Exploration Of The Meaning Of Depression Among Psychologists: A Quantitative And Qualitative Approach

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EXPLORATION OF THE MEANING OF DEPRESSION AMONG
PSYCHOLOGISTS: A QUANTITATIVE AND QUALITATIVE
APPROACH

A Dissertation
Presented to
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Doctor of Philosophy

by
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Abstract

While depression is considered the most common mental illness regardless of age, gender, ethnicity, and socioeconomic status, compared to research on the general population, depression among psychologists has received little attention. However, as they are one of the major mental health care professionals, psychologists’ mental health could greatly affect their clients’ mental health, which raises competency and ethical concerns regarding their work as clinicians. In order to learn more about depression in this group, questionnaires were mailed to 800 randomly selected psychologists in the state of Colorado to examine the prevalence of depression among psychologists, how they dealt with their own depression, their concerns regarding competency and ethics, and the existential meaning of their depression. Nine participants responded to an invitation to be individually interviewed regarding their personal experience of depression.

The results indicated a higher prevalence of depression among psychologists than in the general population. However, no significant gender differences regarding the prevalence of depression were found. The majority of psychologists reported being aware of their own depression, however, regardless of their expertise, several reported that they were not aware of their own depression. The majority of psychologists accepted the
diagnosis either positively or objectively. However, some accepted it negatively, expressing such feelings as shame. The majority of psychologists who experienced depression eventually sought treatment. However, one third of the psychologists did not seek treatment, but instead utilized their own coping skills. A few psychologists mentioned a confidentiality concern as a reason for not seeking treatment.

Regarding competency, most psychologists did not think their own depression interfered with their professional competence. Regarding ethical concerns, nearly half of the psychologists answered it is ethical to practice as long as the psychologist is aware of his/her symptoms and limitations. One third of the psychologists answered the capacity to practice depends on the severity of the depression. Although most psychologists rated their experience of depression positively, stating that it enhanced their understanding of their clients, personal interviews revealed that a stigma about depression or mental illness in general still exists among psychologists. Most of the interviewed psychologists stated that they were very cautious about disclosing their experience of depression to their colleagues due to a concern for their reputation.
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Chapter One: Introduction

It may not be very surprising that mental health professionals such as psychologists (see Footnote 1) are also prone to mental disorders/illness (see Footnote 2), just like the general population. According to Sadock and Sadock (2003), much research has shown that the prevalence of some mental disorders (e.g., major depressive disorder) is universal across gender, age, race/ethnicity and socioeconomic groups. The occurrence of mental disorders among mental health professionals raises interesting questions, as it suggests that having special knowledge of mental disorders and extensive clinical experience in their treatment is not enough to free one from having mental disorders. If so, is there anything that makes mental health professionals special regarding their handling of their own mental disorders? A second question is whether or not a mental health professional who has suffered from mental disorders is capable of treating people with mental disorders. This question addresses not only treatment efficacy and professional competence but also their ethics as mental health professionals.

To explore these two questions, first, I investigated how prevalent mental disorders actually are among mental health professionals, especially psychologists. Second, I examined how those psychologists who are diagnosed with a mental disorder deal with their own mental illness. Third, I examined how those psychologists

Footnote 1: Hereafter, the term, “psychologists” refers to psychologists who are engaged in some clinical work (e.g., counseling psychologists, clinical psychologists and school psychologists).

Footnote 2: Hereafter, I use mental disorders and mental illness interchangeably although I will primarily use the term mental disorder.
handle their professional life, in which they treat people with mental disorders, along with their own mental disorders. This question could be very important since it is inevitably related to the psychologists’ professional competence and ethics as mental health care providers. In other words, is having a mental illness as a psychologist incongruent with being a mental health professional?

I am primarily interested in these questions. However, underneath these questions I have one basic question about mental disorders. That is, having a mental disorder is usually considered a totally negative thing, something which needs to be eliminated as soon as possible. Mental illness negatively affects a person’s psychological/physical well being, as well as interpersonal relationships such as marriage, family structure, academic performance, job performance, etc. (Kennedy, Salsberry, Nickel, Hunt, & Chipps, 2005). It also affects society as a whole by hurting the economy (e.g., reducing productivity, creating a financial burden for mental health interventions such as suicide prevention) (Oliva-Moreno, López-Bastida, Montejo-González, Osuna-Guerrero, & Duque-González, 2009). These negative effects on human lives and society seem to contribute to the strong stigma attached to mental disorders.

This stigma associated with mental illness is a major issue. For example, for the National Alliance on Mental Illness (NAMI), fighting stigma is still one of the major agendas, even three decades after its inception in 1979 (National Alliance on Mental Illness, 2010 b). Much recent research in the United States confirms that the stigma of mental illness still widely exists (e.g., Corrigan et al., 2010; Godfredsen, 2004; Martin, Pescosolido, & Tuch, 2000; Wright, Gronfein, & Owens, 2000). The stigma of mental illness is observed not only in the United States, but also in many other countries,
including the United Kingdom (Mehta, Kassam, Leese, Butler, & Thornicroft, 2009), Sweden (Lundberg, Hansson, Wentz, & Björkman, 2009), Germany (Angermeyer & Matschinger, 2005), China (Guo, 2009) and Brazil (De Toledo Piza Peluso, & Blay, 2009).

Historically, so-called “de-institutionalization,” which started in the 1960s, seems to be a humanitarian, liberating movement for people with mental illness. However, what made this de-institutionalization possible is the new idea that mental illness is caused by a chemical imbalance in the brain, which enhanced the development of psychopharmacological therapy. This idea that mental illness is a biological disease may have helped de-stigmatize having mental illness, to a certain extent, since mental illness could be seen as similar to diabetes or a stomach ulcer. However, it also may have created another stigma since such an idea could lead to more separation between people with mental illness and those who do not experience it. The reason is that treating mental illness is now in specialists’ hands (e.g., psychiatrists and psychologists) and is also biologically-focused, relying heavily on psychotropic medication. This trend may lead lay people to perceive that treating mental illness is now highly specialized and may create the perception that mental illness is a highly complicated organic disease.

Compared to the current situation, mental illness used to be treated more holistically in the community based on the idea of a body-mind-spirit connection.

The stigma of mental illness seems to exist even among mental health professionals. For example, Hinshaw (2008), a clinical psychologist, edited 14 narratives written by mental health professionals, who are mostly psychologists, about their personal experiences with the mental illness of their family members or themselves.
Hinshaw, whose father had bipolar disorder, titled the book, *Breaking the Silence*. This title itself indicates the current situation surrounding mental illness, as something we still somehow need to hide. In fact, most of the authors of the narratives talk about stigma and shame.

It seems that mental illness is viewed more negatively than physical illnesses such as cancer and diabetes. One of the reasons might be that, in the case of physical illness, the cause is visible, concrete. On the other hand, in the case of mental illness, the cause is not visible and concrete. In mental illness, even now, there are many theories that try to explain it. For example, Prochaska and Norcross (2007) pointed out that there are about 400 different psychotherapies, each of which is considered to be based on its own personality theory. In other words, compared to many aspects of physical illness, the etiology and approaches to treatment of mental illness are not universally agreed upon. For example, there are more than a handful of major theories regarding the etiology of mental illness, including genetic and physiological explanations (biomedical theories), intrapsychic conflicts (psychoanalytic theories), learned wrong behavior (behavioral theories), irrational beliefs (cognitive theories), interpersonal conflicts (psychodynamic theories), family dynamics conflicts (systems theories), social, economic discrimination (feminist theories), and distorted self-concept (phenomenological theories). One extreme theory is that mental illness is a politically constructed concept (e.g., Szasz, 1987).

However, apart from the arguments on how mental illness is caused, those theories seem to share one thing in common. That is, having mental illness is considered by all to be a negative thing, which needs to be eliminated as soon as possible.
One question that is not often considered is whether mental disorders/illnesses are all negative. For example, if mental disorders were all unnecessary things for human beings, they would have been eliminated/become extinct a long time ago, especially when theories of evolution such as the theory of the survival of the fittest is considered. In other words, the fact that mental disorders have continued to exist until now suggests that they may have some benefit for human existence. For example, throughout history and even now in some cultures, those who have mental illness and show delusions and hallucinations are sometimes considered as possessing a miraculous or sacred power and become objects of respect or worship (e.g., Shamans).

Another reason why mental disorders are generally considered to be all negative is that there is a clear boundary between sanity and insanity, which was established by Kraepelin a century ago. However, Bentall (2003) criticized this notion by introducing several studies, which reported that hallucinations were experienced by about 10% of “normal” (sane) people, too. This may indicate that some symptoms of mental illness may be a part of normal life in some cultures.

