry, Sociology, and Anthropology

1 Introduction

In this chapter, we will explore different perspectives on depression from different disciplines: biology, psychology, psychiatry, sociology, and anthropology. The biopsychosocial model implies that different disciplines investigate psychopathology from different approaches. As a result, we have different theories, that in some cases we can see integrated into one another, in other cases, they conflict or represent different points of view on the same phenomenon. As said, clear causal theories were still not recognized for mental disorders, and this means that a multitude of approaches are available.

We present the materials we consider necessary to understand depression and its characteristics. Some of the concepts will be then returned in the empirical part of the dissertation. We introduce these theories structured around: Characteristics, Perspectives, and Treatment of depression.

2 Depression and its characteristics

2.1 Biopsychosocial model vs Biomedical model

In psychiatry, nothing has been recognized so far as causes, although researchers still believe in being able, one day, to assess the causes of mental distress (Walter, 2013). At the moment, as we showed in the previous chapter, all psychiatric conditions are considered with the status of "syndromes", which means that a group of symptoms has been observed occurring together.

Rather than giving aetiological explanations, with DSM-III and the following the American Psychiatric Association needed to overcome possible theoretical divisions concerning the causes but instead wanted to provide shared language and classification for health professionals (Shorter, 2013b). For these reasons, we have seen different trends in the psychiatric discipline.

Since the start of the discipline, biological psychiatry has been present with its attempts to explain disorders with problems in the functioning of the body or the brain (Walter, 2013).

However, the advent of psychoanalysis led to a shift in psychiatry towards a more psychoanalytic drift. Psychoanalytical psychiatry was the dominant approach for the first half of the 20th Century. Then, in the '70s, biological psychiatry has taken precedence over psychoanalysis. The dispute among different branches of psychiatry (social, community, psychoanalytic, biological) was won by the biologists, and while the concept of 'biological' previously required explanations, it's now a common term. Psychiatry has always had biological roots, but it was with the advent of medications in the '60s that this characteristic became more evident (Di Paola, 2000).

According to the biomedical model, mental health problems are considered and treated in the same way as physical illnesses. This vision became particularly used with the advancement of psychopharmacology, and it's mostly promoted by academic research and pharmaceutical interests (Cosgrove et al., 2006; Horwitz, 2010). However, this vision has some implications: viewing depression solely as an illness, likely hereditary, due to neurotransmitters issues, sidesteps questioning the actual problem, introducing practices and models lacking a clear epistemological foundation. Biological psychiatry considers itself legitimized taking for granted a series of hidden assumptions, even though this legitimacy doesn't exist. The epistemological confusion and the refuse of any non-biological explanation for mental disorders comes from shaping diagnostic categories from their treatment, instead of vice versa. Rather than beginning with an understanding of the disorder's mechanisms to seek a cure, it commences with the cure itself (the impacts of molecules) to elucidate its functioning (Di Paola, 2000). Neuroscience-oriented psychiatry embraces reductionism, asserting that the mind is merely an epiphenomenon of the brain. However, this emphasis on biological reductionism fail to acknowledge about the inherent complexity of the mind, that transcends mere neuro-circuitry or cellular mechanisms and cannot be entirely reduced to them (Paris, 2013).

While the biomedical model still exists, the main model in the psychiatric discipline is the biopsychosocial model of mental distress, which represents a compromise between different conceptions of mental health disorders. As the fundamental ideas in psychiatry were historically dominated by conflicting dogmas: the rigid beliefs of psychoanalytic orthodoxy clashed with the narrow focus of biological reductionism. However, a different foundational framework emerged - the biopsychosocial model - within the last five decades and has since become the established norm (Engel, 1977; Ghaemi, 2011). Starting from the third edition of the Diagnostic and Statistical Manual of Mental Disorders, the biological, psychological, and

social domains integrated to form a kind of reference triangle called "biopsychosocial" (Ehrenberg, 1997).

2.2 What are the determinants of depression? Biological, psychological, and sociological risk factors

As said, there is no clear causal model that can explain the emergence of depressive disorders in patients. However, research showed the existence of risk factors associated with the emergence of depression, that may elevate the likelihood of experiencing a major depressive episode. According to the biopsychosocial model division, risk factors can be grouped into three areas: biological, psychological, and social. Providing an extensive literature review on these factors would require an entire dissertation. We delineate here briefly the risk factors for depression, dedicating a longer part to the social factors involved[22].

From a biological perspective, potential risk factors are associated with the ability of the brain to produce and maintain a certain balance of neurotransmitters, that have an important function in mood regulation, specifically serotonin, noradrenaline, and dopamine. Individual differences in terms of the biochemical functioning of the brain make some individuals more likely to develop depressive disorders (Haenisch and Bönisch, 2011). Genetic and epigenetic factors play a role in the development of depression (Kendler, 1996; Sullivan et al., 1996; Roy et al. 1995), as well as brain structure and functioning (MacQueen and Frodl, 2011). Depression is also associated with hormonal dysfunction, inflammatory processes, and sleep dysregulation processes (Dobson and Dozois, 2011).

Following a psychological perspective, the theories more recurrent in explaining the development of depression are the psychodynamic one, in which loss and children/parents' relationships are involved (Freud, 1917; Lolli, 2009), and the cognitive-behavioural one, implying a negative view about the self, the world and the future (Beck, 1979). In any case, psychology considers risk factors a great group of life-course stressful events such as losses, stress events, illnesses, traumas, and adversities in childhood (Heim et al., 2008; Kessler, 1997;

[22] For a much more extensive review concerning biological, psychological and social factors, see Dobson and Dozois, 2011.

Tennant, 2002). Then, personality traits such as neuroticism and low self-esteem are associated with the insurgence of depression (Struijs et al. 2021)[23].

In the end, society has its role in the occurrence of depressive disorders. Psychological and social determinants can be tracked together with all the life-course stressing events that are potential triggers for the development of depressive disorders such as losses, stress events, illnesses, traumas, adversities in childhood, social isolation, scarce social support, and economic deprivation are associated to this condition. We now dedicate a special paragraph to this theme.

2.3 Social factors associated with depressive symptoms

No case of depression can truly be attributed to a singular event, but it arises from the intricate interplay of predisposing and precipitating factors, often only partially discernible. Determining the exact extent to which a particular event played a definitive role in precipitating the state of emotional anguish is frequently a challenge (Maj, 2015). Anyway, statistical analysis provided the possibility to distinguish which factors are correlated to the emergence of depression, separating the social factors from the others. We proceed with a review of the social factors related to the emergence of depressive disorders.

Sociologists investigated how exposure to stressful factors, such as significant life events or ongoing negative social situations, affects one's health, categorizing social conditions contributing to depressive symptoms into three groups. First, research indicates that statuses of subordination are more likely to cause, rather than result from, depression. Low positions in social hierarchies expose individuals to circumstances like insufficient financial resources, oppressive work and family conditions, and serious personal health problems affecting themselves or their loved ones, which naturally induce stress and depressive symptoms. The second significant stress source arises from the loss of intimate personal connections. Among average Americans, the most stress-inducing life events include the death of a spouse, divorce, and marital separation. The third source involves adults failing to achieve their goals. "Humiliating losses" erode the self-esteem of individuals and lead to feelings of subordination, resulting in depression. Additionally, "entrapment losses," where individuals can't escape from their situation of loss, also contribute to depressive feelings (Horwitz and Wakefield, 2007).

[23] These aspects constitute risk factors in the advent of depressive symptoms. The discourse on the psychological theories related to depression continues at paragraph 4 of this chapter.

DSM-V-TR takes into account environmental risks factors such as adverse childhood experiences, low income, limited formal education, racism and other forms of discrimination, stressful life events, and gender, considering that women are disproportionately affected by major risk factors for depression across the life span, including interpersonal trauma and adverse childhood experiences (American Psychiatric Association, 2022).

Given this review concerning social risk factors associated with depressive symptoms, we now want to add further studies concerning some events and social vulnerabilities that are related to a higher chance of developing depression, mainly using systematic reviews, meta-analyses, and longitudinal studies. This review does not aim to be exhaustive of all possible situations and events associated with depression. Instead, it is a review that generally allows us to understand which variables are generally taken into consideration, also in light of the empirical study that we will propose later on.

Adverse Childhood Experiences (ACEs), which include physical, emotional, or sexual abuse, neglect, household dysfunction such as substance abuse, mental illness, or domestic violence, and other forms of traumatic experiences experienced during childhood, are associated with higher odds of later-life depressive symptoms, particularly among those with poor perceived social support (Cheong et al., 2017). For what concerns the end of a relationship, longitudinal studies have shown that separation and divorce result in a high prevalence of depression (Bulloch, 2009). Also, a systematic review and meta-analysis found widowhood associated with a high prevalence of depression (Kristiansen et al., 2019). Health conditions are related to higher chances of developing depression. A study in seventeen countries from every continent found that chronic physical conditions were significantly associated with depressive and anxiety disorders (Scott et al., 2007). For what concern working conditions, systematic reviews showed that perceived job insecurity and unemployment constitute significant risks of increased depressive symptoms (Amiri, 2022; Kim and von dem Knesebeck, 2016), while a systematic review and meta-analysis found that the transition to retirement was associated with higher risk of depression (Li et al., 2021). Economic conditions are related as well to depression. According to a study on adults in eighteen European countries, low socio-economic status is associated with a higher prevalence of depression (Freeman et al., 2016). A scoping review showed instead that wealth status influenced depression across the life course, protecting against depression in the face of stressors such as job loss (Ettman et al., 2022). Geral consensus that individuals under threat of eviction present negative mental health

outcomes, including depression (Vásquez-Vera et al. 2017). Finally, higher educational attainment was associated with lower odds of depressive symptoms, independent of sociodemographic and health-related factors (Chlapecka Kagstrom Cermakova, 2020).

2.4 Evolutionary theories and animal models

Evolutionary theories about depression offer insights into why this condition persists despite its apparent negative impact. Two different approaches propose an alternative vision of this condition. One such theory is the idea that depression might have had an adaptive function in our pre-human ancestors. Being depressed is a mechanism that permits individuals to obtain social support, withdrawing from social interactions or experiencing lowered mood, could have prompted others in the community to assist. Also, some theories see depressive symptoms as a form of protection from aggression after status losses, or in other cases a form of promotion of disengagement from unproductive activities (Gilber, 2006; Hagen, 2011).

The other, instead, considers depression as a harmful dysfunction, rather than an evolutionary advantage. The evolutionary advantage can regard the reaction of common sadness, while a greater form of distress such as depression can be more dysfunctional than helpful. Some authors, in this sense, disregard the hypothesis of the evolutionary advantage given by depression (Horwitz and Wakefield, 2007).

Sadness in response to loss seems to be a universal trait found in all cultures. Studies conducted on primates, very young children, and diverse communities indicate that expressions of sadness have biological roots and are not simply the result of predefined social patterns. However, it is important to note that the biological foundations of sadness do not exclude the significant influence of social factors. Cultures contribute to shaping the meanings attributed to sadness, highlighting that this emotion is inherently a combined result of biological and cultural influences. In this context, culture and biological design are not necessarily in opposition; especially when it comes to emotions, they act in a complementary manner. Culture itself represents an evolved human capacity, and many mental functions are biologically predisposed to be susceptible to cultural adaptations (Coppo, 2005; Horwitz and Wakefield, 2007). However, while these evolutionary theories offer intriguing perspectives, it's essential to consider that depression is a complex condition influenced by numerous factors. Evolutionary explanations don't encompass the entirety of its causes, and modern understandings of depression also involve genetics, neurobiology, psychology, and social factors.

2.5 Cultural plasticity of mental distress: the ethnopsychiatric lesson

Anthropological and ethnopsychiatric theories are instead against the idea of a universalistic vision of psychiatric disorders. While symptoms of distress might occur universally in stressful situations for all humans, we know that culture significantly shapes how individuals perceive, express, and manage depressive symptoms. By the late 1800s, mental distress was considered a privilege reserved for whites. According to some authors, outside the Western world depression existed but was disguised by somatic and neuro-vegetative disturbances rather than being connected to mood and thought. Other contributions revisited the epistemological problem highlighting that, in many cultural systems, there's no equivalent term for "depression", expecially when strictly applying screening and diagnostic tools.

The resolution to the universal dilemma of depression isn't about the category of depressive disorders in Western psychiatry being universal. Instead, it's about the universal experience of "unordinary suffering." Western societies name this suffering as "depressive disorders", while elsewhere, it manifests differently. Culture has a pathoplastic function. It does not produce the disorder but selects it, shapes it, names it, and defines its cure. Essentially, culture gives a distinct form to a type of suffering that would otherwise be multiform and unnamed.

In different contexts, forms and outcomes can vary significantly. A broad cultural variability in symptoms aligns with a universal foundation around which symptoms diverge. Each culture constructs, through a complex interplay involving both laypeople and experts, containers into which everyone's suffering can be organized. Western society categorizes a series of painful emotions associated with sadness within medical-psychiatric systems, common in modern and high-modern societies, while in other cultures, they reside within non-medical cultural and philosophical systems. In essence, what we term "depression" is a syndrome organized by culture (Coppo, 2005; 2010).

Culture-bound syndromes are not "masks" for depressive disorders. The manifestation of distress in analogous critical situations in different cultures depends on the available shapes that each culture owns as a response. In this sense, depression should be regarded as a culturally and historically situated phenomenon. Instead of attempting to fit other people's distress into Western psychiatric criteria, it's essential to examine how we've defined these categories (Carr and Vitalino, 1985; Coppo, 2005). Ethnopsychiatry views Western psychiatric discipline not as an absolute truth but as something shaped by history and culture. It acknowledges diverse

approaches to understanding and treating illnesses. Every experience may hold unique significance in various locations (Coppo, 2005).

In Western society, depression is perceived as a set of distressing experiences solely addressed through medical means. Mainstream medicine often considers the distress and the concept of depressive disorder as indivisible. However, in other societies, these issues are not detached but deeply intertwined with cultural considerations regarding existence (Obeysekere, 1985). On the contrary, in Western settings, a particular syndrome has been identified and classified as depression, leading to the assertion that the Western viewpoint should be the exclusive lens through which to interpret it. There's a tendency to focus on its outer appearance, on the way it is categorized and intended through the means of Western psychiatry, rather than delving beneath the surface, giving space to the common experiences of distress that occur regardless of cultural differences (Carr & Vitalino, 1985; Coppo, 2005). This challenges the idea of a global depression epidemic and sheds light on why depressive rates are lower in non-Western contexts. As certain regions become more Westernized, adopting Western criteria and pharmaceutical treatments, depression rates tend to rise (Pignarre, 2012; Watters, 2010).

2.6 Endogenous or reactive depression?

Before the introduction of DSM-III, depressive conditions could be distinguished between the conditions that are intended to be reactive forms of distress, whose cause or trigger can be identified separately from something endogenous, without potential causes[24]. Depressive disorders' categories nowadays are not distinguishing between the endogenous conditions, determined by something that happens inside the organism without any potential cause or trigger from outside, and reactive depression, which is instead determined (although not exclusively) by a reaction of the mind from potential triggers, that comes from the environment. The difference that characterizes them is the presence or absence of an evident cause (Horwitz and Wakefield, 2007; Lolli et al. 2014).

This division is considered outdated in psychiatry because every distress comes as a result of both "internal" and "external" factors that interact with each other (Horwitz and Wakefield, 2007), but also mostly because nowadays pharmacological treatments are working regardless of the origin of the disorder (Ehrenberg, 1997). However, some authors find this distinction

[24] "With cause" and "without cause" are common sense terms used in psychiatry to distinguish between the two conditions. However, as we already said, there are no identified causes when we are talking about psychiatric syndromes.

useful, to intervene on causes and manage treatment (Ehrenberg, 1997; Horwitz and Wakefield, 2007). For our inquiry, it is essential to understand if the presence of social events and conditions that can trigger depression are recognized and assessed in the clinic.

By the late 1960s, it was possible to establish a reasonable classification of depression into three main categories: endogenous depression, neurotic depression, and reactive depression, inevitably exogenous. The first originates from deep somatic factors, involving biological mechanisms related to sensations, emotions, feelings, in short, subjective psychological experience. The second category involves the notion of personality and often overlaps with psychopathological disorders. The third emphasizes the external event as the triggering cause and can affect even well-equipped and psychologically balanced individuals. The classification criteria for depression, and more broadly for psychiatric disorders, proposed by the DSM-III on, discharge of any previous German and French psychiatry founded on the description and analysis of patients' experiences. Since the notions of endogenous, exogenous, and neurotic, implied aetiology, a theoretically neutral manual should not favour one theory over another as part of the definition of the pathology. In this way, these notions are replaced with a singular concept of "Major Depressive Disorder." Similarly, the distinction between these types of depression is given by the possibility of treating any type of depression with the same category of antidepressant medications (Ehrenberg, 1997).

In general, the main distinction concerns endogenous and reactive depression. The losses that act as triggering events for the development of depressive symptoms can be a wide range of negative events. These include a partner's infidelity, losing a promotion, loss of job or status, chronic stress, disasters, unemployment, debts, living in a dangerous neighbourhood, and sickness. Sometimes, it's the loss of precious intimate ties such as family relationships, romantic bonds, and friendships. Other times, it refers to losses related to hierarchical aspects of social relationships, such as the loss of power, status, resources, respect, or prestige. A third type of loss refers to the failure to achieve valuable goals and ideals that give meaning and coherence to life. This type of depression is linked to a specific context (Horwitz and Wakefield, 2007). According to psychoanalysis, the substantial difference lies in the fact that, for the first type, the world becomes empty and devoid of meaning due to conscious losses

suffered, while for the second it's the self that becomes impoverished due to unconscious losses established during childhood (Lolli, 2009)[25].

2.7 Suicidality

It's crucial to highlight the connection between depression and the risk of suicide, as this relationship holds significant importance for mental health professionals and interventions aiming to address this concern. While suicidal ideation can be a symptom that occurs in depressive syndromes, not all people with suicidal thoughts are then attempting or committing suicide. However, according to data presented in DSM-5-TR, people with depression have a 17-fold increased risk for suicide over the age- and sex-adjusted general population rate. Women attempt suicide at a higher rate than men, while men are more likely to complete suicide (American Psychiatric Association, 2022). Although most of the literature recognizes the existence of this relationship (World Health Organization, 2017; Wulsin et al. 1999).A systematic review and meta-analysis on 85,768 showed that suicidal ideation in a lifetime in patients with MDD was 2.88 times compared to non-MDD controls, suicidal plan was 9.51 times and suicidal attempts were 3.45 times. Conversely to what the DSM-5-TR states, no differences in completed suicides for people with or without MDD were found (Cai et al., 2021). Debating the existence of this correlation is over the scope of the dissertation, while mental health professionals consider the two phenomena related.

3 Sociological perspectives on depression

3.1 Medicalization

Although experiencing depression can be incredibly challenging, it shouldn't be viewed as an inherent part of one's identity or solely attributed to psychological or social circumstances. Understanding medicalization helps sociologists explore how societal norms, power structures, and cultural perceptions shape depression as a medical issue addressed within the healthcare system and society at large. Mental health problems can be an example of how variations in human behaviour, cognition, and emotions are considered not part of a “normal” condition and diagnosed as disorders.

[25] Lacanian psychoanalysis calls endogenous depressive states “melancholia”, differentiating it from depression.

Medicalization means “to make medical” and describes the process by which nonmedical problems become defined and treated as medical problems, such as illnesses or distress. There are no entities that can be regarded as illness or disease ipso facto. Conversely, medicalization is the process of describing it using a medical language, and understanding and treating it through the adoption of a medical framework. Medicalization focuses on the source of the problem in the individual rather than in the social environment. It calls for individual medical intervention rather than a more collective or social solution.

Different agents are involved in the medicalization of an entity: 1) patients and social movements, through processes of moral entrepreneurship to give some voice to their condition 2) doctors, who isolate symptoms and uncomfortable body states and reclassify them as diseases 3) pharmaceutical industries and health insurances, that are economically involved in patients’ treatment. All of them are not necessarily involved in all forms of medicalization. A problem can be medicalized depending on the support of medical professionals, coverage of insurance, potential profitability, advocacy of patients, and discoveries of new aetiologies. It’s a form of collective and cooperative action (Conrad, 2007). However, it is necessary to consider the complex, continuous, and tense nature of medicalization phenomena, involving a multiplicity of actors and social forces with logics that can be consonant or opposing (Bianchi, 2019).

Medicalization can have different degrees. A condition can be minimally or only partially medicalized. Some conditions saw also forms of de-medicalization and re-medicalization (Conrad, 2007). New forms of psychological disorders are included in diagnostic manuals and become the subject of medical treatment (Maturo, 2009; Hacking, 1998), often linking them to specific molecules or genetic predispositions. This medicalization of everyday life is enhanced by biomedical discourses on biological and genetic components of depression (Di Paola, 2000).

Moreover, we need to consider the sociology of diagnosis as one of the analytical facets of medicalization in the 21st century focussing on both the historical-social roots of diagnosis and its performative effects. Diagnosis involves reflection on illness, health, suffering, and the various aspects shaping knowledge and practices. Additionally, it contributes to establishing new forms of normalization and shaping subjectivities, impacting social order and control. Diagnosis functions as an arena of conflicts among actors, discourses, devices, knowledge, practices, and technologies intersecting with the diagnostic process (Bianchi, 2022).

3.2 Social constructionism and discourses around depression

While the positivistic image of depression advanced by some psychologists, psychiatrists, and even some social scientists, tends to decontextualize the phenomenon, stripping social and psychological factors from their background context, and treating it as a distinct object (Thomas and Bracken, 2004), the study of mental disorders from this perspective permits to reintroduce of the relevance of context in understanding them. The mainstream approach used by psychiatry and psychology claims objectivity in their way of studying and operating, trying to adopt a position of neutrality and detachment from the distress they observe when describing and measuring it (Thomas et al., 2007). Conversely, the concept of depression is historically, culturally, and practically situated (Horwitz, 2010).

From a constructionist and discursive perspective, we comprehend depression from the practices of definition and medicalization are objects of research. This approach aims to examine how these systems of knowledge and practice have come to take their current form, how they are organized, and finally the consequences and people with distress. Following a social constructionist approach means that experience, knowledge, and practice are constituted through historically specific interpersonal, institutional, and social processes. In this way, to study mental distress we should denaturalize phenomena that are taken for granted and look at them in the historical, cultural, and social context where they take place, highlighting the contingent socially produced character of categories of mental distress and professional practices associated (Georgaca, 2013; O'Reilly and Lester, 2016).

Mental disorders are not part of a pan-cultural human nature but their expression depends on the culture in which they are embedded. Still, this is compatible with what is known about the evolutionary and pre-cultural basis of emotions (Carr & Vitalino, 1985; Griffiths, 1997). Emotions cannot be conceived as a priori, pre-cultural, universally, and uniformly given: emotions can be properly orienting only when they rely on a certain order of meanings. Likewise, the notion of biological precedence over its social learning component should be overcome (Vacchiano, 1999).

Finally, while we can recognize the authenticity of the distress, we should distinguish that what we experience as phenomenon is shaped by the knowledge that we have about it, constructed through historical, interpersonal, and institutional processes the social construction of categories is essential for recognizing and addressing issues of power, bias, and inequality in

society. By questioning the presumed naturalness of these categories, we can critically examine the ways in which social realities are shaped and to consider alternative frameworks for understanding human experience (Hacking, 1999; Georgaca, 2013).

It is necessary to avoid, on one hand, falling into positivistic views that reduce psychological disorders to mere biological derailments, and on the other hand, exaggerating the perspective of social sciences without considering the biological dimension of human beings, thus dissolving the reality of pathology into purely social functions. As Georgaca (2014, p. 56) states: “It is a central social constructionist position that arguing for the social construction of knowledge and practice in the field of mental health does not deny or undermine human suffering. On the contrary, it is claimed that the deconstruction of dominant discourses might enable the emergence of more useful and empowering ways of understanding and dealing with the troubling and distressing experiences which are conventionally classified as mental disorders”.

4 Psychological approaches to depression

We decided to propose here two different visions towards depression according to the two main approaches in the psychological discipline, which are the psychodynamic perspective and the behavioural perspective. For the first, we draw on psychoanalytical theory, and for the second from cognitive behavioural therapy. Other approaches can take into account one of the two or both of these theories and their further development. We propose them because they are then recalled in different interpretations regarding the epidemic of depression and its determinants.

4.1 Mourning and melancholia

In Mourning and Melancholia, Freud (1917) asserts that mourning is the reaction to the loss of a loved person or an abstraction that has taken its place. It involves a painful state of mind, a loss of interest in the external world, the incapacity to select a new object of love, and an aversion to any activity not related to the lost object of love.

The process observed in mourning can similarly apply to melancholia. Melancholia is related to the loss of an object outside the field of consciousness, unlike mourning in which nothing of the loss remains unconscious. Examples of unconscious losses involve becoming adults, ageing, moving, divorcing, and losing jobs. These wounds affect the integrity of a person,

impeding their capacity to find support, affecting their self-esteem, and depriving them of vital attachments (Coppo, 2005).

Psychologically, melancholia exhibits intense emotional pain, a disinterest in the external world, an inability to feel love, a hindrance to all activities, and a decline in self-esteem revealed through self-blame and self-accusations. These symptoms align with those seen in mourning, except for one distinction: the absence of disturbance in self-esteem. Melancholia exhibits a mortification of self-feelings expressed through self-reproach and accusations. Furthermore, while in mourning the subject perceives a world impoverished and emptied, in melancholia it is the ego itself that is perceived as impoverished and emptied. In other words, following the loss of the object, a self-change occurs, of which the subject is not fully aware in this case (Freud, 1917)[26].

Freud emphasizes the necessity of genuine psychic work and introduces the term "work of mourning" in the same text. The gradual relief from pain after a loss doesn't happen automatically but results from an active mental elaboration. The author suggests that mourning begins when a person, pressured by reality, acknowledges the inevitability of the loss and starts gradually withdrawing libidinal investment from the lost object. Abandoning the emotional attachment, despite its resistance to change, makes this process challenging and slow. Initially, individuals detach from reality and persistently stick to the lost object. There's a partial identification of the ego with the object, anticipating a new balance in emotional investments. Usually, reality prevails, and when mourning concludes, the ego liberates itself from the inhibitions tied to the grieving process.

To process mourning means being able to envision a future, contemplate something that seemed unthinkable, and begin to represent something that seemed unrepresentable. It opens up to hope, to the new, to the possibility of imagining something unknown that is worth knowing. Overcoming mourning confronts us with our capacity to remain emotionally alive in an "impoverished" world due to the absence of the object of love. The birth of new hope stems from a life force, linked to the ability to tolerate and accept separation and loss. However, this

[26] Freud (1917) also consider the possibility of a maniac reaction as a potential outcome for a loss. Maniac and depressive reactions are two possible poles. In a similar way, the phenomenological psychiatrist Emile Kraepelin also considers the maniac-depressive syndrome a unique syndrome, without differentiating depression from bipolar disorder (Kraepelin, 1921). The two approaches come from different school of thought, one psychological and one physiological. While DSM is considered neo-kraepelian, the two syndromes (bipolar and depressive) are nowadays considered two distinct entities in the categorical division proposed by DSM-III on, but still some psychiatrists are opposing to this vision (Horwitz and Wakefield, 2007).

natural progression, leading to the emotional investment in another significant object, isn't happening in melancholia. Within this condition, the narcissistic and ambivalent relationship with the object impedes the normal resolution of mourning (Battaglia, 2021). The melancholic's inability to engage in non-narcissistic object-relations seems to be the fundamental obstacle to initiating the work of mourning. It is an unsuccessful expedient to bypass the experience of the pain of loss and one's powerlessness in the face of the fact that if an object is felt as other, it can abandon us, exposing our lack of omnipotence (Lolli, 2009).

Depression, in a certain sense, can be considered as the antithesis of mourning. This is evident in the words of a depressed individual, often expressed through frozen, repetitive language fixated on a point they continuously and persistently return to. The individual, involved in this experience of loss, no longer has the object upon which to invest their emotions. Consequently, the libido turns inward, towards the self, while the world loses its allure, becoming less interesting due to the absence of that object that once made it shine (Lolli at al., 2014). The price the individual pays is extremely high: in exchange for escaping the pain of loss, those who do not engage in mourning work experience a sense of lifelessness because they find themselves immersed in a reality that is frozen, without the possibility of processing the loss in the external world and establishing genuine contact with their own emotions. For narcissistic individuals, it's easier to direct all of this towards the self and experience depression (Lolli, 2009).

Dynamic psychiatry, from its inception, explains mental phenomena as the result of conflicts arising from unconscious forces seeking to express themselves, requiring constant control by opposing forces that prevent their expression (Gabbard, 2014). According to this model, the Freudian Ego operates by attempting to satisfy the Id's needs in a socially and morally acceptable manner, imposed by the Superego, and ultimately mediating with the external reality. Thus, the Ego opposes the so-called three tyrants, and any repression of the Id's demands to cope with the real possibilities and the morality of the Superego results in the emergence of a symptom (Freud, 1933).

However, dynamic psychiatry no longer recognizes only the conflict model of psychopathology, as Freud intended, but also acknowledges what is commonly referred to as the "deficit" interpretation model of illness. Those who suffer from psychiatric disorders, for whatever evolutionary reason, suffer due to lacking or absent psychic structures. This impoverished condition prevents them from feeling whole and self-confident, and as a result,

they place excessive demands on people and the surrounding environment in order to maintain psychological homeostasis (Gabbard, 2014). Critics have already recognized how the psychoanalytic model of Janet, based on the idea of deficit rather than Freud's model based on unconscious conflict, has prevailed in current psychodynamic considerations of psychopathology, especially regarding treatment modalities through psychotherapy and pharmacotherapy, which see the person as the object of their own sickness, not a part of it (Ehrenberg, 1997).

In this context, the interest in a sociology of depression is twofold. Firstly, the Freudian references to depression as a reaction to mourning, which still return in modern psychiatry, must be considered. Secondly, the deficit model shows how the nature of a psychic problem, not only referring here to depression, is the result of a failure to develop capabilities that allow coping with external reality. Thus, we differentiate between internal and external components that interact with each other in defining psychopathology. In this context, individual components can oppose the external reality, of a social nature, which sociology must take into consideration.

4.2 Cognitive Behavioral Theory

According to cognitive behavioural theory, depression is understood as a result of negative and distorted thinking patterns, as well as maladaptive behaviours. Cognitive behavioural theory suggests that our thoughts, emotions, and behaviours are interconnected and influence each other. Cognitive Behavioural Theory is based on Beck, Rush, Shaw and Emery's (1979) theory on the triad of cognitions, which constitute its central component. The triad of cognition consists of three key elements: negative views of the self, the present, and the future.

Negative thoughts can regard a negative perception of oneself, leading to feelings of low self-esteem and self-criticism. A negative vision of the world makes people with depression their environment as hostile, unfair, or devoid of positive experiences. Depressed individuals often have a negative expectation about their future reinforcing feelings of hopelessness and contributing to a lack of motivation. According to the cognitive theory, these negative cognitive patterns are thought to play a significant role in the development and maintenance of depression. Therapy approaches such as Cognitive Behavioral Therapy (CBT) aim to identify and challenge these negative cognitions, helping individuals develop more balanced and realistic thoughts and beliefs. By addressing and modifying these negative cognitive patterns,

individuals can experience a reduction in depressive symptoms and an improvement in their overall well-being.

5 Depression and its treatment

5.1 Pharmacological therapies

Before the discovery of the first effective drugs for the treatment of depression in 1952, other ways to treat depression included phytotherapy, shock treatment, insulin coma, and lobotomy. This discovery represents a milestone in the treatment of mental disorders, as could restore some degrees of functionality in most severe cases. People suffering from depression can see, in most cases, their symptoms reducing their intensity or disappear, and can continue their lives (Coppo, 2005; Ehrenberg, 1997).

There are several pharmacological therapies commonly used to treat depression. In Italy, at the moment are available: Selective Serotonin Reuptake Inhibitors (SSRIs) like fluoxetine, fluvoxamine, sertraline, paroxetine, citalopram, and escitalopram; Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs) such as venlafaxine and duloxetine; Serotonin Antagonist and Reuptake Inhibitors (SARI) such as trazodone; Tricyclic Antidepressants (TCAs) like amitriptyline, clomipramine, dosulepin, imipramine, maprotiline, nortriptyline, trimipramine; Monoamine Oxidase Inhibitors (MAOIs) including phenelzine; Noradrenaline Reuptake Inhibitor (NARI) such as reboxetine; Norepinephrine-Dopamine Reuptake Inhibitor (NDRI) such as bupropion; Noradrenergic and Specific Serotonergic Antidepressant (NaSSA) mirtazapine and mianserin; Melatonergic antidepressants such as agomelatine; Multimodal antidepressants such as vortioxetine. In some cases, the syndrome is treated also using anxiolytics such as benzodiazepines and pregabalin, or with specific antipsychotics at a low dosage. The choice of medication often depends on various factors such as the individual's specific symptoms, medical history, and any potential side effects (Barbato and D’avanzo, 2019).

The use of antidepressants, as we showed in the first pages of this dissertation, is increasing. However, despite numerous studies and significant financial investment, in the last forty years it was more refining existing therapies than discovering new ones. Psychopharmacological drugs were in fact discovered incidentally. This situation has had a big impact on psychopharmacological research: many major companies have greatly reduced or even stopped

looking for and developing new psychotropic drugs. Since there is lack of biological comprehension for complex issues like depression, it's not surprising that specific molecular targets haven't been found to create new therapies with new ways of acting (Fibiger, 2012).

As there's no clear indicator to define depression, it is the introduction of new drugs that have spurred the creation of these classifications and not the other way around. In the absence of biological markers and causal theories, a circular discourse emerges where the assumption is that those who respond to antidepressants are “depressed". This type of classification lacks clinical and biological indicators that can prove the effectiveness of different treatments. Classifications are made to produce pharmacological research: in the absence of etiopathogenic indicators, diagnosis categories are built on their response to pharmacological therapies. Biological psychiatry offers explanations of how psychotropic medications function but doesn't provide insights into the underlying causes of mental disorders. To occur such an eventuality, syndromes would need to be illnesses (Healy, 1997; Pignarre, 2012).

The new medicalized psychiatry transformed both psychiatrists and patients. Doctors do not look at psychological causes for mental disorders but the only things that matter are symptoms and the molecules that can cure them. Furthermore, antidepressants are easily used by general practitioners without requiring specific expertise in psychological concepts and theories, contributing to their widespread use (Barbato, 2015). While the use of anti-depressants is increasing, the assessment of their functioning shows low effectiveness and risks of adverse effects (Barbato, 2015; Pignarre, 2012).

For what concerns effectiveness, a meta-analysis considering sixty-eight trials on SSRIs (n = 17 646) showed a positive response to depressive symptoms with the use of antidepressants in 50.7% of cases compared to 38.7% for the placebo group. At the same time, adverse events were occurring more in the treatment group (77.6%) compared to the placebo (65.8%) (Barth et al., 2016b). Another meta-analysis shows that the difference in effectiveness between antidepressants and placebos is clinically significant only for patients with high initial severity, but remains rather limited even in severely depressed patients. The link between initial severity and the effectiveness of antidepressants is due to a reduced response to placebos among patients with very severe depression, rather than an increase in the response to the medication (Kirsch et al. 2008). A third meta-analysis shows that the level of advantage offered by antidepressants over placebos grows as the severity of depression symptoms escalates. In individuals with mild or moderate symptoms, this benefit might be minimal or even absent, on average. However,

for those experiencing very severe depression, the advantages of medication over placebos are considerable (Fournier et al. 2010).