Even if mental disorders do not have any benefit for human existence, it might still be worthwhile to seek some positive meaning in mental disorders because they are so prevalent. In other words, finding a positive aspect of mental illness is useful when working with people with mental illness since they nonetheless must live with the disorder, at least for a while. This approach is especially meaningful, considering that depression is very prevalent, as it is estimated to affect approximately 9.5% of the American population, or 19 million people in any given year (AARP, 2010). According to Sadock & Sadock (2003), the prevalence of lifetime major depressive disorder is about
15% and may be as high as 25% among women. Psychologists are no exception. Some research has even suggested that psychologists are actually more prone to depression compared to the general population (e.g., Gilroy, Carroll, & Murra, 2002).

Although the pathological aspect of mental disorders has been studied extensively, its existential aspect (meaning) has been much less explored. Some researchers have examined the existential meaning of depression (e.g., Lewis, 1995), but few such studies have been published. One of the reasons may be that the medical model primarily focuses on the biological aspect of mental disorders and does not show much concern about their existential aspect.

Why is studying the existential part of mental illness important? Most researchers admit that mental illness cannot be cured by medication alone and suggest the best treatment strategy is a combination of medication and psychotherapy (Sadock & Sadock, 2003). This suggestion indicates that something besides biological/physiological factors could be related to mental illness, perhaps cognition (thought) or affect (feelings), or perhaps meaning. While the effects of cognition and affect on mental illness have been widely studied, there have been few studies about meaning, especially the potentially positive aspects of mental illness and its effects. In other words, the meaning of mental illness has been overlooked, although it seems to be potentially useful for understanding mental illness.

To this point I have talked about mental disorders in general. However, for the purpose of this study, the focus will be on depression. The reason is as follows: First, although depression itself is not a mental disorder but is considered a symptom,
nonetheless, it is one of the most common symptoms. Therefore, hereafter I use depression and depressive symptom(s) interchangeably.

For example, Sadock and Sadock (2003) concluded that depression can be a feature of virtually any mental disorder listed in the Diagnostic and Statistical Manual of Mental Disorders (4th ed., text rev.; DSM-IV-TR; American Psychiatric Association, 2000). Sadock and Sadock listed mental disorders, in addition to mood disorders, that commonly have depressive features. Those mental disorders include adjustment disorders with depressed mood, alcohol use disorders, anxiety disorders, eating disorders, schizophrenia, schizophreniform disorder, and somatoform disorders. In other words, depression is not limited to mood disorders but is prevalent in diverse mental disorders. Therefore, examining depression among psychologists could represent the general aspect of mental disorders among psychologists. Second, aside from the fact that depression is seen across many diagnoses, having depression can surely be a very painful experience. Since I personally have experienced major depression, I know how deeply painful it can be. Therefore, when the meaning of having mental disorders is considered, depression could be one of the hallmarks used to assess the relationship between positive meanings and painful experiences.

There has been some research about the positive aspects/usefulness and the meaning of having a mental illness. However, that research, especially with psychologists, is sparse, and is mostly based on individuals’ memoirs. My study aims to fill the gap by conducting survey research with a large sample and in-depth interviews with several individuals about the meaning of mental illness, especially depression, among psychologists.
Research Questions

1. How prevalent is depressive symptom(s)/depression among psychologists in Colorado who respond to the survey?

2. How do psychologists deal with their own depression?

3. How do psychologists handle their professional life while having a depression issue?

4. How do psychologists think that having depression relates to their professional competence?

5. Do psychologists feel any ethical concerns about having depression themselves as mental health professionals?

6. What meanings do psychologists attach to having depression?

7. Is there any relationship between psychologists’ theoretical orientation and their perception of depression?

To explore these research questions, I conducted the following research:

1. I conducted a survey to acquire information about the current perspectives on this topic among psychologists in Colorado.

2. I conducted in-depth interviews with psychologists who reported having a depression issue and who volunteered to be interviewed.

Summary

In sum, depression is one of the most common mental disorder symptoms (AARP, 2010), and is widely seen across gender, age, race/ethnicity and socioeconomic status (Sadock & Sadock, 2003). Therefore, psychologists will be no exception. However, if those psychologists, who work with people with mental disorders, themselves have depression, it might create professional competence and ethical issues. Therefore, my
research project first aimed to examine how prevalent depression is among psychologists. My research project also aimed to examine psychologists’ views on the relationship between having depression and professional competence and ethics. Another issue is the meaning of having depression. Since depression has been recognized as a unique condition for many years and is widely seen across cultures, it might or should have some positive aspect, so that having depression could, in a meaningful way, be useful in psychological wellness. Therefore, in my research project I also examined how psychologists find positive meaning in having depression.
Chapter Two: Literature Review

The following chapter provides the literature review for this study. The chapter begins with the terminology/definition of mental disorder. Next, the historical aspects of mental disorders will be discussed. Finally, the previous studies related to mental disorders among psychologists will be presented.

Terminology/Definition of Mental Disorder

There are several terms that refer to mental disorders. For example, there are common, everyday terms such as craziness, madness, mentally disturbed, mental disease, mental malfunctions, and mental illness. Rarely used terms include mental alienation and mental affliction.

In academia, the term “mental disorders” is widely used. It is used in the DSM-IV-TR, published by the American Psychiatric Association (American Psychiatric Association, 2000) and is widely used in the mental health field in the US. The term mental disorders is also used in academia internationally. The World Health Organization (WHO)’s International Statistical Classification of Diseases and Related Health Problems, which is now in its 10th revision (ICD-10) and is widely used as the standard diagnostic classification of diseases, also uses the term mental disorders (World Health Organization [WHO], 2010).

However, in everyday life, the term “mental illness” is widely used. For example, the nation’s largest mental health consumer organization calls itself the National Alliance on Mental Illness (NAMI, 2010a). Nonetheless, while the NAMI, which makes fighting
stigma one of its main missions, keeps using the term mental illness, Godfredsen (2004), in her research on the stigma connected to psychological problems and treatment, stated that many mental health advocates would reject the term mental illness as stigmatizing. Therefore, regarding the term mental illness some controversy exists.

To conclude, mental disorders and mental illness are considered commonly used terms and are used interchangeably. Therefore, for the remainder of the paper, I will use both terms interchangeably.

**Historical Aspects of Mental Disorders**

“Madness may be as old as mankind” (Porter, 2002, p. 10). The author refers to archaeological evidence that human skulls dating from at least 5000 BC have been found that show marks of surgical operation - small round holes that have been made with flint tools. In Deuteronomy (6:5) in the Old Testament, it is written, “The Lord will smite thee with madness.” Regarding depression, the Old Testament story of King Saul describes a depressive syndrome. About 400 BC, Hippocrates used the terms “mania” and “melancholia” to describe mental disturbances. The latter term was used especially to describe the dark mood of depression. Around 30 AD, the Roman physician Celsus described melancholia as a depression caused by black bile (Sadock & Sadock, 2003).

According to Millon (2004), the conceptions of the mind and its disorders started with a sequence of three pre-scientific paradigms, that is, the animistic, the mythological, and the demonological. In other words, behaviors that ancient people did not understand were attributed to animistic spirits. There were considered to be both good and evil spirits, and the bizarre behaviors were attributed to the evil spirits, and possession by evil spirits was considered to be punishment by the gods for not obeying their teaching. But
at the same time, some disordered behaviors (e.g., epilepsy) were seen as possession by sacred spirits that the gods honored (Millon, 2004).

However, Darwinian psychiatry has a different view of mental disorders. Darwinian psychiatry sees mental disorders in an evolutionary context (McGuire & Troisi, 1998). Darwinian psychiatrists suggest that the human mind, just like the human body, was shaped by natural selection. In other words, the human mind evolved in certain ways to cope with certain situations, which is not necessarily pathological (Small, 2006). Darwinian psychiatrists insist that the goal of the human mind is not to seek happiness but individual reproductive success. Therefore, even “bad” human emotions such as depression may not be pathological, but actually important keys to human beings’ ultimate success. In other words, Darwinian psychiatrists think that mental disorders/illness are evolutionary adaptations, and that mental illness may be what nature has provided to help human beings stay alive and pass on their genes (McGuire & Troisi, 1998). Therefore, evolutionary psychiatrists see mental illness as having a positive role in the evolution of our species over millions of years.

McGuire and Troisi (1998) suggested that depression is a common human affliction and deserves consideration as a possible adaptation because the symptoms of depression may warn an individual that past or present coping strategies have failed. In addition, physiological slowness and social withdrawal, often regarded as symptoms of depression, may remove an individual from high-cost social interactions. Nesse (2000) agreed that some types of depression may be adaptative although he concluded that mood disorders are normal but unnecessary in general. He stated that the
negative and passive nature of depression can increase an organism’s coping ability in the case where pursuing goals may result in danger, loss, bodily damage, or wasted effort.

Lehrer (2010) mentioned that Charles Darwin himself had depression and because of it, Darwin could accelerate his research since he could withdraw from the outside world and concentrate on his studies. Nesse (2000) introduced Darwin’s thought about depression as follows:

Pain or suffering of any kind, if long continued, causes depression and lessens the power of action; yet it is well adapted to make a creature guard itself against any great or sudden evil.