The picture presented here shows that pharmacological therapies are not as functional as expected, regardless of the widespread and increased use in the global population. This narrowing of the drug-placebo difference has been attributed to changes in the conduct of clinical trials. First, the advent of DSM-III and the broadening of the definition of major depression have led to the inclusion of mildly to moderately ill patients into antidepressant trials, reducing the treatment-placebo effectiveness differences. Second, reasons for this mismatch can be found in the marketing strategical behaviour of the pharmaceutical companies involved in scientific publications, shaping the knowledge and data regarding the effect of antidepressants (Khan and Brown, 2015). Healy (1997) showed that over half of the most influential studies on SSRIs were ghostwritten by private firms hired by drug companies, who then paid prominent academics to sign the articles. Along the same line, a review of seventy-four studies of antidepressants found that of the thirty-six negative studies, where SSRIs have failed to outperform placebos, only three managed to make it to print. Selective publication of clinical trials, when only the ones with positive outcomes are published, can lead to unrealistic estimates of drug effectiveness and alter the apparent risk-benefit ratio (Turner et al., 2008).

To summarize, there is a strong therapeutic response to antidepressant medication, but the placebo response is almost as strong. This presents a therapeutic dilemma. The drug effect of antidepressants is not clinically significant, but the placebo effect is. Kirsch (2014) poses the following question: What should be done clinically in light of these findings?

5.2 Psychotherapeutic therapies

Psychotherapy often serves as an initial option for mild to moderate depression, particularly when significant psychosocial stressors are influential factors. It provides a structured, supportive environment to explore thoughts, emotions, and behaviours linked to depression. Through various therapeutic techniques, individuals learn coping mechanisms, gain insight, and develop strategies to manage symptoms. Therapeutic approaches available come from different schools and approaches, such as psychodynamic, cognitive-behavioural, systemic-familiar, gestalt, bioenergetic, transactional, interpersonal, and so on.

With the DSM-III, they gradually shifted to primarily targeting the symptoms of mental disorders with psychopharmacological treatment, displacing the prior hegemony of

psychotherapeutic treatment (Meyes and Horwitz, 2005). However, various forms of psychotherapy are still considered to be significant treatments for depression. A systematic review that their effectiveness is not moderated by the severity of the depression at the beginning of treatment and that it is equally effective in mild, moderate, and severe depression. The effectiveness of such interventions is similar to that of antidepressants (Gartlenher et al., 2016). Different psychotherapeutic approaches for depression demonstrated to have comparable benefits (Barth et al., 2016a), even for inpatients with severe depression (Crowe et al. 2015)

From an anthropological perspective, it seems that our society has lost the ability to address fundamental aspects of human existence—such as death, illness, and suffering—using the symbolic tools that traditionally helped process even the most challenging events. These elements of individual experience are thus excluded from social representation, omitted from collective sharing, and regarded as private matters to be resolved in intimacy, shielded from gazes that might not bear the weight of potential confrontation. Conversely to the analgesic road of pharmaceutical therapy, the road of understanding yourself through "talking therapy", involves the healing through the process of becoming conscious (Lolli, 2009).

5.3 Combined use of antidepressants and psychotherapy

After the diagnosis, practitioners should take into account the patient's symptoms and determine in which way to intervene. Scientific literature and general practitioners' dispositions in Western societies mainly include two types of therapy: psychotherapeutic therapies and pharmaceutical therapies. Research showed that both types of therapies are effective in the treatment of depressive disorders, both singularly and combined, with better results when combined (Khan et al., 2012; Pampallona et al., 2004).

However, as meta-analyses do not provide evidence for the efficacy of antidepressants over the placebo in patients with minor depression (Barbui et al. 2011), antidepressants can be considered in special cases with, for example, suicidality, previous suicide attempts, family history of affective disorders or previous major depressive episodes. (Hegerl et al., 2012). The therapeutical relationship is per se sufficient for treating low-moderate symptoms (Kirsch, 2014).

Italian Ministry of Health produced guidelines for treatment, based on the United Kingdom's National Institute for Health and Care Excellence (NICE) (2009; 2022). Following these

guidelines, for mild depressive syndromes, the treatment indicated is psychological support or psychotherapy. For moderate and severe depressive syndromes, the treatment can include psychotherapy or pharmacological treatment. The pharmacological treatment is indicated, alone or with psychotherapy and psychosocial support, for resistant, recurring, and psychotic depression, as well as for people with suicidal risk (Ministero della Salute, 2014).

Treating mental disorders solely by targeting the brain isn't adequate. The entire aspect of the implication of the subject's history, choices, and inclinations in the constitution of the symptom is dismissed as secondary or, possibly, as a consequence of organic imbalance. The subject is relieved of any responsibility regarding their own story and made the object of a treatment in which nothing is asked of them (Lolli, 2009). Truly evaluating the effect of a substance requires considering various factors: the environment, the patient's history, their relationship with doctors, and so on. The "traumatic" break resulting from the use of medication can be seen as a form of "chemical psychoanalysis," as it helps bring forth internal conflicts, a crucial step towards resolving them. These substances aid patients in confronting their conflicts, but the doctor is the true therapeutic agent, that assists the patient in reconnecting with reality and providing a sense of "protection". The medication should not be seen as a mere mechanical tool, but as part of a complex relationship, both in terms of its pharmacological interaction and the relationship between the doctor and the patient. (Coppo, 2005; Ehrenberg, 1997).

If both psychotherapy and psychotropic medication play significant roles in the treatment of psychosocial distress, according to some authors, both before and after the discovery of psychotropic drugs, psychotherapy has been considered the cornerstone of effective treatment, (Ehrenberg, 1997). Even many of the most dedicated psychiatrists to medication now acknowledge that comprehensive care for the disorder necessitates considering the individual's entirety, with treatment involving the reconstruction of one's own story to avoid incomplete therapeutic outcomes (Lolli et al., 2014). Barbato (2015) suggests a few recommendations that can be followed provide the best treatment and reduce the abuse of pharmacological therapies: 1) Restrict the use of psychopharmacology to a specific and temporary period 2) Assess the costs and benefits meticulously, while steering clear of adverse effects 3) Provide psychosocial assistance for families and opt for psychotherapy in cases of non-severe depression 4) Integrate psychosocial therapies into mental health services and ensure medical professionals receive adequate training in this domain 5)Make brief psychotherapy accessible within general medical

practice 6) Equip doctors with training for judicious and discerning use of psychopharmacology

5.4 Other treatments

Ethnopsychiatry generally embraced a relativistic view concerning depression, suggesting that there is no way to apply a concept of distress or normalcy beyond local cultural practices. Outside of Europe and the US, as we have seen, things can unfold differently: in communal societies equipped with collective mechanisms for prevention, negotiation, and care, this type of suffering arises less frequently. And when it does arise, it follows different paths and outcomes.

It seems that depression emerges more likely in contexts of lack of social ties and social support for adverse life events such as losses. The development of medical-psychiatric practices, the loss of other ways of curing it, the life condition of modernity, the loss of connections and points of reference, with discourses on autonomy and independence, left the individual alone and frightened in this world. In this way, the fragile self is exposed and helpless.

In diverse cultures, medical practices might not hold as much prominence, with significant emphasis placed on experiences related to death, loss, and traumas. Rituals, employed as interventions in certain contexts, serve as techniques as effective and valuable as psychotherapy and medications (Coppo, 2005). It's important to strive for the most effective system to benefit patients. This might involve assessing whether an intervention is necessary or if depression is merely a symptom. If it isn't, considering alternative repertoires - both individual and collective - is crucial. Problem-focused coping, high communal mastery, high social support, self-mastery, high self-esteem, cultural identification and cultural practices, traditions, and cultural continuity represent protective factors for depression (Coppo, 2005).

Rather than relying solely on psychotherapy and medications, it's crucial to cultivate a healthier environment. Assessing the collective aspect of the issue involves creating strategies for fostering healthier individual identities. It's not just the therapist's responsibility to care for the patient; the entire context should contribute to this endeavour. Considering the relevance of these aspects for depressive disorders, we should ask ourselves if there are other interventions for patients who are experiencing depression, aside from psychological and pharmacological therapy. Social interventions include helping the person to overcome social and economic

disadvantages that, as shown previously, are involved with the emergence of depressive symptoms.

6 Conclusions

The chapter defines the perspective used to address depression as a concept in this study. As sociologists, we specifically embrace a discursive and constructionist approach, where the definition of what is called depression comes through the discourses and practices that mental health professionals use in their everyday activities. This approach is also useful to understand, later, how the diagnosis is addressed as well as the different perspectives on the phenomenon according to different professionals.

The views on depression are manifold. Some converge while others differ. It has therefore not been deemed possible to offer a theoretical explanation for depression, in the description of potential mechanisms underlying the emergence of such symptoms, not solely in their descriptionHere, the most relevant sociological perspectives have been presented, along with those theoretically aligned to provide the reader with the foundations to understand the subsequent empirical chapters on this topic.

Conversely to the atheoretical stance of the DSM, this study aims to take a stance and define certain approaches as explanations to consider when discussing depression. This is for two reasons. Firstly, due to the sophisticated theories they propose, based on compelling considerations. Indeed, the theories presented here share many common points, enhancing their solidity. Secondly, the presented theories are useful for explaining what emerges in the empirical part of the research, thereby verifying which findings align and which do not.

Chapter 4 - Sociological explanations regarding the epidemic of depression

1 Introduction

As mentioned in the first chapter, an epidemic of depression has been recognized by international health institutions, the press, scholars, and common sense. In that chapter, we briefly presented sociological explanations for this epidemic, and we now can spend more words on the different accounts.

As we stated, we decided to divide the explanations into two groups: the "social change explanations" and the "diagnostic explanations". The social change explanations include all the theories that see the increase of depressive disorders' prevalence as a consequence of social processes. Social changes involved are the modernization process and their effects on people's life conditions and social structure, as well as cultural changes and discourses concerning individuals' lives and *self*. Conversely, the diagnostic explanations regard all the theoretical contributions that see the epidemic as a matter of change in diagnostic criteria, as well as general transformations that involved psychiatric theory and the way mental disorders are intended, classified, and treated.

In this chapter, we will present many authors, but most of the space will be dedicated to reviewing two important contributions to the sociology of depression: "The Weariness of the Self: Diagnosing the History of Depression in the Contemporary Age" by Alain Ehrenberg, (1997) and "The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder" by Allan V. Horwitz and Jerome C. Wakefield (2007). These two books are considered here respectively as the main contribution to the social change explanation and the diagnostic explanation. The two books seem not to communicate with each other, as they understand the phenomenon from two different perspectives. Conversely, as we show at the end of the chapter, the two explanations should not be intended as mutually exclusive but conversely, they reinforce one another in the understanding of the phenomenon.

The chapter will include mostly sociological explanations but also a few psychoanalytical, psychiatric, anthropological, and philosophical interpretations. All of them are psychosocial interpretations of the changes that involved Western societies in the last forty years. The whole

literature presented here will be used later for the interpretation of the results of the case studies. We can assess, in this case, whether these theories will be useful to "read" the fieldwork.

Not many authors tried to sketch a literature review about the explanations concerning the epidemic of depression, and this chapter represents one of the few attempts. All the explanations of this epidemic of course involve social factors, in some cases also interfering with biological and psychological ones. All the possible explanations of the epidemic are fundamentally social, sometimes psychosocial, for the following reasons.

First, drawing from the biopsychosocial model, we consider the rise of depressive diagnoses, it is difficult to think that the biological and psychological functioning of humans can be changed, increasing the occurrence of depressive disorders. Depressive diagnosis increased much in the last few decades, and we cannot expect the human body and mind to be changed that much, as these processes generally evolve in way longer times. This also represents a mark against biological psychiatry: If psychiatry were biological, there could be no epidemic, because we cannot expect to have an increase in depressive disorders' rates in such a short time, but we should consider instead the evolution of the context in which individuals live (Pignarre, 2012).

Pignarre (2012) and Grippaldi (2021) are the only ones who sketched a review of the possible explanations. The first one distinguishes between four types of common sense explanations, without providing references for them: 1) modern social contexts create stressful environments that can enounce depression; 2) depression increases because of new modern parental patterns, which are affecting childhood and increasing mental distress in adulthood; 3) the percentage of patients that are affected by depression didn't change much, diagnoses are increased because we improved our tools to diagnose it; 4) the definition of depression comes through an operation of marketing conducted by the pharmaceutical industry (Pignarre, 2012). Grippaldi (2021) instead provides a wider analysis, including most of the references in sociological literature, saying that depression increased due to the intervention of different social dynamics, namely 1) the introduction of new ways to conceptualize psychological distress through new diagnostic categories; 2) the effect of norms that imply self-realization behaviours; 3) social disintegration and secularization, that leave individuals without points of reference.

We prefer to divide all possible contributions from social sciences into two groups, which we already presented in Chapter 1: the social change explanations and the diagnostic explanations.

In the first group, we include all contributions that consider the rise of depressive syndromes prevalence as an effect of social change. In the second, conversely, depressive syndromes' presence is not necessarily increased in the global population, but instead, changes are mainly happening in the way psychosocial distress is narrated both by scientific and common-sense voices. We will use this division to present the literature on the topic, and then provide a reflection on the researcher's account of these theories.

2 The social change explanation

2.1 Modernization and depressive disorders

Modernization seems to be the cause of most individual problems according to many sociologists, and the same happens for depression. This type of explanation, although common, is also common-sense-based. It is quite easy, as many do, to blame modernization and capitalist contexts as common problems, without then explaining why. Different aspects connected to modernization can be distinguished, to avoid tautological explanations.

Late modernity is described by many as the "age of depression" (Grippaldi, 2021, Horwitz, 2010), claiming that depression became the most widespread psychiatric condition in Western societies due to discrepancies between the objective world and the subjective experiences. According to Giddens (1990), late modernity is characterized by ontological insecurity, with individuals' existential desire for an experience of the social world as relatively safe and reliable. Depression represents the widespread existential crisis associated with the loss of meaning in life (Grippaldi, 2021).

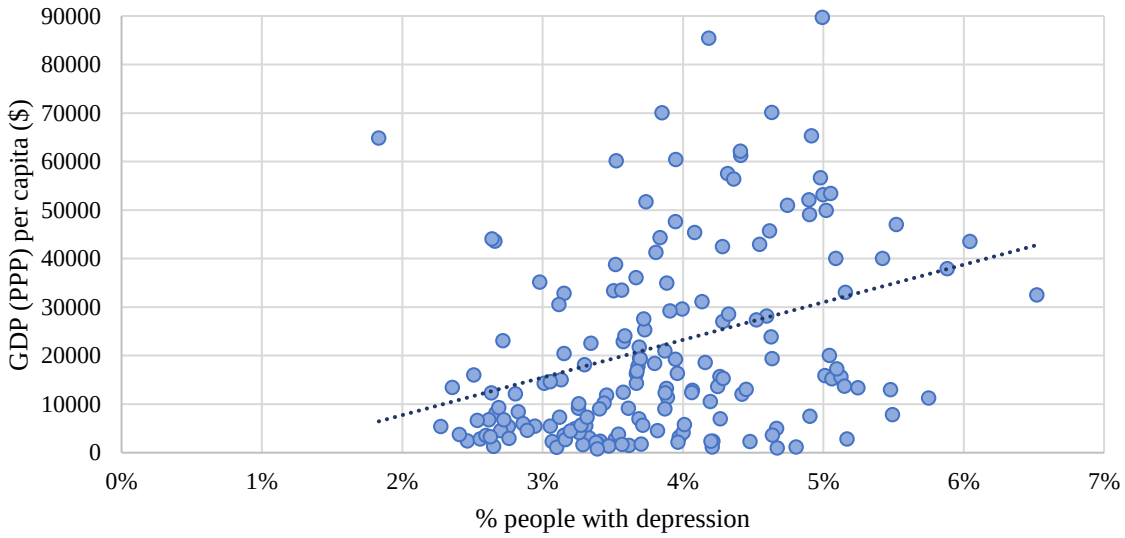
2.1.1 Modernization and lifestyle

Hidaka (2012) systematic review shows that modernization processes are affecting individuals' biological activities and bodies, bringing, showing the positive association between GDP and the prevalence of depression. This can be explained both by modern lifestyles (namely sedentary lifestyles, sleep deprivation, and unhealthy dietary habits) and also by competitive, inequitable, and lonely social contexts. Modern populations are increasingly overfed, malnourished, sedentary, sunlight-deficient, sleep-deprived, and socially-isolated. These lifestyle changes each contribute to poor physical health and affect the incidence and treatment of depression. The growing burden of chronic diseases, which arise from an evolutionary

mismatch between past human environments and modern-day living, may be central to rising rates of depression.

The highest prevalence in the European and American regions, as shown in Chapter 1, should be explained by these theories. However, reproducing the analysis made by Hidaka (2012) to draw his conclusion using GBD 2019 data together with GDP at parity of purchase power (PPP) per capita data provided by the World Bank from the same year (World Bank, 2021), we obtain a distribution with a weak positive correlation (0.3) between the GDP and the percentage of people with depression. Figure 7 shows this association. The dots over the line show that many countries have low rates of depression even with very high GDP (PPP) per capita. On the contrary, in the lower part, we can see countries with similar GDP (PPP) per capita but with very different depression prevalence. Indeed, the points in the distribution do not fall on the line. This high degree of dispersion suggests that there is no systematic relationship between the two variables. The coefficient of determination (R^2) is 0.09, so practically 99.91% of the variance in this relationship is not explained. The relationship showed by Hidaka is therefore weak for various reasons, for example, because GDP is a measure that does not necessarily explain high levels of modernization in countries.

Figure 7 - % people with depression vs GDP (PPP) per capita



Source: GBD, 2019; World Bank, 2019

In the end, this review also suggests that declining social capital and greater inequality and loneliness are candidate mediators of a depressiogenic social milieu. This point is widely explored by anthropology and ethnopsychiatry as a relevant factor for the emergence of depressive disorders.

2.1.2 Modernization and secularization

In the previous chapter, we showed how depression, according to psychoanalytical theory, occurs after the loss of a significant object, conscious or unconscious, when the loss is not elaborated through normal paths of bereavement (Freud, 1917; Lolli, 2009). In this context, lacanian psychoanalysis identifies the structural problem in the advent of depressive disorders in the absence of rituals in contemporary contexts. Specifically, funerals and burial ceremonies mark the beginning of the transformation of the dead from an object of reality to a symbolic object. They represent the first attempt of the human being to resist the non-sense of reality through a symbolic intervention. The funeral rite can now be considered, in some ways, a practice in danger of extinction. The increasingly pressing tendency to deny castration, in favour, conversely, of the obsessive pursuit of the possibility of achieving a status of omnipotence, eternal and almighty. It takes on the appearance of those pathologies that are configured as the new symptom of the community; drug addictions, depression, and anorexia-bulimia, therefore, spread with very particular virulence, as something that could not be done otherwise is consumed symptomatically in them: the elaboration of the loss (Lolli, 2009). Of course, these considerations should not be understood exclusively regarding funeral ceremonies, but for a general inability to overcome losses and individual limits in the way modern societies are thought of. There is, according to this point of view, a lack of space for bereavement and acceptance of human limits.

On the same page, research in ethnopsychiatry shows how rituals are protective factors against unelaborated bereavement. Becoming adults, getting older, leaving the hometown, breakups, and death are all situations that can wound the integrity of the person, depriving vital attachment, and hampering their capacity to be sustained. Rituals are techniques that can help the individual to overcome the loss and they are considered as efficient and valuable as psychotherapy and pharmaceutical treatment (Coppo, 2005). In Western societies depression is considered a series of painful experiences that find answers only in medicine, in other societies, these problems are locked in cultural questions about existing (Obeysekere, 1985).

2.1.3 Modernization and social disintegration

According to ethnopsychiatry, social disintegration brought about by modernization plays its role in the unpredictable rise of depression rates. Collective activities such as the rituals already mentioned are useful to protect from depression so that the individual is not alone in facing the loss. In individualistic societies, where the individual is weakened by autonomy and the lack of social ties, the individual is more dependent on the attachment to another type of objects, material and not, who gives them sense and value to their life while, conversely, they are evanescent (Coppo, 2005).

Many different studies conducted in Africa and Europe showed that social support can be identified as a possible protective factor against mood disorders. Dislocation from the original group is a significant risk factor for depression (Carta et al., 2001).

2.1.4 Modernization, individualization, capitalism, or neoliberalism?

One of the first studies in the sociology of depression discovered that depressive symptoms such as feelings of low self-esteem, self-blame, and helplessness were observed by physicians in several areas of England at the end of the 17th century at the end of feudalism as a result of the passage from feudalism to capitalism. The fundamental elements of this passage were identified in the disruption from the disruption of the enlarged family with consequent changes in educational patterns and the loss of close emotional support for the individual (Murphy, 1978). Those social transformations are also described by Durkheim in "Le Suicide" (1897), where anomie and lack of social ties are seen as causes of distress and the consequent rise of suicide rates, following the sociological debate on the effects of the transition from *gemeinschaft* to *gesellschaft* on social life (Tönnies, 1887).

However, while Durkheim's reasoning has found that individualization and secularization were somehow related to distress, the rise of suicides was to be attributed to other correlates to a wider cultural change that was happening from the previous centuries and culminating in the 19th century, namely the disappearing of prescriptive norms that would forbid suicide, as well as an emerging discourse on the individual right to put an end to their lives (Barbagli, 2009). Social ties and rituals, lost through individualization and secularization processes, are of course protective factors in this sense, but their occurrence diminished with the process of modernization and the advent of capitalism, and their related cultural change (Coppo, 2005; Lolli, 2009).

Speaking of capitalism, some authors recognize the responsibility of the rise of depressive disorders to the advent of this socio-economic system. Success, virtue, and happiness in a neoliberal market society are often associated with material wealth. Acquiring services and products is thought as essential in the pursuit of a fulfilling and productive life (Esposito and Perez, 2014), objects whose satisfaction is given for a short amount of time, in a loop of constant unsatisfaction (Lolli, 2009). In our advice, implying that capitalism is responsible for depression is a shortcut that does not provide any further reasoning. Capitalism is an economic system while, conversely, we should consider the cultural system associated with it. If we take Murphy's study (1978) on the transformation from the feudal to the industrial context, we can see that the reason is, more than the social displacement of individuals, the cultural changes that affected peoples' lifestyles and values. Economic individualism invested individuals with full responsibility for themselves and modified their attitudes towards the meaning of life. To recall another sociological masterpiece, Weber (1905) described well how with the introduction of capitalism not only the economic and work conditions of the society changed, but also the values and the way to understand the world. Again, for people at that time, the future is no longer defined by fate and providence but rather as the result of individuals' efforts (Murphy, 1978)[27].

On the same page, ethnopsychiatric research shows how "Westernization" as the loss at the individual level of the traditional lifestyle, working habits, culturally determined values, and the language in favour of attitudes influenced by Western culture, represents a risk factor for depressive disorders, at least in clinical expressions common in western contexts. Areas in rapid transformation seem to indicate that environmental factors may influence the evolution of depressive symptoms from one form to the other and modify the threshold of triggering depressive emotional or behavioural patterns. It is assumed that these perturbations of the social structure have resulted in the population's adaptive attitudes to "compulsive hyper-responsibility" (Carta et al., 2001).

Therefore, we believe that the rise of depressive disorder is not related only to capitalism, individualization, and secularization, but instead the cultural system underneath a neoliberalist way to define individuals. The occurrence of depressive disorders depends, as we can already

[27] Murphy (1978) disagrees with Weber about the advent of Protestantism as the cause of these change, which he instead considers secondary to the economic transformation.

see, on pressures on self-realization in life, the inability to accept individuals' limits, and the lack of symbolic space for losses and adversities.

2.2 The pathology of self-realization

The following contributions define the rise of depressive disorders rates as a consequence of contemporary lifestyles not looking at their material and social conditions, but rather following what type of cultural scenarios can be recognized as underlying. The idea, in this sense, is that the values, representations, and discourses have their effects on shaping intimate life. Psychosocial distress is the consequence of contemporary lifestyles, and discourses on the way to define individual *self* and societal requirements. The main point of this analysis is brought by Alain Ehrenberg's book "The Weariness of the Self. Diagnosing the History of Depression in the Contemporary Age" (1997), which first described how recent social transformations are fundamental to understanding the emergence of distress. The further contributions are somehow similar and dialogue with the author, but they all maintain a certain conclusion: the high demands of self-realization and the inability of individuals to pursue and maintain certain standards are important factors in understanding the epidemic of depression, showing the effect of discourses on identity on the human mind and psychosocial wellbeing.

2.2.1 Alain Ehrenberg: The weariness of the self

A fundamental contribution to the sociology of depression, Alain Ehrenberg's work (1997) perhaps constitutes the most comprehensive analysis of the social transformations of the last century in Europe and how they have led to the definition of depression as a disorder characterizing our contemporary era. The study is based on tracing the modern changes through the psychopathological categories used in psychiatry, thus reviewing first neurosis, then depression, and finally addiction. We will trace the changes in our subjectivity through the changes in its pathologies. The contributions used are not only of a historical nature but also strongly sociological and psychoanalytic.

Ehrenberg states that depression represents the "pathology" of a society in which norms are no longer based, as in the past, on the experience of guilt and inner discipline, but, instead, on individual responsibility and initiative, on autonomy in decisions and action. The experience of guilt, which has marked the conscience of countless generations, would thus today be replaced by the implacable and absolute need for responsibility. Just as neurosis, a century ago, loomed over the individual torn apart by conflicts, fractured between what is permitted and

what is forbidden, today depression threatens an individual apparently emancipated from prohibitions but surely diminished by the gap between the possible and the impossible. If neurosis is a drama of guilt, depression is a tragedy of insufficiency: the "success" of depression is based on the decline of the reference to conflict, on which the idea of the subject that we inherited from the nineteenth century was modelled.

In the 70s the concept of neurosis knows its decline. The decline of the allowed/forbidden opposition and the overcoming - by the progress of biology and pharmacology - of the limits imposed on man by nature means that everything becomes concretely possible. We then see depression going outside the medical field before any pharmacological innovation yet inspiring its diffusion: the determining factor is emancipation, with its shift of emphasis from the forbidden to the permitted and from guilt to responsibility. The contrast between the permitted and the forbidden sets makes room for a lacerating contrast between the possible and the impossible.

The person is no longer moved by an external order or by compliance with the law but must appeal to internal resources. The individual is confronted with a pathology of insufficiency and no more with a disease of guilt. The private sphere no longer reveals in terms of guilt as the social sphere no longer imposes in terms of discipline. The measure of the ideal individual is no longer given by docility but by initiative. The necessity to choose one's own life and the pressing duty to become oneself place individuality in a condition of continuous movement. The pressure to constantly prove oneself and meet high expectations contributes to feelings of inadequacy and exhaustion. The depressed is the “stalled” man.

Every depressive experience, to the extent that it is expressed with this fatigue of living, with this more or less extensive loss of initiative, and with this subjective rebound of failure and setback, comes into implacable collision with the paradigms that today's society considers as essential to define and designate, precisely, the dignity and existential significance of the existence of each of us. Depression enlightens us about our current experience of the person since it is the pathology of a society in which the norm is more based on responsibility and initiative. Efficiency and the ability to make decisions and pragmatic initiatives, which society requires of each of us, cannot be reconciled, and indeed have a pathogenic function. The contemporary individual is a sort of “individual-trajectory”, an individual wholly intent on conquering his own personal and social identity.

Depression thus appears not as a loss of the joy of living but as a pathology of action. The symptomatic axis of depression shifts from sadness, melancholy, and *Stimmung*, to inhibition and loss of initiative which constitutes, moreover, an elective therapeutic horizon of antidepressants. Depression expresses through its symptoms the very impossibility of living, and so it does in the language of sadness, asthenia (fatigue), inhibition, and psychomotor retardation. Exhausted and emptied, agitated and violent, we bear the weight of individual sovereignty within our bodies. In a culture of performance and action, where not being up to individual initiative has its cost, inhibition is a pure dysfunction, an insufficiency.

Nowadays perturbances are coming from inside ourselves. When Nietzsche (1913), announced the advent of the sovereign individual, the *Übermensch*, redeemed by the ethics of customs, he pictured a solid human being. The sovereign individual, the individual equal only to himself whose advent Nietzsche announced, is now a common form of life. On the contrary, individuals redeemed by morality, who tend towards the superhuman, acting on their nature, going beyond themselves, being more than themselves, instead of possessing the strength of the demiurges, are intimately fragile, exhausted by their sovereignty. We are now emancipated, in the proper sense of the term: the modern political ideal, which makes the individual the owner of themself. But emancipation has upset, on a collective level, the intimacy of each of us: we are pure individuals, with no longer any moral law or any tradition to show us from the outside who we should be and how we should behave. The fact is that this new sovereignty does not make us omnipotent or free to do as we please, nor does it mark the triumph of the private man. The individual, once placed in front of themself, withdraws from their self, realizing that he is grappling with a stranger (Ehrenberg, 1997).

Lolli (2014) commented the Ehrenberg in this way:

> “If I could do anything, why don't I? Why don't I realize all my potentials that they tell me are unlimited? So, if I don't realize them, and it's practically certain that I won't be able to fully realize them, this fatigue emerges, this pain of being myself which has a sense of depression as its relapse. Dostojevski said: "If God is dead, everything is possible"; Lacan reverses it and says: "If God is dead, nothing is possible anymore", that is, if there is no longer a limit, then there is nothing left to do. Here I see more of a difficulty in coming to terms with one's limit, with one's castration. This, in my opinion, is the specific trait of contemporaneity. Because, as I said, subjective castration, limitation, failure, I don't know what to call it, are abolished in the contemporary.”

Depression is thus the old melancholy updated by equality, the “disease” of the democratic individual, the inexorable counterpart of who claims to be sovereign. Depression is not, like inhibition, thinkable in terms of freedom, but in terms of capacity. The history of depression helps us understand this social and mental turn. Psychic liberation is accompanied by identity insecurity, while individual initiative by the impotence to act. Emancipation has perhaps freed us from the dramas of the sense of guilt and the spirit of obedience, but it has undeniably condemned us to those of responsibility and action. This is how depressive fatigue took over neurotic anguish. Now, depression is a pathology of time (the depressed has no future) and a pathology of motivation (the depressed has no energy, their movements are numb, and their speech is stunted). It is difficult for the depressed to formulate projects: they lack the energy and motivation to do so. Inhibited, impulsive, or compulsive, he communicates with difficulty with himself and with others. Drained of plans, drained of motivation, drained of communication skills, the depressed is the exact opposite of our social norms.

2.2.2 Neoliberalism and burnout

As we showed Ehrenberg’s (1997) idea of contemporary individuals is someone institutionally called to act at any cost, on the edge of his internal resources, who experience distress. Other authors have similar ideas on what Ehrenberg is claiming, but recognizing systemic violence inherent in the performance society, elaborated more than on a psychological level but rather on an economic/political one, finding its justification in neoliberalist performance culture.

Han (2015) argues that modern society is characterized by a new form of exhaustion called "burnout." Unlike traditional forms of exhaustion that arise from external pressures, burnout emerges from internal factors such as self-exploitation and the relentless pursuit of achievement and success. In the past, societies were governed by disciplinary power, where individuals were subjected to external constraints and regulations. However, in the current era of neoliberalism, individuals are driven by self-discipline. They willingly subject themselves to constant self-monitoring, self-optimization, and self-exploitation. This internalization of disciplinary power leads to a sense of fatigue and burnout.

Unlike Ehrenberg, the author believes that it is not the imperative to belong to oneself that causes depression but the pressure to perform, the imperative of performance as a new obligation of the late modern working society. it is a tiredness of doing and of being able to do. The subject is no longer subjugated by anyone but himself. The psychic disorder of the performance society is precisely the pathological manifestation of this freedom.

Along the same line, critics of neoliberalism come from Fisher (2014), where depression is seen as a tragedy of inadequacy, where individuals experience a loss of initiative, fatigue, and a struggle to live up to societal expectations. Neoliberalism demands individuals to pursue autonomy and success can be overwhelming and lead to feelings of inadequacy and a struggle to find one's place. In support of this, the author claims that many forms of depression are best understood — and best combatted — through frames that are impersonal and political rather than individual and psychological.

2.3 Final remarks on the "social change explanation"

The theoretical contributions discussed so far identify societal changes as the catalyst for the increase in depressive rates. While the first group attributes this rise to modernization and its associated social transformations, emphasizing individualization and secularization, another group points to the impacts of cultural transformations in recent times. Nonetheless, all groups agree that cultural factors play a crucial role in these shifts.

While much literature on the topic still considers only one of the two possibilities - modernization and capitalist disruption vs neoliberal cultural influence - we should instead define how the two things are part of the same process. The main point of this review is not to understand which social factors are protective or can enhance depression, in a similar way that most quantitative studies, both in psychiatry, psychology, or social sciences are doing, but to understand the general social discourse that underlie the emergence of depressive disorders. The high number of depressive cases is a signal of something that changed, not many decades ago, in the way people are living their lives, structuring their *self*, and thinking about themselves.

The advent of capitalism might have introduced depressive symptoms (Murphy, 1978), but the biggest transformations involved the last fifty years when the discourse of depression rose and depression became the syndrome that can describe individuals from our era (Ehrenberg, 1997). So, as capitalism might have its role in the disruption of social ties and rituals, and modernization might bring secularism and individualization, according to classical Weberian rationalization patterns (Weber, 1978), recent cultural transformations had their main role in this epidemic of depression. Neoliberalism, the pressure to become oneself, and the culture of performance are the main triggers of this increase according to the social change explanation theories.

The main point, however, is that a society that relies only on performance and self-realization does not foresee failure. Contemporary representation of individuality wants us as semi-gods or, again, super-humans. Narcissism is the rule of being. Narcissism is not that extreme self-love and self-esteem, but conversely the experience of being kept captive by a paralyzing ideal self-image, the fear of not being up to it, with the resulting sense of emptiness and impotence and the need to be reassured by others about one's own identity (Ehrenberg, 1997).

We are witnessing the emphasis of the narcissistic character of modern forms of depression, in which a particular exposure of the ego in facing any life event that can represent an "offence", an affront, or a threat to its power. Contemporary subjects are no longer as familiar with losses as they were in past ages. Not used to thinking of themselves as finite and limited, deceived by the promise of eternity and power, they experience any life event that contrasts the narcissistic illusion, that could question their endurance and strength, as an unbearable trauma (Lolli, 2009).

This cultural context, where failures and losses are excluded from discourses on life and self-realization, does not contemplate any ritual for losses, whether they are real or symbolic. Moreover, success is intended as an individual goal, rather than a social one, and failure is conceptualized in the same way as an individual problem. We can see this, as we will be able to explain later, also in the way we treat depression, through the use of antidepressants and psychotherapy, as individual responses to the distress (Esposito and Perez, 2014) although the distress is dependent (also) by social dynamics. Social ties and rituals could be protective factors against depression and general psychosocial distress but are not intended to be part of the Western way of intending treatment, because any social component is excluded from a medical standpoint of intending psychosocial distress (Coppo, 2005; Obeysekere, 1985). Given that, we just anticipated how depression is somehow relegated to a medical paradigm. The way we intend depression is bound to the way it is classified, and diagnostic and medicalizing patterns are another fundamental focus to take into account to understand the rise of diagnosis.

Social disintegration and secularization, that came through modernization in the last centuries, can be intended as a relevant problem in the occurrence of depressive disorders, but the space taken by the newborn imperative of becoming the ideal oneself is something more recent that we should not forget, and that somehow exclude any possible form of social involvement in dealing with distress.

3 The diagnostic explanation

While depression now dominates clinical practice, treatment, and research, before 1970 it was considered a rare syndrome associated with many mental disorders, studied mostly within hospitalized patients (Shorter, 2008). In more recent years it has reached such a diffusion that it is held responsible for most of the difficulties we encounter in daily life: tiredness, inhibition, insomnia, and anxiety, would all be caused by this "disease". Today, depression, like psychosis until the second half of the 20th century, monopolizes psychiatric interest. Even the media do not hesitate to present it as a trendy disorder (Ehrenberg, 1997). Why is depression so "successful"? Why has it imposed itself as the main disturbance of our interiority?

Many authors tried to picture the events and phenomena responsible for making depression the widely diagnosed syndrome that everybody knows and speaks about. This part of the literature review proposes that, conversely than being more present in the population, depression has instead been diagnosed more and more in the last forty years, making this condition also an important concept in defining contemporary days' suffering.

3.1 The advent of DMS-III and the change in diagnostic criteria

In the 1950s the prevailing concern in psychiatry was anxiety, emerging as a consequence of the demands of modern life, encompassing work and family. Notably, depression was conspicuously absent from diagnostic summaries at this time, and instead was linked to psychotic symptoms and therefore encountered infrequently. Horwitz (2010) posits that a blend of factors between 1970 and 1990 transformed the perception of anxiety into depression, previously a broad term encompassing various psychological and physical complaints associated with stress.

It's challenging to attribute the rise of one condition and the decline of another to a single factor. One first crucial shift was in diagnostic specificity. Throughout much of psychiatric history, only a few imprecise categories existed (e.g. mania, melancholia, hysteria). Before 1970, the psychodynamic approach focused on understanding unconscious mechanisms rather than specific disorder categories. However, in the 20th century, evolving scientific norms demanded defined disease categories for diagnosis and treatment. Stress, being a blend of psychological distress and challenges in daily life, lacked this specificity. Although anxiety and depression are closely related, psychiatrists were now required to use distinct categories.

A second factor was the professional competition between different approaches to psychiatry, particularly the rise of biological psychiatry, as discussed in the previous chapter. By 1970, biological psychiatrists were critical of the unscientific nature of psychoanalysis. As anxiety was more aligned with a psychoanalytical perspective on mental health, biological psychiatrists found it more advantageous to focus on depression. The introduction of the diagnosis of depression served as a more effective avenue to fulfil the scientific aspirations of biological psychiatry, providing greater legitimacy to the field.

Third, the introduction of DSM III marked a pivotal shift from anxiety to depression. Anxiety disorders were divided into a range of specific conditions with distinct diagnostic criteria. In contrast, Major Depressive Disorder encompassed a spectrum of conditions, extending from melancholia to depressive neurosis. Pignarre (2012) and Caponi (2009) share the belief that this "epistemological fragility" of the depression category allows for a broad range of situations to be diagnosed within it. Frances (2013) argues that the amalgamation of formerly separate diagnoses into a singular category of Major Depressive Disorder, as occurred since DSM-III, has led to increased complexity in clinical trials, foundational genetic investigations, treatment methodologies, and initiatives aimed at reducing overmedication due to the diversity within this unified classification.

Fourth, the introduction of antidepressants themselves was an important reason to define the classification of distress with the depression category. The introduction of SSRI, working both on anxiety and depression, needed a specific name and a condition to be associated with. The new drug could be sold in the same way for both categories, but in previous years, some concerns and lawsuits were addressed to anxiolytics and their collateral effects. The development of a treatment shaped the nature of the distress instead of defining only a way to treat it. Because these kinds of drugs were called antidepressants, depression became the condition treated (Horwitz, 2010).

3.2 The increased use of antidepressants

We've just discussed the role of antidepressants in defining DSM-III categories for depressive disorders. The advent of antidepressants in 1957 marked a significant milestone, providing an effective treatment for a wide range of symptoms on the fringes of psychiatry, usually managed by general practitioners. This breakthrough allowed for the classification of these conditions under the overarching term "depression." The practical application of therapeutic validation led

to a compelling inclination where only depression responsive to antidepressants was considered authentic (Ehrenberg, 1997). This implies that the category of depression and the symptoms included in it were significantly influenced by the advent of antidepressant drugs. As psychiatry do not establish causal theories for psychopathology, no definitive biological markers available. The drug itself represents the primary reference point for diagnosis (Pignarre, 2012).

Additionally, countries with the highest prevalence of depression are often characterized as "psychopharmacological societies" (Coppo, 2005). The diagnosis of Major Depressive Disorder, which relied on common symptoms like sadness, low energy, or sleep disturbances, proved to be highly beneficial in expanding the market for psychotropic drugs. This diagnosis inevitably covered many patients who had previously been seen as grappling with existential challenges. Consequently, it didn't take long for pharmaceutical companies to seize this advantageous aspect of DSM-III (Horwitz and Wakefield, 2007).

Furthermore, investigations into the connections between DSM panel members and the pharmaceutical industry reveal significant financial links between the industry and those responsible for shaping and revising the diagnostic criteria for mental disorders. These financial ties have raised questions about impartiality and objectivity in the development of diagnostic criteria, particularly in areas where pharmaceutical interventions play a prominent role in treatment (Cosgrove et al., 2006; Mayes and Horwitz, 2005).

3.3 Media and socialization to the intimacy

As psychiatrists, patient advocacy groups, the media, books, and literature delve deeper into discussions surrounding the disorder, its perception solidifies as a tangible reality. The medicalization of depression is not a given assumption. Scientific publications about depression are much more numerous than for any other psychiatric diagnosis. Media attention is particularly focused on depression while in some countries there is also a proliferation of direct-to-consumer advertising for antidepressants. The media plays a significant role in promoting discourses that confer a medical status upon depression (Pignarre, 2012). Also, a series of mechanisms of antidepressant marketing able to transform the perceptions of physicians and shape the experiences of those seeking treatment and the self-understanding of those not in treatment, such as the sponsoring of educational events, ghost-written scientific papers authored by celebrity researchers, and patient advocacy and awareness campaigns. This

outcome shapes the perception of what it means "to be depressed," while concurrently advocating for the aforementioned predominant use of antidepressants as the primary treatment for addressing this condition (Heily, 2004).

Finally, let's not forget that the attention to common mental health problems from psychiatry was enhanced by the deinstitutionalization of asylums, also promoted by the advent of pharmacological treatment for psychiatric disorders. Once psychosis and schizophrenia were no longer the main concern, psychiatric research increased to be interested in other problems, widely present in the outpatient population (Grippaldi, 2021). This happens together with the widespread of new discourses about the self. As explained with Ehrenberg's theory (1997), a new grammar of inner life becomes available to broad social strata: a framework that equips everyone with sufficient reflective tools to take an interest in their intimate life. The dynamics of self-esteem are completed with its language, its literature, its technologies (pharmacological, psychological), and its professions. Intimacy is no longer purely a private matter (Ehrenberg, 1997; Healy, 2004).

3.4 The Americanization of psychiatry

While increasing globally, depression prevalence is higher in Western compared to non-western countries. While we might deliberate that this is linked to different degrees of modernity, secularization, and individualism, we have to assess that the lower prevalence of depressive disorders can also be related to diagnostic issues. The lower prevalence can be determined not only by different societal conditions but also by a lower attitude toward diagnosing depressive disorders.

As a shortcoming, some account this difference as a consequence of a more accurate use of diagnostic tools and conduct more pervasive epidemiological research by Western countries (Pignarre, 2012). This is unlikely, considering that depressive disorders appear in different shapes all over the world, due to the cultural plasticity of mental disorders. The concept of depression as is intended in European and North American context, do not fit all the areas in the world, and neither the related assessment tools (Coppo, 2005). On the contrary, the rise of diagnoses in non-western areas in the last decades can be attributed to what is called the "Americanization" of mental disorders (Wykes and Callard, 2010). For the last four decades, the American Psychiatric Association has been actively disseminating their perspectives on mental health worldwide. Their definitions and approaches to treatment have now set the global

norms. While these tendencies have typically been driven by good intentions, the full ramifications of these endeavours were often not anticipated. By instructing the world to adopt Western perspectives, they have, both positively and negatively, standardized the way mental distress is perceived globally. Instead, there exists a substantial body of research indicating that mental health conditions do not manifest uniformly worldwide but emerge in diverse cultures in intricately varied and distinct expressions (Watters, 2010).

3.5 Misclassification of common sadness

One of the main contributions in the sociology of depression and the critics regarding psychiatric classifications comes from “The Loss of Sadness: How Psychiatry Transformed Normal Sorrow into Depressive Disorder” by Allan V. Horwitz and Jerome C. Wakefield (2007). The authors did an accurate analysis of DSM diagnostic criteria regarding depressive disorders, starting from the history of the concept and the classification of depression and reviewing the actual social, psychological, anthropological, epidemiological, and psychiatric knowledge regarding it.

The authors believe that the recent surge in presumed depressive disorders is not primarily due to a real increase in the prevalence of the disorder, but rather stems mainly from the merging of two conceptually distinct categories: normal sadness and depressive disorder. The current "epidemic," though influenced by various social factors, has been made possible by a changed psychiatric definition of depressive disorder, often allowing sadness to be classified as a mental disorder, even when it is not. To understand how this phenomenon occurred, it is useful to frame current psychiatric practices in a historical context and assess how today's diagnostic definitions of depressive disorder from DSM-III onwards compare to historical standards.

The "age of depression" thus arises from an erroneous definition of depressive disorder. Commonly cited causes, such as modern life having fewer social anchors and greater alienation, or the media constantly showcasing extremes of wealth and beauty leading to feelings of inadequacy, can at most explain reactions of normal sadness. The symptoms reported by these individuals are neither abnormal nor inappropriate given their specific situations. These symptoms arise after a specific life event involving significant loss and disappear when circumstances improve. This does not mean that “depressive disorders” do not exist. Disorders of this kind do exist and can be devastating, and the DSM's definition encompasses them. However, they appear very different from the normal reactions described

here. Popular representations of depression consistently depict a picture of deep, immense, and paralyzing suffering that is visibly disconnected from the circumstances of concrete life: it is the absence of an appropriate 'context' of symptoms that indicates a disorder disproportionate to the circumstances. The fundamental flaw in the DSM's definition of Major Depressive Disorder is simply this: it does not take into account the context of the symptoms and thus does not exclude from the category of disorder the intense sadness that arises from how humans naturally respond to significant losses.

Successes in treating depression with psychotropic drugs have encouraged their use in cases where the doctor believed it might bring some concrete benefit. Perhaps this has led to diagnosing cases that were previously ambiguous as depression in the hope of offering effective treatment. Treatment trends reflect a growing view of sadness as a medical disorder that is a 'mental illness,' best treated by doctors and with medicine. This ultimately leads to easy pharmacological prescription, with serious consequences not only because they consider human realities pathological when they are not, but also because they justify the misuse of drugs that can have a negative impact both neurobiologically and behaviorally.

By qualifying certain responses as 'normal,' the authors do not intend to diminish the level of suffering involved. However, the overly inclusive criteria for depressive disorder in the DSM ultimately compromise psychiatry's goals and concepts of identifying psychological conditions that can be considered authentic medical disorders and distinguishing them from problematic conditions that do not constitute disorders. Patients may be erroneously led to consider themselves ill and undertake unnecessary treatment, and social responses to non-pathological conditions and pathological disorders should also be considered distinct. Separating normal sadness from depressive disorders can help recognize the relationship between sadness and adverse social conditions and thus identify appropriate social interventions. Finally, it allows researchers to select samples that more accurately reflect real disorders, thus maintaining the conceptual integrity of psychiatry.

3.6 Final remarks on the "diagnostic explanation"

As we have seen, depression has thus become the ideal tool to define an unspecified number of conditions from a clinical and scientific perspective, thanks to its ability to encompass a wide variety of situations. Additionally, it serves as a widely understood concept used by both individuals and the media to describe various states of distress. Today, everyone knows what

the term "depression" means. Depression is a form of disorder that lends itself particularly well to understanding the contemporary individual and the new dilemmas they face. Its centrality is based on an excellent reason: both in the past and today, psychiatrists are not entirely sure how to define it. Hence, its susceptibility to diverse interpretations would justify its capacity to become a condition capable of describing an epidemic.

The most positivistic approaches to psychiatric distress diagnosis would see the increase of diagnosis to a better definition of assessment tests, that would provide a better ability for clinicians to diagnose (Pignarre, 2012). Of course, we cannot exclude that part of the increase in diagnoses comes from increased awareness and reduced stigma towards common mental distress and higher access to healthcare settings. However, this review shows a different picture, where categories are built ad hoc for scientific and pharmaceutical market purposes, spread throughout the world even in a context where they don't fit completely. Indeed, the "epistemological fragility" of this classificatory category and the lack of biological markers favour the increasing multiplication of diagnoses (Caponi, 2009). This might also explain why in Western contexts, where these categories better fit and are employed, we have a higher prevalence of depressive disorders reported in statistics (Global Burden of Disease Collaborative Network, 2020).

4 Conclusion: social change or diagnosis?

At the end of the presentation of these two theoretical frameworks, a question can be raised: is it societal change that determined the epidemic of depression or it is just a matter of increased diagnosing patterns and psychiatric scientific turn? The answer is both. While some of the authors we presented are considering only one of the two as the correct explanation, we instead suggest taking both of them together. Not only a social change and a diagnostic explanation are not mutually exclusive, but they are also part of the same phenomenon.

The author that mostly reports this connection between societal conditions and the birth of new psychiatric standards is Ehrenberg (1997), as the reader might have noticed that his work is relevant for both sides of the explanation. Following the author's path, we cannot avoid considering societal transformations from a discursive lens. The last century has been characterized by the birth of new discourses on the self and, according to the author, the high increase of diagnosis is due to the interiorization of a new idea of the self. This would not be possible without the introduction of technologies of the self (Foucault, 2005), such as

psychotherapy, antidepressants, pharmaceutical therapies, assessment tests, and so on, that can also frame these types of problems inside of a medical frame. The medicalization of depression could not proceed without a cultural shift that would determine the condition itself as relevant to attention to understand nowadays life, and in the same way, the spread of the commonsense knowledge on depression comes from the newborn scientific knowledge behind that from the last two centuries.

Societal change, discourses on the self, medicalization, and diagnostic features cannot be divided. The two groups of explanations should not be regarded as alternatives but integrated. The emergence of an epidemic corresponds not only to the increase of the phenomenon itself but also to the way it has been understood by the Western psychiatric discipline. We cannot separate the object itself from the way it is described. The diagnoses are increasing because we have better ways to assess their presence but it is first necessary that the condition itself is considered relevant. And the condition itself represents part of the nowadays way of living so to be considered the condition that can describe this epoque.

The chapter informs us about the history of how depression, in the way we intend it nowadays, was born and socially constructed in the last four decades, more than being better understood with nowadays scientific standards. The post-structuralist and constructionist approach used in the thesis collides with Horwitz and Wakefield's (2007) theory representing depression as a dysfunction from natural human functioning, as something existing regardless of the discourses and practices around the way we understand it. While we recognize the importance of their theory, reflecting on whether situations of common sadness are instead recognized as something pathological, we criticize their essentialist position.

Part 2 – The empirical research

Chapter 5 – Introduction to empirical research. research questions, methods, and fieldwork.

1 Introduction

In this chapter, we will introduce the empirical investigation that we conducted in the study of depression as a sociological object of inquiry. We will present the design of the research, starting from the research questions and the methods. Then, we will dedicate space to provide information regarding the fieldwork, justifying the choice of the institutions and people involved in the research. The chapter will also define ethical implications, anonymization procedures, and the language categories that can define mental distress.

Conversely to the first part of the dissertation, where we explored the theories associated with the epidemic of depression, we will dedicate this empirical part to the understanding of the discourses, representations, practices, social contexts and factors involved in depression. These empirical chapters will delve into depression from the viewpoints of both the practitioner and the patient, using qualitative methods to investigate practices and narratives in two healthcare settings in the city of Milano.

2 Research questions

Chapter 4 proposed two different sociological explanations concerning the epidemic of depression, namely the diagnostic and the social change explanations. The diagnostic explanation is related to the recognition of depression as a medical problem and the recent transformation in psychiatric discipline both theoretically and practically. The social change explanation regards, instead, analysing which social factors are involved in the development of the greater proportion of the phenomenon. Two different lines that converge and integrate. Following these two lines, we have defined two different groups of research questions.

2.1 Research question: representation, practices, treatments

The first group of questions is: Which representations regarding depression do mental health professionals hold? Are all professionals sharing the same ideas regarding depression? What is their vision regarding the causes and the aetiology of the disorder? Specifically, are mental health professionals considering the social factors involved? And what are the consequences

for clinical practice? Do different representations regarding depression shape the way depression is treated?

As we can see, the questions follow the diagnostic-medicalization path of the two lines of research delineated from the literature. Also, this question addresses representations and practices of treatment regarding depression, and it is strictly regarding the professionals' side, and not considering instead the patients' side.

2.2 Research question: social dynamics involved in depressive and anxiety disorders

The second group of questions is: Which individual and social factors are connected to the emergence of depressive and anxiety symptoms in patients? How can different social conditions and life events be involved with these syndromes? Do difficult situations act differently for people from more deprived or less deprived contexts?

This set of questions follows instead the literature concerning social conditions and their relationship with depression. The questions are regarding patients and their individual and social conditions.

3 Research design:

3.1 Methods and techniques

To address the aforementioned questions, qualitative methods will be employed, using different techniques. Specifically, semi-structured interviews, participant observation, and document analysis will be used to provide different perspectives and types of information. All the techniques presented were used while conducting the fieldwork in two clinics in the city of Milano, Italy. All the people interviewed, the situations observed and the documents come from those clinics. We will provide further information later about the characteristics of the fieldwork sites and the participants in the research.

3.1.1 Research technique: Semi-structured interviews

First, twenty-eight interviews have been conducted with mental health professionals, namely psychiatrists, psychotherapists, educators, nurses, and social workers. Specifically, seven psychiatrists, ten psychotherapists, three educators (two of them were specifically psychiatric rehabilitation technicians), six nurses, and two social workers were part of the sample. All the

participants were working at the two clinics at the time data collection was done, and this represents the only selection criteria for the sample. All the people at the clinic have been informed about the research and asked their availability for an interview. Almost everyone agreed, while only a few of them declined. Sample characteristics are showed in the appendix, table A1.

However, for time and organizational reasons, not all the people available have been interviewed. It is hard to assess in which proportion of professionals have been interviewed, as while the fieldwork was conducted some of them left the job to work in another place, and some others joined the clinic. We counted that three or four psychiatrists, three psychotherapists, five nurses, one or two educators, and one social worker were employed in each clinic. Also, a variable number of trainee psychiatrists and trainee psychotherapists, which are included in the sample, were present at the clinic. As we can see, considering the small number of professionals present at each clinic, we are covering a high proportion of the actors involved in the fieldwork. After collecting all the interviews, we believe that the content in our data was satisfying the saturation criteria (Cardano, 2011).

The use of qualitative interviews aims to understand the point of view of the professionals regarding depression. This technique was particularly useful in answering the first set of questions and exploring representations and professional practices but also to understand how the Italian public healthcare system provides treatment for people with depression. In a smaller part, interviews were also useful to better understand professionals' accounts regarding which social dynamics are involved in depression. The layout of the interview is available in the methodological appendix at the end of the dissertation.

In a preliminary phase of the research, we collected fifteen preliminary interviews to test the interview layout, as well as to better know the different psychiatric services publicly available and the possibility of conducting participant observations. Interviews were held with professionals in public and private facilities, both in the city of Milano and outside. While we are not using the data from these preliminary interviews for the analysis, we can use the data only to check the robustness of our considerations, checking if the results are idiosyncratic to the clinics studied.

3.1.2 Research technique: Participant observation

Eight months of participant observation in two psychiatric facilities have been conducted. The facilities selected are public, specifically outpatient clinics composed of a multidisciplinary equipe and operating in different areas of the city. The researcher got access to the clinics to observe activities and interactions inside the clinic. Specifically, participant observation was held mainly during psychiatric interviews, equipe meetings, and everyday activities. The observations aimed to understand 1) how the mental health public system addresses treatment for people with distress 2) how the work is organized inside the clinics 3) how practitioner-patient interaction happens 4) what social dynamics are involved in the emergence of depressive symptoms. Data gained through participant observation is mostly used to answer the second set of questions.

The researcher participated in many different activities inside and outside the clinic, to observe everyday work for all the professionals involved, but the efforts were mostly dedicated to observing the practitioner-patient interaction. Observations have been recorded manually and organized in three separate files: one regarding psychiatric interviews and information on patients, one regarding general observations on everyday activities in the clinic, and the last regarding the researcher's emotions and impressions on fieldwork. Observation of psychiatrist-patient encounters were conducted following the work of seven different doctors, between the two clinics, in the eight months considered.

3.1.3 Research technique: Document analysis

Finally, as we have witnessed about two hundred psychiatric interviews, we selected clinical records for forty-six patients who experienced depressive symptoms, thirty-one for patients from the first clinic, and fifteen for patients from the second. As psychiatric interviews observed were regarding patients with all kinds of symptoms and diagnoses, we selected only patients that would fit with our inquiry. Specifically, the forty-six patients selected for the study 1) were affected by depressive and anxiety symptoms 2) were not affected by other major syndromes such as schizophrenia or bipolar disorders, apart from certain types of personality disorders which could be related to anxiety and depression 3) the researcher had observed at least one psychiatric-patient encounter[28].

[28] Furter information concerning the diagnosis attributed to patients considered in the research at chapter 7 paragraph 3.

Patients have been selected to determine which social conditions are involved in the emergence of depressive symptoms. We defined then an analytical grid to analyze the data coming from each patient, to record and codify biographical information, symptoms, treatments, social and individual dynamics, economic, cultural, and social capitals, and development of the distress. The analytical grid can be found in the methodological appendix.

3.2 Integrating different qualitative research techniques and addressing research questions

The whole fieldwork experience lasted one year, starting from the preliminary interviews, getting access to fieldwork, conducting observations, and analysing clinical records. As said, interviews were mostly useful to understand professionals' representations concerning depression, while observations and document analysis to understand patients' individual and social dynamics involved in depressive symptoms. However, the three methods integrate one another, enhancing the overall robustness of the analysis.

Indeed, interviews not only capture practitioners' perspectives on mental health issues but also provide insights into their experiences with clinical practices. Of course, interviewees' accounts can be biased by their perspectives as well as from social desirability issues. In this way, participant observation permitted us to check the practices narrated. Also, being on the fieldwork site provided a deeper comprehension of the reality narrated through the interviews. At the same time, interviews were essential to properly understand what happened on fieldwork.

Similarly, observations and clinical records analysis are integrated. Observing practitioners-patient interaction provided information regarding individual vulnerabilities and adverse events occurring in their lives. However, observation occurred for just one or two psychiatric interviews for each patient considered. Analysing their clinical records permitted them to understand the whole history of the patient, the development of the disorder, and the social factors involved, checking for information recorded before and after the interviews observed. A single observation was sometimes insufficient to obtain the whole picture of the patient because some information regarding their lives was instead reported in previous encounters. At the same time, we realized that not everything said during the psychiatric encounters was reported on clinical records, because not considered relevant for the practitioner. Integrating both observations and clinical records permitted us to give a wider picture of the individual and social problems that were affecting patients.

Qualitative data was collected through written notes, audio-recorded interviews, and notes taken while accessing clinical records. Qualitative data was analysed using data analysis software (Nvivo).

4 Fieldwork

4.1 Psychiatric services after Basaglia law

Conducting qualitative research on depression requires understanding how to address the questions, as we are talking about something that is generally understood as happening inside the individual. The dissertation challenges this limit and looks at depression from a societal framework. This implies that we have to think about in which places and situations we can gather data.

The fieldwork selection implied choosing an environment where both patients and professionals were present. The medicalization of depression can be studied in medical environments, such as hospitals and clinics. As different mental health care services are available, preliminary interviews gave the possibility to understand which ones were more appropriate for the research. Indeed, it was crucial to locate a setting where individuals suffering from depressive disorders could receive treatment.

The Italian healthcare system, since its reform with Legge 180 and Legge 833 in 1978 and the dismissal of patients from asylums, assigned to the Regions the task and responsibility of planning mental healthcare systems that responded to the principles of deinstitutionalization and territorialization of assistance. Territorial assistance is strictly provided to citizens residing in their areas of competence, considering the need for it to be carried out in the ordinary contexts of people's lives, to promote their social, housing, working, and relational inclusion and to avoid any internal migration phenomena would create epidemiological concentrations of disadvantaged subjects (Starace, 2018). Only psychiatric wards are still inside the hospitals but only with a limited number of beds and aimed at people with distress in acute phases that would require hospitalization.

4.2 Psychiatric services in the city of Milano

Fieldwork has been conducted in the city of Milano, Italy. The selection of the city comes from the great availability of public and private mental health care services. The city counts four

publicly funded hospitals (Aziende Socio Sanitarie Territoriali - ASST) that administer different psychiatric services spread across the city territory, under the supervision of the Region. Psychiatric services are diverse, divided into facilities based on the specificities of the treatments, and access is based on one's place of residence. As for the current division of psychiatric services in the city of Milan, they are divided into the following services[29].

Centri Psico-Sociali (CPS) represents outpatient clinics where an equipe of professionals offer the initial psychiatric evaluation. Patients are addressed by general practitioners, emergency rooms, or psychiatric wards when a psychiatric assessment is needed. Then, these clinics take care of patients for as long as necessary, with regular visits. These services, like all the others, embrace a biopsychosocial vision of mental distress. In this way, they are composed of a multidisciplinary team of psychologists, psychiatrists, nurses, social workers, and educators. This team of professionals is referred to as the “equipe”.

Patients not only receive medical evaluation and pharmaceutical treatment, but also psychotherapeutic interventions, social worker support, and participation in socialization programs led by educators and nurses. The types of activities provided by these clinics are various and come from simple face-to-face visits with a psychiatrist to help with economic and housing situations, psychological support, employability, and educational programs and social activities. CPSs generally meet the needs of people with mild or moderate symptoms, or even for people with severe distress but whose symptoms are compensated pharmacologically. Patients aren't confined to the clinics; they only visit as necessary.

Centri Diurni (CD): these spaces intend to provide psychiatric patients with rehabilitation and social reintegration activities. CDs offer help mostly to people with moderate/severe psychiatric disorders, who require a flexible rehabilitation program aimed at combating social isolation. Through the proposal to different daily activities, it promotes in users the maintenance and/or development of personal autonomy, and interpersonal, social, cultural, and work-related relationships, about their respective individual potentials and attitudes.

Servizi Psichiatrici Diagnosi e Cura (SPDC): these are psychiatric wards whose intent is to stabilize the situations of patients in the acute phase of distress. They are the only services that

[29] Most of the services offered are the same all around the country.

are located inside the hospitals. In these closed wards, patients are admitted for compulsory or voluntary treatment. Hospital stays are generally short but coercive.

Comunità Riabilitative ad Alta Assistenza (CRA): these are facilities that offer intensive rehabilitative and care interventions in a residential setting for individuals with notable psychiatric conditions across various aspects of psychosocial functioning. Patients can stay in these settings for months.

Unità Operative di NeuroPsichiatria Infantile e dell'Adolescenza (UONPIA) – All the previous services are not intended for children and adolescents but for adults. UONPIAs are the specific outpatient clinics that offer multidisciplinary care for underage patients.

Servizi per le Dipendenze (SerD) and Nuclei Operativi Alcologia (NOA) – Specific care for people with addiction and alcoholism is offered through these services, separated from the other psychiatric services.

Other services such as other long-term residential assistance, services for eating disorders, and mood disorders, other youth services, postpartum depression care, ethnopsychiatric services, and other specific services. All the above-mentioned public services are then coordinated by ATS Milano (Azienda Territoriale Sanitaria), the Territorial Health Agency, which mediates between the region and the ASST for the provision of services.

Finally, let's not forget that many other services are offered privately. Among these, psychiatrists and psychologists engage in private practice and cover a portion of the service demand, especially for psychotherapy. Additionally, there are private clinics for hospitalization and treatment, in some cases also affiliated with the national health system.

4.3 Outpatients' clinics

The choice to conduct the study in outpatient clinics comes from our interest in depressive disorders, which constitute "common mental health disorders" (World Health Organization, 2017) and most often can be considered mild or moderate forms of mental distress. According to preliminary interviews, patients with depressive symptoms can be more easily found in outpatient clinics instead of in inpatient ones. CPSs are the most appropriate contexts, as from our interviews and observations about half of the new patients coming for the first clinical

assessment are for anxiety and depressive symptoms. Patients in treatment in outpatient clinics are facing distress only in mild and moderate ways, and only rarely require hospitalization.

The city counts fifteen outpatient clinics (Centri Psico-Sociali – CPS) spread around the city, are spread on the municipal territory and their access is based on residency. These clinics are administered by four hospital companies, which are indeed private, but they work as public hospitals whose services are offered through public healthcare.

Opting for public hospital services over private clinics is motivated by three factors. First, outpatient clinics provide an opportunity to witness a comprehensive, multidisciplinary approach to addressing mental health issues. These clinics include into their equipe psychiatrists, psychotherapists, social workers, nurses, and educators. Secondly, these public services are available to the entire Italian population, ensuring economic affordability or even free accessibility. Choosing public facilities not only allows one to experience firsthand the workings of the public healthcare system but also reveals the diverse range of services available for managing mental health distress.

4.4 Two clinics, two areas, two populations

To better understand the involvement of social conditions in depressive disorders, we selected two clinics managed by the same hospital but located in two different parts of the city. As the access to the clinics is based on residency, the patients of the two clinics will be living in the surrounding neighbourhoods. For this reason, neighbourhoods characterized by different social strata have patients with different social backgrounds.

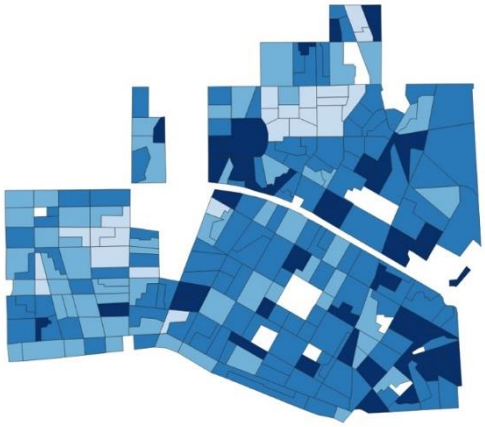
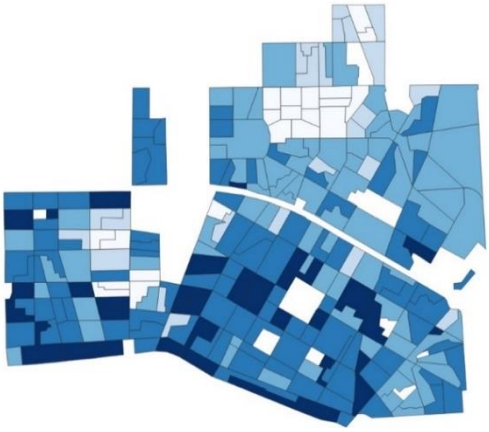
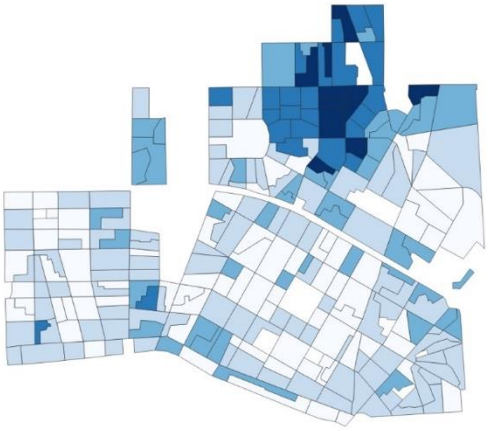
In the case considered, we choose two clinics with the most possible differences in terms of social stratification. Specifically, the two areas are characterized by different degrees of occupation, house ownership migrant population, and level of education. For anonymization reasons, we will not provide information on the names of the clinics, the hospitals that administer them, or the neighbourhood where they are located. We will instead call them the Blue Clinic and the Orange Clinic. Between the two clinics, the Blue Clinic is located in the more deprived area, while the Orange is in the less deprived.

Specifically, we took Italian census data from 2021 to evaluate the differences between the two areas according to some socioeconomic variables[30]. Data shows that the areas from Blue and Orange Clinic have a similar level of occupation for residents aged 15-64 years old, specifically 72,2% and 71,9%. While these percentages are similar, we don't have statistical information regarding the type and quality of jobs for people in the two areas. However, people interviewed and observations showed that, in the Blue Clinic's area, people are more often employed in low-skilled jobs. This can be partially confirmed by the lower educational level that is registered in the Blue Clinic's area compared to the Orange's. People with at least the secondary school degree are 70.3% in the Blue Clinic's area, compared to the 75.6% in the Orange Clinic's Area. The differences are wider if we consider tertiary degrees: 37.9% vs 43.9%. In the end, we have different levels of residents with migrant backgrounds, 13.5% for the Blue Clinic's area vs 11.4% for the Orange Clinic's area. Migrants are from both areas for more than 80% are from outside the European Union (Isat, 2022). For what concerns the presence of house ownership, the Blue Clinic's area is characterized by a high presence of social housing buildings, while the Orange Clinic's area has none (Hess et al. 2018).

Table 1 shows the distributions of the three variables in the two areas considered. Data comes from the Italian Census from 2021 (Istat, 2022). Each small area represents a single census block-level distribution of each variable. Darker shades represent a higher prevalence of the phenomena considered using Jenks natural breaks optimization. Maps have been created using QGIS software and then rotated to mask the original orientation of the areas.

[30] Data presented here concern the resident population, while the access to the clinic is residence-based, permanent or temporary. Looking at data, we recognize that the census population showed here is probably smaller than the actual population of the two areas, considering the high number of people only temporary resident. At the same time, for the Blue Clinic area we expect a quote of irregular migrants not considered in these data.

Table 1 – Distribution of socioeconomic variables in the two areas considered

	Blue Clinic's Area	**Orange Clinic's Area**
Level of employment (15-64 years old)		
Level of education: Secondary school or higher		
Residents with a migratory background		

Source: Author's elaboration on Istat (2022) Census 2021 Data

The variations among the three factors examined—occupation, education, and migration level—aren't substantially wide, except for the educational level. However, the graphs indicate an uneven distribution of educational levels and the percentage of residents with a migrant background in the area of the Blue Clinic. Conversely, these factors show an even distribution in the area surrounding the Orange Clinic.

If we consider the Blue Clinic, we can distinguish between a wealthier area and a more deprived area. The second and third maps display this, with the northern part of the area considered as less educated and with a higher prevalence of residents with migrant backgrounds. Specifically, the wealthy area has 73.4% of the population with at least a secondary school degree, and 42.7% with tertiary. People with migrant backgrounds are 8.6%. In this way, the educational level is similar to the percentages of the Orange Clinic's area, while the percentage of residents with migrant backgrounds is even lower. On the other side, the northern part of the area considered, which is more deprived, has conversely significantly lower levels of educational attainment and higher levels of migration. The population with at least a secondary school degree is just 65.8% and only 31.0% with a tertiary degree. At the same time, 20.5% of the population has a migratory background. These differences show us how a specific area that is served by the Blue Clinic is characterized by a population with a lower educational level, low-skilled jobs, living more often in public house buildings, and with migratory backgrounds. All these situations, as explained in the theoretical part, represent risk factors for psychiatric distress.

Studying two different contexts gives us the possibility to assess what type of patients are seeking medical attention at the clinics, and which social backgrounds and life events are connected to these disorders, taking into account all possible differences between the two different areas. The research follows a comparative perspective. Specifically, the design of the research follows the "most different systems" design, with the robustness of the results arising from the common fundamental traits shared by the two cases (Cardano, 2020). The two contexts are intended to be completely different except for one variable, which is that both clinics are managed by the same hospital. This means that the comparison between the two clinics and their relative areas and patients is based on the most different criteria (Della Porta, 2012).

4.5 Access to fieldwork and position of the researcher

Access to fieldwork was obtained after getting in touch with healthcare institutions, which has been possible thanks to the contacts obtained with the preliminary interviews. Specifically, the head of the Psychiatric Services from one of the hospitals in the city, together with the head of one of the outpatient clinics, was keen to support this research and gladly invited the researcher to join in the clinic's daily activities. The access was obtained by formal invitation by the hospital, in respect of health and safety regulations as well as privacy issues. Observations started in one of the two clinics and continued later to the second one, parallelly. While the whole fieldwork lasted for one year (January 2022 – January 2023), observations of everyday activities and psychiatric interviews lasted for eight months (June 2022 – January 2023). The researcher had the opportunity, later, to come back on fieldwork to solicit further information or have access to clinical records.