_The Life and Letters of Charles Darwin_, Charles Darwin, 1887. (Nesse, 2000, p. 14)

Andrews and Thomson (2009), using an evolutionary perspective, introduced the analytical rumination hypothesis and argued that depression is an evolved response to solve complex problems. They argued that depression gives a person persistent rumination, which is necessary for analyzing complex problems and also reduces the person’s desire to engage in distracting activities that include food, sex and social interactions. Their view challenged the common notion that persistent rumination is a negative symptom of depression. Instead, they argued that it could actually be a benefit. In other words, the notion of evolutionary psychiatry is that mental disorders are not necessarily pathologies but rather are strategies, adaptations, or responses that make evolutionary sense (Small, 2006).

Small (2006) summarized the evolutionary perspectives on depression in the following two points: (a) depression might be a way for an individual to conserve energy while under great stress by disconnecting from society, and (b) depression can be a
manipulative strategy to get attention and resources from others, which would work to get the depressed person back into society.

Small (2006) also pointed out how culture affects our view of mental illness, or the normal-abnormal continuity, mentioning Ruth Benedict’s field study. In Benedict’s study among the Shasta Indians in California, a person with seizures was not considered sick. Instead, s/he was respected and offered a leadership position. In Dobuan society in New Guinea, where life is very difficult, a person with an optimistic and happy personality was considered crazy. Small further indicated that the current negative view about mental illness might come from the phenomenon that mental illness does not match with today’s cultural and social expectations and pressures.

How culture affects the concept of mental disorders is now recognized in the section on culture-bound syndromes in the DSM-IV-TR (American Psychiatric Association, 2000). Small (2006) also pointed out that culture-bound syndromes can be seen not only in “exotic” cultures but in Western culture, too. She used anorexia nervosa as an example of a culture-bound syndrome, referring to research on it conducted by Joan Brumber, a professor of history and human development. Brumber’s work on anorexia nervosa has suggested that its origin is associated with abundant food, the availability of doctors and the appearance of advertisements of slim female figures, and this condition is less likely to be seen in less affluent societies.

Some researchers have pointed out the current US culture is in a “psychotropic medication frenzy” and most people believe that not only is mental health a prerequisite for happiness, but also that only the mentally healthy person can properly seek happiness (e.g., Szasz, 1994). This attitude drives people with mental illness to seek professional
help, not to first rely on their own self-healing power. This phenomenon was well
documented in One Nation under Therapy: How the helping culture is eroding self-
reliance, by Sommers and Satel (2005), and Ritalin Nation: Rapid-fire culture and the

Cockburn (2004) pointed out that, in the US, in the case of depression, a vast new
territory opened up for “exploitation” after the economy peaked in the mid-1960s and
(the author jokingly said) people stopped drinking dry martinis. In other words,
economic conditions (slump) greatly affect people’s mental conditions (although it is
kind of common sense) and people had their own remedy.

These opinions sound a little extreme. However, in the US alone, 213 million
prescriptions for antidepressants were issued in 2003 (Cockburn, 2004). And in 2002
alone, the total profits of the nine largest pharmaceutical corporations reached $35.9
billion, which is more than the profits of the other Fortune 500 companies combined
(Berman, 2004). Therefore, one could suspect that mental illness, especially depression,
is commercialized.

**Meaning of Depression**

In general, finding existential “meaning” in having a mental disorder has not been
a topic of scientific investigation. In contrast, finding “meaning” in physical suffering has
been explored and most studies have found that it has a positive effect on a patient’s well-
being (e.g., Breitbart, Gibson, Poppito & Berg, 2004; Greenstein, 2000).

Nonetheless, among the previous “meaning” studies in mental disorders, most
studies have found results similar to those dealing with physical suffering. That is, there
have been negative correlations between meaning in life and negative affect, typically
depression (Scannell, Allen & Burton, 2002). In other words, there is a positive correlation between the loss of meaning in life and depression. Therefore, if the meaning could be found in depression, this trend might be reversed.

Among the previous studies, maybe one of the first scholars who shed light on the meaning of psychological suffering was Viktor Frankl, a Jewish psychiatrist who survived the Nazis’ concentration camps. He observed that those who lost the meaning of life became apathetic and eventually gave up struggling to survive (Frankl, 1972). This experience led him to establish logotherapy. Frankl (1955) used “logos” to signify the spiritual meaning. He said, “[h]uman life can be fulfilled not only in creating and enjoying, but also in suffering!” (Frankl, 1955, p. 122). Through his own experience of enduring the cruelty of a Nazi death camp, he argued, “[l]ife holds a potential meaning under any conditions, even the most miserable ones” (Frankl, 1972, p. 16). Frankl said that striving to find meaning in one’s life is the primary motivational force in a human being. Frankl mentioned research in which some prisoners in the Vietnam War claimed that they benefited from their captivity experience, seeing it as a growth experience. Frankl concluded that suffering could sometimes mature a person. However, he did not explicitly mention that having a mental disorder itself could be a meaningful experience although he suggested that it is possible to find meaning in any human activities (Frankl, 1972).

Some researchers have found positive aspects of having mental illness. For example, Murphy (2000) found that there are positive themes in psychosis such as beautiful, encouraging or supportive hallucinations. He said that some people with psychosis found that these hallucinations had real meaning and considered them to be
divine in nature. He referred to one client who said that her psychosis had made her stronger. Murphy also related that another client said, “I feel I am a better person than I might have been. Otherwise I might have been more shallow and superficial.” (p. 183). Murphy concluded that therapy should involve in-depth exploration for such beneficial and positive changes that may have taken place and provide encouragement for them to evolve. Egnew (2005) also said that suffering could be transformed into something positive. That is, suffering can help a person grow in their understanding of self and others.

Some researchers have examined the meaning of depression per se. For example, Slavik and Croake (2006) examined the phenomenological meaning of depression from the perspective of individual psychology. They pointed out that an individual gives idiosyncratic meaning to circumstances and events, and then meaning influences individual behavior in return. Blair (2004), based on existential theory, especially Frankl’s logotherapy, said that if depression is reframed [emphasis added] as purposeful, the individual starts searching for its cause and is more willing to bear its effect. Bookless, Clayer, and McFarlane (2000) tried to quantitatively evaluate the personal meaning of experiencing depression by developing a new instrument, the Personal Appraisal Inventory (PAI). Their normative sample was those who had inpatient or outpatient treatment due to a major depressive episode. The purpose of this study was (a) to provide a workable definition of “personal meaning,” (b) to provide a new instrument that quantifies the personal meaning of depression, and (c) to identify a positive appraisal factor for having depression. The authors identified five appraisal factors through factor analysis of the PAI. Among them they found one “positive” factor that they named a
“challenge” factor because it arose as a result of depression and had a correlation with positive adjustment indicators (e.g., “the experience offered potential for growth”).

Stoppard (1998) analyzed depression in the context of culture from the feminist, social constructionist perspective. Stoppard challenged the mainstream approaches to human psychology that are based on the dualism of body-mind and nature-society by introducing a non-dualistic, cultural perspective, especially regarding women’s bodies. As an example of how culture affects women’s physical bodies, Stoppard cited Lock’s research, in which the researcher found that regarding the experience of menopause, in contrast to North American women, women in Japan do not report depression or hot flashes as typical menopausal experiences. Stoppard also analyzed the language of depression. She pointed out a metaphoric link between “low,” “down,” and “flat,” words that are used to express depressed mood. According to her, these terms represent a bodily position associated with sickness, defeat, or an effort to hide the body from view. Taking a low position to respond to those who are of a higher social status is a cultural norm. Therefore, feeling low or down also implies not only the quality of mood but also the relationship with others.

Stoppard (1998) concluded that the DSM diagnostic criteria, which are based on the reductionist medical model, need to be read critically. For example, Stoppard pointed out that the DSM-IV-TR criteria for major depressive episode, which are based on the number of symptoms (e.g., five or more), and which include either depressed mood or loss of interest or pleasure, are questionable. She argued that each symptom is regarded equally (not weighted) except for the above two, whereas for a depressed individual, each
symptom may not be perceived equally. In other words, the DSM-IV-TR does not consider an individual’s subjective importance of each symptom.

**Previous Studies on Mental Disorders among Psychologists**

Regarding how prevalent mental disorders are among psychologists, some survey research has been conducted. For example, Pope and Tabchnick (1994) conducted a national survey about the major problem of psychologists who themselves were in psychotherapy. They sent questionnaires to 800 randomly selected psychologists belonging to the American Psychological Association (APA) Division 12 (Clinical Psychology), 17 (Counseling Psychology) and 42 (Psychologists in Independent Practice). The return rate was 60%. What they found out was that the majority (61%) reported that they had experienced at least one episode of what they would characterize as clinical depression. In addition, 29% reported that they had felt suicidal and nearly 4% reported that they had made at least one suicide attempt. However, the weakness of this study is that the questionnaire did not specifically ask the diagnosis based on DSM. Therefore, respondents’ major problems were vaguely classified as “depression or general unhappiness,” “marriage or divorce,” or “anxiety,” in which Axis I, II and III are mixed.