The researcher took part in psychiatric interviews sitting next to the psychiatrist and silently taking notes. The researcher sometimes helped in taking clinical records or inviting the patients inside the room for their appointments. The researcher's involvement in certain activities at the clinic resembled the experience of psychiatry trainees, where they observed clinical interviews with patients while seated beside the doctor. However, unlike actual psychiatry trainees, the researcher didn't engage in any clinical tasks or activities.

Even if the researcher remains silent and endeavours not to interfere with field activities, the mere presence of fieldwork can inevitably exert an influence on the proceedings, illustrating how any form of researcher presence can impact the fieldwork itself (Cardano, 2011). In any case, we are reasonably confident that the presence of the researcher was not affecting the way the activities in the fieldwork were occurring.

The presence of the researcher has always been negotiated with patients. The researcher was introduced to patients before the encounters, asking if they would agree that he would be present and taking notes about their situations. In almost all cases the researcher has been accepted to psychiatric interviews, without constituting a problem for the meeting itself. It is commonly used to have trainee psychiatrists and psychotherapists participating next to the psychiatrist, and their presence is generally considered by patients as part of the normal setting. Further information regarding the presence of the researcher on fieldwork, positionality and

emotion management can be found in the methodological appendix at the end of the dissertation.

4.6 Semi-structured interviews

Interviews with the professionals at the clinic were done on fieldwork, before and during participant observations. As the researcher was waiting for the formal approval of the hospital, people at the Blue Clinic were interviewed before the beginning of the observations[31]. This helped to understand the field before the official start. Later, further interviews at the Orange Clinic permitted to deeper investigation of some of the situations observed. The layout of the interview is available in the methodological appendix.

4.7 Observations: clinical interviews and equipe meetings

Most of the observations were regarding clinical interviews and equipe meetings. Clinical interviews are based on face-to-face interaction between the patient and the psychiatrist, they take place in the doctor's office and generally are intended to last about thirty minutes[32], by appointment. Psychiatrists are the first in outpatient clinics to encounter patients and manage their treatments and their access to clinical help. The psychiatrist asks questions about physical and psychological symptoms, everyday life, personal problems, and socioeconomic issues. The clinical interview is not structured, and no tests have been used in the assessment of disorders. The interaction takes place differently according to the different patients. Although there are no strict patterns for the interview, we can recognize three moments: the discussion of the symptoms and the general situation of the patient, the discussion of the therapy, and the definition of goals and further plans. In the first encounter, the diagnosis is also set and, in some cases, communicated to the patient. Generally, psychiatric encounters are set regularly according to the severity of the patient's symptoms, until the dismissal of the patient from the care of the psychiatric service. The health status of the patient, their socioeconomic situation, and the prescribed treatment are reported in clinical records.

Some patients' situations are discussed in equipe meetings, where all the professionals in the clinic gather to define treatment and interventions. Equipe meetings are encounters aimed to collaboratively discuss those patients who are facing particularly complex situations. The input

[31] Interviews with professionals did not require formal approval from the hospital but only informed consent from participants.
[32] Except the first interview, which is intended to last one hour.

and insights of other equipe members are crucial in determining the appropriate course of action. Additionally, these meetings prove valuable to contribute with their involvement towards specific patient scenarios and keeping the entire team informed about ongoing developments within the clinic. The researcher took part in these meetings to gather further information about patients.

4.8 Patients and clinical records

We collected information for about two hundred patients for both clinics. For some patients, we have observed more than one encounter, as well as recorded information coming from equipe meetings or everyday talks between professionals working in the clinic, while for others we obtained a less significant amount of data. Then, we selected all the patients with depressive and in some cases anxiety symptoms, that we could consider as "common mental health problems" (World Health Organization, 2017) and analysed their clinical records. Combining the information coming from clinical interviews, equipe meetings, and clinical records we can have a picture of the clinical and social situation of each patient considered, that we can use to understand social dynamics involved in the advancement of depressive disorders.

Clinical records report information regarding age, gender, education, profession, housing situation, family situation, somatic and psychopathological situation, familiarity with physical and mental disorders, substance abuse, use of medication, and contacts of general practitioners and psychotherapists. Then, clinical records contain a diary for each patient, redacted each time the patient encounters one of the professionals at the clinic. In this way, we have a continuous and rich report of the development of the psychosocial situation of the patient. Patients observed are heterogeneous concerning age (range: 21-82 years old), gender (Male/Female/Non-Binary), country of origin and length of the treatment at the clinic (from very recent symptoms to a maximum observed of nine years, although in clinical records some patients report previous treatments in the past). Patients differ also for educational level, house property, family situation, health condition, work situation, and other socio-economic and individual variables. All patients except one were on pharmacological treatment. Thirty-six patients were on psychotherapeutic treatment, or already completed the treatment, or were about to start. Ten patients were hospitalized, before or during the time considered.

Patients have been selected according to their symptomatology and related syndromes. Between all the patients observed, we selected all the patients that would fit the sample of

people with depression, without exclusion. The higher number of patients observed is about four times the number of patients involved in this study. This happened because the researcher was everyday clinical interviews between patients and doctors, in many cases without knowing much in advance which patients would come into the room. This suggests that the patients' characteristics were not regulated but rather varied randomly. However, this study does not have the purpose of being statistically representative of any population of the city. Some information regarding patients can be found in the methodological appendix.

5 Linguistic distinction: disease, distress, disorder

It often comes that research and health reports speak indifferently of depression and other psychiatric issues as diseases, disorders, or distress. Conversely, the appropriateness of these terms cannot be taken for granted and instead requires attention. We have to distinguish the triad disease-illness-sickness from disorders and distress.

One of the most used definitions for health issues, Twaddle's tripartition (1994), distinguish conceptually disease from illness and sickness. Disease is described as a physiological malfunction leading to potential reductions in physical capacities or life expectancy. It is viewed as an organic phenomenon, measurable through objective means and independent of subjective experiences or social conventions. Illness, on the other hand, is defined as a subjectively interpreted undesirable state of health, involving feelings such as pain and weakness, and perceptions of bodily functioning. Ontologically, illness refers to the subjective feeling states of the individual, often manifesting as symptoms, and can only be directly observed by the individual. Sickness, however, is viewed as a social identity, representing an individual's health problems as defined by others within social contexts. It encompasses a set of societal rights and duties. Ontologically, sickness is situated within society and defined by participation in social systems. Epistemically, it is understood by measuring an individual's performance against expected social activities.

Although the triad of disease-illness-sickness may have utility in addressing certain physical conditions, our research diverges from employing the terms “disease,” “illness,” and “sickness.” As elucidated in the conceptual chapter, we refrain from categorizing psychiatric disorders as diseases; rather, we view them as syndromes characterized by a constellation of symptoms lacking a widely recognized causal theory. Consequently, Twaddle’s tripartite framework results unsuitable. Instead, we opt to utilize two terms: distress and disorder. With

“distress” we are defining the person's emotional or psychological discomfort or suffering, which can be a response to various life situations. Psychosocial distress, specifically, refers to those conditions in which the patients feel and report suffering that is connected, in its causes and consequences, with the psychological and social dimensions. "Disorder," on the other hand, refers to a recognized and diagnosable pattern of psychological symptoms. We employ this term when referencing the medicalized manifestation of distress, specifically denoting the manner in which distress is categorized via diagnostic labels and acknowledged as a medical condition necessitating care and treatment. For example, the Diagnostic and Statistical Manual of Mental Disorders (DSM*)* refers to these conditions as disorders. This definition means that these conditions of distress are recognized as dysfunctional and conditions of consideration for psychiatric care, even though they are not considered as diseases.

In short, distress is a more general term, used without any a priori value about the appropriacy or not about being categorized as a disorder. From a sociological perspective, being impartial to the psychiatric discipline definitions and stance, there is no claim to define any condition as a disorder, but they are all considered distress. What is a disorder is what is transformed into a medical condition through mental health care practices and the organized job of the clinic. In the text, we might refer to disorders when

Two other terms that we might be using in this text are symptoms and syndromes. *S*ymptoms are individual signs or indicators that suggest the presence of a medical condition or disorder. They are subjective experiences reported by the patient and can include physical sensations (such as pain, nausea, fatigue), cognitive experiences (such as memory problems or confusion), emotional states (such as sadness or anxiety), and other observable changes in the body or behaviour. Symptoms provide valuable information to healthcare professionals for diagnosing and treating health issues. A syndrome is a collection of symptoms and signs that tend to occur together and suggest a specific medical condition or disorder. Essentially, it's a pattern of symptoms that commonly co-occur. While syndromes can provide useful information for diagnosis, they might not always have a well-defined cause or underlying mechanism. At the moment, from a Western psychiatric perspective, none of the psychiatric syndromes have been categorized as diseases. Again, "symptoms" and "syndromes” imply a medicalized view of distress, whereas “distress” itself does not necessarily. From an epistemological perspective, distress exists no matter the existence of the medical knowledge that categorically defines it, while symptoms, syndromes and disorders don’t.

Briefly, in the text we will prefer the use of distress when considering discomfort and suffering, and disorders when considering the distress from a medicalized perspective. However, the terms "disease" or "illness" will be only found when employed by the participants of this study.

6 Ethical Implications

The type of study proposed here has also some ethical implications. The researcher was heavily involved with sensitive information regarding patients, as well as participating in the everyday activities of the people working in the clinic. The information and data obtained were treated following ethical research standards.

Informed consent was asked to both professionals interviewed and patients observed[33]. Clinical records could only be consulted inside the clinics and never copied or taken away. The hospital defined the modality of the situations and the time that the researcher could spend in the clinics. Anonymization of the information of the participants of the study (both patients and professionals) is done according to the following criteria. For professionals, when it comes to quote excerpts of the interviews, we are only reporting the profession (Psychiatrist, Psychotherapist, Educator, Nurse, Social Worker) and the clinic (Blue Clinic or Orange Clinic), without other information, to prevent their identification due to the small number of people working in these clinics. For what comes to the patients, we are only reporting their Gender, Age, and Nationality (only differentiating between Italian and Other).

To better anonymize professionals, patients, and the hospital institution that permitted access to the clinics, we decided that it would be more convenient to avoid providing any information regarding the name of the hospital and which clinics were observed. The decision to name them "Blue" and "Orange" clinics is the way to identify them without giving further information. While we provided an analysis of the social conditions of the people of the neighbourhood where observation took place, we cannot say more to avoid the identification of the clinics, and further of the professionals and patients involved. We hope that the reader would understand the importance of the anonymity of the people and institution involved, and can learn from what comes from the text without knowing specifically where all this was happening[34]. At the

[33] Professionals signed a written informed consent for interviews, while patients agreed to take part to the research verbally, due to the practical reasons.
[34] We also hope that the institution and professionals involved in the study could understand this choice, without seeing this as a form of ingratitude or a way to not acknowledge their contribution, which indeed has been fundamental.

same time, the anonymization of the hospital and clinics permitted to provision of a little more information regarding patients, such as some biographical characteristics and some extracts from the psychiatric interviews. Considering the high number of clinics, professionals, and patients in the city of Milano, we are sure that with the information reported here, it would be difficult to identify the people who took part in the research.

Finally, this study aims to find in which way depression is determined and treated in different contexts. The results of this study can be relevant to finding problems and solutions in the healthcare system. Considering the limited impact on the people involved, this can justify this study on such a sensitive topic.

7 Conclusions

This chapter aims to outline the methods employed and elucidate the research questions driving their application. The following chapters will follow the two groups of research questions. First, Chapter 6 will investigate representations that professionals have towards depression, their ideas concerning the biological, psychological, and social factors, and how different representations shape treatment practices. Chapters 7 and 8 will instead investigate patients' side, specifically the social dynamics involved in the occurrence of their depressive symptoms.

The foundational theories and concepts presented in the initial four chapters regarding depression and its perceived "epidemic" will serve to comprehend the outcomes emerging from the analysis. All other information regarding methods can be found in the methodological appendix.

Chapter 6 - Medicalizing depressive symptoms: the effects of representations of psychiatric disorders on diagnostic and therapeutic practices

1 Introduction

This chapter aims to understand which representations are shared by mental health professionals about the aetiology and development of depression. Professionals' practices of diagnosis and treatment intervention will be evaluated, examining how they consider the biological, psychological, and social dynamics involved in the distress and consequently the treatment of depression according to these factors.

As we showed in the theoretical part of this dissertation, psychiatric theory was built on the compromise between different conceptualizations of mental disorders. With this in mind, our objective is to explore whether professionals assign varied importance to biological, psychological, and social factors when addressing mental health issues. Accordingly, this chapter seeks to address the following research inquiries: How do professionals describe depression? Do they share the same definitions and criteria of DSM-5 regarding depressive disorders? What are the causes that they consider underlie these disorders? Do they embrace the biopsychosocial model or the biomedical model? Do they consider social factors involved in their occurrence?

Considering this, we can infer that different theoretical perspectives may impact treatment practices. Specifically, professionals can set treatment for depressive disorders embracing the biomedical model, which implies a prevalent psychopharmacological treatment, or a biopsychosocial model, which implies the integration of pharmacological, psychotherapeutic, and social intervention for the patient. For this reason, we can set another research question: Do different representations concerning mental disorders affect the way treatment is addressed, namely giving more importance to psychotherapy, pharmacological treatment, or social intervention for depressive disorders?

The questions delineated so far intend to define the presence of different representations in mental health professionals concerning the way they intend depression, from the biological, psychological, and social points of view. Then, we investigate the relationships between

representations and practices, to see if treatment practices are related to different theoretical standpoints.

To address these questions, this chapter analyses the interviews conducted with the professionals working in the two public psychiatric clinics considered for this study, in the city of Milan, Italy. The professionals interviewed are psychiatrists, psychotherapists, social workers, nurses, and educators. We integrate data coming from interviews with extracts from observations on fieldwork, to help the reader to understand whether there is correspondence between accounts and practices.

The first part of the analysis will regard depression, specifically what concerns different discourses and ideas concerning what are its characteristics and determinants. Then we will compare representations with treatment practices. The interviews have been collected from a sample of professionals from both the clinics included in this study. We found a high degree of homogeneity in the answers from the people from both clinics, according to their profession. Specifically, psychiatrists showed similar ideas concerning depression and its treatment, and the same happened for psychotherapists, social workers, nurses, and educators.

The accounts used in this chapter come mostly from the interviews conducted with psychiatrists and psychotherapists, as they are the ones entitled to prescribe therapies for patients, and are more informed about scientific theories regarding the nature and determinants of psychosocial distress. We will report excerpts from the interviews, together with information regarding the interviewee, specifically the profession, gender and clinic where they work. While we assessed conflictual ideas between what are the "causes" of depression and the appropriate treatment between psychiatrists and psychotherapists, we saw that the other groups of professionals had less of a precise idea of its determinants, while were more informed about the importance of societal inclusion for people with mental distress.

2 Representations regarding depression

In the theoretical section of this dissertation, we demonstrated that although research indicates that risk factors associated with depression encompass biological, psychological, and social aspects, there remains a lack of consensus among professionals regarding the nature and characteristics of depression. The different conceptualizations depend on different ideas on the nature of the distress. These conflicts reflect the absence of a unique and shared theoretical approach that can describe mental disorders and their causes (Shorter, 2013). The different

ideas concerning mental health disorders imply that professionals do not share the same representation of the same phenomenon. As a result, we have many different explanations concerning mental disorders, all of them somehow related to different scholars and schools of thought.

Let's start the analysis with an excerpt from interviews elucidating the fragmented nature of the psychiatric discipline, which is characterized by diverse schools of thought aligning predominantly with one of the three components of the biopsychosocial model.

> "Psychiatry is like a religion; you decide to adhere to a particular school of thought, and that's it. You can adapt a bit, but fundamentally, there are three major branches of psychiatry. First, there's psychodynamics, which encompasses the world of psychoanalysis. Then there's democratic psychiatry, which believes that mental illness doesn't exist; it's the environment that creates mental illness. It's very focused on the social aspect. And finally, there's biological psychiatry and psychopharmacology, which is the more scientific version of the three.
>
> In my ideal world, a psychiatrist should have a bit of all three. It rarely happens; you might lean more towards one than the others. In some situations, it's convenient to gain knowledge from various branches. Depending on where you receive your training, you might miss certain pieces. For example, if you go through a psychodynamic school where I graduated from, and if I had done my specialization there, I wouldn't have known anything about medications or neuroscience. It was a significant gap.
>
> On the other hand, if you study in a neurosciences-focused environment like where I did my specialization, you might miss the more psychological aspects. They don't even acknowledge personality disorders; they don't talk about them at all. […] These specialization programs are not comprehensive."
>
> - Dr M, psychiatrist, F, Orange Clinic

In the following paragraph, we will investigate whether diverse approaches to mental health conduct to varied treatment paths for patients. Additionally, we will explore how different perspectives are integrated into the functioning of the multidisciplinary equipe and how this is essential for patients' care from a biopsychosocial perspective.

2.1 Depression: descriptions, symptoms, and boundaries

While symptoms are listed in a similar way that DSM-5-TR or ICD-11 list them, the description of depression by professionals always goes beyond that, embracing it as a profound and complex experience. A holistic vision of depression connects it to the spheres of body, emotions, and patient's life. Depression is described as a "depletion of vital energy", a response to a loss characterized by a lack of propensity towards the future. Two examples from the interviews:

> "I would describe clinical depression as a depletion of vital energy, a total inability to move forward, make plans, to even simply plan out your day, to feel presentable in the eyes of others, to think about effectively taking care of anything... a complete loss of confidence in yourself, in your resources, and possibilities."
>
> - Dr E, psychiatrist, F, head of the territorial services

> "Depression is a complete closure of future horizons, meaning it's a total lack of future planning. The depressed individual constantly lives in the present without being able to imagine or envision a future because they lack plans, they lack a propensity towards the future. This, in part, is why they struggle in the present to move forward because without any plans, they cannot see themselves in a year's time, in several months, or even the next day, which is precisely the reason for the total closure that may lead them to see suicide as the only solution."
>
> - Dr V, psychotherapist, F, Blue Clinic

The description of depression is always accompanied by some disclaimer regarding its definition. First, professionals specify that depression can have a high variety of forms, with different symptoms, severities, and meanings for patients. Depression, as evidenced by the DSM-5 (American Psychiatric Association, 2013), can manifest with varied symptomatology, leading to diverse experiences for patients. This diversity in manifestations renders this category of distress exceedingly broad, extending beyond the confines of a specific definition.

> "Depression is a response to loss, and each person has a different response to this loss. By 'loss,' we don't just mean the death of a person but also the loss of relationships or the loss of a job, which can trigger strong depression. It's a negative response to this kind of loss. There are various facets of depression: there's the more passive depression that tends towards isolation, and then there's the kind of depression that somehow drives you to do things. It depends a bit on where you position yourself on the spectrum of distress."
>
> - Dr C, psychotherapist, F, Blue Clinic

Additionally, depression serves as a common-sense descriptor employed by both patients and practitioners to characterize feelings of low mood and disinterest in daily activities. As elucidated in the theoretical discourse, there exists a proliferation of dialogues surrounding the concept of 'depression,' frequently encompassing a generalized form of distress intertwined with diverse psychological and social issues. The classification of depressive disorder frequently lacks specificity and falls victim to an 'epistemic fallacy', leading to its broad application across a diverse spectrum of conditions (Caponi, 2009).

> “I don't know, depression is a bit like a “minestrone soup" where there's a bit of everything, Also, because a bit of depression is not denied to anyone, and indeed it's not stigmatizing. Then there are true and proper depressions that can be classified as disorders, as the major recurrent depressions… there is the adjustment disorder with depressed mood... there is discomfort due to various reasons that for convenience labelled as depression... it's a category in which there's a lot inside, and each time it should be seen what's in it, what's behind this generic diagnosis... maybe a post-traumatic stress disorder can have depressive repercussions... then in the same depression, as for any disorder, there's mild, moderate, and severe depression.”
>
> - Dr S, psychiatrist, M, Orange Clinic

However, within psychiatric disorders, symptoms often manifest across various syndromes. Mental health professionals are required to distinguish between different possible diagnoses to

correctly distinguish syndromes. In this way, patients who show depressive symptoms are not necessarily affected by depression. Aware of this difficulty in defining the correct diagnosis in the first encounters, practitioners prefer generally to speak of “depressive symptoms” instead that to refer directly to the syndrome.

> "You can have depressed mood in a hundred different diagnoses, so... there's the depressed mood, yes, but it’s not enough for a diagnosis of depressive disorder. So, it makes more sense to me to give a description of the various dimensions […] According to me the trans-diagnostic view works better, beyond categories, otherwise as sometimes happens, you have a hundred diagnoses, and it’s just a waste of time.”
>
> - Dr M, psychiatrist, F, Orange Clinic

2.2 Anxiety

Professionals note that anxiety symptoms, alongside depression, are highly prevalent and typically present as mild to moderate conditions for patients. Given their widespread occurrence, patients are commonly managed either by outpatient facilities (CPS) or directly by general practitioners. The two syndromes constitute a very big portion of the total number of patients that come to these types of clinics. At CPS clinics, patients exhibiting these symptoms undergo several appointments over a span of months to monitor the progression of their distress and assess the effectiveness of treatment. While they represent the largest patient group at these clinics, they do not consume the majority of professionals' time, as the focus is primarily on treating individuals with more severe conditions.

Anxiety symptoms are often intertwined with the onset of depressive symptoms, and they frequently call for similar treatment approaches. This typically involves a combination of pharmacological treatments such as antidepressants and anxiolytics, alongside psychotherapeutic interventions.

> "In anxiety the basic emotion is fear, while depression is sadness, so these are two different emotions that can exist independently of each other. The disorder can develop primarily around one of the two, or both of them can be present together.”

- Dr N, psychotherapist, F, Blue Clinic

In many cases the two set of symptoms appear together, and psychiatrist identify it as “Anxious-Depressive Syndrome” to define those situations in which anxiety and depressive symptoms are co-occurring. The emergence of anxiety or depressive symptoms can be correlated, or one group of symptoms can cause the other, and depends also on idiosyncratic and personological characteristics.

> "I see them as very close, like two ways of reacting to a disturbing external context for the patient, as if based on their personal characteristics, including their character and personality, they tend more towards one side or the other, in light of the same initial stimulus. [...] Very often, you see similar narratives from patient to patient, with a way of leading to either anxiety or depression that is completely opposite but starting from a very similar point, at times. And you see the two ways of interacting with the world: the anxious one who tries to maintain their personal stability by trying to control certain aspects of life or by trying to avoid them, becoming somewhat avoidant in many situations, [...] and on the other hand, reacting with a complete withdrawal, because I totally deprive myself of the experience, and therefore, I don't put myself in danger at all, [...] I'm just not capable. So I avoid, avoid getting involved in the experience, even with two different perspectives, because maybe the anxious one has a plan that they manage to maintain, even if it's difficult to carry forward, while as I mentioned earlier, the depressed one may not even have the drive to pursue a goal because their sense of purpose has dimmed.”
>
> - Dr V, psychotherapist, F, Blue Clinic

> "Indeed, a couple of my patients initially present with anxiety as the primary concern, but when you delve deeper, you may also find a profound sadness. It's a bit of a “chicken and egg” situation – they might have felt dissatisfied, leading to anxiety. However, I believe that it's often this debilitating anxiety that prevents them from fully realizing themselves, feeling well, and being at peace [...] so depression comes secondary."
>
> - Dr A, psychotherapist, F, Orange Clinic

2.3 Diagnosing beyond DSM-5-TR

Psychiatrists have difficulty defining depression, as depressive syndromes can include a wide variety of symptoms and heterogenous conditions. As discussed in the theoretical section, one of the factors contributing to the success of the concept of depression is its adaptability to a wide range of applications (Caponi, 2009).

Some of the problems we can see psychiatrists facing for diagnosis stem from inherent aspects of the DSM. The DSM inherently carries ambiguity, as it's crafted more for research purposes than to be used in clinical settings. If the DSM is exclusively used as a diagnostic tool in the hands of clinicians, it risks confining medicine to mere recognition of syndromes, without going further (Ehrenberg, 1997).

> "The role of diagnosis should be to guide the treatment process. Once a diagnosis is formulated, there should be a whole series of interventions designed for that diagnosis, theoretically the interventions that work best […] So, I believe it's useful only from that point of view; otherwise, the diagnosis doesn't matter much [...]. Then, consider that these diagnoses are made by people who don't necessarily... I mean, it's not guaranteed that the diagnosis made by two colleagues will coincide perfectly, right? [...] Usually, you use diagnoses for research, when a protocol needs to be established involving different doctors. In a CPS, it's not useful. But in my opinion, there's agreement at least for the major diagnoses"
>
> - Dr E, psychiatrist, F, head of the territorial services

Diagnosis is generally set in order to guide the treatment but, as we will show in Chapter 7, diagnoses were missing at least in one-fourth of the clinical records considered. Psychiatrists observed tend to diagnose based on diagnostic categories resembling those outlined in the DSM-5-TR and the ICD-11, even though not always specify the syndromes with the same definitions and often without fully assessing patients against the diagnostic criteria. DSM diagnostic categories picture mental disorders as a list of symptoms, limiting the complexity of real patients' situations. DSM criteria are not enough for clinical practice, and it is necessary to understand personal and social situations to treat patients effectively.

All the psychotherapists interviewed perceive this classification as irrelevant to their practice, as they prioritize understanding patients on a deeply individual level rather than merely assessing their symptoms.

> “For me, diagnoses are just indicators that I take distance from. I know that patient’s diagnosis is 'depression' but I only take it as a general indication, and then I look at how that disorder manifests in the individual patient [...] It's simply something that gives me an indication, but it's important to understand how the patient functions rather than the label assigned to them."
>
> - Dr N, psychotherapist, F, Blue Clinic

However, both psychiatrists and psychotherapists say that diagnoses are useful to communicate between professionals, to broadly give an idea of the patient’s problems. On patients’ side, diagnosis can help them to understand what they are experiencing from a clinical point of view, but in some cases it might be.

> "I don't work with diagnosis, and I don't fit within diagnosis... Clearly, diagnoses are a way to communicate with colleagues, it's a way to speak, let's say, the same language... it's a tool, but what interests me most is not finding a diagnosis but staying within the process, within the process of that suffering, of that vulnerability [...] Because in the end, patients fit into these labels and then end up being the disorder they have."
>
> -Dr W, psychotherapist, F, Orange Clinic

> "It's reassuring to know that there's a first and last name for what you have because many come in saying, 'I feel bad, I don't understand.' So knowing that it has a name paradoxically reassures, if things are clear. For instance, if they have OCD, I tell them, but for personality disorders, I never say ‘Borderline personality disorder’, I say ‘There's an emotional dysregulation’. I use a lot of paraphrases, so yes, I focus on what they might need at the moment."
>
> -Dr M, psychiatrist, F, Orange Clinic

We also witnessed situations in which the appropriateness of the diagnosis can be debated between different professionals.

> Researcher: I don't understand. I read Bipolar II on the clinical record but then in the end I saw that the doctor wrote "The patient denies experiencing maniac episodes". I don't know.
>
> Doctor I: (Takes a look at the record) Actually you are right. I'm tired of reading the bipolar diagnosis in this way, I wouldn't feel comfortable giving such a heavy diagnosis. (Take a closer look at the record). It's Doctor Z's signature… Keep in mind that sometimes diagnoses are made for convenience, to have broader intervention margins, etc…
>
> - Fieldwork extract regarding Patient #5, *M, 47 y.o,* Orange Clinic

Despite these circumstances, the diagnosis is ultimately confirmed by the effectiveness of the pharmaceutical treatment administered to the patient. More than provide a correct diagnosis, it is important for doctors to provide the right pharmacological and psychotherapeutic treatment according to the set of symptoms experienced.

> "I'm interested in treating people, making them feel well. There are few categories of pharmacological medications, but there are many medications within the categories. We have: anxiolytics, antidepressants, mood stabilizers, and antipsychotics. Within these categories, we can have countless variations. Now, if a medication is given for an adjustment disorder, depression, dysthymia, or a mood disorder, and the medication works - *ex adiuvantibus*: undisputed principle in medicine - it just works. If there is no harm, if I don't cause monstrous side effects and it works, hooray. Then I try to diagnose well, refined, also to avoid looking like an idiot with colleagues."
>
> - Dr S, psychiatrist, M, Orange Clinic

This extract, together with the experience on fieldwork, shows how diagnosis is somehow provisionally set by the psychiatrist during the first interview on clinical records. If the

medication and the other types of interventions are benefit the patient, it means that the diagnosis posed is correct. While theoretically, the diagnostic process should proceed from symptom recognition to treatment, following the path: symptoms → diagnosis → treatment, in clinical practice, psychiatrists often approach it in reverse, with diagnosis being the final step: symptom → treatment → diagnosis. The effectiveness of pharmacological therapy is indeed a way to assess whether the diagnosis made is appropriate. The diagnosis is corroborated depending on how the patient reacts to the pills, as Bianchi (2015) showed for ADHD patients. Pignarre (2021) suggests that this happens because psychiatry did not establish causal theories for psychopathology, making the drug itself representing the primary reference point for diagnosis.

In conclusion, professionals go beyond DSM diagnostic categories and picture mental disorders as a list of symptoms, limiting the complexity of real patients' situations. DSM criteria are not enough for clinical practice, and it is necessary to understand personal and social situations to treat patients effectively.

2.4 Reactive and endogenous depression

Mental health professionals generally concur on the notion that in many cases, there is an external event or circumstance that serves as a trigger for depressive symptoms. Some psychiatrists talk about "adjustment disorder" to classify a condition characterized by anxiety and depressive symptoms that come as a reaction to a stressful event or change in a person's life (American Psychiatric Association, 2022)[35]:

> "Generally, people come with some degree of anxiety, but perhaps more than anxiety, I would say it's an adjustment disorder in the sense that the situation around you changes, and you can't adapt to it. You continue to behave as if you were in the previous situation, and since you don't feel comfortable, depression sets in."
>
> - Dr R, psychotherapist, F, Blue Clinic

[35] If, as said, most of the situations described are reactive to an event, shall we call these syndromes depression or adjustment disorders? We have seen both things on clinical records, regardless the fact that all of the patients observed had at least one stressful life event or a social disadvantaged condition.

Regardless of this definition, what comes here is the recognition of the existence of symptoms that would not exist without a stressor. Stressors could be personal and societal conditions as well as life events, for example, losses, breakups, changes in working conditions, economic and housing problems, failures, other illnesses and so on. What is interesting here, is that the interviewees think that most of the patients that come to their clinic with depressive symptoms are having something derived from their conditions, and very rarely without any clear reason for the distress. Psychiatrist interviewed think that most depression have a reactive nature, and only in a few cases you can find an endogenous one. Psychotherapists, instead, think that there is always an identifiable event that triggers symptoms, leaving no space for endogenous distress to exist. According to this vision, there are no "endogenous depressions"[36], but only conditions in which the loss is very deeply unconscious, and very hard to identify.

> "I don't know if endogenous depressions exist. I don't want to be presumptuous, but I'll say what I see based on my experience. All the patients I've met, starting from my internship, have shown a connection with a history of suffering. I have never seen any depressed person with a happy history behind them."
>
> - Dr D, psychotherapist, F, Orange Clinic

We can distinguish in this way from distress that comes as reactive distress ("with cause") and instead of something endogenous ("without cause")[37]. This distinction is outdated in psychiatry because every distress comes as a result of both "internal" and "external" factors that interact with each other (Horwitz & Wakefield, 2007). Still, professionals find this distinction useful in understanding different forms of distress.

As any form of psychopathology, depressive and anxiety symptoms are the reaction of a break in individual functioning, whose "caused" by the interplay of internal and external forces. Determine which events "break the balance" and create the reactive condition is a way to

[36] Excluding mood disorders that are generated from other physical condition, such illnesses or hormonal imbalance. Those cases are not competence of psychiatry nor psychology.
[37] We use here the terms "with cause" and "without cause" referring to the debate in psychiatry between reactive and endogenous depressions. This idea of "cause" is outdated, as in psychiatry we cannot actually talk about causes but we can just identify risk factors. The term is used only as a commonsense way to define when we can or cannot identify a potential stressor in patients' lives.

understand, both for scientific and clinical reasons, which external pressures are contributing to distress, without forgetting the individual psychobiological characteristics.

> "That said, it seems very difficult to determine which event to exclude as a potential cause or contributor to depression, in the sense that each person has their own unique balance, and it's impossible to determine what can disrupt that balance. It's true that not all situations of loss, grief, or sadness need to be medicalized. Perhaps a good criterion, which I believe is present in the DSM, is to assess time: someone passes away, and you're sad for a day, a week, a month, but after a while, you should start to recover. If you don't work for a week, that's fine, if you don't work for a month, we can already discuss it, but if you've been at home mourning and not working for a year, perhaps, unless there's a social context that not only justifies this but also enforces it […] but in Milan, if you've been locked at home in despair for a year, in my opinion, it's depression. Then we can discuss what type of depression."
>
> - Dr S, psychiatrist, M, Orange Clinic

In conclusion, while the distinction between endogenous and reactive condition is no more used in psychiatry, professionals generally use the category of "reactive" to describe the conditions see identifiable triggers in patients' lives, considering the whole functioning of the patient, from a biopsychosocial point of view.

2.5 Representations concerning the determinants of depression: the biopsychosocial model

We just showed how the distinction between reactive and endogenous forms of distress lays on the recognition of a stressor that generated it. Stressors can be something that occurs in life or is determined by psychosocial conditions and these events are recognized by the bio-psycho-social model. All the professionals interviewed embrace this vision of mental health, with slightly different positions on the relevance of the biological, psychological and social features. Clinicians represent the phenomenon differently according to various factors, namely generation, profession, theoretical background, and affiliation to private or public services. For instance, interviewees claim that different generations of doctors are bound to different psychiatric and psychological traditions.

“You have to consider that I attended university in the 1980s, when biological theory was dominant. I focused entirely on cerebral localizations, hemispheres, and so on. I believe that now there is no one with such a fundamentalist approach anymore. People have been trying to blend various theories together. And if there are still those who remain more fundamentalist are the ones with psychodynamic approaches that are less influenced by other perspectives."

- Dr E, psychiatrist, F, head of the territorial services

“So, in my experience, I've encountered psychiatrists who had a much more old-school conception, more focused on the organic cause. Therefore, they were more inclined towards medication and less attentive, if you will, to the psychological aspect. I must say that at this moment in this CPS, I don't sense this aspect. On the contrary, I sense attention to those nuances. This is also evidenced by the many referrals made for psychotherapy, at least to some extent. […] which means there's also an appreciation for the role of psychologists, in addition to valuing the psychological component of the disorder. So fortunately, those experiences I was telling you about belong to the past and certainly not to this hospital.”

- Dr H, psychotherapist, F, Orange Clinic

The question arises as to whether various perspectives on mental health issues can influence the treatment approach for patients. While, in private practice, differences stemming from various schools of thought and educational backgrounds may yield diverse treatment outcomes, the presence of a multidisciplinary team ensures that care encompasses the biological, psychological, and social aspects of distress.

> “The viewpoints aren't really a big issue... in the sense that we're here to work, and all professionals do their work. If we need to discuss the causes of mental illness and we have different viewpoints, that's okay. The important thing is that things get done. My mission is to offer the best service to the users.”
>
> - Dr G, head of nurses, M, Orange Clinic

Working in outpatient services is considered by the interviewee one of the most effective ways to learn the multifactorial nature of mental health disorders. Different types of professionals do their job and include their different perspective in order to obtain the best result for patients.

> "Another change has been the discovery of teamwork, meaning that if there are many variables, it's better to have different professionals with diverse skills taking care of a person. Previously, I used to work in the psychiatric ward, me and my colleagues with me, exchanging opinions, but we didn't work on the same patient... and in the CPS I discovered the importance of teamwork."
>
> - Dr E, psychiatrist, F, head of the territorial services

> "Yes, and it's understandable because the training is completely different. These are ways of conceptualizing psychological distress from different angles. So, everyone focuses on their own theoretical model and also on their intervention approach."
>
> - Dr D, psychotherapist, F, Orange Clinic

As a result, we see the application of the biopsychosocial model, that considers biological, psychological and social dynamics, embracing a multifactorial vision of mental health. Psychiatrists claimed that universities usually give priority to the biological features of psychiatry, with almost no space for another type of knowledge, that they had to collect in further studies and training. Here an extract of a psychiatrist who decided, after the degree in

medicine, to attend the training as psychotherapist in order to overcame the limits of a merely biological training.

> "I chose a very scientific specialization, a psychobiological school, very focused on pharmacology, on the scientific approach to mental disorders, and I was afraid that I could lack some of the psychological, relational aspects which, in my opinion, that type of approach doesn't provide. So, for me, that was an integration."
>
> - Dr M, psychiatrist, F, Orange Clinic

Psychotherapists, instead, are more concentrated on the psychological factors involved in mental distress.

> "I would say that distress largely depends on what was lacking in primary relationships. […] I believe that the environment is very important, and therefore, the also the experiences a person has outside the family context are relevant. However, I also believe that a person can have many experiences outside the family micro-context, even strong and traumatic ones, and if they have had sufficiently good experiences within the family, they will have the tools to overcome them."
>
> - Dr D, psychotherapist, F, Orange Clinic

However, all the people interviewed wish for the use of this integrated and holistic approach, specifically from new generations of professionals. Recognizing the complexity of mental disorders generally implies a specific status of these conditions compared to other types of physical illnesses. As said in the literature review, psychiatry tried to appear similar to other medical disciplines standardizing measures and giving priority to biological features (Horwitz, 2010), but failing in practice (Middleton, 2007). All the interviewed criticised this way of representing psychiatric problems and think that they should have a specific status that goes beyond this:

> "The mainstream model in psychiatry is the bio-psycho-social model. Therefore, everyone is free to take only the social point of view, only the biological point of view and so on. It is clear that everyone also does a piece of work. […] I generally think that my generation is evolving entirely on integrated medicine."
>
> - Dr T, psychiatrist, F, Blue Clinic

In the absence of specific markers to validate any psychopathological condition, disorders represent compilations of symptoms categorized into syndromes, thus warranting consideration as abstractions rather than concrete entities. The absence of knowledge about the etiopathology of mental distress is one of the reasons for professionals to consider psychopathological conditions as something different from other physical diseases.

> "The biological markers are still very dubious and labile. You do not have a test, you can not say "Do the CT scan rather than the blood test" and you know that you will certainly have depression. We speak only of "syndromes", we do not speak of "diseases" where "disease" has a clear etiopathogenesis, while the "syndrome" is a set of symptoms that you put together, but you just think so. In these hundred and more years there indeed are a little more than apparent certainties but, conversely, many diagnoses change over time, as demonstrated by the path of the DSM. These are always conventions useful to be able to talk to each other among colleagues, to share information, to be able to deal with health services or insurances […]. They remain abstractions: we think that these symptoms go together and have a diagnosis."
>
> - Dr S, psychiatrist, M, Orange Clinic

Assessment tests, which are available for many disorders included in the DSM, are generally not used by professionals, who prefer instead doing diagnosis through interaction with patients. It is considered more important to treat symptoms regardless of the diagnosis, assessing the effects of treatment on the disorder.

3 On treatment for “common mental health disorders”

3.1 Pharmacotherapy vs psychotherapy: are guidelines followed?

The types of disorders considered here, namely anxious and depressive symptomatology, as previously explained, are recognized to have a reactive nature. For all types of psychopathologies, a combination of biological and genetic factors, psychological and personality traits, as well as environmental and social influences interact to form the syndrome. Particularly, however, there's a rather significant role recognized for environmental and social components in life events and relational matters in the emergence of anxious and depressive disorders, which manifest as common syndromes experienced by a large portion of individuals throughout life. The reactivity of these disorders shouldn't solely be understood as stemming from an external event but as how it combines with the subject experiencing a situation, thereby eliciting a dysfunctional reaction. The subjective and environmental components interact, giving rise to psychopathological syndromes.

Recognizing, therefore, that these disorders have a reactive nature, that the environmental component is relevant, and that the psychological and personality components - i.e., how one reacts to such situations - interact with the environmental one, we can see how psychiatrists face a series of intervention alternatives to resolve these symptoms. In analogy with the biopsychosocial model, it's possible to intervene in biological, psychological, and social components in different ways.

Firstly, pharmacological treatment aims to alleviate or eliminate symptoms[38]. By intervening at the level of neurotransmitters, pharmacological treatment influences the individual through a chemical intervention in their biological functioning. The goal of pharmacological treatment is the symptomatic improvement of patients, thereby enabling their return to a normal functioning state before the disorder. Pharmacological treatment, in this sense, has a 'traumatizing' function (Coppo, 2007), acting as a “door” to the possibility of experiencing and reasoning about the symptoms and the situation that triggered them. In this sense, the medication has a psychological effect beyond its biological impact, inducing transformations in what is mentally experienced.

[38] Let's set aside the other types of treatment available for depression that can be used in more or less severe cases, such as supplements, phytotherapy, UV lamps, transcranial magnetic resonance, shock therapy, etc. In almost all cases, pharmacological treatment is the preferred method to address the disorder from its biological component.

> "I always make metaphors where I depict antidepressants as a shall or crutches. They are a support."
>
> - Dr I, psychiatrist, M, Orange Clinic

Secondly, psychotherapy[39] is a type of treatment that allows individuals to recover from these disorders dually. On the one hand, it can prompt reflection on which life contexts and situations triggered a syndrome, and consequently, intervene on them. On the other hand, as the psychotherapist interviewed explained, some life events can trigger an individual's symptoms from an unconscious level. Therefore, psychotherapy permits to work on an unconscious level regarding conflicts, traumas, and past situations that have determined vulnerability in this sense (Lolli, 2009). Therefore, progress occurs both unconsciously, as individuals delve into their inner workings, and through conscious choices informed by newfound self-awareness and understanding of their functioning.

> "The external event causes an emotional rupture that somehow affects the overall functioning of this person. The loss of employment can create stressful situations. To simplify, stress somehow impacts biological activities, disrupts sleep, triggers a whole range of symptoms that affect relationships, quality of life, etc. So, in addition to job loss, other types of psychophysical and psycho-emotional reactions occur, which impact overall functioning. Our goal is to restore the person to their previous balance."
>
> - Dr C, psychotherapist, F, Blue Clinic

Finally, there are interventions in the socioeconomic, familial, environmental, and individual life events spheres. In this case, some problems are structural and difficult to dismantle, for example, material conditions like poverty, economic and housing difficulties, the onset of diseases, bereavement, and social isolation. These are conditions related to the social structure, involving certain segments of the population more than others unequally. In other cases, they involve cultural issues learned and internalized through various socializing agencies, such as family, school, peer context, social environment (Berger, 1972), and discursive, for example,

[39] We include psychotherapeutic approaches that can occur individually or in groups, including psychoeducational intervention and self-help support groups.

expectations regarding one's life path, work-related success, personal fulfilment, as well explained by Ehrenberg (1997). In this case, social and individual issues intermingle.

Regarding the social context, therefore, interventions are aimed at mitigating existing inequalities. Specifically, setting aside macro social issues that logically fall outside the scope of a territorial service, the work of territorial clinic operators also involves intervening in social and economic support questions for the individual, as well as in educational and resocialization aspects if there are certain aspects related to the individual's relationship with the living context.

> "I strongly believe in pharmacology, not as the sole answer, but certainly as a response in the acute phase undoubtedly... it's obvious that other things need to be associated with it because it alone doesn't solve... of course, I'd like to talk about prevention, but talking about prevention means that somehow structural changes in society are needed, which I doubt can happen... to be more realistic, I would say... well, certainly creating community and social relationships... also looking at the concrete causes to intervene on... I imagine family support, daily life support, rather than, I don't know, talking to the employer... somehow creating a network around these situations so that the person doesn't feel alone in their distress and then doesn't identify solely with the illness".
>
> - Dr G, head of nurses, M, Orange Clinic

Social issues, therefore, concern events involving the individual, their social and familial relationships, and adverse events like socioeconomic conditions related to social stratification. Material matters are linked to the cultural context of reference. Deprivation has its role, and similarly, bereavements do, but how they are experienced also depends on the cultural substrate that allows us to interpret these situations differently. This means that even in situations of well-being, as we will show in this study, they are not free from the presence of reactive psychopathological issues.

The three types of intervention are not mutually exclusive, and integrating all three can be a functional way to recover from a distressing situation. However, pharmacological treatment is the primary and most frequently offered option by psychiatrists in nearly all, situations. Interviews showed that psychiatrists acknowledged that although psychotherapy is an effective intervention for resolving many psychopathologies, specifically for anxiety and depressive

symptoms. In these cases, in accordance with the viewpoint of some interviewee and in the international guidelines concerning the treatment of depressive disorders (Ministero della Salute, 2014), psychotherapy is the first and preferred intervention for mild and moderate symptomatology, then combined with medication for more severe and recurrent cases. Psychotherapy remains the primary intervention also for personality disorders associated with anxious and depressive symptomatology.

Various reasons can be considered for why this happens. Firstly, it's a matter of roles. According to their role, doctors are seen as the ones who identify the problem and prescribe a treatment. In most of the medical specialization, professionals are providing primarily pharmacological treatment. Psychiatrists, like other doctors, are trained in the biological functioning of the body. Regardless of recognizing other psychological and social components that are present in the skills of territorial service psychiatrists, fundamentally, the doctor offers something to alleviate symptoms and treat the syndrome when possible.

Therefore: the patient goes to the doctor feeling unwell with a psychophysical discomfort, often not consciously understood by the patient. The patient expects from the doctor some help, and in many cases, the expectations of both the doctor and the patients are met when pharmaceutical treatment is prescribed to cure the symptoms. While, on one side, doctors are encouraging patients to take medication for their distress, we observed that sometimes patients pretend the medications themselves, because they expect their disorder to be treated in the same way as other physical illnesses.

> "It's much more cost-effective in every aspect, including from a psychological perspective. It's much cheaper to take an antidepressant than to do the work on one's own history, which involves suffering. […] It's the response of the 21st century, certainly very neoliberal as a response, very, very easy [...] and obviously, for me, it's not the most ethical way to use pharmacological therapy […] A patient told me yesterday, 'Doctor, how much easier it would be to come here, take a magic pill... it's so much easier, there's much less suffering,' but then it's difficult for the changes to be substantial."
>
> - Dr I, Psychotherapist, F, Orange Clinic

This brings us to the second point: the type of pharmacological intervention is convenient for the patient in many senses. First, financially: antidepressants cost a few euros, as they are

covered by the national healthcare system and they can provide relief for symptoms quickly, even giving the impression of solving completely the symptoms and allowing a return to daily life with serenity. These treatments are also very cheap and affordable, as the national healthcare system asks patients to pay only a small fee instead of the full price. Psychotherapy is quite the opposite, as it costs a lot in terms of time, money, and effort, can provide discomfort, and, generally, symptoms are overcome after a while.

Also, psychotherapy needs the patients to be open to acceptance and transformation, which can produce an unconscious resistance against it. Suggesting pharmacotherapy is therefore easy. Patients are used to taking medicine when feeling sick; there is no asking for any interior transformation, and to delve into the past. Patients are seeking help to alleviate pain, not to confront it.

> "In my opinion, the psychotherapeutic work is not at all easy, and it often encounters resistance. It's very, very difficult and must begin from a truly subjective motivation […] So, I advocate for talk therapy when the time is right because sometimes it's not the right time. I mean, sometimes you're in such a bad place."
>
> - Dr J, Psychotherapist, F. Orange Clinic

The national healthcare system finds pharmacotherapy to be the most cost-effective option due to smaller reimbursements for pharmaceutical and psychotherapy treatments, making it a preferred choice for the same reasons.

There's a third reason: legal protection. Clinical records are legal documents that, in case of a trial, can be used by a judge to understand how the therapist behaved towards the patient. As said, in psychiatry, without any 'reliable witnesses' for psychiatric syndromes, the correctness of the diagnosis and the subsequent appropriateness of therapy is something discovered only over time. Psychiatrists aim to legally protect themselves in this sense. Providing pharmacological therapy can protect from accusations of not having treated the patient correctly, specifically in contexts in which the timing for access to psychotherapy is uncertain, as it is for the public sphere.

They have to write in the patient's file that they administered a medication, because if something happens and you haven't given medication to a sick person, you're screwed."

- Dr J, psychotherapist, F, Orange Clinic

3.2 Treating depression: biopsychosocial model vs biomedical

The previous analysis shows in which way patients' symptoms are medicalized. Regardless of their reactive or endogenous nature, practitioners' decisions are primarily pharmacological, declaring their pathological and dysfunctional nature and thus addressed through medicine. This act is what transforms psychological discomfort and suffering, problems of a psychosocial nature, into a medical problem, into an illness, since every illness is treated with medicine.

Regardless of ideas on approaching mental health disorders through approaches that integrate biological, psychological, and social dimensions, depressive symptoms are addressed through pharmaceutical treatment in almost every case. Psychotherapy, while suggested, is on the patient's finances and responsibility. Conversely, mild and moderate neurotic disorders benefit a lot from psychotherapeutic therapies and should be considered as the primary form of intervention. Although long, the following interview extract resume the problems of providing psychotherapy in public healthcare clinics.

"As for anxiety disorders and some mild forms of depressive disorders, by mild I mean not that they aren't heavy for the patient, but that there's no suicidal ideation, obviously there are guidelines that instead indicate starting psychotherapy. [...] My point of view is that I have to provide the best possible care according to international guidelines, so, in theory, I should do psychotherapy for borderline, give medication to the psychotic, and cognitive psychotherapy for anxiety disorder. Why don't I always do that? Because it's not feasible. […] There's an issue of service order, namely psychological resources are extremely limited in public services. I don't know how many years it's been since a position for a permanent psychologist has been opened. I believe this clinic hasn't had a permanent psychotherapist for more than a decade, relying on professional contracts. Unfortunately, at the moment, only one psychotherapist, for 14 hours a week virtually has to meet all the needs of a one-thousand patient clinic. Obviously, there are monstrous waiting lists. Some of these patients are redirected to therapies provided by psychologists in training, supervised by a psychiatrist. […] It's possible that a patient who comes in for a mild

> depressive syndrome that could evaluate psychotherapy as an initial treatment, actually may not be able to undergo it before a waiting list of several months, and therefore, it becomes unethical to send them away without offering them pharmacological support."
>
> - Dr T, psychiatrist, F, Blue Clinic

In short, people with distress don't always find access to psychotherapeutic treatment due to the inadequate resources. Psychological treatments offered by those services are insufficient, as the number of psychologists and the number of patients is unbalanced. As this happens, psychiatrists can only suggest to patients to start a psychotherapeutic treatment on their finances in private practice. This imply that, while interviews show that professionals refuse a biomedical approach to mental distress, embracing a more complex vision, the lack of resources and the way psychiatric services are organized make treatment options unbalanced on the pharmaceutical side.

Out of the forty-six patients we studied, all but one were undergoing pharmacological treatment. In contrast, only thirty-six patients were either receiving psychotherapeutic treatment, had finished a course of treatment, or were on the brink of starting one. So, while the biomedical model is discharged in theory, treating patients mostly through psychopharmacological therapies brings the model applied in practice.

"The depression that is purely organic, chemical, without any cause and loss, I believe it doesn't exist. Everyone simply has coping resources, and depression tests them. And that's how it works. There are also depressions that derive completely from environmental factors, like prolonged mourning. Even those, paradoxically, are treated pharmacologically, because the situation established that reactive depression [...] A recent case we had was a patient who had lived his whole life in symbiosis [...] with his mother, and obviously, as soon as his mother died, he had a pronounced depression with all the common criteria of suicidal ideation. How can you treat of a patient like that? That depression is clearly reactive to mourning, and also clearly reactive to relational symbiosis. That's a depression that clearly will be resolved by psychotherapy. But how can you not give pharmacological treatment?"

- Dr T, psychiatrist, F, Blue Clinic

Ehrenberg (1997) suggests that this depends on the "trans-nosographic" significance of antidepressant psychopharmaceuticals. This refers to their administration for any form of depression, whether reactive or endogenous, based on their ability to function for any type of depression. This renders understanding the causes less relevant. The broadening of their use is likely influenced by this indifference toward determining their genealogy as well.

"The approach shifted to simply referring to them as 'depression' without differentiation. But that's not entirely accurate because one might have an external cause, and the other might be more internal, so they should ideally be managed differently. Instead, when it comes to deciding on the treatment, you tend to use the same approach, there isn't a clear distinction. However, if I expect a certain outcome, in exogenous depression, I know that by addressing a specific social factor, I can achieve a certain result. In endogenous depression, on the other hand, I would probably expect much more from an antidepressant."

- Dr I, psychiatrist, M, Orange Clinic

At a societal level, a clear orientation towards a biomedically based treatment approach is evident. This involves treating psychological disorders as if they were physical illnesses, thereby allowing widespread use of pharmaceutical therapies, while not granting the same consideration to psychotherapeutic treatment.

Support for managing distress in the context of public mental health is in a critical phase. The dominance of the biomedical model stiffens it, emphasizing an exclusively drug-based approach to "mental distress" and, generally, to all existential issues, thus reducing our desires, feelings, thoughts, and actions to mere biological reflexes, based on an outdated naturalistic determinism (Thanopulos et al., 2021).

There's no valid reason for people to endure emotional pain stemming from common sadness when safe and effective means exist to alleviate it. The systematic use of medication represents a way to avoid truly confronting life's challenges. The use of antidepressants might lead people to passively accept stressful situations rather than actively addressing them. There's a tendency to mistakenly interpret social problems as purely personal. Medicalizing distress arising from these issues implies that medication is the sole appropriate method of treatment, thereby neglecting other potential solutions. This process diverts attention from the need to develop policies capable of changing the conditions that cause distress (Horwitz and Wakefield, 2007).

Nevertheless, relying solely on medication to address issues presents a difficulty for psychotherapists. Addressing symptoms becomes challenging when they are suppressed or removed by medication.

> “There are situations where medication is indispensable. However, medication alleviates the symptoms but at the same time shuts down the entire world of emotions, closing it off. It lowers the level, making it difficult to connect with what that person is actually feeling at that moment."
>
> - Dr D, psychotherapist, F, Orange Clinic

Opting for pharmacological therapy over psychotherapy may offer the advantage of aligning with the categories outlined in the DSM for mental disorders, attributing the issue to brain

imbalances, a concept many individuals can relate to, as it has a name and identifiable characteristics. This approach often avoids questioning personal intimacies. The importance of psychotherapy lies in challenging this tendency because it focuses on the uniqueness of the individual, regardless of diagnostic classifications. It moves towards embracing diversity rather than uniformity in treatment, acknowledging the individuality of each person's experience and needs.

Drugs should be used while informing patients about their effects: they can traumatize, pave the way forward, enable other possibilities for development, and modify situations that cause suffering. They become artificial tools compensating for previous issues (Coppo, 2005). Examining the antidepressant effects of molecules using the Freudian model of melancholia, it becomes evident that the depressed patient struggles to reconcile the loss of the invested object, internalize it, and consequently directs aggression inward. The antidepressant restores object relations and enables psychotherapy to resolve the psychic conflicts in the patient that couldn't previously be addressed. The changes observed in individuals always relate to their overall personality (Ehrenberg, 1997).

4 Conclusion

The perspective within psychiatry has evolved beyond the strictly biomedical approach that characterized some practices over the past 40 years. Nowadays, a more holistic viewpoint is gaining traction among the newer generations of psychiatrists. The biopsychosocial model is taken for granted by all the interviewees as the most accurate theoretical model in psychology and psychiatry. This imply that professionals are generally aware of the impact of social conditions on mental health, specifically when it comes to recognizing the reactiveness of certain depressive conditions. This awareness distances them from the idea - indeed very popular in sociology - that psychiatrists are entirely dominated by the neurobiological paradigm.

Conversely, biological psychiatry still dominates psychiatric research and academic teaching, but it is considered detached from clinical practice. The professionals interviewed needed to update their knowledge and clinical skills with further studies and experiences. In this regard, one limitation of the analysis regards the possible biases encountered in the selection of the participants. Even though our sample showed homogeneity in the answers, we believe that there is the possibility that certain psychiatrists working in other clinics embrace the biomedical

approach instead.

Also, professionals interviewed could be more open towards the holistic and biopsychosocial model of mental health because, as explained, working in a multidisciplinary equipe means being in contact with other professionals from different disciplines. Private psychiatrists and psychotherapists could be more oriented toward different visions of mental health, giving different weights to one of the three components – biological, psychological, and social - of mental health problems. In our sample selection process, at first, we were considering involving private psychiatrists and psychotherapists in our interviews. However, the analysis proposed is built on a comparison between two areas, as we did in our analysis. Also, we have noticed that most of the private professionals that we were selecting as a potential sample were also working or worked in the past in public institutions, and vice versa. In fact, on the other side, many of the professionals that we interviewed were also working privately.

In any case, understanding that biomedical training is insufficient to comprehend and solve patients' problems hasn't led to pervasive changes in practices that would enable psychotherapy as a first-line therapy for patients. While considering both biological, psychological and social dimensions of the distress, the lack of availability of psychotherapeutic treatment led to a pharmacological medicalization of all forms of distress, including the ones that are clearly connected to psychosocial dynamics. Neurotic symptoms such as depressive mood and anxiety are considered reactive in most cases, and psychological treatment would be an effective way for patients to solve inner conflicts, find new resources to tackle life problems and reflect on personal and social conditions. While pharmaceutical treatment is required for severe conditions such as psychosis or bipolar disorder, in mild and moderate reactive disorders it is more indicated to follow a psychotherapeutic approach, while using drugs mainly to eliminate symptoms.

As we showed, while the bio-psycho-social model is the mainstream approach, the clinical practice is still mainly addressing pharmaceutical medicalization, where those forms of psychosocial distress are treated in a similar way to any other physical disease. Answering to the second research question, we can say that in the case studied representations have limited effect on treatments as clinicians cannot provide psychotherapeutic treatment but only the pharmacological one.

This chapter wants to give three main suggestions concerning the way psychosocial distress is

addressed in Italy. First, clinicians are complaining about the outdated model of biological psychiatry that dominates research and academia. While professionals find their way to fill the gaps in their knowledge, there is still a worrying simplistic idea of mental distress that approaches distress only through medical treatment, without giving individuals important tools to overcome and learn from conditions, through psychotherapy. The use of antidepressants is growing and worrying, as it should not be the primary form of treatment for these conditions (Barbato, 2015). Second, psychosocial distress is still not considered a priority in Italy, as financial resources are constantly insufficient. Financial resources should be addressed taking into account what was previously said: there is the need for psychosocial interventions, as the pharmaceutical part is well covered in that sense. In the end, as many recognize social dynamics as important risk factors for every psychiatric disorder, it would be a priority to recognize the main social conditions that could represent a problem, as well as to provide support for social inequalities and adverse life events.

The next two chapters will be regarding the relationship between patients' social conditions and distress, and we will also have the chance to further explore access to psychotherapy as a resource used to overcome depression.

Chapter 7 - Social dynamics and the occurrence of depressive and anxiety disorders: ethnographic report from two outpatient clinics

1 Introduction

Based on a year-long participant observation in two public outpatient clinics in the city of Milan, Italy, this chapter analyses how social dynamics are involved in the occurrence of depressive and anxiety disorders. The clinics are located in two different neighbourhoods characterized by different degrees of poverty, unemployment, house ownership, migrant population, and level of education. Within these two contexts, we consider notes taken from forty-six clinical interviews and records regarding patients with depressive symptoms.

As we showed, the biopsychosocial model considers biological, psychological, and social factors involved in depression. Psychiatric and sociological literature considers these symptoms and their correlated syndromes as reactive disorders, implying that social dynamics and adverse events are involved in their emergence. Given that, from a sociological perspective, we can focus on social dynamics and ask the following questions: Which social factors are connected to the occurrence of depressive symptoms in patients? How can different social conditions and events be involved in these syndromes?

This chapter will try to provide some ethnographic extracts from psychiatric interviews, clinical records and communications between doctors and between doctors and the researcher in the clinic to answer the aforementioned questions. Data is categorized according to different labels and organized for themes. Social dynamics involved regard bereavement, intimate and familiar relationships, gender, age, health, social environment, satisfaction and individualization, work, and socio-economic situation. A theoretical clarification of the dynamics involved is provided in the next chapter, as well as its implication for treatment and interventions.

2 The implication of social dynamics and data for this research

As we stressed in the conceptual chapter, the biopsychosocial model implies that the three factors (biological, psychological, and social) are bounded and interfere with one another (Borrell-Carrió, Suchman, and Epstein, 2004; Engel, 1977), implying that in any psychiatric conditions, we can expect social factors to be implied somehow in most or any situation. However, what determines depressive – as well as anxiety - symptoms is the reactive nature of

these disorders. The previous chapter showed how the psychiatrists interviewed think that contextual characteristics can be recognized in all or most of the patients with depressive disorders. Although the distinction between reactive and endogenous is outdated in psychiatry, mainly because of the inability to determine which effects are essentially determined by the environment and which ones by a dysfunction of the brain, part of the psychiatric, psychological and sociological theories still believe in the importance of this distinction.

We cannot know the origin of these disorders from an unconscious perspective. It would be, for example, interesting to understand the reasons why the individuals considered in this study, each one individually, experience their own distress. Often, behind the same symptoms, completely different, even opposing, psychological conditions are concealed. This assumption is generally taken into account at the two clinics studied.

> "We cannot provide a universally valid answer to the question of what triggers depression. Indeed, each person, each story requires a specific analysis. By analysing each specific story, we can identify the elements that help understand why that person experienced such a profound closure to the point of losing complete contact with their most vital element […] Let's consider the precipitating event, in the sense that it's not that one event that determines depression. There is already a series of situations upstream to which you have been exposed repeatedly that lead to a certain vulnerability. Then there is a triggering event that leads from vulnerability to pronounced symptom. In addition to the triggering event, we must consider the backstory behind that individual."
>
> - Dr D, Psychotherapist, F, Orange Clinic

In any case, we some social events and dynamics in which the patients of the clinics are involved can be considered relevant topics of investigation. Specifically, when we are speaking about some reactive conditions, such as depression and anxiety, some specific events constitute a possible source of "break" in the psychological balance of the person, targeting the vulnerabilities of certain individuals, causing a disruption in the economy of their psychological functioning. These elements of social nature will be isolated only for scientific analysis purposes, in order to understand their relevance.

However, in line with professionals' accounts, the observations of psychiatric interviews provide us with new confirmations about the reactive nature of this type of disorders. All the forty-six patients observed with depressive symptoms were presenting problems bound to their social conditions or adverse events that could happen during the life course. Patients often recognise their individual and social issues as relevant to their symptoms and report them in psychiatric interviews. Doctors were asking specific questions to detect which conditions regarding everyday life can be relevant to understanding the distress of the patient. Then, the health status of the patient, their socioeconomic situation and the prescribed treatment are also reported in clinical records.

The possibility of both observing the interaction patient/doctor as well as having access to clinical records where the personal and socioeconomic situation is reported gave us the possibility to understand in which way social factors are connected to the emergence of depressive disorders and their implications. As a potential critic, we have to consider that, while clinical interviews were not structured, the way psychiatrists consider social problems as relevant to understanding, diagnosing and treating the patient, represents the medicalized knowledge regarding the effects of social problems on psychiatric disorder. This means that what is reported in clinical records is the interpretation that doctors give to social dynamics and life events and their relevance to the clinical condition.

However, this analysis considers different sources of data to present which social dynamics are considered as relevant in the occurrence of depressive symptoms: observations of the clinical interview, clinical records and discussions between the researcher and the doctor, and equipe meetings. In this way, we can recognize different accounts for which situations can be considered relevant, as well as their role in the distress. Researcher's observations and points of view, doctors' and other clinical professionals' points of view, equipe reasoning, and formalization of the problem in the clinical record are different sources of information that can provide the researcher with more clues on which social and individual problems can be related to the occurrence of depressive symptoms. Of course, the definition on which social conditions could be defined as a problem means always to undertake choices (Kitsuse and Spector, 1973), in this case relying on both professional knowledge as well as common sense, for both the researcher and the psychiatrist. In this analysis, anyway, patients' vision of which social problems are involved in the occurrence of their symptoms emerge only in the clinical

interviews but, in general, this research does not involve further patients' interviews on their conditions.

We offer now examples of the data collected in these situations. As mentioned, due to the sensitivity of the information presented here, we will solely furnish brief excerpts from field notes, abstaining from divulging sociodemographic indicators about the patient or disclosing the specific clinic where the situations were observed. The reader will discover more details regarding the distinctions between the two neighbours by persisting in reading and subsequently uncovering how diverse scenarios are unfolding in the two clinics. To present a clearer understanding of the observations made, we will additionally provide some extracts from field notes concerning the observed cases.

3 Depression: the missing diagnostic category

As we showed previously, depression is not only a common-sense term used to describe a low mood state but also a specific diagnostic category, with precise criteria shared by part of the scientific community. In this way, the diagnosis represents the practitioner's evaluation of the patient's symptoms and their definition through a diagnostic label, providing suggestions concerning the type of treatment that will be followed (Wykes and Callard, 2010). Diagnosis is made during practitioners' assessments when the patient "becomes depressed". From a constructionist perspective, diagnosis is not an act of discovery of a pre-existing entity lying inside the sufferer but an active process of transforming the patient's experiences in a diagnostic category as an explanation. Diagnosis structures the reality of individuals, as it clarifies and sometimes explains what they experience (Jutel, 2009; O'Reilly and Lester, 2016).

In Chapter 6 we provided some accounts concerning the diagnosis and the positions of the professionals towards them. According to what we observed on fieldwork, diagnoses were not posed in a precise way as they pretend to be by the standard training in psychiatric discipline, such as through assessment tests and the use of DSM-V-TR categories. As a first prove of this consideration, we noticed that the diagnosis was missing in many of the clinical records considered. While in the Orange Clinic the diagnosis was missing on the clinical record only for one patient, for the Blue Clinic one-third of the diagnoses are missing.

This observation contradicts the conventional understanding of the diagnosis being the crucial precursor to treatment. In fact, as shown in the previous chapter, our observations showed that

the standard path identifying symptoms – diagnosis – treatment is not essentially applied in all the situations, but rather a model of identifying symptoms – treatment, without the necessity of a specific diagnosis. The diagnosis is then corroborated depending on how the patient reacts to the medication. From the situation pictured, we can understand that diagnostic categories are not posed in a regular and standardized way. It is more important, for psychiatrists, to understand the general situation of the patients, their symptoms and how to treat them, and then pose a diagnosis that can imply somehow an idea of what is happening. This is also confirmed by the interviews: the diagnosis should be as accurate as possible, but diagnostic categories are vague, and the same symptoms can occur in different syndromes. It is although more important to understand the patient's symptoms and life situation and try to help them through therapies and interventions.

> "According to me, there is the risk of categorization. They make sense, if you need to conduct a clinical study, so you need parameters, black or white. When you talk about clinical matters... it's not very helpful. I tend to look at the various dimensions of that patient, what they are, not just give them a diagnosis and that's it. I look at the entire spectrum, so to speak, of their functioning from a dimensional perspective."
>
> - Dr M, psychiatrist, F, Orange Clinic

For what concern this study, while we are missing around one-fourth of the diagnosis for patients, all patients observed were reporting depressive and anxiety symptoms, on their clinical records. As depressive and anxiety disorders can be detected in most psychopathological syndromes, while they are not the primary symptoms but generally a reaction to another existing distress, patients involved in this study, according to ol psychoanalytical definitions, are patients whose syndrome can be recognized as forms of neurosis and in some cases as personality disorders, excluding any form of psychosis. Once more, the diagnoses assigned to patients are not always in accordance with the categories outlined in DSM-5 or ICD-11. In fact, in some cases, the diagnosis is missing and the clinical record only specify symptoms. In other cases, the diagnosis exists but without using any of the existing diagnostic categories. Finally, it happens that the diagnosis is debated or redefined by

another professional. We include in this study patients who report depressive and anxiety symptoms, and their treatments involve antidepressants, psychotherapy, and anxiolytics.

Speaking of the patients involved in this study, for what concerns the diagnoses that are included in the Depressive Disorders category by the DSM-5 (American Psychiatric Association, 2022)[40], the diagnostic category "Major Depressive Disorder" was in seven cases, then one case of "Recurring depression"[41], one of "Other Specified Depressive Disorder", one of "Dysthymia[42]" and one with "Complicated Grief". Then, we have three cases of "Anxious-Depressive Syndrome". This type of syndrome does not exist according to psychiatric categories but is conversely well used by Italian psychiatrists to define those situations in which anxiety and depressive symptoms are co-occurring. For what concern anxiety, we report three cases of "Generalized anxiety disorder", one "Social Anxiety" and one "Anxiety with Panic / Insomnia". These syndromes are similar in symptomatology and co-occurring with depressive ones, as well as they share the same type of pharmaceutical treatment and are considered in a rather similar way. Then, six cases of "Adjustment Disorder"[43], reporting their related depressive or anxiety component. Then, we have two cases of "Bipolar II Disorder" and two of "Cyclothymia"[44]. Technically, patients with these diagnoses should not be included in the study as they do not align with the classification of neurotic or reactive disorders. However, the patients under consideration were those whose diagnosis had been initially established by a previous doctor. The new doctor harboured doubts regarding the diagnosis, and the patient was undergoing pharmacological treatment for depression. In the end, we have eleven patients who have reported "Personality Disorder" as a diagnosis, eight of them without any specific and three as "Narcissistic" "Borderline" and "Histrionic". Out of these eleven, seven "Personality disorder" diagnoses were associated with other diagnoses of depressive or anxiety syndromes, while four were reported as exclusive diagnoses. "Learning Disabilities",

[40] Depressive Disorders include disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder (American Psychiatric Association, 2022).
[41] Which is not present in DSM-5-TR categories but it is present in ICD-11 classifications (World Health Organization, 2023d).
[42] Dysthymia, also known as Persistent Depressive Disorder, is a depressive disorder characterized by a depressed mood with less intensity than Major Depressive Disorder but more persistent in terms of time (American Psychiatric Association, 2022).
[43] Adjustment Disorder is a type of distress characterized by anxiety and depressive symptoms triggered by a stressor that disappear when the stressor is removed (American Psychiatric Association, 2022). This implies sometimes some confusion with depressive and anxiety disorders, as their boundaries are difficult to define, as we previously discussed the reactive nature of these disorders (Casey, 2009).
[44] Bipolar II Disorder and Cyclothymia are conditions that involve hypomanic episodes and can involve depressed mood (American Psychiatric Association, 2022).

"ADHD", and "Eating Disorders" were also reported in one case each, and two cases for "Substance Abuse". For the twelve clinical records that do not present any clear written specification concerning the diagnosis, clinical records are reporting depressive and anxiety symptoms as well as personality disorders.

4 Events and conditions associated with depressive symptoms

We proceed by introducing some fieldwork extracts from fieldwork data, namely from psychiatric interviews, personal communication between professionals and between professionals and the researcher, everyday activities at the clinic and clinical records. We now report extracts from fieldwork data, together with gender (male, female, nonbinary), age, nationality (Italian/Other) and the clinic referring for treatment. The reader can find two tables in the Appendix showing for each of the forty-six patients considered in this study the events and conditions associated with some socio-biographical. Table A2 will show patients from the more deprived context, while Table A3 will show patients from the less deprived. In the same way as ethnographic extracts, events and situations reported in the table come from the information gathered on clinical records, through the observation of clinical interviews and equipe meetings, and from discussion regarding patients between the researcher and the doctor.

Data show how different social and life dynamics are involved in depressive disorders. Data has been codified and categorized through different dimensions following a grounded theory approach (Glaser & Strauss, 1967). These categories emerge from the fieldwork and do not rely on any specific theory, then grouped according to different themes. Nevertheless, in Chapter 2, we have presented a collection of quantitative studies that examine the associations between depressive symptoms and certain domains outlined in the following pages.