Gilroy, Carroll and Murra (2001) conducted a survey about depressive symptoms among female psychologists. They sent a questionnaire to 790 members of the Association of Women in Psychology (AWP). The response rate was 31%. Among the usable data (220), 167 (76%) of the respondents reported that they had experienced some form of depression since beginning clinical practice. Unlike the previous study by Pope and Tabchnick (1994), Gilroy et al. asked the diagnosis based on the DSM – IV criteria.
Among the 167 respondents, 76 psychologists identified their diagnosis on Axis I of the DSM-IV. Major diagnoses were as follows:

1. Adjustment disorder with depressed mood 33 %
2. Dysthymia 25 %
3. Major depressive disorder, recurrent 13 %
4. Major depressive disorder, single episode 7 %
5. Depressive disorder not otherwise specified 7 %

Gilroy et al. (2002) again conducted a survey about depression, this time among counseling psychologists. They sent a questionnaire to 1,000 randomly selected psychologists who were members of APA Division 17 (Counseling Psychology). The response rate was 43 %. Among them, 55 % were women and 45 % were men. Out of the 425 respondents, 264 (62 %) reported being depressed. Among them, 114 reported a formal DSM-IV diagnosis during treatment. Major diagnoses were as follows:

1. Dysthymia 36 %
2. Adjustment disorder with depressed mood 33 %
3. Major depressive disorder, recurrent 6 %
4. Bipolar disorder 3 %
5. Major depressive disorder, single episode 2 %

The authors also provided data about suicidal ideation. Out of 184 who sought psychological treatment, 78 (42 %) reported they had some form of suicidal ideation or behavior. Among them, 6 (3 %) reported suicidal ideation with a plan and one psychologist reported an attempted suicide.
However, the authors cautioned there were some possible flaws in this study. One concern was the limitation of self-report. As the response rate (43 %) suggests, respondents might have included those who were especially interested in the topic of depression among psychologists. The other concern was that since the survey did not include the assessment of stresses in the respondents’ work environment, it is not clear if the depressive symptoms were related to these factors.

Although there are the above-mentioned limitations in these quantitative studies, it cannot be said that psychologists are not prone to mental disorders. On the contrary, the incidence rates among psychologists seem much higher than those in the general population. For example, while the prevalence of adjustment disorders is 2-8 % among the general population (Sadock & Sadock, 2003), the prevalence rate among the psychologists in this study was 9-11 %, which is distinctly higher. The same is true for dysthymia. That is, while the prevalence rate among the general population is 5-6 % (Sadock & Sadock, 2003), among the psychologists in this sample, the prevalence rate was 9-10 %. Even after considering some possible flaws of this study, these data could raise the question of whether psychologists are actually more vulnerable to mental disorders than the general population.

Besides the prevalence of mental disorders among psychologists, another issue is how psychologists with mental disorder(s) handle their professional lives and their mental/psychological situations.

Actually, studies about the treatment of psychologists/psychotherapists have a long history, although they are not primarily focused on mental disorders. The best known example is Freud’s self-analysis. Pope and Tabachnick (1994) quoted Freud:
“Every analyst ought periodically…to enter analysis once more, at intervals of, say, five years, and without any feeling of shame in doing so” (p. 247). They also referred to a book written by Fromm-Reichman in 1950, who argued that attempting to be a therapist without first being a patient is “fraught with danger, hence unacceptable” (p. 247).

Quantitative studies in the 1980s addressed psychotherapists’ personal treatment experiences. Representative studies include those by Peebles (1980), Norcross, Strausser-Kirtland and Missar (1988) and Thoreson, Miller, and Krauskopf (1989). However, these studies did not specifically focus on psychologists alone and the classification of their presenting problems was not based on the DSM criteria.

On the other hand, as mentioned earlier, the studies by Gilroy et al. (2001, 2002), which focused on clinical/counseling psychologists and showed a diagnosis based on the DSM-IV criteria may give a clearer clinical picture about mental problems among psychologists.

In their study about female psychologists with depression, Gilroy et al. (2001) found some common characteristics among female psychologists. One characteristic was that the majority reported experiencing depression since beginning clinical practice. Gilroy et al. suggested this phenomenon might be due in part to the pressure women feel to fulfill multiple care-taking roles. They also mentioned that female psychologists tend to receive more referrals for clients who present with issues of trauma. However, they did not discuss specific supporting data related to this assertion. Finally, the authors indicated that the vast majority of responding female psychologists sought therapy. This contradicts the common finding that psychologists are reluctant to seek personal therapy. They concluded that seeking treatment is more common among women in general. The
psychologists who sought therapy mentioned the assurance of confidentiality as a key factor in their selection of a therapist (secondary to the reputation of the therapist). This is interesting because those psychologists who did not seek therapy also mentioned a concern about confidentiality as a reason not to seek therapy. In other words, confidentiality was a critical factor, whether or not respondents decided to seek therapy.

Another interesting finding in the studies by Gilroy et al. (2001) was that at least half of the respondents reported that experiencing depression had a positive impact on their clinical work. The main positive impacts were:

1. Enhanced empathy with depressed clients.
2. More patience and tolerance when progress in therapy is slow.
3. A heightened appreciation for how difficult therapy can be.
4. Greater faith in the therapeutic process.

However, regarding the relationship with their colleagues, more than half of the respondents (54 %) reported receiving negative reactions from their peers, such as feeling judged.

In another study by Gilroy et al. (2002), which was addressed to both men and women counseling psychologists, the results indicated there was no difference regarding treatment seeking between male and female psychologists. Researchers did not find a significant difference between men and women psychologists regarding the reasons why the respondents did not seek treatment, either. The only exception was that female psychologists were significantly more concerned about confidentiality than male psychologists. Otherwise, both male and female psychologists reported the following reasons (top two) for not seeking therapy: (a) depressive symptoms went away, and (b)
sought alternative coping strategies. Some other top 10 reasons were: (a) financial costs too high, and (b) belief that therapy wouldn’t be helpful. This list is similar to the results of Gilroy et al. (2001)’s previous study of female psychologists. This result is surprising since the respondents were all clinicians and, therefore, they themselves administer treatment to their clients as a job. It raises the question of why does such a reluctant or even negative attitude toward treatment exist among the clinicians? The answer seems to be partly related to their relationship with their colleagues, who are clinicians, too.

Gilroy et al. (2002) found that regarding the impact of their depression on their relationship with their colleagues, respondents’ report of a negative impact was three times higher than their report of a positive impact (20 % vs. 6 %). Aspects of the negative impact that respondents reported were: (a) more withdrawn and isolated, (b) more irritable with colleagues, and (c) reduced professional development activities. These three examples basically match some of the DSM-IV criteria for a major depressive episode. Therefore, the cause of the negative impact on their relationship with their colleagues may be the respondents’ depressive mood disorder.

**Psychologists’ Attitudes toward Mental Illness**

Numerous studies have been conducted to examine psychologists’ attitudes toward mental illness. Among them, a 1978 study conducted by Morrison and Hanson (1978) is especially notable regarding the historical aspect. The authors claimed the characteristics of their study were as follows:

- The previous studies did not adequately measure the attitudes toward the anti-medical model, which has had a significant impact on the attitudes of mental health professionals.
• Only a few studies had attempted to compare the attitudes of mental health professionals with those of people with mental illness (consumers).

By using a new measurement, the authors reported that clinical psychologists showed greater acceptance of the anti-medical model, which was proposed by Szasz (1987) and others, than other mental health professionals such as psychiatrists, psychiatric social workers and psychiatric nurses, and also psychiatric patients. This result is interesting as the idea of the medical model is said to liberate people with mental illness from stigma since according to the medical model, mental disorders are organic diseases, and an ill individual has no responsibility for the disease. The result reflects the rise of the anti-medical model movement, which coincides with the anti-authority movement in the 1960s and 1970s (e.g., student power, commune movement). However, as the authors themselves noted, this result needs to be seen as a pilot study due to the small sample size (e.g., 16 clinical psychologists, 21 psychiatrists) and limited geographic area (New York state).

Wyatt and Livson (1994) examined the attitudes of psychologists and psychiatrists toward the etiology of mental illness. The authors used the Mental Health Questionnaire (MHQ) developed by one of the authors (Wyatt) to measure those mental health professionals’ attitudes. The factor analysis of the MHQ identified six factors: biogenetic psychopathology, psychosocial perspectives, medical ideology, diagnosis, drug treatment, and sociocultural values. The authors found that psychologists and psychiatrists largely agreed in most of the six dimensions, although their degree of agreement differed slightly for the different dimensions. However, one dimension, the attitude toward the medical ideology, showed a clear difference between the two groups.
Psychiatrists supported the medical ideology, which is the core of the medical model, while psychologists rejected it. The authors attributed this difference between psychologists and psychiatrists to the differences in their training. However, the authors also found that the attitudinal differences between psychologists and psychiatrists were not unidimensional, and could not be placed on the bipolar attitudinal continuum of the medical model as opposed to the psychosocial model. For example, although psychologists rejected the medical ideology, they nonetheless supported drug treatment. Psychiatrists, while supporting the medical ideology, also strongly supported psychosocial perspectives and sociocultural values. As psychologists themselves, the authors concluded that psychologists’ apparently inconsistent attitude (e.g., rejecting the medical model, but supporting drug treatment), was representative of the politics of the mental health world: battles for control, power, and monetary gain (e.g., psychologists’ seeking prescription privileges).

Casey and Long (2003), psychiatric nurses, reviewed the literature related to how people make sense of mental illness. The literature review included a number of memoirs and narratives of people with mental illness. The authors found that there were discrepancies in understanding the meaning of mental illness between mental health professionals and people with mental illness. It appeared that while people with mental illness tried to regain a sense of order by imposing a narrative structure on their experiences, mental health professionals tried to impose socially acceptable meanings on their experiences. In other words, personal meanings embedded in narratives are often suppressed and categorized to make them fit into dominant cultural or biomedical explanations. The authors argued that psychiatric diagnoses are not objective but political
since the process of understanding constructions of life experiences is inevitably related to the social and political context.

Servais and Saunders (2007) surveyed clinical psychologists’ perceptions of people with mental illness. The authors randomly selected 1,000 clinical psychologists from the 1997 Directory of the American Psychological Association and conducted a mail survey. The questionnaire consisted of six semantic differential scales: effective-ineffective, understandable-incomprehensible, safe-dangerous, worthy-unworthy, desirable to be with-undesirable to be with, and similar to me-dissimilar to me. Respondents were asked to rate five targets: themselves, a member of the public, a person with moderate depression, a person with borderline features, and a person with schizophrenia. They obtained a 34% response rate. The authors concluded that, overall, psychologists perceived themselves as more comparable to a person with moderate depression than a member of the public does regarding effectiveness, understandability, safety, and worthiness but not desirability. On the other hand, a person with borderline features was rated the least desirable and a person with schizophrenia was rated the most dissimilar. The authors suggested that these results might have underestimated clinical psychologists’ negative attitude toward people with mental illness since the respondents did not represent the entire clinical psychologist population. (For example, psychologists who work in the field of corrections tend to show negative attitudes, but they were underrepresented in this survey.) This process is called “disidentification,” in which people with mental illness are viewed as being different from “normal” people while viewing oneself as “normal.” The authors pointed out that disidentification is a professionwide bias. As a conclusion, the authors warned that if psychologists perceive
themselves as distinctly different from people with psychosis and people with personality disorders, such perceptions likely hinder the therapeutic process by inhibiting the psychologists’ ability to display empathy and genuine concern for persons and their diagnoses.

**Professional Competence and Ethical Aspect**

One of the most important issues related to professional competence and ethical aspect issues is whether a psychologist with a mental disorder is able to work as a mental health care provider/therapist.

Historically, the American Psychological Association (APA) started working on the issue of psychologists in distress (see Footnote 3) in 1980 (Kilburg, 1986). The APA established the Board of Professional Affairs Steering Committee on Distressed Psychologists, the proposed Volunteers in Psychology (VIP) Organization, and Psychologists Helping Psychologists (PHP) (Wood, Klein, Cross, Lammers, & Elliott, 1985).

The APA’s latest Ethical Principles of Psychologists and Code of Conduct (hereafter referred to as the Ethics Code) stated the importance of psychologists’ awareness of their own mental health (APA, 2002). In Principle A: Beneficence and Nonmaleficence among the General Principles, it is stated that “Psychologists strive to be aware of the possible effect of their own physical and mental health on their ability to

Footnote 3: Although the terms “distressed” psychologist and “impaired” psychologist are often used interchangeably, Nathan (1986) defined this as follows: A distressed psychologist refers to a psychologist who experiences the subjective sense that something is wrong, whether or not that feeling is associated with actual impairment in any area of life. On the other hand, an “impaired” psychologist refers to the psychologist whose professional work is impaired by/interfered with by something in the professional behavior or environment. But the impaired psychologist may or may not experience distress and may or may not believe himself/herself to be impaired.
help those with whom they work” (p. 1062). However, the Ethics Code does not directly address mental illness per se among psychologists. Instead, its focus is on “the welfare and protection of the individuals and groups with whom psychologists work and the education of members, students, and the public” (p. 1062).

Nonetheless, the following sections are related to the issue of having mental illness while practicing as a psychologist. They are: 2.01 Boundaries of Competence, 2.03 Maintaining Competence, 2.06, Personal Problems and Conflicts, and 3.04 Avoiding Harm (APA, 2002). Among the three, 2.06 Personal Problems and Conflicts could be mostly related to having depression. Standard 2.06 has the following two subsections:

2.06 Personal Problems and Conflicts
(a) Psychologists refrain from initiating an activity when they know or should know that there is a substantial likelihood that their personal problems will prevent them from performing their work-related activities in a competent manner.
(b) When psychologists become aware of personal problems that may interfere with their performing work-related duties adequately, they take appropriate measures, such as obtaining professional consultation or assistance, and determine whether they should limit, suspend, or terminate their work-related duties. (See also Standard 10.10, Terminating Therapy; APA, 2002, p. 1064)

These standards are based on the fundamental principles of beneficence and nonmaleficence. That is, “In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons” (APA, 2002, p. 1062).

These APA standards should work as safeguards to protect psychologists from engaging in malpractice and also protect their clients from receiving harmful therapy from impaired psychologists. However, the problem of these APA standards is that psychologists’ impairment is not objectively or operationally defined. The question then
becomes how to measure the degree of competency and interference (Williams, Pomerantz, Segrist, and Pettibone, 2010)?

To address this issue, Williams et al. (2010) conducted research to provide empirical data to identify the severity of the impairment. The authors conducted a survey with some members (N = 285) of APA Division 42 (Psychologists in Independent Practice). They asked the members to rate five levels of severity regarding vignettes that describe a psychologist’s symptoms of either depression or substance abuse. The authors found specific levels of impairment such as psychologists are too impaired to practice and it would be unethical for them to continue to practice. Nonetheless, the problem is, as the authors warned, impaired psychologists may not be fully aware of the degree of their impairment and therefore their self-assessment would be greatly different from their assessment by others. Therefore, the issue is when psychologists become depressed, whether or not they are able to objectively assess their competency as psychologists.

Many researchers have pointed out the importance of psychologists’ self-awareness regarding the degree of their impairment (e.g., Canter, Bennet, Jones, & Nagy, 1994). Some pointed out the importance of self-monitoring and seeking early intervention before those problems impact their clients (Canter et al., 1994; O’Connor, 2001).

Orr (1997) pointed out self-awareness is more important than impairment itself. Orr argued that recognizing the impairment does not necessarily negate the consequences of unethical behavior or incompetence, for these consequences could be a necessary deterrent against potentially damaging behavior, and therefore could provide an incentive to address problems before they become out of control.
Nonetheless, in order for them to be able to safeguard against impairment, the existence of psychologists’ self-awareness needs to be the premise. Some researchers showed a rather pessimistic view about psychologists’ self-awareness. For example, Smith and Moss (2009) pointed out that psychologists may not be able to identify signs of impairment in themselves because they are not trained to express doubts or concerns about themselves; therefore, they tend to rationalize their behavior. Kitchener (2000) also pointed out difficulty in identifying psychologists’ problems because sometimes it is difficult to discern what psychologists are missing.

To sum, the APA Ethical Standards do not specifically address mental issues among psychologists, but instead rather vaguely address these and do not seem to put much emphasis on this issue. This may reflect the assumption that psychologists are not prone to mental illness or that having mental illness and practicing as a psychologist are not compatible. In other words, psychologists’ own psychological wellness does not seem to be a major theme in research. Nonetheless, Weiss (2004) discussed the importance of psychologists’ self care, not only for their own sake, but also for the sake of their clients. Some of the things that Weiss recommended were (a) to know themselves, and (b) to get some personal therapy. Coster and Schwebel (1997) identified factors that contribute to functioning well as a psychologist. Those factors were (a) self-awareness and self-monitoring; (b) support from peers, spouses, friends, mentors, therapists, and supervisors; (c) personal values; and (d) a balanced life such as taking vacations. To conclude, the importance of self-awareness and seeking therapy is generally approved by psychologists.
Review of Memoirs

Although the above-mentioned survey research gives an overall view of how psychologists handle their mental disorders, ethnographic studies such as individual memoirs written by psychologists with mental disorders provide a more in-depth understanding of this issue. Individual accounts vividly describe the “inside stories” about how mental disorders affect their personal as well as professional lives and how they handle their own mental disorders. In the past decade or so, there have been several memoirs published by psychologists who have experienced mental disorders. Some examples are: Manning (1994), who wrote about depression; Endler (1982) and Jamison (1996), who wrote about bipolar disorder; and Bassman (1997) and Frese (2000), who wrote about schizophrenia. Although only several accounts have been published, it seems there are proportionately more memoirs about psychologists’ own struggles with schizophrenia than memoirs about mood disorders. This is somewhat strange since the lifetime prevalence of schizophrenia (about 1%) is far less than that of mood disorders. The reason may be that schizophrenia’s dramatic alteration of mental/psychological states has attracted more readers than has mood disorders.