4.1 Loss and bereavement

4.1.1 Bereavement

Bereavement refers to the period of mourning and adjustment that follows the death of a loved one. It encompasses the emotional, psychological, and physical responses that individuals experience as they come to terms with the loss and adapt to life without the presence of the deceased person. As said, classical psychoanalytical theory sees mourning as the most representative situation for the occurrence of depressive symptoms (Freud, 1917). Technically, DSM-5 recognizes that "such symptoms may be understandable or considered appropriate to

the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered" (American Psychiatric Association, 2022 p. 134), but critics complain of an actual bereavement exclusion for the diagnostic criteria (Wakefield, 2013)[45]. However, psychiatrists observed in fieldwork are well aware of the occurrence of depressive symptoms as a classic response to losses. In some cases, however, people experience what is called "complicated grief", if symptoms are occurring for longer than would be expected according to social norms and that causes impairment in daily functioning (Shear, 2015).

In our observations, ten of the patients considered were experiencing a loss of loved ones in the period of treatment at the clinic. In some cases, the loss of a loved one can also be the starting event for the occurrence of depressive disorders.

4.2 Intimate relationships

4.2.1 Breakup, separation, divorce

Breakups, separations, and divorces are events in which there is the loss of a beloved one. Patterns of bereavement can be experienced in the same way that for the death of a beloved one. This category is occurring for eight of our patients.

4.2.2 Conflictual intimate relationship

Intimate relationships can be sometimes challenging and can be the trigger for distress, even when the relationship is not over. We report an example from the fieldwork.

> "Nothing serious. Some little things were omitted. I tried to overcome them. He didn't call me right away. I understood some things about the fact that he made me feel the only important one. I've never been in a serious relationship. I have difficulties with feelings. It's the first time that I feel involved […] I fear betrayal. I experienced abuse in my first relationship with maybe this is a consequence of what I am now."
>
> - Patient #7, M, 26 y.o., IT, Orange Clinic

[45] The revision of the fifth edition of the DSM (DSM-5-TR, American Psychiatric Association,2022) included the "Prolonged Grief Disorder" in the category of "Trauma and Stressor-Related Disorder", but with a different set of symptoms.

4.3 Family

4.3.1 Concerns regarding family situation (economic, work, life)

In some of the cases considered, distress was coming from concern about the family situation. In the situation observed, we had parents concerned about the economic and precarious work situation of the sons and daughters, as well as migrants concerned about the precarious life conditions of the family in their home countries.

4.3.2 Family member's health problems

Health problems for people for familiars were occurring for six patients. While this can be a concern, in some cases it directly affects patients that take the role of caregivers. This happened specifically for females and older people.

> "It's a complex familiar situation. Her husband is disabled. She is taking care of him and she doesn't want that."
>
> - Dr M (psychiatrist), personal communication concerning patient #8, F, 68 y.o., IT, Orange Clinic

> "The problem now is not knowing how to deal with this life change after 65 years of living like this. Changes are 50% of the problems for older people."
>
> - Dr T (psychiatrist), personal communication concerning patient #33, M, 68 y.o., IT, Blue Clinic

4.3.3 Conflictual familiar relationship

We have many situations in which conflictual familiar relationships are reported and discussed by the patient as the main issue. Some extracts from the fieldwork:

> Patient: "I have serious relationship problems with my family. Those are the problems, and not the alcohol. At home, without family, I'm fine.

Doctor: “Are you sleeping?

Pt: “Kinda. 6 hours maximum,”

Dr: “What about the mood?

Pt: “If it wasn't for the family, fine. I no longer feel like an alcoholic.

Dr: “What are the disputes?

Pt: “Maybe they would like a different son. I wouldn't drink and I would sleep if I didn't have problems. My brother graduated but he didn't want me there. […] Relatives who walk away are just the icing on the cake.

- Patient #10, M, 35 y.o., IT, Blue Clinic

"I don’t feel well, my life is a bit complicated. My son is 18 years old. My mother has recently become sick and my father is a hyena with me. It's a conflictual relationship”

- Patient #90, F, 52 y.o., IT, Blue Clinic

4.3.4 High expectations from the family

In a different way from the previous example, families produce relationship dynamics of high expectations for one of their members. Patients reported feeling pressure from the family and distress related to the gap between family expectations and the actual life conditions of patients. This type of issue is affecting patients in different realms, such as individual and professional choices. This type of problem can affect families regardless of other types of socioeconomic issues involved.

“This summer some things hurt me. I understood that I was not appreciated and also that I was overestimated by my parents. I'm afraid I don't live up to expectations. I want to disappear, leave, change life.”

- Patient #7, M, 26 y.o., IT, Orange Clinic

4.4 Gender

4.4.1 Gender roles constraints

Data show that in any part of the world and for any population considered depressive symptoms are more prevalent in women compared to men (Global Burden of Disease Collaborative Network, 2020). Psychiatric literature claims that this is attributed to hormonal differences between the sexes (American Psychiatric Association, 2022). Others, instead, think that these differences remark different representations between men and women, where women are more likely to take into consideration their mental health problems (Lafrance, 2007).

Our experience on fieldwork cannot prove one or the other position, as we are not counting how many depressed men, women or non-binary people are reporting these symptoms. Still, we see how some specific social conditions affect more often women compared to men, specifically when it comes to familiar gender role constraints. Gender roles often dictate how parenting and caregiving responsibilities are divided within families. In a couple of cases observed, housekeeping duties and childcare were expected to be women's duties, and are reported in interviews as a source of distress for patients.

> "Very bad. We sent her children to kindergarten to ensure that she had time for herself and now she is pregnant again [...] The husband also gives her a hand with children but that's not enough for her and he doesn't understand it."
>
> - Dr T (psychiatrist), personal communication concerning Patient #59, F, 28 y.o., Other, Blue Clinic

We might express that the same happens for men who are experiencing depression for not fitting into their male-breadwinner role, for instance for losing a job.

4.4.2 Single parenting duties

Single parenting can come with unique challenges and stressors that are distinct from those faced by two-parent households. Dealing with the responsibilities of raising children, managing a household, and often working to provide for the family on one's own can lead to significant stress. Traditional gender roles in the Italian context limit fathers' involvement in childcare and

reinforce the idea that mothers are the primary caregivers. In this way, we noted that the responsibilities of single parenting act as a catalyst for distress, particularly among women.

> "I was exhausted, I did too much, I was overactive. My daughter, plus university, plus work. For me, covid was traumatic. I couldn't study. I was already overloaded. [...] Since I was studying, I didn't have much entertainment, and with the pandemic ongoing I had no more. I am a single mom. I have a job and a daughter."
>
> - Patient #52, F, 39 y.o., IT, Blue Clinic

4.5 Old Age

4.5.1 Retirement

For many people, their careers provide a sense of identity, purpose, and routine. When they retire, they might struggle to find meaningful activities that give them a similar sense of fulfilment. The loss of their professional role can be experienced also with the emergence of symptoms of grief.

4.5.2 Widowhood

Widowhood is reported separately here to remind us that can occur both as a form of bereavement but as well as a transformative event in occurs most often for older people.

> "Hyperthymic that poorly adapts to ageing. Two depressive episodes due to sickness and the death of her husband died in 2019. [...] Lack of prospects. Locked up in everyday domestic life, managing three children at home."
>
> - Clinical record, patient #54, F, 82 y.o., IT, Blue Clinic

4.6 Physical and mental health

4.6.1 Health issues, illness, disability

Physical health conditions and disabilities can alter an individual's self-concept and identity. The inability to engage in activities they once enjoyed or perform everyday tasks can lead to a sense of loss and confusion about their identity.

4.6.2 Substance abuse

The relationship between substance abuse and mental health would require a lot of discussion. First, if substance abuse is considered the primary form of distress, patients would have not been taken into care by these clinics but conversely sent to specific public clinics for addiction. In the same way, if symptoms of depression or anxiety arise due to substance abuse, we are no longer categorizing these symptoms as mental disorders, but rather as outcomes of the substance abuse itself. Finally, substance abuse can be a strategy to mitigate or alleviate the distressing emotional symptoms associated with depression.

Considering all of this, substance abuse can further complicate preexisting vulnerable situations. It can act as a trigger for distress and add complexity to established relationships and social dynamics, while also serving as a generator of stigma.

4.7 Social environment

4.7.1 Social isolation and loneliness

Social isolation denotes the absence of social interaction and engagement, whereas loneliness represents the emotional reaction to this absence of significant social bonds. Someone can be socially isolated without experiencing loneliness if they find contentment in solitude. Conversely, an individual can engage in many social interactions but still feel lonely if these interactions lack emotional depth and connection. Both social isolation and loneliness can have adverse effects on mental and physical well-being, underscoring the significance of nurturing meaningful social connections and establishing strong support networks. Social connections and meaningful relationships not only serve as essential resources for overcoming depression (Coppo, 2005) but also fulfil a fundamental human need.

> “So, I don’t know, I fill the voids left by a woman. But I'm of a certain age. It's a more social difficulty than mine in getting to know people. Everyone does stuff on the phone. No one comes to the mountains with me.”
>
> - Patient #5, M, 47 y.o., IT, Orange Clinic

The COVID-19 pandemic has also enhanced the feeling of social isolation and loneliness. Our data show that five patients are reporting social isolation during the pandemic as a trigger for distress. In line with our observations, data from the OECD (2021) clearly show an increase in symptomatology in the period considered.

4.7.2 Displacement from the original context

The displacement from one's original context holds particular significance for migrants, as it can result in profound emotional and psychological distress. The disruption of leaving behind a familiar environment, culture, and social connections often triggers feelings of disorientation, isolation, and a profound sense of bereavement. These distressing emotions often emerge from the complexities of assimilating into a new culture, navigating language barriers, grappling with limited social support, and the erosion of one's previous identity and sense of belonging. Furthermore, the uncertainty surrounding what lies ahead, the challenges of adapting to unfamiliar norms, and the potential exposure to discrimination within the host country all collectively contribute to the distress experienced by migrants who find themselves uprooted from their original context.

> “Immigrant, her high life expectations were unfulfilled. She doesn’t have social ties; she has to look after her children who once were looked after by the community. She is not coming from a lower social class, and now she is locked at home”
>
> - Dr T (psychiatrist), personal communication concerning Patient #59, F, 28 y.o., Other, Blue Clinic

4.7.3 Trauma (COVID-19 pandemic, war, sexual abuse, violence)

Trauma often leads to distress, as traumatic experiences can profoundly impact an individual's emotional well-being. As we are referring to the reacting nature of depressive symptoms, we now consider here only recent traumas. However, childhood trauma can also impact an individual's personality and shape the overall functioning of the mind. Some of the clinical records were also reporting childhood trauma as a leading event for patients with depressive conditions. On other occasions, the traumatic condition was more recent.

> "Anxious-depressive syndrome without suicidal ideation, resulting from the death from COVID-19 of many users of the RSA where she worked. The patient remained the only operator working."
>
> Clinical record
> - Patient #50, F, 64 y.o., IT, Blue Clinic

4.8 Satisfaction, future, individualization

4.8.1 Autonomy and individualization issues

Both autonomy and individualization are essential for personal growth, self-fulfilment, and well-being. They empower individuals to live authentic and meaningful lives, fostering a sense of agency and control over their destinies. When this is not possible, individuals can perceive distress.

> "He is 40 years old and hasn't achieved what she should have achieved. Not so much from the depression but from the narcissistic wound. I don't know if therapies are needed... It's more a question of personality"
>
> - Patient #16, M, 39 y.o., Other, Orange Clinic

4.8.2 Future-life planning difficulties

Patients might feel entrapped in their present life without seeing perspective for what they can do in future. While this can be also symptomatic of depressive syndrome, we might also see that being stuck in their present lives. Feeling entrapped in an adverse life situation can trigger the development and maintenance of depressive symptoms (Coppo, 2005; Harris, 2001).

> Doctor: “How do you feel from a general clinical perspective?”
>
> Patient: “On a roller coaster, but when I go down there are reasons.”
>
> Dr: “What are the triggers?”
>
> Pt: “They are linked to the family, to not leaving the house, to being blocked towards change, to frustration, towards starting things. I’ve been enrolled in a mindfulness course. One week and then I stopped. I don't take care of myself as I would like, I don't get into healing.”
>
> - Patient #24, F, 54 y.o., IT, Orange Clinic

4.8.3 Existential meaning issues, lack of satisfaction in life, recurring frustrations

In certain patients, we have noted challenges related to existential meaning, in terms of the inability to find a deep sense of significance, purpose, and understanding in their lives. It is difficult to assess in which situations the lack of existential meaning can be the trigger or the consequence of depression, as perceiving a lack of sense in life can be itself a depressive symptom. However, we have situations in which people have not found any purpose to their life situation yet, and this can be a source of distress. Linked to this, a lack of life satisfaction and persistent life frustrations can lead individuals to perceive reduced control over their lives, fostering a sense of being trapped in their current circumstances.

> "He has had recurring frustrations in life. Recurring depressive episodes… he had no job. Then he started and now he has a good job. He then bought a house because at 47 he was still living with his mother."
>
> - *Patient #5, M, 47 y.o., IT, Orange Clinic*

4.9 Work

4.9.1 Dismissal, unemployment, and unstable job situation

Job insecurity is a recognized stressor for depression. We encounter varying circumstances of job instability, encompassing the possibility of job loss, situations where individuals have already been separated from their employment, and scenarios where people are currently experiencing unemployment. The conditions pictured can lead to financial instability, loss of social status, and a sense of purposelessness, all of which contribute to a heightened level of distress.

4.9.2 Mobbing

"Mobbing" denotes a type of workplace mistreatment or bullying characterized by ongoing and deliberate acts of harassment, humiliation, or intimidation aimed at an individual or group. This conduct involves tactics such as verbal abuse, isolation, rumour-spreading, and other harmful behaviours designed to damage the victim's mental and professional state. Mobbing has significant emotional and psychological consequences for the target, underscoring the need for workplaces to address and prevent such behaviour to foster a positive and productive atmosphere.

> "He obtained from the ATS[46] the authorization to work from remote indefinitely, given that the workplace is "toxic and harmful". Even it is already "15 years of struggle". He can't go to work. He has been suing them for mobbing for many years. He continues to reiterate about causes, judges' decisions, mobbing ("straining", he says, because it is prolonged mobbing). 13 years of mobbing, two dismissals, transfers."

[46] "Azienda Territoriale Sanitaria", Territorial Health Agency.

"Medical record – Diagnosis: Adjustment disorder with depressed mood.

Occupational medicine document: Dismissed in 2014, then contested and resulting in reinstatement. Relocations, no compensations recognized, no remote work offered. He has no contact with colleagues or supervisors. He spends his time in the office without any task. Not actively seeking another employment, no future life programming.

Symptoms: Stable since 2014 – anxiety, panic, irritability."

- *Extract from fieldwork notes and clinical record*
  Patient #32, M, 54 y.o., IT, Blue Clinic

"I'm fine, but analysing my problems I see they are related to my job. They offered me an incentive to sign and leave. I didn't accept and they demoted me. […] I see other colleagues working and I get anxious. When I'm alone I'm fine [...] I'm always precise in everything. They always do like this with people with disabilities."

- *Patient #114, F, 54 y.o., IT, Blue Clinic*

4.9.3 Work-related stress

Work-related stress occurs in scenarios where the job situation maintains stability, even though the working conditions are less than optimal.

Doctor: "Do you like your job?"
Patient: "Yes"
Dr: "You don't look convinced"
Pt. "It's stressful. I didn't want to work there because my brother also works there and I didn't want to break the balance between us. In 2020 I joined the family business because there was a position for me."
Dr: "And how has work been up to now?"
Pt: "Under pressure"
Dr: "Is it for the job or because you have your brother as a boss?

Pt: (cries) “Too many responsibilities. I don't feel prepared, I'm afraid of making mistakes. Then my father and brother tend to prevail. I have to train myself to stand up to them.”

- Patient #108, F, 29 y.o., Other, Blue Clinic

4.9.4 Working expectations and frustration

Ultimately, we encounter stable working conditions without any stress originating from the work environment. However, in situations where individual or familial job expectations are not aligned with reality, repeated occurrences of unmet expectations result in feelings of frustration.

Doctor: “Do you like your job?”
Patient: “It sucks. I do data entry. The advantages are that I only work 4 hours in the morning, with the tutor by my side.”
Dr: “Is it poorly paid?”
Pt: “I think so. But this would be a start. I'm sick of the world of work. I find it hard to see myself relocated. I would like to work in a kindergarten.”
Dr: “As an educator?”
Pt: “As a support teacher. I have no titles. I am a drama therapist. [...] It’s difficult to prepare a CV when I'm at home. I have an interview for a job in a cooperative. […] I cannot get back in the game as I would like."

- Patient #24, F, 54, y.o., IT, Orange Clinic

4.10 Socio-economic situation

4.10.1 Economic deprivation, debts, fraud

Economic deprivation refers to the condition of lacking the financial resources, opportunities, and material well-being that are necessary to meet basic needs and achieve a reasonable standard of living. It encompasses a range of economic hardships, including poverty, unemployment, limited access to education, inadequate healthcare, and insufficient housing.

People who experience economic deprivation often face challenges in accessing essential goods and services required for a decent quality of life.

> "I've made sacrifices all my life and now I can't spend money. I live on my husband's pension"
>
> - *Patient #8, F, 68, y.o., IT, Orange Clinic*

Fraud, debts, and distress are interconnected concepts that often play a role in complex financial situations.

> "The situation is connected with my ex-husband, the father of my children. We had loans with the bank. After 30 years I thought they were solved but no. He had left a lot to pay. I collapsed. I felt responsible for something that wasn't mine. [...] He said he had paid but, instead, he did not pay. I sold a house. It was a considerable amount."
>
> - *Patient #45, F, n/a, y.o., IT, Blue Clinic*

4.10.2 Unstable housing situation and eviction

Uncertainty about where one will live and concerns about housing stability can create chronic stress. This ongoing stress can lead to the development or worsening of depressive symptoms. Unstable housing conditions and evictions are linked to situations of economic deprivation. Many patients from Blue Clinic, anyway, were living in public houses administrated by the municipality, and this could partially protect them from the risk of eviction.

4.10.3 Trials and jail

Trials and legal disputes can be a source of stress. Jail time can be a challenging and stressful experience, and it has the potential to impact an individual's mental health, including contributing to the onset or worsening of depression.

"April 2022: brief incarceration for attempted robbery, where he has suicidal ideation not acted. After the episode, the treatment started"

- *Clinical record for patient #18, M, 23, y.o., IT, Orange Clinic*

5 Relationships and cumulation of different adverse events and situations

In almost all cases, patients are bringing to the attention of the doctor more than one issue that characterizes present or past life.

(The patient cries. She regrets that she no longer has the functionality and vitality to cook meals and take care of the house.)

Doctor T: "You are referring to a stage of life where you have problems with work, plus your daughters, plus home duties, plus the abandonment by your husband.

- Patient #66, 50 y.o., IT, Blue Clinic

However, aggregating various forms of distress might exacerbate or trap individuals in distress, without necessarily implying that those with more complex situations or a higher number of issues experience more severe symptoms. Each situation is unique and influenced by individual characteristics. Furthermore, it is not guaranteed that individuals facing similar problems will develop identical forms of distress.

"Debut: moving to Italy alone at the age of 30, then appearance of a depressed mood. [...] Unemployed husband, the recent death of the father, difficult management of his pathologies [...] Deflected mood with crying spells, ideas of uselessness with anxious symptoms and irritability. Initial insomnia […] Picture of reactive depression without suicidal ideation. [...] The physical pains paralyze the general functioning [...] The patient reports permanence of anxious symptoms, also due to the news for the country of origin. Problems sleeping. Increased therapy. […]

> Complex problems from an organic + socio-economic point of view, exacerbated by the bad relationship with her husband. […]
>
> Psychiatric interview: mood is still depressed because she is unable to get her mother transferred to Italy. The last medical screening showed a worsening of the cysts. Increased therapy."
>
> - *Clinical record, patient #104, 41 y.o., Other, Blue Clinic*

We have also to consider that, some of the issues presented, are related to one another. For example, patient #8 from the Orange Clinic reports issues related to the disability of the husband and the conflictual relationship with him, a condition that is worsened by the fact that she is taking the role of being his caregiver. This circumstance is further influenced by constrained financial means that hinder the family's ability to afford private home care for the husband. Additionally, the limited options provided by a familistic welfare system result in a significant portion of care responsibilities being shouldered within the family, mainly by women (Saraceno, 1994). Socioeconomic conditions, gender roles and health problems for a family member are connected. Similarly, for patient #52 from the Blue Clinic, single parenting duties and gender role constraints are determining her condition to be the parent who is caring most for her children, which affects the possibility of having time for herself. Lack of time available, together with work stress and social isolation determined by the COVID-19 pandemic, determined the emergence of distress. Patient #59 from the Blue Clinic was experiencing displacement from the original context, social isolation, gender role constraints and individualization issues in the new context. Patient #45 from the Orange Clinic was seeing an interrelation between a bad relationship with the original family and the previous partner, resulting in an unstable economic and housing situation. Similarly, the conflictual familiar situation for patient #20 produced unstable living conditions protracted for years. For patient #45 of the Blue Clinic, fraud resulted in economic deprivation and concern for the son and daughter's economic situation. For patient #114 from the Blue Clinic a condition of disability was determined respectively a situation of mobbing in the workplace. Patient #13 from the Orange Clinic and #117 from the Blue Clinic were experiencing future life-plan difficulties due to their health conditions and disability.

6 Conclusions

This ethnographic exploration shows the intricate interplay between social dynamics and the emergence of depressive and anxiety disorders within the realm of two outpatient clinics situated in Milan, Italy. The information elucidated within this chapter offers a clear illustration of the interconnected nature shared between social dynamics and the symptoms of depression. By drawing upon data sourced from clinical interviews, dialogues among healthcare practitioners, and direct observations within the clinic settings, a panoramic view emerges, highlighting the interlaced relationship between diverse social factors and individual experiences, which together give rise to psychological distress.

All patients presented evident social issues and adverse events coinciding with their symptomatology, and physicians regarded these events as significant elements contributing to their distress. Only one patient did not show many social issues (patient #87) intervening in his life, who had “retirement” as the sole potential element of distress. This patient, specifically, was pharmacologically treated as someone with depression, but previous psychiatrists believed his diagnosis would be bipolar disorder. In any case, if the diagnosis were depression, it might be one of the few cases where social dynamics are difficult to define, or inexistent.

The upcoming chapter will delve into a theoretical discussion of the intricacies at play, further enriching our grasp of the interplay between social circumstances and psychological distress. Furthermore, the limitations encountered during the analysis will also be critically examined in that section.

Chapter 8 - Context-related and context-independent issue. The relevance of the context in the emergence of depressive disorders

1 Introduction

This chapter explores the intricate relationship between social dynamics and the manifestation of depressive symptoms. By examining two outpatient clinics in two different areas, it becomes evident that similar symptoms are underpinned by divergent social forces. However, while shared triggers for depressive symptoms emerge in both contexts, in both contexts we have found similar triggers for depressive symptoms, we recognize that some adverse events and conditions are independent from social conditions, while others are more related.

The analysis shows the relationship between the lack of fulfilment of materialistic and post-materialistic needs and the emergence of reactive symptoms. Two paths for intervention emerge: firstly, addressing the dearth of economic and social fulfilment; secondly, catalyzing a cultural shift towards healthier narratives surrounding self-realization and life goals. This dual-pronged approach offers a comprehensive framework to tackle the epidemic of depressive disorders.

In the latter section of this chapter, the study contemplates the extensive impact of inequalities. These disparities not only contribute to the emergence of distress but also restrain personal and social resources for mitigation. By acknowledging the multifaceted ramifications of inequalities, this research lays the groundwork for a more holistic understanding of the complex interplay between social forces and mental well-being.

2 Four groups of adverse events and conditions

By examining the data derived from both clinics, we aim to assess which social contexts, issues, and adverse life events are associated with the onset of depressive symptoms. Data have been coded into categories that could summarize the social factors involved. Table 2 represents all themes collected through participant observation in the two clinics.

Table 2-Event or condition associated with depressive symptoms

Section	General Category	Included Events or Conditions
4.1	Loss and Bereavement	Bereavement
4.2	Intimate Relationships	Breakup, separation, divorce; Conflictual intimate relationship
4.3	Family	Concerns regarding family situation (economic, work, life); Family member's health problems; Conflictual familiar relationship; High expectations from the family
4.4	Gender	Gender roles constraints; Single parenting duties
4.5	Old Age	Retirement; Widowhood
4.6	Physical and Mental Health	Health issues, illness, disability; Substance abuse
4.7	Social Environment	Social isolation and loneliness; Displacement from the original context; Trauma (COVID-19 pandemic, war, sexual abuse, violence)
4.8	Satisfaction, Future, Individualization	Autonomy and individualization issues; Future-life planning difficulties; Existential meaning issues, lack of satisfaction in life, recurring frustrations
4.9	Work	Dismissal, unemployment, and unstable job situation; Mobbing; Work-related stress; Working expectations and frustration
4.10	Socio-Economic Situation	Economic deprivation, debts, fraud; Unstable housing situation and eviction; Trials and jail

Source: Author's elaboration

We now group the different outcomes according to the different types of stressful situations or events involved.

2.1 Transformative events

First, we have events that can be seen as a transformation of themselves or their life. Those events are most likely independent of the context and life situation of the patients. In this category we include problems related to bereavement and widowhood, classically defined in depression literature as the occurrence of "complicated grief" (Coppo, 2005; Lolli, 2009; Horwitz and Wakefield, 2007). Then, depressive symptoms can arise from the acknowledgement of a health condition or disability. Symptoms can derive from the end of a relationship with a significant other (divorces and separations). Retirement can also be a transforming life event that can be connected to depressive symptoms.

2.2 Relational issues, stress, trauma

We then have some other situations common to both deprived and not-deprived contexts. Recent trauma, substance abuse, relational issues in family and intimate relationships, concern for family members for health or life situation, work-related stress and mobbing. These situations can occur in both contexts of wealth or socioeconomic deprivation.

2.3 Socio-economic disadvantages

Some of the issues considered are more likely to take place in one context compared to the other. Conditions involving the socio-economic situation are related to economic deprivation, debts, being victim of a fraud, unstable housing situation and eviction, unemployment and precarious work situations, as well as criminal acts and their consequences in terms of trials and jail time. Next to these, the displacement from the original context and social isolation are affecting mainly migrant patients, who are mostly living in the more deprived context. However, social isolation and loneliness were also producing depressive symptoms during the COVID-19 pandemic, regardless of their social status. In the same way, gender role constraints and single motherhood stress were found in both contexts.

2.4 Expectations, frustration, existential meaning

Counterposed to the previous ones, we have some social factors that are instead intended to be related to a wealthier context, in which socio-economic factors are no longer a matter of distress, but other individual life conditions are experienced as reasons for suffering. In this category, we can include issues concerning individualization, autonomy in defining life paths

and future planning difficulties, as well as the search for meaning in one's life. We also have distress resulting from the gap between individual and family expectations concerning life and work situations.

3 Context-related and context-independent issues: commonalities and differences in the two contexts

In the previous paragraph, we grouped different social dynamics into four groups: Transformative events, Relational issues, stress, trauma, Socioeconomic disadvantages, Expectations, frustration and existential meaning. We then clarified that, even though most of the situations recognized here as problems can affect individuals differently according to their social conditions, the first two groups involve problems that are more independent from the context while the second ones should be regarded as related. Table 3 resume the categorization of depressive symptoms-related events by context dependency, presenting a theoretical division that later we try to verify.

Table 3- Categorization of depressive symptoms-related events by context dependency

Context Independent	
Transformative events	**Relational issues, stress, trauma**
Bereavement	Concerns regarding family situation (economic, work, life)
Breakup, separation, divorce	Conflictual familiar relationship
Health issues, illness, disability	Conflictual intimate relationship
Retirement	Family member's health problems
Widowhood	Trauma (COVID-19 pandemic, war, sexual abuse, violence)
	Substance abuse
	Mobbing
	Work-related stress
Context Related	
Socio-economic disadvantages	**Expectations, frustrations, existential meaning**
Dismissal, unemployment, unstable job situation	Autonomy and individualization issues
Displacement from the original context	Existential meaning issues, lack of satisfaction in life, recurring frustrations
Economic deprivation, debts, fraud	Future life planning difficulties
Gender roles constraints	High expectations from the family
Single parenting duties	Working expectations and frustration
Social isolation and loneliness	
Trials and jail	
Unstable housing situation and eviction	

Source: Author's elaboration

Conventional literature on mental disorders often identifies disadvantages as risk factors associated with the onset of depressive disorders. In contrast, this analysis reveals a more intricate scenario in which social dynamics manifest divergently within a more advantaged and a more disadvantaged context.

As outlined in the methodology chapter, this research employs a comparative approach involving two distinct case studies of clinics situated within the same city. These clinics operate in the most and least deprived areas, both administered by the same hospital. This methodological framework aligns with the "most different systems" design (Cardano, 2020), with the strength of the outcomes stemming from the shared fundamental characteristics between the two cases.

The analysis shows that most of the conditions are reported in both the contexts studied. This has the following implications. First, the same social dynamics that affect individuals and trigger depression can be found in both the deprived and the wealthy areas. Second, both context-dependent and context-independent issues can be found in both contexts. The four categories that emerged in the analysis apply both to the more deprived (Blue Clinic) and the less deprived (Orange Clinic) context. The classification proposed in the previous paragraphs does not represent a repartition of social conditions and events between our contexts studied, the more socioeconomic disadvantaged context of the Blue and the wealthier context of the Orange Clinic, but they represent a theoretical division of which situations could provoke distress.

To be fair, while some of the conditions occurred in both contexts in a balanced way, others were affecting one context more than the other. Specifically, displacement from the original context, economic deprivation, debts, fraud, mobbing, single parenting, social isolation and work-related stress occur exclusively or way more often in the more deprived context (Blue Clinic). Conversely, existential meaning issues, future life-planning difficulties and working expectations and frustrations are more often or exclusively happening in the less deprived context (Orange Clinic). The analysis proves that there is some sense in the distinction between some problems that could be context-related and others that could be independent from the context.

4 Moving the analysis from contexts to individuals

In synthesis, the analysis shows an ambivalence regarding the relevance of the context in the emergence of depressive disorders. Depressive disorders occur for similar events in both deprived and less deprived contexts, but some of these events are more likely to appear in one context compared to the other. This can be explained by the fact that the two clinics are operating in two different areas, with different populations and social needs.

> "The Blue Clinic and Orange Clinic meet completely different social needs. The Orange clinic has a fairly affluent user base [...] Social needs are still present, but mostly people who still own a house in the area and have different economic needs. There are then some dramatic and particularly disadvantaged situations, but not as frequent as for the Blue Clinic, which covers a different area, with many public housing buildings."
>
> - Dr U, Social Worker, F, Orange Clinic

In short, the analysis should follow patients from an individual level, considering individual characteristics, socioeconomic conditions and disadvantages, as well as considering the context in which they come from. People from a lower social class are located, in our study, more often in the Blue Clinic area rather than in the Orange. Still, the conditions defined here should not be taken as mutually exclusive, for different reasons. First, we also cannot rely on a statistically significant sample to define which conditions are occurring more or less in the two neighbourhoods. As stated, this is not the aim of the chapter. Second, while the Blue Clinic area is characterized by a higher level of socioeconomic disadvantages, the clinic also covers a an area close to the city centre, where people from a higher social class are living. Third, the two areas are not intended to define a clear-cut division between poor and rich people, disadvantaged and advantaged, but instead some poverty and disadvantaged conditions can be present in the wealth context, and vice versa. Finally, most importantly, the conditions are not mutually exclusive between the two parts of the city. Losing a job or being in financial insecurity can happen also to people in wealth conditions. Similarly, self-realization and expectations can be relevant also for people who are in socioeconomic difficulties.

5 Three theoretical accounts for the occurrence of depressive symptoms

As said, epidemiological theories are limited to identifying possible social factors that occur together with depressive symptoms. Similarly, within this chapter, we tried to describe the social dynamics involved in the occurrence of depressive disorders, which we could observe in psychiatric encounters as well as in clinical records. The description itself is important, however, we can try to give some interpretation of these results by trying to provide a theoretical clarification of what is observed.

Attempting to offer a single overarching explanation or a comprehensive sociological theory for depression would be overly ambitious. Instead, we will explore three theoretical perspectives derived from psychoanalysis, sociology, ethnopsychiatry, and anthropology. These perspectives provide potential interpretations of the occurrences observed within these contexts.

5.1 Materialistic vs post-materialistic needs.

If we exclude factors that are unrelated to the context, it becomes evident that the last two groups of social dynamics under consideration (Socioeconomic disadvantages and Expectations, frustration, existential meaning) are related alternatively to a more deprived or a less deprived context. As mentioned earlier, the two clinics provide psychiatric services to two separate populations characterized by different social strata. Consequently, each population presents distinct needs for the attention of the practitioners.

We can differentiate, according to these two groups, between social factors that involve some needs that we will define as “materialistic” and social factors that involve “post-materialistic” issues. Materialistic needs and post-materialistic needs are concepts that describe different categories of human desires and necessities. Materialistic needs refer to basic physical and tangible needs and desires that fulfil the material requirements of an individual. These needs are often linked to survival, security, and physical well-being. Materialistic needs are generally considered primary because they must be satisfied to ensure an individual's basic survival and comfort. Post-materialistic needs refer to needs and desires that go beyond basic physical and material requirements. These needs arise when people have fulfilled their basic materialistic needs and seek to achieve higher purposes and attain emotional and spiritual well-being. Post-materialistic needs include self-actualization, self-expression, education, creativity, autonomy, political participation, social justice, environmental quality, and the search for meaning and purpose in life. These needs are often connected to values such as freedom, equality, personal growth, and self-fulfilment.

The division designed here is drawn from Inglehart's "The Silent Revolution: Changing Values and Political Styles Among Western Publics” (1977) and from Maslow’s paper "A Theory of Human Motivation" (1943). Inglehart's influential work (1977) revolves around the concept of post-materialism as a cultural shift in values and priorities within societies. The author argues that as societies become more affluent and meet their basic material needs, a new set of values

emerges, focusing on self-expression, quality of life, and non-material concerns. While this theory is based on values, it demonstrates the necessity of fulfilment of materialistic needs before moving to the post-materialistic ones. This resembles Maslow's theory (1943), where human needs can be organized into a hierarchical structure, where lower-level needs must be satisfied before higher-level needs can be pursued. The five levels to reach are Physiological Needs, Safety Needs, Love and Belongingness Needs, Esteem Needs, and Self-Actualization Needs. The hierarchy sees the necessity to fulfil the first needs, which we can define as materialistic, before moving to a higher level of needs, less materialistic but still recognized as important.

This division of materialistic/non-materialistic is controversial and requires explanations. According to our division, materialistic needs correspond to the whole "Socioeconomic disadvantages" group. In this case, these issues were mostly belonging to patients coming from the more deprived context. On the other hand, post-materialistic needs are well described by the "Expectations, frustration, existential meaning" category, and partially by the "Relational issues, stress and trauma" one. Again, we can find the neglect of materialistic needs as potential social factors that can trigger depressive symptoms in the most deprived area, while less likely in the wealthier. Post-materialistic needs, after all, could be found in both the contexts studied. Materialistic and post-materialistic needs are not mutually exclusive in none of the two contexts. Also, as explained before, individual distress can be triggered by more than one social issue, which means that patients are reporting a mix of life situations that can involve both materialistic and post-materialistic needs.

Given that, believe that it is most likely not necessary to say that Maslow's (1943) hierarchy is correct. Conversely, we can say that the fulfilment of material needs can be an additional problem for the most disadvantaged group, and represents further inequalities in mental health issues.

5.2 The Weariness of the Self

The second group of theories revise Ehrenberg's "Weariness of the Self" theory adding Freudian vision on mourning and melancholia and ethnopsychiatric theory on social ties and rituals.