Regarding psychologists’ memoirs about their mental disorders, Frese (2000) claimed that he pioneered it by publicly disclosing his diagnosis with schizophrenia in 1986. However, Endler (1982) seems to be considered the first psychologist who published a memoir about having a mental disorder, *Holiday of Darkness*. And in 1985 Rippere and Williams compiled short essays about the depression of 19 mental health workers that included psychologists who were mostly in England, in which they used some pseudonyms to partly protect their relationships with colleagues and employers.
Nonetheless, the phenomenon that the memoirs by psychologists became national bestsellers (e.g., Jamison’s *An Unquiet Mind* in 1996) itself shows that this self-disclosure among psychologists about their mental illness is still rather sensational and uncommon.

Among psychologists’ memoirs (e.g., Bassman, 1997; Endler, 1982; Frese, 2000; Jamison, 1996; Manning, 1994), it is important to note that each mentioned the stigma of being diagnosed with a mental disorder and the fear about the damage to their professional credibility. In other words, even among psychologists, the stigma of having a mental disorder is a major concern.

The memoirs of Endler (1982) and Jamison (1996) will be especially examined in detail. The reasons are as follows: First, both authors had the same diagnosis (bipolar disorder), in which depression is a major symptom. Therefore, by comparing the two memoirs, I could learn how depression was experienced differently or similarly (how idiosyncratic depression is). Second, there is a 14-year time gap between their publications. Therefore, by examining the two memoirs, I could make some historical comparison about how depression is perceived by the authors themselves and by other psychologists. The following review will focus on the authors’ attitudes toward (a) stigma, (b) treatment, (c) professional competence and ethical issues, and (d) having mental illness.

**Attitudes toward stigma.**

Endler, a prominent clinical psychologist at York University, was chair of the largest department of psychology in Canada, when he was diagnosed with a mental disorder. His diagnosis was considered bipolar II disorder, recurrent major depressive
episodes with hypomanic episodes, although he himself did not clearly write the exact diagnosis. Endler especially mentioned the stigma of having a mental disorder. He wrote that even when he experienced noticeable symptoms such as difficulty sleeping and concentrating, “…yet I was too proud to seek help” (Endler, 1982, p. 7). He also said, “My sophistication was a two-edged sword” (p. 25). On the one hand, he was easier to treat since he could understand what was happening. On the other hand, treating him was more difficult since he could not really accept the fact that he was sick. He especially had difficulty accepting the fact that he was mentally ill. Even in the midst of his treatment, he did not think he suffered from bipolar disorder, instead, he thought he suffered from unipolar disorder [depression]. For him, going to a psychiatric hospital was being labeled insane. Therefore, he persistently refused to go to a psychiatric hospital. He, as a psychologist, surely thought that some people need to be hospitalized to get better treatment. However, when the issue became his own, rational thinking, which was based on professional/academic knowledge, did not convince him to seek professional help. In retrospect, he said that why he did not seek professional help sooner was perhaps because he thought having an emotional problem was admitting that he was susceptible to human frailty and weakness. In other words, he himself, even though he was a prominent clinical psychologist, was entangled with stigma. He also mentioned that when he decided to publish his memoir to educate the public, some psychiatrists warned him, saying it would show his poor judgment or it would ruin his career. Endler concluded that the stigma attached to mental illness dies hard (Endler, 1982).

Jamison, who is also a prominent clinical psychologist, published her memoir 14 years after Endler. In her case, the stigma of mental illness appeared to be somewhat less
than Endler’s. For example, she wrote that even after her manic-depressive symptoms became very visible (her diagnosis is bipolar I disorder, recurrent, severe with psychotic features, with full interepisode recovery), her colleagues and bosses were very supportive and carefully watched her performance and encouraged her to seek professional help. During this time she set up the UCLA Affective Disorders Clinic with physicians and she became its director. In addition, when she applied for a faculty position at the Department of Psychiatry at Johns Hopkins University and disclosed her bipolar disorder to the chair, he laughingly responded, “I know you have manic-depressive illness…If we got rid of all of the manic-depressives on the medical school faculty, not only would we have a much smaller faculty, it would also be a far more boring one” (Jamison, 1996, p. 209).

As these illustrations show, the stigma of mental illness seems less obvious in Jamison’s case. However, Jamison confessed that it took a long time for her to get rid of the stigma for herself. Jamison said she initially refused treatment for her mood disorder, just as Endler did. She said, “Even after my condition became a medical emergency, I still intermittently resisted the medications that both my training and clinical research expertise told me were the only sensible way to deal with the illness I had” (Jamison, 1996, p. 5). She reasoned that her negative attitude toward medical treatment of her mood disorder was rooted in academia. When she was an undergraduate student at UCLA, one psychology professor and she were discussing antidepressant medications since both of them felt depressed. But they were very skeptical about taking them since they thought, “…we felt our depressions were more complicated and existentially [emphasis added] based than they actually were” (p. 54). Therefore, “Antidepressants might be indicated for psychiatric patients, for those of weaker stock, but not for us” (p. 54).
Even when Jamison became a Ph.D. student in psychology at UCLA, her skepticism toward psychiatry continued. When she needed to make a decision either to see a psychiatrist or to buy a horse, she chose to buy a horse because she had an absolute belief that she would be able to handle her own problems. As a clinical psychology graduate student, she still did not make any connection between her clinical training and her own symptoms. On the other hand, she was more comfortable treating psychotic patients than many of her colleagues were. This clearly showed how she detached herself from the reality.

In retrospect, Jamison said her denial was incomprehensible. However, she also mentioned that at that time mood disorders were far less focused on, compared to schizophrenia, in clinical psychology programs. Therefore, academia as a whole ignored mood disorders and she was merely a product of the time. As a result, even though her first major depressive episode appeared in her adolescence, it was only after she became an assistant professor of the Department of Psychiatry at UCLA that she first saw a psychiatrist. She said seeing a psychiatrist made her terrified and deeply embarrassed, but she had no choice since without it her life would be ruined (losing her job and her marriage). However, even after she started seeing the psychiatrist regularly, she was reluctant to take her medications as prescribed. In looking back, she said it was partly due to her fundamental denial that she had a real mental illness. In addition, even though her psychiatrist repeatedly urged her to go to a psychiatric hospital, she strongly refused since her concern was if her hospitalization became public, her professional job would be suspended or even revoked.
These attitudes were very similar to Endler’s. Jamison wrote that her major concerns about disclosing her mental disorder tended to be professional in nature. Her concerns were twofold: one was the relationship with her colleagues. She wrote that she worried that once she disclosed her mental disorder to her colleagues, they might suddenly become suspicious about her credentials as a clinician. She wrote that, for example, when she expressed her opinion at a “scientific” meeting, “will it instead be seen as a highly subjective, idiosyncratic view of someone who has a personal ax to grind?” (Jamison, 1996. p. 203).

To sum, although there is a 14 year-time difference between the two memoirs, the fear of stigma was prominent in both accounts.

**Attitudes toward treatment.**

Both Endler and Jamison received psychotropical treatment. Lithium was a major medication for both of them and they both said that it worked well. Endler also mentioned some antidepressants such as the MAO inhibitors and tricyclics that he took. Jamison, on the other hand, did not mention antidepressants. Instead, she extensively wrote about lithium. Although this does not necessarily mean she had no antidepressants, the implication is she did not think antidepressants were important for her.

In terms of psychotherapy, Endler mentioned his psychiatrist as a therapist. He did not seek a psychologist for professional help although his colleagues (psychologists) were very supportive. He more emphasized medications and electroshock therapy (ECT). On the other hand, Jamison actively sought psychotherapy. She wrote, “Psychotherapy is a sanctuary…it is where I have believed…” (Jamison, 1996, p. 89). Nonetheless, she did not mention her therapist’s name although she mentioned her psychiatrist’s name. She
said she saw her psychiatrist at least once a week for many years, except when she was abroad. Therefore, I suspect that her psychiatrist was also her psychotherapist. If so, both of them, who are prominent psychologists, did not seek a psychologist for professional help. It is possible that this decision may also have been stigma-related. 

While Jamison said the combination of medication (lithium) and psychotherapy assisted her recovery from bipolar disorder, Endler emphasized the combination of medication (lithium) and ECT; especially the effectiveness of ECT. Actually he preferred ECT over hospitalization, because ECT could be administered on an outpatient basis. Even though a stigma was also attached to ECT, again, this suggests how afraid he was to be hospitalized. He said most of his psychologist colleagues had a negative view of ECT. He mentioned that a psychologist, one of his friends, asked him why he was not getting deep psychotherapy instead. Endler said the movie, *One Flew over the Cuckoo’s Nest* in 1975, sensationalized the fear of ECT. Endler mentioned that while bilateral ECT would bring some temporary confusion and memory loss, unilateral ECT, which avoids placing electrodes in the speech area, greatly reduced the level of confusion and memory loss. Therefore, he followed his psychiatrist’s suggestion even though his psychologist colleagues had a prejudice against ECT. 

To conclude, although Endler first denied that he had a mood disorder, once he accepted it, he sought medical treatment (medication and ECT), not psychological treatment. The reason is that he thought that major affective disorders (bipolar and unipolar) are primarily physical, metabolic, and biochemical disturbances of the nervous system. Endler’s theoretical position logically led him to seek medical treatment.
On the other hand, Jamison’s position about medication was somewhat more personal. She said that she believed that manic-depression illness was a medical illness. However, she also said that all of these beliefs aside, she still thought that she ought to be able to carry on without drugs. She thought medication was the last resort. She also said that love is ultimately more extraordinary, even compared to medication.

**Professional competence and ethical issues.**

One of the most important issues related to this topic is whether a psychologist with a mental disorder is able to work as a mental health care provider/therapist. Needless to say, from an ethical standpoint, this dual role may violate the “no harm policy” of the APA’s Ethics Code (2002). Although the Ethics Code does not clearly mandate the need for self-care (Gilroy et al, 2002), self-care is obviously important for any clinician, particularly for those experiencing some distress.

Endler did not talk about this issue. The reason may be his mental illness was not severe enough, i.e., he himself described his depression as moderate. Also, it lasted for only three years. In addition, even at the height of his symptoms, he could manage his professional duties as a psychology professor. Therefore, he did not think his mental illness significantly affected his competency as a psychologist. On the other hand, Jamison extensively discussed this issue. The reason is, unlike Endler, she significantly suffered from mental illness, both privately and professionally. Her question was, “Do I really think that someone with mental illness should be allowed to treat patients?” (Jamison, 1996, p. 204). Although she did not give a clear answer to this question, she kept asking this question of herself. Instead Jamison said that
she had become fundamentally and deeply skeptical that anyone who had not experienced a manic depressive episode can truly understand it.

**Attitudes toward having mental illness.**

Both Endler (1982) and Jamison (1996) said that their own experiences of mental disorders motivated them to educate people, including mental health professionals. Jamison wrote extensively about how greatly she benefited from having a mental disorder. In her epilogue, when asked, she said that she would choose to have manic-depressive illness, although on the condition that lithium is available. She said that because of manic-depressive illness, “I have seen the breadth and depth and width of my mind and heart and seen how frail they both are, and how ultimately unknowable they both are” (Jamison, 1996, p. 218).

To sum, these previous studies have revealed several common themes: (a) The stigma of mental disorders exists even among psychologists. (b) Many psychologists still seem to be reluctant to admit they have a mental disorder and to seek treatment. (c) Some psychologists do not choose to receive treatment from other psychologists.

Why does this phenomenon exist? Gilroy et al. (2002) pointed out that this stigma and resistance to seeking treatment may originate in current graduate training for psychologists. The authors suggested that personal psychotherapy in graduate training be strongly encouraged. Frese & Davis (1997) proposed more collaboration between clinicians and consumers.

**Summary**

To sum the literature review, some previous survey studies on mental disorders among psychologists found the prevalence of depression among psychologists was
sometimes higher than in the general population. Both the survey results and the memoirs
which were written by psychologists who had experienced depression pointed out that the
stigma about having a mental disorder still exists even among psychologists and other
mental health professionals. As a result, psychologists who have depression struggle not
only with managing their depression but also with managing their relationship with their
colleagues and supervisors to hide their depression. However, some research has shown
that some psychologists found a positive meaning in having depression (mental illness)
since they could more deeply understand their clients who also had mental illness.
Chapter Three: Method

Research Design

For this study, a mixed methods research design was utilized. Mixed methods research is defined as 'the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language in a single study” (Johnson & Onwuegbuzie, 2004, p. 17). The use of mixed methods was chosen in order to obtain descriptive statistics that would allow the investigator to gain an overview of depression among psychologists, and also to gain an in-depth understanding of psychologists’ personal experiences of this. As a tactic, sequential quantitative (a questionnaire) – qualitative (in-depth interviews) methods were utilized to follow up on the survey results (Waszak & Sines, 2003). The combination of quantitative and qualitative research could produce more complete knowledge and understanding of depression among psychologists than either method used alone.

Descriptive and both parametric and nonparametric inferential statistics were used to quantitatively analyze the survey data. The constructivist approach was used to qualitatively analyze the in-depth interview data from the perspective of the research participants (Waszak & Sines, 2003).

Participants

Participants were licensed psychologists in the state of Colorado. For the survey research, a total of 800 psychologists were randomly selected from the list of licensed psychologists (total 2,149 active, licensed psychologists) which was provided by the
Colorado Department of Regulatory Agencies (DORA). For the individual interview, the first nine psychologists who responded to an invitation to participate in the qualitative part of the study were chosen.

The reasons for using the list of licensed psychologists provided by DORA were as follows:

1. This population was chosen because they most comprehensively represent active, practicing psychologists in the state of Colorado. Another potential local database was available through the Colorado Psychological Association (CPA), which has a membership of about 500, but it was far smaller than the DORA database (its active membership is 2,149).

2. The list is also open to review by the public (http://www.dora.state.co.us/) for convenient use.

3. The state of Colorado was chosen for logistical reasons as the current researcher resides in the state of Colorado and he wanted to conduct the interviews in person.

For the survey, a total of 325 psychologists responded to it. The demographic data of responding psychologists were as follows: Regarding their age, the mean was 54.0 years old (SD = 11.1) based on 315 usable data. The age ranged between 28 years old and 85 years old (Although a total of 325 psychologists responded to the survey, the number of usable data varied from question to question. The reason was they often left some questions unanswered. Those unanswered questions were treated as missing/unusable data.) Regarding their gender, out of the 317 who responded, 191 (59.1 %) were female and 126 (39.0 %) were male. Six people did not identify their gender. Regarding other demographic data, please see Table 1 to Table 6 in the Results section.
Among the nine participants who took part in the individual interview, five were female and four were male. They all were in their fifties and sixties. In order to ensure interview participants’ anonymity, no further demographic information about them will be given.

Materials

To conduct the survey, the current researcher developed a questionnaire about the “Experiences of Depression among Psychologists.” To do so, the current researcher first reviewed the questionnaire that was used by Gilroy et al. (2002) to examine counseling psychologists’ personal experiences with depression and treatment. The questionnaire then focused on creating trust in the respondents and reducing the cost for being a respondent, according to the tailored design method (Dillman, 2007). To create trust in the respondents, the current researcher disclosed in the cover letter that he himself has experienced severe depression, and as a future psychologist, he is keenly interested in how psychologists have experienced and perceived this issue. To reduce the cost of being a respondent, the questionnaire was (a) made easy to answer (self-explanatory), (b) short (it would take less than 10 minutes to answer), (c) avoided inconvenience (a prestamped return envelope with a return address was provided), and (d) minimized the request to obtain personal information. The draft of the questionnaire was presented to four psychologists (two university psychology faculty members, one retired university faculty member and one chief psychologist at a jail) to gain expert opinions. The revised final version of the questionnaire is attached in Appendix A.
For the individual interview, five interview questions were developed after consulting two psychologists (university faculty members). The interview questions are attached in Appendix B.

**Procedure**

In the selection process for the survey participants, originally, 500 psychologists were randomly selected from the list provided by DORA. However, soon after another 300 psychologists were added through random selection because the current researcher thought that the original 500 sample might not be enough.

To each of the 800 psychologists a cover letter (Appendix C), informed consent form (Appendix D) and questionnaire (Appendix A) were sent. As stated in the cover letter and in the informed consent form, the return of the questionnaire was considered to imply consent to participate in this project. Informed consent for the individual interview (Appendix E) was obtained when the investigator met the participant for the interview. The interview questions can be found in Appendix B.

During the initial survey research, participants did not interact with the investigator since anonymity was assured. The investigator provided his email address and phone number, so, if participants had specific questions about the survey, they could contact him. If participants agreed to have an individual interview, they could reach the investigator either by email or phone and then provide the investigator with their contact information.

Minimal risk regarding participating in this research project was anticipated. However, since they were asked to answer questionnaires regarding their experience/perception of depression, it was possible that administration of the
questionnaire might have had the potential to place them at risk for experiencing some anxiety. To minimize this risk, several safeguards were put in place. First, in the cover letter, participants were informed that questions regarding their experience/perception of their depression were going to be asked in the attached questionnaire. The cover letter also explained the informed consent process and participants were notified that they could skip any questions or stop responding if they felt uneasy answering any of the questions. Participants were also informed that they had no obligation to return their surveys.