Freud: "Mourning and melancholia": Freud's theory on mourning and melancholia (1917) is still used by the mainstream psychiatric and psychoanalytical theory for the communalities of

symptoms. Depression, according to psychoanalytical theory, is generally considered a reaction to the loss of a person or something significant. The loss is generally regarding a conscious "object" in bereavement, while a symbolical and unconscious object for depression. In most cases, the loss is associated with some ideal image that individuals have about themselves.

According to the founder of psychoanalysis, depression happens when certain losses are not elaborated through normal paths of bereavement. The libido moves from the object to the self, instead of moving towards a new object, leaving the outside world empty and without meaning (Freud, 1917; Lolli, 2009).

Ehrenberg: "The Weariness of the Self": Ehrenberg (1997) suggests that depression is intrinsic the contemporary society, where the rules of civil coexistence are based on responsibility and the spirit of initiative and, conversely to Freud's times, no more on guiltiness and discipline. From the 70's western societies were characterized by limitless possibilities due to the absence of prescriptive norms, leaving the individuals with the task to realize all their potential. In a context in which individuals are crushed by the need to always show themselves up to the task, which is mostly unlikely to be able to do, depression is nothing but the counterpart of the large reserves of energy that each of us must expend to become ourselves. Depression becomes the disorder representing contemporaneity.

Ethnopsychiatric theory - The importance of social support and rituals: Ethnopsychiatry found that different cultures developed higher protection from depression through the benefits of social support and community rituals, useful tools with symbolic elaboration for bereavement. However, due to the secularization and the deterioration of social cohesion, these elements are lacking. Contemporary societies leave no room to overcome losses, providing instead more space for depression (Carta et al. 2001; Coppo, 2005).

Combining the three groups of theories we can try to give a broader picture of how social factors are involved in the emergence of depressive disorders. Depressive symptoms emerge when loss is experienced, specifically, to losses connected to the inability of the realization of the self. As modern societies are demanding individuals to take the initiative to realize themselves. This happens not only when material conditions are hampering individual realization, but in general when the ideal image of oneself does not correspond to an individual's actual conditions. Moreover, as pointed out by the ethnopsychiatric theory, the lack

of opportunities to repair loss through community rituals within less integrated societies does not leave the possibility to elaborate bereavement, leading to depressive symptoms.

5.3 Humiliation and Entrapment

The entrapment model of depression, proposes that the experience of feeling trapped or stuck in aversive situations contributes to the development and maintenance of depression. It suggests that when individuals experience life events involving loss (whether it's the loss of a person, an object, or a cherished idea) combined with feelings of humiliation and entrapment, they are more prone to developing depression (Brown, Harris, and Hepworth, 1995; Coppo, 2005; Harris, 2001). According to our data, we can think that most of the dynamics considered can be understood in this model. The situation described sees individuals losing loved ones, jobs, properties, opportunities, perspectives, freedom, and in general their previous living conditions. Social dynamics described are interfering then with personal traits and coping abilities. People in the described situation perceive themselves as unable to escape or find solutions to distressing circumstances, they are more likely to experience depressive symptoms.

6 Integrating the multifaced nature of social dynamics in depressive disorders

The recognition of the multiple nature of social dynamics connected to depressive disorder led us to understand their occurrence with three different explanations. The socio-economic explanation, the cultural explanation and the entrapment psychosocial theory gives us insight on the emergence of depressive symptoms. It is important now to discern whether these theories regard these contexts as discrete and autonomous entities necessitating distinct explanatory frameworks or, alternatively, the potential validity of utilizing the same theoretical frameworks to comprehend the multifaceted nature of both contexts.

The first group of theories (materialistic vs post-materialistic needs) give the impression of separating the two contexts into distinct problem sets: one focused on materialistic issues and the other on post-materialistic ones. Conversely, it is not necessary to view the populations of the two clinics as completely separate groups. As previously mentioned, we believe that there is no hierarchy of needs, and it is likely that both sets of needs (materialistic and post-materialistic) must be addressed to prevent the occurrence of psychosocial reactive distress, such as symptoms of depression and anxiety. This implies that while one context only requires

consideration of post-materialistic needs, the other context also necessitates attention to socio-economic deprivation as a potential trigger. The pyramid is, conversely to Maslow's (1943), upside down, as in both the areas considered post-materialistic needs apply while, in only one of them, socioeconomic issues are present.

Ehrenberg's theory on the "Weariness of the Self" (1997), primarily focuses on situations where individuals are unable to actualize their full potential. This specific theory appears to be more closely associated with challenges experienced by individuals belonging to the middle-high social class, specifically the group of social issues previously categorized as "Expectations, frustration, existential meaning". However, we can imagine that all issues considered, according to this theory, involve a loss, and they are experienced in a way in which we are not up to be ideal as we would like to be, regardless if these losses involve materialistic or non-materialistic conditions. In summary, Ehrenberg's theory aims to understand the cultural components of depression by examining discourses related to contemporary self-construction, identifying them as the seeds of psychosocial distress and perceiving a narrative substrate underlying individuals' life, democratically permeating through discursive devices and the dissemination of "technologies of the self" (Foucault, 2005), such as psychoanalysis and pharmacotherapy.

Furthermore, theories of entrapment offer psychosocial explanations can complement these two perspectives, depending on personality traits. The possibility of feeling trapped and humiliated by a situation, which is also determined by a personological component and coping abilities, can either support the aforementioned theories or provide an additional perspective. The theory of entrapment can act as further confirmation of the presence of discourses related to self-realization as well as the risks of socioeconomic disadvantages. In the first case, individuals might narcissistically adhere to high standards of self-definition, attempting to keep up with a grandiose and unattainable self-image. Consequently, any misstep could be perceived as a situation of entrapment and humiliation from which it is difficult to escape. In the second case, it is acknowledged that entrapment situations are more numerous and more likely to be experienced by those who are most deprived. Such individuals face a series of life difficulties that can be interpreted as losses or bereavement.

Following this line, the theory of "Humiliation and Entrapment" holds applicability across all social conditions, as the sense of entrapment can be influenced by any circumstance that inhibits our ability to break free from it (Brown, Harris, and Hepworth, 1995; Coppo, 2005;

Harris, 2001). In accordance with evolutionary psychiatry (Gilbert, 2006), sociological research found that low social positions in status hierarchies, such as inadequate financial resources, oppressive work and family conditions, and serious personal health problems or those of close relatives and friends, naturally produce stress and consequently the development of depressive symptoms (Horwitz and Wakefield, 2007).

In conclusion, an attempt can be made to integrate the three theories into a comprehensive understanding of how social dynamics contribute to the manifestation of depressive symptoms. The fulfilment or lack of various needs plays a significant role, with different sets of issues emerging in populations belonging to different social classes. Despite the distinct nature of these needs, whether they pertain to socio-economic challenges or self-realization concerns, the inability to achieve individual goals can result in the internalization of societal expectations, leading individuals to experience a sense of entrapment. The relationship between desire and powerlessness explains something about depression.

> "The demand has changed a bit after COVID, especially in a reality like Milan. So, people in total burnout come to you in a state of unmanageable emotional overload, due to excessive demands at work, and everything is too fast and too much. So, they feel like they can't handle this volume of demands and continuous performance anymore, which is something I've noticed in recent years, especially here in a metropolitan reality like Milan... it has become truly impactful, where you are asked for more, faster and faster, you have to keep updating yourself more and more, and as soon as you stop for a moment, you're out of the loop. I see these anxious forms with depressive tendencies because you feel out of place.
>
> - Dr M, psychiatrist, F, Orange Clinic

7 Interventions: social needs or cultural change?

Cultural and social explanations, navigate the realm of a sociological perspective of depression, supported, respectively, by philosophical-political reasoning about the implications of discourses on individuals' mental health and by quantitative studies on the social determinants of depression. On one side we take into account how social disadvantages such as economic deprivation, debts, social isolation, eviction, and unemployment impact individual mental

health, on the other side it is important to understand their sense-making. In the words of one interviewee:

> "Undoubtedly, the disorder impacts social aspects in 99% of cases, but it's often the society itself that, in certain contexts, either originates the disorder or at the very least exacerbates it. I strongly believe that psychiatric disorders are often not just the disorder of the individual but also that of the context in which the individual is rooted. In my opinion, the problem many times lies within the context, and I would like to be able to act on this context because in many situations, I am convinced that it could truly be the linchpin."
>
> - Dr T, psychiatrist, F, Blue Clinic

On the other side, other needs not necessarily related to the social context, such as individualization issues, future-life planning difficulties, and expectations, highlight how it is not necessary to be in deprived conditions to experience distress, due to the aforementioned discourses on the self.

> There's not much to say: it's a crappy world where even compared to our parents, the living conditions are worse, and everything is increasingly privatized […] It's a crappy world where what matters is what you have, not what you do. I mean, I challenge anyone to feel good in a world like this, and it's not just that; it significantly contributes to the lack of meaning. Can the real meaning of life be having a cool car, making a lot of money? The whole TikTok video-making thing, becoming famous, becoming millionaires, OnlyFans... it's all nice, right? But can that really be the purpose of a human being's life? It seems so now. Horrible."
>
> - Dr J, psychotherapist, F, Orange Clinic

The recognition of the social dynamics involved in the occurrence of depressive disorders gives us the possibility, but also the duty, to think about possible interventions to reduce their manifestation. Although simplistic, but still important to mention, it's evident that individuals

with lower incomes and greater socioeconomic challenges are prone to developing disorders, a trend our analysis validates. Addressing economic and social needs, along with reducing inequalities, could alleviate distress among the most deprived segments of society. Welfare services addressed by the outpatient clinics themselves are important to overcome at least the forms of distress that are a reaction to socio-economic disadvantages. Given that, this solution would not be enough to provide a real response to the contemporary problem because part of the problem is not merely socioeconomic (again, "materialistic"), but rather cultural ("post-materialistic"). As said, discourses on the self permeate bodies and unconsciously inform us on how to feel about our success and unsuccess. Healthier discourses on self-realization and life goals should be promoted as well, to avoid the negativity of individualistic and neoliberal perspectives on the self, which are proven to be dangerous for well-being, giving space to the experience of bereavement and loss.

8 Are more deprived people more likely to be depressed than less deprived?

One of the questions always raised during my fieldwork experience by colleagues and scholars was: are people in the more deprived context more likely to develop depression than people in the less deprived context? The answer to this question cannot be provided, as this research does not employ quantitative methods but rather qualitative ones. However, we can draw some considerations from the ethnographic experience to provide at least some information and help the reader to draw some consideration regarding inequalities and depressive symptoms.

The quantity of patients, as well as the severity of their condition, are aspects related to several conditions. From our observation, we can say that the Blue Clinic (situated in the more deprived area) has around one thousand patients who are regularly using the service, while the Orange Clinic (situated in the less deprived area) has around three or four hundred, which is one-third of the patients[47]. Let's discuss how this is possible.

While we don't have data on the proportion of patients with depressive and anxiety symptoms in the two clinics, we can say that in any case the amount of them was prevalent in the Blue Clinic. This can depend on two main factors: the actual prevalence of depressive symptoms in one of the two areas, and the extent of the utilization of the service. First, as we showed in our analysis, people from the Blue Clinic area report additional forms of socioeconomic

[47] Given the small number of patients consulting the clinic, the Orange Clinic is also employed as a specialized clinic for some other specific diagnosis.

disadvantages compared to Orange Clinic's population, and this increases the chances of developing depressive symptoms. This is confirmed by data shown in Chapter 1, where the less educated and the lowest income population have more chances to experience depressive symptoms (Eurostat, 2021; Istat, 2018). Then, the size of the area: the area served by the Blue Clinic is bigger and more populated than the area served by the Orange Clinic and this, excluding other conditions, should provide a greater number of patients at the first clinic. As the head of the territorial services explained:

> "The Orange Clinic area has a smaller population compared to the Blue Clinic area and, above all, it is much a less disadvantaged population. Therefore, there are probably people who have mental health problems but do not refer to the CPS, while the Blue Clinic attracts everyone."
>
> - Dr E, psychiatrist, F, head of the territorial services

However, this cannot justify the wide difference in terms of the Blue Clinic treating three times the patients than the Orange. Two additional factors related to the socioeconomic characteristics of the population can influence the likelihood of seeking help at the local clinics when needed, either increasing or decreasing the probability.

Individual economic means can make any person with depressive symptoms be keener to seek help from a private clinician, rather than going to a territorial public clinic. This can happen for several reasons. First of all, to be scared of the stigma of being addressed as "crazy" or "mentally ill". Psychiatric issues, including prevalent conditions like anxiety and depression, continue to be discursively linked to feelings of shame or perceived weakness. For this reason, people prefer not to show others the necessity to go to a psychiatric facility in order not to be stigmatized, and this is specifically true when it comes to going to a public facility. A psychiatric interview done in a private practice can provide a higher sense of privacy.

Also, public psychiatric facilities, even outpatient ones, are still recalling the idea of old asylums. Aesthetically, most of the public facilities are in old and crumbled structures, with waiting rooms in untidy and crowded spaces. This is confirmed by professionals working in the clinics.

> "In general, the facilities are terrible aesthetically. They don't look like healthcare contexts. Think that in any case a chronic person already lives in a situation of suffering, they usually also live in houses where the environment is not welcoming, and there are situations of really strong discomfort so this person should move from the house to a place where everything it's a little nicer, tidy, etc. The word itself: this is a place for *care* and we must start from ourselves. I would absolutely commit to the reconstruction of the structure. This is a simple thing. However, in my opinion, we need to work on our hospitality, on beauty in terms of care."
>
> - Dr C, Psychotherapist, F, Blue Clinic

These spaces are also frequented by patients characterized by different severity, and this means that patients with non-severe conditions such as anxiety and depression might encounter patients in crisis or acute conditions while waiting for their interview. This can sometimes be bothering patients, that might be impressed by situations which might not be often exposed. The fear of encountering severe and discomforting situations can be a reason to choose a private practitioner. A patient expressed this openly during an interview:

> "It hurts me to see the lost gazes of other patients in here. Mental illness is not like physical illness"
>
> - Patient #45, F, IT, Blue Clinic

Finally, having an appointment in a public clinic requires at least some weeks or a month, while an appointment with a private doctor might require less time. Again, another reason for this choice could be the idea that private doctors can give more attention to patients compared to the ones working in public clinics.

As a general result, we might say that the higher the economic possibility of patients, the higher the chance they will be more likely to choose a private clinician rather than a public service. Imaging all other conditions being equal, the Orange Clinic tends to be less utilized by people in need compared to the Blue Clinic. This is specifically true for anxiety and depressive

disorders, where people generally need only at most the help of a psychiatrist and a psychotherapist, and in a few cases by other professionals[48].

Another social condition that is relevant when we are talking about access to the clinic is the level of education. Education is one of the dimensions that best predicts adult health. Education plays a fundamental role in providing the necessary skills to access, understand, evaluate, and use information to improve one's health, forming the basis for one's *health literacy*. Individuals with low health literacy tend to make less healthy choices, engage in riskier behaviours, experience poorer health conditions, have limited self-management abilities, and face a higher number of hospitalizations (Nutbeam, 2008). In the case of mental health problems, people with lower educational levels can be less able to recognize symptoms, manage their wellbeing and prevent further complications (Furnham and Swami, 2018). In the case considered, the inhabitants of the Blue Clinic have a generally lower educational level compared to the Orange Clinic, and for this reason less able to consider their symptoms something to be checked or cared for. This means that, *ceteris paribus*, people from the Blue Clinic have a lower propensity to check their symptoms at the territorial clinic.

Higher immigration rates in the Blue Clinic area might have the same effect: people with diverse cultural backgrounds may not be aware of the possibilities of treatment for their symptoms and also discourage individuals from seeking help for their mental health issues because of different beliefs and representations of them. Income, level of education and migration rates are social factors that can be interrelated, developing further disadvantages in access to psychiatric services.

These latter aspects raise some questions about the severity of symptoms in patients attending the two clinics. In both cases, professionals interviewed claim that those who seek private services exhibit significantly less severe symptoms.

> "The patients I see here have much lower functioning compared to those you see in private practice who have higher, more neurotic functioning. The latter are generally more well-adjusted individuals who bring different issues, namely more existential, relational, and

[48] Public clinics' care is essential for patients with other severe psychiatric conditions, that require the care of the whole equipe through individual programs, and there are not many private clinics that can offer such multidisciplinary care.

> possibly even work-related problems [...]. Instead, in the cases I see here, I observe more complex problems, of emotional and identity stability [...] The reality I see here suggests the presence of disorders with a more psychiatric than psychological connotation, honestly."
>
> - Dr D, psychotherapist, F, Orange Clinic

We do not have statistical data to prove the following affirmation, but if we consider only this aspect, the selection bias makes the Orange Clinic the one with more severe symptoms, and this can be proven by the higher number of patients of the Blue Clinic, as it is also the context where people face more disadvantages. Nevertheless, the lower ability of the population of the area of the Blue Clinic would make only the ones with severe symptoms take into consideration the clinical help. All these aspects make the situation uncertain.

To conclude, while we cannot provide statistically accurate information regarding the lower or higher presence of patients with distress in the two areas, we wanted to show here how socioeconomic inequalities are not only affecting people as potential triggers or factors related to depressive disorders, but that have their role regarding the possibilities of getting access to clinical help.

9 Inequalities in means to overcome depressive symptoms

Inequalities represent a further problem when it comes to providing care. The ones who have the additional disadvantages, who are at more risk of developing depression due to all the dynamics presented, have also fewer means to face these situations. As we observed from the data presented in Chapter 1, there is a greater occurrence of depression within the lower socioeconomic strata. The limited resources available to cope with this condition further exacerbate the challenges in mental health faced by this population.

We can now present here a discussion to discuss which capital or means patients can rely on when it comes to relating to depressive and anxiety disorders. Some of the capital exposed here (economic, cultural, social) comes from the classical division by Bourdieu (1979), while other dimensions are recognized as relevant from our fieldwork data.

Economic capital

Economic means can be relevant to overcome depressive symptoms. First, people with higher economic capital might have fewer socio-economic problems, are in a safer position in case of employment loss, can afford caregivers to take care of children, the elderly and people with disability in the family, and are less likely to risk eviction or being in the unstable housing situation. Given that, people with higher economic means can have access not only to public healthcare but also to private. As said mental healthcare services are provided also by private psychotherapists, psychiatrists and even from educators and nurses. It is easy to think that economic means are very much relevant in these situations to avoid queues and waiting, both for psychiatric and psychotherapeutic treatment. For the latter, it is specifically true. As showed in Chapter 6, the availability of psychotherapeutic treatment is insufficient for public service, and having higher economic capital permits to get access to private psychotherapists. Given the financially demanding costs of psychotherapy, and recognizing the importance of psychotherapy to treat depression, we recognize that economic capital is very important.

Cultural capital

Cultural capital is important first of all possibility when it comes to economic disadvantages, such as guaranteeing a higher possibility to find a job when lost. In Bourdieusian terms, to be converted into economic capital (Bourdieu, 1979). However, in these situations, we already stated how to higher level of education is associated with higher abilities to take care of health conditions. People with higher cultural capital are more likely to be able to recognize, treat, and overcome depressive symptoms than others.

Social capital

The role of social capital in overcoming depression is ambivalent. As we can see, some of the issues reported as significant for the emergence of depressive symptoms are connected to unhealthy relationships, breakups, and concerns bound to other people in the family. However, it is important to state that generally social ties are very much relevant for the patient to be sustained during the occurrence of the distress.

> “The family was against her. She lives with roommates who take care of her. She hurted herself and the roommates took her to the clinic. She is lucky to have these roommates who are close to her”
>
> - Dr T, personal communication concerning patient #3, F, 22 y.o., Other, Blue Clinic

Psychiatric outpatient clinics and welfare services

The implication of the CPS in alleviating patient distress extends beyond the clinical realm. Considering the disparities in economic, cultural, and social resources among patients, which play a crucial role in overcoming challenging circumstances, psychiatric services assume a supportive role aimed at levelling these disparities. As previously mentioned, these services offer social workers support to ensure access to welfare programs, secure economic benefits, and facilitate access to public housing. Also, beyond clinical treatment, psychiatrists and psychologists are actively engaged in assisting patients in shaping their life goals and plans. This involvement goes beyond recognizing patients' potential and motivating them during sessions; it also involves enrolling them in educational and vocational programs designed to aid individuals in need.

While psychotherapy and pharmacological treatments can be effective in addressing specific situations, it's important to acknowledge that, if in certain instances underlying structural and material issues persist, eliminating the distress could prove more challenging.

> “But who cares about psychotherapy is that the person has no money to live. Social issues must be solved with social interventions.”
>
> - Dr K, Educator, F, Blue Clinic

Clinical help and therapeutic relationship

We should also consider the importance of the therapeutic relationship that clinical help provides to patients. A strong therapeutic alliance is consistently linked to positive treatment

outcomes (Coppo, 2010). When clients feel understood, supported, and valued by their therapist, they are more likely to engage in the therapeutic process, follow treatment recommendations, and experience positive changes in their mental health and well-being. According to some literature, the therapeutic relationship itself can treat depression even without any form of medication involved (Coppo, 2005).

> "He hasn't taken any medications or treatment. He came for a chat […] He prefers to be in contact with us. If he doesn't come to the clinic, he experiences somatizations. His wife is sick."
>
> - Dr T, personal communication concerning patient #33, M, 68 y.o., IT, Blue Clinic

Additionally, our observations indicate that the CPS serves as a social anchor for patients with limited social capital. The clinic can also function as a site for mitigating social isolation by providing resocialization programs, and fostering a sense of connection and belonging among patients.

10 Inequalities in access to psychotherapeutic treatment

A dedicated paragraph is reserved to discuss the accessibility of psychotherapeutic treatment. Examining the consequences arising from the scarcity of publicly available psychotherapeutic treatment in response to the demand, it becomes crucial to once again consider the impact on individuals with fewer financial and personal resources. As discussed in the previous chapter, psychotherapy can be a fundamental treatment to overcome many types of psychosocial distress of its transformative nature. Again, while access to pharmaceutical treatment is overall easy and affordable, we cannot say the same for psychotherapeutic treatment. Public services are offering free or pretty much affordable psychotherapy with a licensed therapist or trainee, but the offer is limited in terms of availability, duration and frequency. This means that the most severe cases are taken into account first, while the others have to wait or are excluded from this treatment. The only alternative is to find a private psychotherapist, whose therapy is not covered by the national healthcare system and can be a significant expense for some patients.

In general, psychotherapy is more likely to be used by the most educated and wealthy. The scarcity of public-funded psychotherapy and the high costs of private one makes it more likely to be used by the ones with higher financial means, compared to the poorest. However, financial resources are not the sole to be taken into consideration when contemplating access to psychotherapy.

Cultural capital also holds significant importance. Mental health literacy is the ability to obtain, understand, and use health-related information and services effectively to make informed decisions about their mental health (Furnhgloam and Swami, 2018). People with higher education are more likely to understand that psychotherapy is an important tool to overcome psychological distress compared to the less educated. People with higher education experience then a higher socialization to psychotherapy compared to the lower educated. The effect of low education and income levels is twofold. On one hand, as seen, people with lower education and income are more closely associated with the onset of depressive symptoms; on the other hand, we must then consider the fewer opportunities and abilities they have to address such symptoms through psychotherapy.

11 Limitations of the analysis

11.1 Who determines which social factors are relevant? An epistemological discussion

This analysis encounters some limits. First, social factors that we identified as possible triggers for depressive symptoms are based on patients' accounts expressed during the interaction with the psychiatrist, as well as on the faculty of the psychiatrist to register them on clinical records. As said, what we consider as social dynamics what the patient, the psychiatrist and the researcher recognize as relevant and connected to these conditions. This poses an epistemological question: are those social actors able to define what is relevant to the distress? These three different actors use three different sets of knowledge. Data show that patients use common sense and their experience to determine which factors are involved in depression, psychiatrists use as well common sense (Bergmann, 2016) as well as practical knowledge learned through clinical practice, the researcher is using both common sense and scientific knowledge coming from the sociological discipline. What is reported on clinical records, is what psychiatrists, psychotherapists and other professionals have selected and consider relevant to define the distress of the patient, and cannot be taken for granted.

Using a constructionist approach to social problems, ethnomethodological critics would say that in this chapter we are not providing an analysis of the characteristics and causes of social problems, but a reconstruction of the activities that define the phenomenon as a social problem (Kitsuse and Spector, 1973). In the situation pictured, three groups of actors (patients, professionals, researchers) are defining what are the issues that can determine the occurrence of depressive symptoms.

In psychiatric interviews the actors are playing in the interaction their narratives and points of view to determine the "causes" or the dynamics involved in each situation, which could be social, psychological or biological. From an ethnomethodological perspective, the discourses reproduced in these interactions are used to maintain the expectations regarding what is an *accountable* representation of distress (Garfinkel, 1967). Let's take this fieldwork extract:

> "Yes, but it's not just seven years of mourning. It's also, twenty years for cancer and its therapy. Then I made some professional choices that were serious mistakes. One tries not to worry others while, instead, is not thinking much about it."
>
> - *Patient #38, 69 y.o., F, IT, Orange Clinic*

In this extract, a lady is describing what she thinks is the reason for her distress, naming different problems (mourning, cancer, bad professional choices). In the same way, professionals are describing and making accountable why patients are facing their distress. This happens with patients, to explain why they think they are depressed, as well as in equipe meetings and discussions with other colleagues and the researcher. Another example from a clinical record.

> "He has plans for the future and vitality, but right now he cannot see anything else than present actions. In March he had a daughter who activated experiences about his adoption."
>
> - *Clinical record for patient #18, M, 23 y.o., IT, Orange Clinic*

There are situations in which patients and professionals agree agreeing one another about which situations and events are relevant to make accountable the depressed situation of the patient. In other cases, although, professionals and patients might disagree. As we can expect, power relationships are in favour of professionals (Palmer, 2000), whose visions are the ones that will be taken into account for patients' treatment. What is considered true or not is the professionals' account, reported in clinical records, which are considered from both a clinical and legal perspective the "reality" regarding patients. In most cases, however, patients and professionals agreed on recognizing the same relevant conditions and events.

> "The patient identifies the reason for her distress in a split between life in Italy and that in her home country. She reports relationship problems."
>
> - *Clinical record for patient #56, F, 41 y.o., Other, Blue Clinic*

In the end, the researcher was able in most of the cases to get both patients' and professionals' accounts, participating in psychiatric interviews, equipe meetings and having access to the clinical record. The researcher can decide which accounts were more accurate in describing each situation, whether the patient's, the professional's, or both. Of course, also the researcher's point of view can be biased from his perspective and his professional knowledge. We hope that providing extracts from fieldwork data can convince the reader about the interpretation given.

Getting back to our epistemological reflection, we stated that the causes of social problems are not the social processes that determine the condition but the processes that define the condition as problematic. In this way, the definition of something as problematic does not depend on the intrinsic "nature" of the condition. There is something external, namely the process of defining them as social problems, in which different actors are involved (Caniglia and Recchi, 2018; Kitsuse and Spector, 1973). In this chapter the definition of what is a social issue for depression happens twice: once, when we describe which problems are considered by professionals and patients regarding the emergence of depressive symptoms. Then, when we are doing our sociological examination of the social issues and dynamics involved in depression, building scientific knowledge and contributing to the definition of the social problems themselves.

11.2 Other limitations

Once more, as we posed in the literature review, psychiatric theory lacks causal models on mental disorders but instead defines a biopsychosocial model to understand which factors can enhance disorders more than others (Borrell-Carrió et al., 2004; Engel, 1977). The biopsychosocial model is only a theoretical division helpful for scientific reasons to better understand disorders while, in reality, it is not possible to divide these dimensions. The focus of a sociological investigation primarily lies on social factors. However, it's crucial not to ignore the significance of biological and psychological aspects in understanding the functioning of individuals. In fact, on clinical records, psychiatrists were also recording information about familiarity, cognitive decline, personality traits and childhood traumas. The social dimension here considered was mainly regarding recent or actual conditions or events that were providing depressive symptoms as a reaction. However, the past psychosocial situation of the individuals is essential in understanding mental disorders, as the definition of inner structures of the mind is the starting point for individuals' distress. In this way we are not referring to the emergence of depressive symptoms as a response to events that are occurring for the whole lifetime, but for a significantly shorter but indefinite period. In the same way, patients' perspectives on which causes are relevant for patients' condition are, in our analysis, filtered by their perspective on their life, which we cannot prove is or is not accurate.

This qualitative analysis does not aim to present a statistically precise depiction of the varying occurrences of problems in the two contexts. Conversely, we tried to provide a more organized analysis through the codification of the social dynamics and events reported in interviews and clinical records. Moreover, to steer clear of adopting a positivistic paradigm that oversimplifies the link between social dynamics and depressive symptoms, we furnished fieldwork notes and excerpts from interviews. This enriched comprehension of these dynamics underscores their recurrent emergence in the interactions between the psychiatrist and the patient.

12 Conclusion

The chapter aimed to define which social dynamics are involved in the occurrence of depressive disorders, and how inequalities play their role in that. Our analysis showed the existence of both context-related and context-independent issues that can be relevant to the emergence of depressive symptoms. Both the contexts related and independent are happening in both the contexts studied. Yet, due to the differences in terms of social classes living in the

two neighbours, the issues concerning socio-economic disadvantages and self-realization issues were more likely to be present in one context than the other. Also, under the same conditions of distress, patients are characterized by access to different means (economic, social, cultural) to overcome distress, providing different opportunities and trajectories.

Literature in the sociology of depression either sticks to showing which individual and social factors are occurring in a small sample, through the use of quantitative methods and generally without providing proper explanations, or conversely, political, philosophical and sociological literature propose general theoretical reasoning without empirical data. This chapter represents one of the few examples of empirical assessment on general socio-anthropological theories using an inductive approach, starting from observation, through codification of the information gathered, and trying to provide theoretical explanations.

This study can also be a starting point to reflect on which type of interventions can reduce such a high prevalence of depressive symptoms in the general population. As said, part of the distress is related to socio-economic disadvantages, and the fulfilment of economic and social needs can enhance the psychosocial well-being of the general population. Social support can also be a tool to prevent unhealthy bereavement patterns. Although these things are very important, the increase of the phenomenon is also cultural, and yet a cultural change is necessary through the promotion of healthier discourses regarding self-realization and life goals.

Finally, easy and public access to psychotherapy and its promotion as a tool to overcome distress could be an important way to tackle the problem, specifically for social strata which are not able to afford it privately. Healthcare institutions, clinics and professionals should take into account this aspect while considering how depressive and anxiety symptoms occur for different reasons in different social classes and the opportunities for people to address them through clinical help. From our experience on fieldwork, the Blue Clinic proved to be aware of the special necessities of people living in the area, trying to address them through the introduction of a second social worker in support of the only one working in the clinic and increasing the number of psychotherapeutic treatment available at the clinic. Still, due to the limits of the available public funded psychotherapy, although no patients were excluded from the treatment, some of them were placed on a waiting list for a few months. Their treatment is also intended to conclude once first significant improvement was observed, to accommodate new patients.

To conclude, we took the opportunity to overcome the limits of sociological inquiries on depression, which see on one side fragmented analysis that sees factors singularly intervening in depressive disorders without looking for a wider picture of macro social processes, and on the other side general macro theories lacking empirical support. In this chapter, we tried to connect what we observed on fieldwork with theoretical reasoning. The central question remains as to whether a comprehensive theory is essential, given our attempt to integrate three distinct perspectives. Alternatively, considering the intricate nature of this phenomenon and its inherent inconsistencies, might it be more advantageous to convey it through narration and description rather than explanation, and this chapter can be also read in this terms.

Conclusion

1 Theoretical and practical implications of the study

This dissertation tried to address the world of depression from a sociological standpoint. As stated in the introduction, mental health problems are still considered something mainly addressed by disciplines such as medicine and psychology, and very rarely by sociology. While the biopsychosocial model includes social factors as indispensable, sociological literature on mental health either sticks to a more historical and political view or conversely just assesses the effect of social variables on the probability of being depressed.

This dissertation rediscussed the concept of depression both from a theoretical and an empirical standpoint. The contribution of this thesis, one of the few if we consider Italian social sciences, is to study depression as a social phenomenon, to investigate with qualitative methods, and to understand narratives and practices accompanying this diagnostic category. As we are addressing depression not only as a medical issue or a psychological disorder but also as a social problem, this work will help researchers in different disciplines, such as medicine and psychology, to take in account also its social dimension. Providing an example of how an individual issue and a medical disorder is shaped though cultural and societal forces can provide a better understanding on the phenomenon. In this sense, if social research can underline the constructed aspects of disorders, other disciplines can concentrate their efforts on the biological and psychological features.

If depression is considered to be the second largest contributor to health loss and disability, there is a need to understand which social dynamics are involved in the distress. The thesis used patients' accounts and clinical records to understand these two aspects, letting emerging the social problems related to depression as well as which means are used to overcome this problem. The study also evaluates the practices of diagnosis and treatment, describing the possible different paths that patients follow from diagnosis to the cure. The research give insights about clinical definitions of depression and about mental illness categorization, illustrating how different representations of the disorder affect the development of the distress. Future research on depression can take in account this study as a contribution on the practices of medicalization of the distress.

Results from this research are relevant also for policy makers and society as whole. The study provide a description of the organized work of psychiatrists, psychologists and other professionals, which can be useful to improve their way of engaging mental disorders. Moreover, the study discusses the implication of the lack of psychotherapeutic treatment for patients in economic needs. Inequalities and their effects on mental health are also discussed as a potential area of intervention for policies.

To conclude, we decided to try to better clarify the implications of this study answering to some questions that emerged throughout the dissertation. We won't provide data and references for the current discussion; instead, we will guide the reader to the chapter where these topics have been previously covered. These questions also reflect on the actual status of psychiatry, both theoretically and practically, and the possible interventions to adopt to improve individual and societal mental health.

1.1 Inequalities and depression: is depression the disorder of wellness?

How come depressive disorders are more common in wealthier countries but at the same time, in these countries, they are more prevalent for people in the lowest social classes? Is depression the disorder of contemporaneity, defined by the imperative of self-realization and neoliberal discourses on personal success? Data, theories, and fieldwork experiences can lead to confusion. We briefly try to provide an answer to these questions.

1) Depression is a condition more prevalent in the Western world. Both data (Chapter 1) and sociological theories (Chapter 4) prove this idea that depression is a condition of the West, both for social change and diagnostic dynamics. First, as we have seen how some authors define this problem as the consequence of the advent of neoliberal capitalism, new discourses on the self and the disruption of social ties and rituals as protective factors (Chapter 4 paragraph 2). Second, the lesson of ethnopsychiatry about the pathoplastic function of culture in shaping mental distress, which means that depression does not exist and is not experienced in the same way globally, but instead what we are describing is something emerging in the Western context, both as a result of social change as well as shaped by diagnostic and medicalizing discourses on the distress (Chapter 3 paragraph 2.4 and Chapter 4 paragraph 3.4).

2) In the Western context, depression is more prevalent in the lower social strata (Chapter 1) and socioeconomic issues can be additional triggers for depressive disorders (Chapter 7 and 8). While the “Weariness of the Self” (Ehrenberg, 1997) and other similar theories generally

refer to the middle-upper classes, we can imagine that the gap between ideal conditions and actual life conditions can explain the higher presence of depressive disorders even in lower classes. Given that, in Chapter 8 we proposed also theories concerning the existence of both materialistic and post-materialistic needs as potential triggers for depression, as well as a psychosocial "entrapment theory", that integrates psychological and social dynamics in its explanation.

3) Less educated and lower income populations have less means to overcome depressive disorders. Less educated people are less able to recognize their symptoms as something to take into consideration, they are less able to use mental healthcare services and they have less access to psychotherapeutic treatment. In this way, in addition to the higher probability of developing depressive disorders, the less educated and poorest experience also lower possibilities for treatment. This constitutes a further disadvantage, and can also be an additional motivation for the higher prevalence of distress.

4) Finally, as explained in Chapter 3, let's not forget that the type of measurement used in assessing psychopathology prevalence uses a positivistic approach that embraces a position of detachment from distress. A positivistic approach ignores two main features regarding psychopathologies: diagnostic bias, which can produce overdiagnosis and misclassification of other conditions and cultural specificity of psychopathology. As we suggest to take into account the concept of depression should be analysed also taking into account the historical, cultural, and social contingencies.

1.2 Did the COVID-19 pandemic enhance the presence of depressive and anxiety symptoms in the Italian population, becoming a social problem?

As discussed in Chapter 1, data clearly show that the population in OECD countries is reporting a higher prevalence of depressive and anxiety symptoms during the COVID-19 pandemic. Some would claim that data is showing that depressive and anxiety disorders are increasing, and this increase is what makes depression a social problem. Conversely, it is the fact that it is more spoken about that makes depression itself a social problem.

Without refusing this evidence, we although want to give light to the potential increase of prevalence registered also due to the circulation and promotion of discourses concerning mental health issues provoked by the disrupting effects of the pandemic. In this way, we have to recognize that, in the same way as the epidemic of depression, we can hardly distinguish between the actual increase of distress in the Italian population and the increase of new

diagnoses obtained through this change in people's awareness of the problem. We cannot divide the object from the way it is measured and talked about (Hacking, 2008).

Discourses on the effects of the pandemic on mental well-being circulated through common sense, scientific discourses and media, and corresponded with government healthcare programs, such as the increase of psychotherapists working in public and private institutions or partially refunding the population that needed a psychotherapist. As stated in the introduction, characterizing depression as problematic isn't hinged on the intrinsic "nature" of the condition. Rather, an external element, specifically the process of labelling them as social problems, involves different actors, as noted by Caniglia and Recchi (2018) and Kitsuse and Spector (1973).

1.3 How can we recognize when depression is caused by internal and external problems, such as societal conditions?

As we stated in Chapter 3, we cannot talk about causes in psychiatry, but rather of risk factors. All the possible psychopathological conditions are the results of the interrelation between biological, psychological and social conditions. The interviews collected show that psychiatrists are aware that most (or even all) depressive conditions are triggered or enhanced by social conditions and individual life events. Similarly, all the psychotherapists interviewed believe that in patients is always recognizable some sort of psychosocial dimension that produced or activated those symptoms.

The dilemma lies between what is intrinsic and extrinsic. At first glance, anything can seem to be either intrinsic or extrinsic. It's possible to consider any condition as the result of some misalignment due to an external event, which could be associated with a loss. Conversely, it's also possible, as psychology does, to reflect on individuals' internal capacity to develop defence mechanisms that can protect you from these losses. Nonetheless, issues related to one's biological makeup and personality remain relevant.

Modern psychiatry sees the overlapping of social and psychiatric distress, whose boundaries are often difficult to define. Conversely, interiorizing the "causes" of individual distress and reducing everything at a psychological or biological level can hide the presence of social problems. Therefore, we suggest to take into account social and contextual factors regarding mental health problems without forgetting the biological and psychological ones, and embrace an holistic perspective on mental health problems.

As expressed in Chapter 4, it seems that social conditions have changed in recent decades, creating a pervasive need to be infallible in one's life, excluding any form of mourning, whether real or symbolic. In today's social context, there is an expectation to fully achieve oneself as the main goal of life. This context is strongly centred on individualism, where there are no longer restrictions on becoming who one wants to become, but there's also a lack of grand narratives, rituals, and social ties that once offered protection. However, one faces various difficulties: some are material, like poverty, while others are personal. With mourning eliminated from social life, individuals may be less adept at overcoming it independently.

1.4 What kind of social intervention can we expect to reduce this epidemic of depression?

The analyses in Chapter 7 and 8 had revealed that a portion of the distress stems from socio-economic disadvantages. Improving economic and social well-being can significantly boost the psychosocial health of the broader population. Social support also plays a pivotal role in countering detrimental patterns of bereavement. While these factors hold great significance, the prevailing increase in this phenomenon is fundamentally tied to cultural factors. Thus, it becomes imperative to instigate a cultural shift by promoting more constructive narratives related to self-discovery and life aspirations.

While access to pharmaceutical treatment is easy, convenient, and almost completely covered by the national healthcare system, psychotherapeutic treatment is insufficient and financially challenging for some patients. Ensuring easy and widespread access to psychotherapy, along with actively promoting it as a means to conquer distress, could prove to be a vital strategy in addressing this issue. This becomes especially relevant for segments of society that lack the means for public therapeutic support. Healthcare institutions, clinics, and practitioners should consider this aspect, recognizing the varied reasons behind the onset of depressive and anxiety symptoms within different social strata. Equal access to clinical assistance becomes pivotal in addressing these challenges across diverse social contexts.

Finally, the commodification of psychotherapy and pharmacotherapy reflects that the emphasis and responsibility are specifically placed on the individual, failing to recall the social context's responsibilities. Both primarily focused on the individual, the proposed therapies align with people's expectations, effectively addressing contemporary challenges in a world dominated by neoliberal capitalism. The internalization processes of distress as problems stemming from an individual's idiosyncratic characteristics also depend on a discourse of medicalization. It is

conversely possible to reverse this discourse, recognizing that the context negatively influences the individual and actively working on the latter to create a more favourable and healthier environment.

1.5 What are the primary challenges in ensuring adequate access to psychotherapy within public services

We can consider two perspectives: structural and cultural. Structurally, indicators show that the amount of psychotherapy hours provided by public services is insufficient and impossible to guarantee for all those in need. This relies on an organizational issue rooted in a specific cultural substrate: there's a lack of culture to consider psychotherapy as a serious, equally dignified therapy compared to pharmacological ones. Patients aren't always socialized toward psychotherapy due to a mix of rejection and scepticism and doctors fulfil their roles in the medicalization process, while public decision-makers are anchored in a biomedical view of mental health issues, coupled with a neoliberal perspective focused on public savings. In this way, psychotherapy remains an accessory, accessible privately or as a supportive intervention in severe cases.

The national healthcare system is not providing sufficient resources for psychotherapeutic intervention. In 2022 was introduced the Bonus Psicologo, which was an initiative that provides financial support to Italian citizens to cover expenses related to psychotherapy sessions (articolo 1-quater della legge n. 15/2022). In this case, the strategy opted for a "nudge" approach, gently nudging individuals towards buying psychotherapy sessions, instead of investing in public psychotherapy.

What potential solution can be expected? From the structural side, psychotherapy should be free and available for all the people in needs, and not only in severe cases. Then, there's an understandable cultural issue at its root. Patients, doctors, and policymakers need to stop considering mental health in the same way as physical health, where pharmacological treatment is essential to their solution. The biomedical model is outdated; the biopsychosocial model is what modern psychiatry believes in, acknowledging the psychosocial components of disorders. The specificity of psychiatric conditions requires specificity in treatments compared to other medical branches, making psychotherapeutic treatment indispensable. Revolutionizing the perspective on mental health by providing a new culture about it is necessary, both through awareness processes and by providing care.

1.6 What does healing from depression means? Discussing pharmaceutical therapy

Discussing the meaning of recovering, implies discussing the meaning of sanity and insanity, which can definitely convey a philosophical rather than scientific argument. This discussion would indeed require an in-depth exploration. However, when we speak about certain psychological conditions, it is anyhow important to ask ourself the boundaries between sanity and insanity, and from being healthy and suffer. Does suffering means to be unhealthy? And does being sane mean to avoid distress?

Discomfort often signals a recognition that something isn't working, although no one wishes to feel unwell, but suffering might be considered an almost inevitable condition. This is true if we think about stressful situations or losses, where a certain amount of distress is considered as normal and sometimes even a necessary reaction. If the individual is under the pressure of a societal context where bereavement is forbidden, where human limits are neglected and where socioeconomic issues are limiting the possibility to obtain a decent life, this confrontation with reality can determine conditions of psychopathological suffering, regardless any potential rational intent and perseverance. As psychoanalysis tried to teach since its foundation, the unconscious is stronger and wiser than the ego itself.

Some authors even claim that feeling unwell, slowing down, or surrendering might inadvertently be a revolutionary act in a capitalist and neoliberal context, where individuals feel the pressure of a performative culture (Araujo, 2006). In other terms, before madness and reason diverged during the “Age of Reason” (Foucault, 1965), there was once a recognition that madness held the capacity to perceive truth, and that was especially true for melancholics, who could have a clearer view of reality (Coppo, 2005). Melancholics appears to be paradoxically more able to cruelty and senselessness of reality in which us, as humans, are living, albeit not about themselves and their condition (Lolli et al., 2014; Freud, 1917).

What we discussed so far challenge the limits of sickness or health itself. Is it more sick to stick in unhealthy situations without experiencing distress or some forms of distress are then helpful for individual growth and to overcome certain situations (although recognizing the suffering experienced)? According to psychoanalysis - but this can be true for most of psychotherapeutic approaches – healing from distress can happen only by integrating the distress into patient’s own experience and personal history. True healing doesn't involve a return to the past, to a state preceding the distress, but occurs when the therapy becomes unnecessary (Lolli, 2009). But

being healed, from this perspective, doesn't necessarily mean being happy; it means being free. In this perspective, pharmacological medications don’t seem to free entirely the person from psychological suffering, but only from the obligation to confront conflicts.

Ehrenberg (1997), whose work has been enlightening for the work presented so far, poses a second dilemma: since we use aspirin systematically as a painkiller, why shouldn't we do the same with an antidepressant, provided it is harmless? By fostering the hope of alleviating psychological suffering in individuals who may not be properly depressed through appropriate mood stimulation, could an entirely artificial well-being insidiously take the place of true healing? Is suffering useful?

At the foundation of the concepts attributing therapeutic omnipotence to antidepressant psychopharmaceuticals for every form of depression lies an inclination towards an unrelenting "reduction" of psychological events into biological occurrences. These notions assign drugs the ability to standardize patterns of experience and emotions, stripping away any creative emotion and personal way of experiencing and processing life events. This constructs a way of life devoid of depth and contemplation, where one is immersed in a standardized emotional state marked by the erasure of sadness, preventing thoughts and reflection on life's contradictions. From this perspective, it is not only unimportant to distinguish between a depression of neurotic origin and an endogenous depression, but also to recognize the presence of simple existential sadness from sadness resulting from a life event. This leads us down the path of indiscriminate administration and use of antidepressant drugs: in the desperate and reckless attempt to erase any form of suffering and sadness that could overwhelm, or even just touch upon, each of our existences.

The author suggests that, while antidepressants are not "drugs," indeed, and they do not create dependence, the risks associated are in terms of endless medicalization, considering their efficiencies on symptoms but not addressing the causal factors, losing its therapeutic effectiveness when discontinued. Simply taking an "antidepressant pill" and instantly being happy perpetuates a triumphant and unstoppable cycle of efficiency and productivity. Anxious and depressive symptoms can act as warning signs related to stress or traumatic events. They can also push towards resolving situations and discovering helpful strategies.

Is there a compromise between feeling good, avoiding suffering as much as possible, and the need for growth and acquiring the ability to face situations that psychological therapy might

encourage instead? We believe we have addressed these questions, but we still leave it to the reader to define their own responses.

2 Limitations and further development

2.1 Methodological limitations

First, the study does not take directly patients' accounts and experiences through interviews but only through the observations of their clinical interviews and records. This was hampered by the actual involvement of the patients in the study. Interviewing patients was in contrast with the regular everyday activities of the clinic, and we preferred to observe their presence at the clinic without soliciting further. We instead have patients' points of view

A second methodological limit regards the number of interviews (twenty-eight) which are also regarding different professionals (psychiatrists, psychotherapists, nurses, educators, social workers). Having five groups of professionals means that the number of interviews for each professional category is small. However, we are not worried that this would hamper our analysis for the following reasons. First, most of our analysis regards the opinion of psychiatrists and psychotherapists, who compose two-thirds of the interviews. Second, our sample was limited to the people working inside the two clinics, and we covered most of the people working there. Third, interviewees reached a consensus on the majority of the explored topics, indicating a high level of saturation within the sample. Fourth, our study include data collected with the use of other qualitative methods. Finally, we compared the information obtained with the preliminary interviews collected before starting the fieldwork (fifteen) with the interviews from our sample and we found similar outcomes. As preliminary interviews involved professionals from other psychiatric services inside and outside the city of Milano, the comparison revealed a certain robustness to our analysis.

We might pose that professionals interviewed could be particularly open towards the holistic and biopsychosocial model of mental health compared to people working as private practitioners because, as explained, working in a multidisciplinary equipe means being in contact with other professionals from different disciplines. At first, we were considering engaging private psychiatrists and psychotherapists in our interviews but subsequently changed our strategy, primarily because it would have been challenging to associate these professionals with a specific territorial area, as we did in our analysis. Moreover, we observed that the

majority of the private professionals we considered as potential participants were also concurrently employed in public institutions[49].

Another critic can regard the selection patients, as it is excluded from our analysis the population that decides to proceed with private treatments, which represents a part of the wealthier social strata. Our sample could be then more unbalanced towards the lower social strata than representing the actual population of the two neighbourhoods[50]. However, services were used by people of any type regardless of their education, professional and economic situation and social class. Our analysis, also, does not pretend to be statistically representative.

Finally, as written in Chapter 8, while using the analysis of clinical records and the observations of psychiatric encounters, the identified social factors contributing to depressive symptoms are drawn from patient narratives shared during interactions with the psychiatrist and documented in clinical records. Our perception of these social dynamics coincides with what patients, psychiatrists, and researchers acknowledge as pertinent and interconnected to these conditions. What's documented in clinical records represents the deliberate selection by psychiatrists, psychotherapists, and other professionals, indicating what they consider essential in defining a patient's distress. Nonetheless, it's important to avoid assuming these records as unquestionable truths. We guess that only extensive psychoanalysis of the patient could determine which conflicts happened inside each patient, giving us the possibility to determine which social factors intervened as elements for the distress[51].

2.2 Gaps and further development

The first gap regards the point of view of the patient, their account towards their condition and their opinion regarding the way they are diagnosed and treated, as we explained in the previous paragraph. The narrations of depression and their opinion of which social dynamics are affecting their condition, as well as their opinion on diagnosis, is something investigated by other sociological inquiries[52]. Of course, further research could follow this line to fill the gap.

[49] In fact, on the other side, many of the professionals that we interviewed were also working privately.
[50] We discussed all the possible biases regarding the sample of patients considered in Chapter 8.
[51] To complete the information gathered in the empirical chapters, we remind the review of quantitative studies that explored the association of certain social problems and the emergence of depressive symptoms in Chapter 3. However, in Chapter 2 we also criticized the possibility of these studies to measure and assess the presence of depression in patients, which motivated the use of qualitative methods for this research
[52] We report, among others, studies by Grippaldi (2022; 2023), Karp (1996), and Kangas (2001).

Speaking of patients, we have explained how one of the possible factors explaining the increase in the prevalence of depression is the lack of rituals and, in general, the processes of secularization. However, even in the most secularized societies, rituals exist such as interaction rituals or the daily micro-rituals that characterize our lives (Collins, 2004). The absence of religious rituals, the secularization of beliefs, and the rationalization of the world do not imply that secularized micro-rituals have not remained or been created to help individuals overcome such situations, as seen, for example, in mourning. Ritualistic behaviour serves as a coping mechanism, aiding individuals in addressing depression. This understanding underscores the development of policies, as individuals consistently engage in activities to manage and overcome depression. By comprehending these individual coping mechanisms, one can brainstorm potential policies aimed at supporting mental health. This could be a future line of investigation to pursue using qualitative methods.

Then, we explained in the previous paragraph why we did not consider private professionals in our study. In the same way, some studies are considering also general practitioners' points of view towards depression, and their treatment attitude[53]. While our study was set inside the walls of the clinics, others could consider their previous phases taking into account the contexts and people that send patients to clinics, which are general practitioners and emergency rooms.

[53] See, among others, Thomas-McLean and Stoppard (2004).

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Methodological appendix

Ethnographic Note - Emotions and positionality while doing research in mental healthcare contexts

1 Introduction

The following section is based on field notes recorded during the whole research process. These notes were taken specifically regarding my position as a researcher, my feelings, and my thoughts about what I was experiencing. Reflections were coming both during the observation and later, then gathered in a unique file as some sort of diary of my experience. The following section provides some reflections on methods as well as identify any personal tendencies in the interpretation of the results.

2 Overwhelmed by the emotions on fieldwork

I will start the discussion by showing some notes recorded four months after the beginning of the fieldwork, and a few days after starting my observations in the second clinic. These notes were written just after the observation, following the notes that I took specifically regarding an interview with a patient.

> "After lunch, I was in the reception office transcribing some notes on my laptop, when Doctor S came in the room to take the clinical records for his afternoon patients, asking me if I wanted to observe the next two patients' interviews. I quickly take my tablet to write notes, my facemask and run to his office, without thinking twice.
>
> Doctor S: "How are you?
>
> Patient: "I feel a bit of anxiety about my work situation"
>
> As the patient said the word "anxiety", I instantly started sweating, I felt breathless and could not concentrate on my writing. I recognize I am having a panic attack. Doctor T, some months before, taught me to keep the facemask - required in the clinic for both patients and doctors – on patients' mouths when they are panicking, and so I do this to time. I draw some lines on my tablet and I attempt to shift my focus towards writing, to concentrate on something else and overcome it. It works.

> I am ok. I start smiling a bit, under the facemask. Apparently, neither the patient nor his relative who was accompanying him, Doctor S or Doctor O realized it, probably taking care of the patient's case."

This episode made me think about possible emotional difficulties that I could be experiencing on fieldwork. I knew since the beginning that doing research in psychiatric facilities could be hard. I have seen any type of things since the beginning, I have heard of any type of problems, seen patients with basically any syndrome, voluntary and mandatory hospitalizations, and suicidal attempts. I always felt protected from being overwhelmed by these situations by the fact that I saw my colleagues doing the best they could and helping people. But, at that time, I was very much stressed, overworking, restless, and not feeling much accepted in the new clinic.

3 A matter of face and empathy

It did not take much to understand that this emotional outburst was happening because I was not allowing myself to express and let free emotions in those particular situations while taking part in the interaction between the patient and the doctor. Since the first days, Doctor T, who was my gatekeeper, strongly recommended staying silent and not interfering with the interaction between the doctor and the patient. This worked fine with me, as being as invisible as possible was turning out to be the best to record my data. Also, I was concerned that any interference from me could potentially be disturbing for patients in sensitive situations.

Even though the patients were most of the time not caring at all about my presence, I had also to learn quickly to fake all possible facial expressions that could be expressing any emotional response or follow the ones that the doctor was carrying on (laugh, smile, appear worried or sad, and so on). So, most of the time, when patients were telling the saddest story about their lives, I had to pretend not to be sad or crying and conversely not laugh when patients were saying funny things.

While this could appear necessary and somehow manageable, the difference between me and doctors was a matter of being active or passive in the interaction. Doctors have to deal with face management in interaction to maintain their position of authority and their alliance with the patient. Face-work strategies (Goffman, 1955) are used by professionals to hide certain emotions to maintain their face and role in the interaction. In any case, while emotional

management in the interaction for the doctor could be hard to maintain and require effort, doctors are an active part of the interaction and can respond to patients, both verbally and physically. Being in an “active position” can allow you to defend yourself from being overwhelmed by these emotionally dense interactions. On the contrary, I was taking notes always trying to be empathetic with patients’ experiences, while recording them, almost word by word, on my notes. It was very intense to collect many difficult stories and situations every day. It was all taking and nothing giving back.

The next day I tried to solve this problem, allowing myself some emotional reactions during these interactions.

> “Dr S, are there any interesting patients for me?” “Yes, many. The clinic is full”. I take a breath, enter the studio, and see the first patient, a middle-aged lady diagnosed as schizophrenic, accompanied by her husband. I was feeling nervous, but I kept on. Later, at the end of the interview, the lady says something very sad "When I was young, I used to drive my car 160 km per hour in the rain ... now I can't arrange the wardrobe. If it weren't for him [the husband], I would have died". The conversation was so sad that I could not hold it back. I realize that letting it go instead of faking it makes me feel better. I both smile and cry a bit, without showing it.
>
> The next patient complains of severe anxiety. She is nice. I feel sympathy, specifically when she said that this is a "crazy anxiety period". I feel the same, I nod. I allow myself to react a little, a minimum so that I will not “go crazy" myself.”

Masking completely my emotional reactions had its costs, and I realized that through panicking. The solution was found when I started to care less about it, guaranteeing myself some minimum space for interaction. I decided I could let my facial expression a bit more freely and move my body as a response to some specific stress, to recall my presence, there, at least for myself. This would not constitute any problem.

Denying my presence was not the best choice after all. To avoid any potential effect of this situation on my emotions and their consequent expression, I was denying my feelings. Emotions, however, are essential in understanding the situation while observing (Bergman Blix

and Wettergren, 2015). Empathy was achieved at the point of being overwhelmed by others' feelings, but even better achieved when even the researcher's emotionality was in play, instead of holding them and passively recording the interaction.

4 On which side of the desk? Positioning both as patient and professional

This situation had further implications: shall I talk about those symptoms to my colleagues? It's somewhat ironic that I didn't feel comfortable discussing that emotional disruption in a psychiatric clinic, considering it's precisely the environment designed to address such situations. I had the impression, all over my fieldwork time, that professionals were reluctant to show themselves vulnerable, not just with patients but also with other colleagues. I decided to see how it goes and not talk about it with my colleagues, fearing that confessing my feelings would somehow affect my access to the fieldwork, for being considered not appropriate to the described situations. This was supported by the way my colleagues were speaking in everyday situations, that suggested the idea of a clear division between patients (or users) and professionals. I got the impression that patients were consistently referred to as "them" by professionals, who instead used the term "us". Mental health professionals (me included) are on one side of the doctor's desk, and then patients, are on the other side. The two roles were divided, spatially, by the desk. Here is an extract of my notes from December 2022.

> "Sometimes it is difficult to think of myself as belonging to the same group of patients. I feel like we are playing an "us vs them" game. And I picture myself on this side of the desk, with professionals. But I mustn't forget that this is only a temporary role in a life-course situation, after all. Other times, however, I wonder if I am not already part of the patient group. After all, in the past, I had been a patient of an outpatient clinic as well."

What was giving me the possibility to stay on the "doctor's side" of the desk, instead of the other part? Thinking about it, both professionals' and patients' roles are temporary and bound to the specific situation, as also mental health professionals might become patients in other situations. Speaking of me, in my life I have been on both sides. Almost a decade ago I was a patient coming to this type of clinic seeking help for some anxiety symptoms. At that time, I started a pharmacological therapy with antidepressants, which I did not find very useful and,

only after finishing that treatment, psychotherapy, which I found beneficial and that is still ongoing.

Given the fact that I assumed the role of the patient in the past and later the role of the worker in the clinic, it is necessary to discuss the possible implications of this in analysing the data coming from the fieldwork. First of all, experiencing some of the symptoms of the patients studied could give me a much higher understanding of peoples' experiences, although my diagnosis was more in anxiety disorders compared to depression, and these disorders are experienced differently from one patient to another. I felt I was more able to understand, more empathic, and less distant with people with this type of distress compared to others. As psychoanalysis lately admitted, to understand others' neurotic symptoms we should recognize our own everyday small neurotic symptoms. Paying attention to one's own (small) psychopathological experiences allows understanding of the other in this process. All psychopathology belongs, to a small extent and never with the same consequences, both to the patient and the analyst (Musatti, 1987), and I guess this lesson could be useful also to understand the phenomenology of depression even from a sociological perspective.

Second, we have to discuss how much my experience as a patient, and the successfulness and unsuccessfulness of certain treatments were guiding my interpretations of data. This dissertation, and I guess it is clear, takes a stance for a higher promotion of psychotherapy as an intervention that could help patients because of its transformative nature, counterpoised to the static symptom-relief-based pharmacological treatment. Of course, this position is given not only according to my personal experience but also proved by the account of all the psychotherapists and – at least in theory, not always in practice – psychiatrists interviewed.

During the research process, some of my initial hypotheses were proven wrong and I genuinely changed my perspective according to what I observed. My interest in this research started from the unlucky experience, mine and of some friends, of being treated for psychosocial distress never with psychological interventions but always through pharmacological treatment. Following this belief, sociological literature was speaking of conflictual perspectives in psychiatric discipline that were also affecting the way psychosocial distress is treated. The fieldwork showed a different picture. The distinction between biological, psychodynamic and social psychiatrists can sometimes be still detected, as well as different schools and universities providing different training, but clinical practice most of the time converges. Finding a doctor with a purely biological psychiatrist was something I would say unlucky and uncommon

considering what I observed on fieldwork. The holistic approach, as explained in Chapter 6, is recognized as essential by all the professionals interviewed. The lack of use of psychotherapy had to be explained differently, and my initial mistrust of psychiatrists' way of working was revised. I hope this can justify my ability to be as honest as possible in giving interpretations, regardless of any previous experience, mine or the close ones.

Many challenging situations I have seen and experienced, and many other reflections came. However, I conclude the discussion here, questioning which limits should be given when discussing personal feelings and experiences, in the same way ethical boundaries and sensitive materials are respected in sociological inquiries.

Methodological materials: interview track for professionals' and patients' information

1 Interview track for professionals working at the clinics

Good morning, my name is Gabriele Cerati, and I am a doctoral student in Sociology at the University of Milan-Bicocca. I am conducting a research project on mental health, specifically focusing on certain forms of psychosocial distress, diagnoses, and how they are represented and treated. The research has a sociological approach, mainly exploring how it represents a social phenomenon and a socially addressed issue rather than focusing on its intrapsychic aspects.

In the coming weeks I will be conducting observations in this facility. Meanwhile, I will start with some interviews to understand dynamics related to psychosocial distress in preparation for this observation period. I'll ask you some questions, feel free to express your thoughts. There are no right or wrong answers.

(Non-directive interview. Let topics emerge spontaneously, in no particular order.)

Punchline: *(Understand the interviewee's role and activities)* a) So, to begin, could you tell me about a typical day in your work? What is your role within the CPS (tasks, division of labor, roles, etc.)? b) What other activities (professional and non-professional) related to mental health do you engage in outside of work? Are you part of any political association, third sector or research center related to mental health issues? c) What kind of training and path did you follow before taking on this job?

Nature and Characteristics of Psychosocial Distress:

1. How would you describe the **psychosocial distress** of those who come to the CPS? In your experience, what is psychosocial distress? What personal characteristics, life events, and contexts do you think can trigger these disorders?
2. In your experience, what does **depression** mean? What personal characteristics, life events, and contexts do you think can trigger these disorders?
3. *(If not already discussed)* Criticism of modern psychiatric taxonomies believes that the category of "depression" often fails to circumscribe a group of symptoms attributable

to a single disorder, instead often identifying a series of related disorders. Do you agree? Is there a with **anxiety disorders**?

Paths and Treatments: We've talked about a range of disorders characterized by anxious-depressive symptoms and mild/moderate severity and their determinants. I would like to know:

4. What types of **therapies** are recommended for treating depressive and anxiety symptoms? Give me examples of paths that patients generally follow, if possible, including the role of therapists in addressing treatment.
5. From my experience, I've noticed that pharmacological treatment is always present in the treatment of these disorders, while psychotherapy only partially. Why do psychiatrists tend to **prioritize pharmacological therapy over psychotherapy**, despite recognizing the importance of psychotherapy for reactive disorders?
6. In your opinion, which services are lacking and should be subsidized? Let's think, for example, about **psychotherapy**. What are the risks of the insufficiency of public psychotherapeutic treatment from the perspective of the National Health Service (SSN)? Are there other types of interventions (real or hypothetical) that could help people facing difficulties in this regard?

Representations and Conflicts: Let’s talk about different conceptualizations, ideas, viewpoints regarding the phenomenon of mental illness and depression

7. Do you and your colleagues have **different views on the nature of psychosocial distress**? Are there psychiatrists and psychologists with purely biological, psychodynamic, or social perspectives on the matter? Do different perspectives influence the methods and types of treatments offered to patients?
8. What is the purpose of psychiatry? What is the role of the CPS compared to privately offered services?

Conclusion: We have finished. Thank you again for your availability and time. If you have anything you'd like to explore, feel free to ask.

2 Interviews sample

The composition of the sample for the interviews is showed in Table A1.

Table A1- Distribution and Composition of Interviewee Sample by Clinic

	Blue Clinic	**Orange Clinic**
Psychiatrists	3	3
Psychotherapists	5	5
Nurses	4	2
Educators	2	1
Social Workers	1	1
Total	**16**	**12**

Source: Author's elaboration

In particular, seven psychiatrists were interviewed, including one trainee and one serving as the head of territorial services. Additionally, ten psychotherapists were interviewed, with four of them in training. The participants also included six nurses, two of whom held the position of head nurses, three educators, of whom three were psychiatric rehabilitation technicians, and two social workers. It's noteworthy that some professionals had experience working in both clinics at different points in their careers.

3 Observed patients' characteristics

Table A2 – Event or condition associated with depressive symptoms for patients of the Blue Clinic

BLUE CLINIC										
#	**Age**	**Gender**	**Nationality (IT/Other)**	**Event Or Condition Associated with Depressive Symptoms**						
3	22	F	Other	Sexual Abuse	Family Violence	Neglected by Family	Trials			
9	23	NB	IT	High Family Expectations	Conflictual Intimate Relationship	Social Isolation (COVID-19)	Working Expectations / Frustration			
10	35	M	IT	Conflictual Familiar Relationship	Future Life Planning Difficulties	Economic Deprivation	Substance Abuse			
16	55	F	IT	Widowhood	Bereavement	Substance Abuse In The Family	Conflictual Familiar Relationship	Economic Deprivation	Conflictual Intimate Relationship	Single Parenting Duties

				Unemployment	Loneliness	Family Member's Health Problems		
17	39	F	IT	Mobbing	Conflictual Familiar Relationship	Family Member's Health Problems	Bereavement	
22	56	M	IT	Work-Related Stress				
31	57	M	Other	Social Isolation (COVID-19)	Loneliness	Health Issues		
32	54	M	IT	Mobbing				
33	68	M	IT	Family Member's Health Problems	Concern Regarding Sons/Daughters Lives Situation			
45	n/a	F	IT	Separation	Fraud	Debts	Economic Deprivation	Concerns Regarding Sons/Daughters' Economic Situation

50	64	F	IT	Conflictual Intimate Relationship	Substance Abuse In The Family	Bereavement	Trauma (COVID-19)	Work-Related Stress		
52	39	F	IT	Single Parenting Duties	Work-Related Stress	Social Isolation (COVID-19)	Gender Roles Constraints			
54	82	F	IT	Widowhood	Concerns Regarding Sons/Daughters Work Situation	Gender Roles Constraints	Future Life Planning Difficulties			
56	41	F	Other	Conflictual Intimate Relationship	Displacement From The Original Context	Conflictual Familiar Relationship				
59	28	F	Other	Displacement From The Original Context	Social Isolation	Gender Roles Constraints	Autonomy / Individualization Issues	Economic Deprivation		
66	50	F	IT	Separation	Family Member's Health Problems	Conflictual Familiar Relationship	Work Dismissal	Trials	Economic Deprivation	Single Parenting Duties
84	52	F	IT	Work-Related Stress	Family Member's Health Problems	Health Issues				

85	50	M	IT	Work-Related Stress					
87	70	M	IT	Retirement					
90	52	F	IT	Substance Abuse	Separation	Single Parenting Duties	Conflictual Familiar Relationship	Future Life Planning Difficulties	
104	41	F	Other	Displacement From The Original Context	Concerns Regarding Familiar Life Situation	Bereavement	Economic Deprivation	Health Issues	War In Home Country
108	29	F	IT	Work-Related Stress	Conflictual Familiar Relationship				
109	54	F	Other	High Family Expectations	Conflictual Intimate Relationship	Conflictual Familiar Relationship	Work-Related Stress		
110	82	F	IT	Widowhood	Eviction	Bereavement			

111	26	M	IT	Substance Abuse	Autonomy / Individualization Issues	Social Isolation (COVID-19)				
112	36	M	IT	Bereavement	Substance Abuse					
114	54	F	IT	Mobbing	Disability					
117	54	F	IT	Disability	Economic Deprivation	Future Life Planning Difficulties	Health Issues	Separation	Unstable Job Situation	Bereavement
118	65	F	IT	Disability	Work-Related Stress	Conflictual Familiar Relationship				
119	n/a	F	IT	Separation	Conflictual Intimate Relationship	Family Member's Health Problems	Conflictual Familiar Relationship			

Source: Author's elaboration

Note: We decided to provide only a few demographic information for the patients (Age, Gender and Nationality) to guarantee the anonymity of the patients involved in the study. Gender categories represent Male (M), Female (F), and Non-binary (NB). Nationality is categorized as Italian (IT) and other nationalities (Other), for a higher degree of anonymity.

Table A3 – Event or condition associated with depressive symptoms for patients of the Orange Clinic

ORANGE CLINIC										
#	**Age**	**Gender**	**Nationality (IT/Other)**	**Event or condition associated with depressive symptoms**						
4	21	M	IT	Intimate Relationship Breakup	Substance Abuse	Existential Meaning Issues	Future Life Planning Difficulties			
5	47	M	IT	Working Expectations / Frustration	Autonomy / Individualization Issues	General Recurring Frustration	Loneliness	Health Issues		
7	26	M	IT	Disability	Conflictual Intimate Relationship	Future Life Planning Difficulties	High Family Expectations			
8	68	F	IT	Health Issues	Substance Abuse	Economic Deprivation	Conflictual Familiar Relationship	Bereavement	Gender Roles Constraints	Family Member's Health Problems

13	n/a	M	IT	Health issues	Disability	Future life planning difficulties			
16	39	M	Other	Substance abuse	Future life planning difficulties	Autonomy / individualization issues			
18	23	M	Other	Alleged fatherhood at a young age	Jail	Substance abuse	Economic deprivation	Displacement from the original context	
20	23	M	IT	Family violence	Parents lose at a young age	Violence witness	Conflictual familiar relationship	Unstable housing situation	
21	22	F	IT	Conflictual intimate relationship	Work-related stress	Working expectations / frustration			
24	54	F	IT	Working expectations / frustration	Unemployment	Conflictual familiar relationship	Future life planning difficulties	Social isolation	Existential meaning issues
38	69	F	IT	Health issues	Multiple Bereavement	Widowhood	Family member's health problems		

40	23	F	IT	Disability	Conflictual familiar relationship	Future life planning difficulties	Unstable job situation		
44	61	F	IT	Retirement	Future life planning difficulties	Bereavement	Social isolation (covid-19)		
45	60	F	IT	Separation	Conflictual familiar relationship	Fraud	Eviction	Unemployment	Concern for the familiar economic situation
49	32	F	IT	Conflictual familiar relationship	Family member's health problems	Social isolation (covid-19)	Intimate relationship breakup		

Source: Author's elaboration

Note: We decided to provide only a few demographic information for the patients (Age, Gender and Nationality) to guarantee the anonymity of the patients involved in the study.

4 Analytical grid for patients' information

The following analytical grid was used to gather information regarding patients. The first column was filled with information collected from the clinical records. The second, instead, was an evaluation and summary made by the researcher concerning symptoms, treatments, cultural/social/economic capitals and resources available (Table A4).

Table A4 – Analytical grid for patients' information

Patient's Information	**Evaluation of Patient's Status**
Patient #:	Symptoms:
Age:	Pharmacological therapy:
Gender:	Access to psychotherapy:
Nationality:	Traumas/Fragility:
Education:	Cultural capital:
Profession:	Economic capital:
Family status:	Social capital:
Number of people co-living:	Development of distress:
Housing situation:	Evaluation of the determinants:
Other physical illnesses:	Evaluation of the resources:
Substance abuse:	
Psychiatric Diagnosis:	
Name Psychiatrist	
Pharmacological therapy	
Psychotherapy (Y/N)	
Name of Psychotherapist:	
Date of Access to the Clinic:	
Past Access to the Clinic:	
Frequency of Psychiatric Encounters:	
Frequency of Psychotherapy:	
Hospitalization (Related to Depression):	

Source: Author's elaboration