In the second stage of the research, at the end of the questionnaire, participants were asked if they were interested in participating in an in-depth interview about the personal meaning of having depression. The interview questions were clearly stated at the end of the questionnaire. Like the questionnaires, the interview questions might have caused participants to feel anxious, though this risk was minimal because the interview questions were stated on the initial survey before they volunteered for the interview. Those who were interested in participating in the interview were informed they should contact the investigator either by email or phone. Interviews were conducted individually, with only the participant and the investigator present, at either the participant’s office or home, so as to assure confidentiality. The interviews included five structured, open-ended questions. To further decrease the risk for experiencing some anxiety, the interview participants were told that during the informed consent process they could skip any questions or stop responding if they felt uneasy answering any of the questions. They were also told they had no obligation to complete the interview. The interviews usually lasted up to one hour and were audiotaped using two voice recorders, one as a backup,
and were later transcribed. While audiotaping could increase the confidentiality risk to participants, steps were taken to minimize this risk, such as not identifying participants by name either during the interviews or on the transcripts. Further, the data were stored in a locked secured file cabinet by participant number and were not associated with personally identifying information.

Participants, who are all licensed psychologists in the state of Colorado, may have been concerned that the principal investigator, who is a psychology student, and his dissertation committee, which includes psychologists, would become aware of their depression and/or their history of depression. This risk was minimized with careful measures taken to ensure anonymity and confidentiality. The response to the questionnaire was anonymous and participants' demographic data was minimal. Only general demographic data such as gender and age were collected. No specific geographic data such as what region they live in was collected other than that they are licensed psychologists practicing in the state of Colorado. To further ensure anonymity, the data from the questionnaires are being presented as group data. The only exceptions are some qualitative data, which were descriptive responses to open-ended questions (Survey Questions 12 and 14). In this case the data were presented with no identifiable information such as name and address.

In the case of the interview data, the transcripts of the interviews were conducted by a professional transcriber who strictly followed the confidentiality as professional ethics. I reviewed all the interview transcripts and extracted only information which directly related to the five interview questions. Those transcripts were presented only
with their gender and age range. All identifiable information such as name and address were removed from the transcripts.

This research project was approved by the Institutional Research Review Board (IRB) on June 9, 2009 and reapproved on June 8, 2010.
Chapter Four: Results

Out of 800 questionnaires, eight were returned due to being not deliverable as addressed or because the addressee was deceased. In total, 325 psychologists responded out of 792 psychologists to whom the questionnaire was delivered. The response rate was 41.0%.

Demographic Questions

The demographic data of the responding psychologists are summarized as follows:

Age. Regarding age, the mean was 54.1 years old (SD = 11.0), the median was 55.0 years old and the mode was 62.0 years old based on 318 valid cases (seven persons did not report age). Age ranged between 28 years old and 85 years old. An independent-samples t-test comparing the mean age of female psychologists to male psychologists resulted in a significant difference between the means of the two groups ($t(316) = -7.662$, $p < .001$). The mean age of male psychologists ($M = 59.5$, $SD = 9.4$) was significantly older than the mean age of female psychologists ($M = 50.6$, $SD = 10.6$).

Gender. In terms of gender, out of 319 valid responses, 193 (60.5%) were female and 126 (39.5%) were male.

Ethnicity. Table 1 summarizes the distribution of ethnicity within the sample. The greatest number of participants were European American.
### Table 1

**Ethnicity**

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>European American</td>
<td>293</td>
<td>92.7%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7</td>
<td>2.2%</td>
</tr>
<tr>
<td>Multiracial</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>African American</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Asian American</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other(^a)</td>
<td>9</td>
<td>2.8%</td>
</tr>
</tbody>
</table>

*Note. N = 316.*

\(^a\)In the answer part, “Other” was provided to give respondents more options in addition to the provided categories. Some respondents identified themselves as Caucasian or White in the “Other” instead of a provided “European American” ethnic category. Both Caucasian and White were included in the European American category. Hereafter, the “Other” category was grouped based on the content similarity.

### Marital status

Table 2 summarizes the marital status of the sample. The greatest percentage of participants were married (72.1%).

### Table 2

**Marital Status**

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
<td>230</td>
<td>72.1%</td>
</tr>
<tr>
<td>Divorced</td>
<td>43</td>
<td>13.5%</td>
</tr>
<tr>
<td>Single</td>
<td>26</td>
<td>8.2%</td>
</tr>
<tr>
<td>Widowed</td>
<td>9</td>
<td>2.8%</td>
</tr>
<tr>
<td>Partnered</td>
<td>5</td>
<td>1.6%</td>
</tr>
<tr>
<td>Separated</td>
<td>2</td>
<td>0.6%</td>
</tr>
<tr>
<td>Other</td>
<td>4</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

*Note. N = 319.*
**Academic degree.** Table 3 summarizes the academic degrees of the respondents, with the greatest percentage having Ph.D. degrees followed by Psy.D. degrees.

Table 3

*Academic Degree*

<table>
<thead>
<tr>
<th>Degree</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ph.D.</td>
<td>205</td>
<td>64.3 %</td>
</tr>
<tr>
<td>Psy.D.</td>
<td>99</td>
<td>31.0 %</td>
</tr>
<tr>
<td>Ed.D.</td>
<td>14</td>
<td>4.4 %</td>
</tr>
<tr>
<td>Sc.D.</td>
<td>1</td>
<td>0.3 %</td>
</tr>
</tbody>
</table>

*Note.* N = 319.

**Direct client contact hours per week.** Regarding the number of direct client contact hours per week, Table 4 summarizes the results in the order of category frequency.

About two thirds of the respondents had more than 10 direct client contact hours per week.

Table 4

*Number of Direct Client Contact Hours per Week*

<table>
<thead>
<tr>
<th>Direct Client Contact Hours</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>21 hours to 40 hours</td>
<td>110</td>
<td>34.9 %</td>
</tr>
<tr>
<td>11 hours to 20 hours</td>
<td>99</td>
<td>31.4 %</td>
</tr>
<tr>
<td>10 hours or less</td>
<td>99</td>
<td>31.4 %</td>
</tr>
<tr>
<td>41 hours or more</td>
<td>7</td>
<td>2.2 %</td>
</tr>
</tbody>
</table>

*Note.* N = 315.
Years in full or part-time clinical practice (post-degree). Regarding the number of years in full or part-time clinical practice (post-degree), Table 5 presents the results in the order of category frequency. The results indicated that nearly half (46 %) had worked more than 20 years.

Table 5

*Number of Years in Full or Part-Time Clinical Practice (Post-Degree)*

<table>
<thead>
<tr>
<th>Years in Clinical Practice</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 years to 20 years</td>
<td>94</td>
<td>29.8 %</td>
</tr>
<tr>
<td>21 years to 30 years</td>
<td>91</td>
<td>28.9 %</td>
</tr>
<tr>
<td>31 years or more</td>
<td>60</td>
<td>19.0 %</td>
</tr>
<tr>
<td>6 years to 10 years</td>
<td>41</td>
<td>13.0 %</td>
</tr>
<tr>
<td>1 year to 5 years</td>
<td>29</td>
<td>9.2 %</td>
</tr>
</tbody>
</table>

*Note. N = 315.*

Employment setting. There were various employment settings represented among the participants. Table 6 shows the results by category frequency. By far the largest group represented in this sample was in private practice.
Table 6

Employment Setting

<table>
<thead>
<tr>
<th>Settings</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice</td>
<td>159</td>
<td>49.7%</td>
</tr>
<tr>
<td>Multiple settings</td>
<td>35</td>
<td>10.9%</td>
</tr>
<tr>
<td>Hospital</td>
<td>24</td>
<td>7.5%</td>
</tr>
<tr>
<td>University</td>
<td>24</td>
<td>7.5%</td>
</tr>
<tr>
<td>School</td>
<td>19</td>
<td>5.9%</td>
</tr>
<tr>
<td>Community mental health center</td>
<td>14</td>
<td>4.4%</td>
</tr>
<tr>
<td>University counseling center</td>
<td>9</td>
<td>2.8%</td>
</tr>
<tr>
<td>Corrections</td>
<td>5</td>
<td>1.6%</td>
</tr>
<tr>
<td>Government (state/federal) agency</td>
<td>4</td>
<td>1.3%</td>
</tr>
<tr>
<td>Military</td>
<td>4</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other</td>
<td>23</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

Note. N = 320.

Survey Items Addressing Research Questions

In addition to the demographic questions, a number of other questions were asked that were related to the research questions. The results were as follows. Some responses were further analyzed to determine whether any gender differences existed.

Survey Question 1. The question was, “Have you ever experienced depressive symptom(s)?” This question addressed Research Question 1, “How prevalent is depression among psychologists in Colorado who responded to the survey?” Out of 320 psychologists who responded to this question (5 were missing), 221 (69.1 %) answered, “Yes” and 99 (30.9 %) answered, “No.” Among those psychologists who answered, “Yes” (221), 141 (63.8 %) were females and 78 (35.2 %) were males (2 were missing).
To examine the gender and depressive symptom association, a chi-square test of independence was calculated comparing the frequency of the experience of depressive symptom(s) for male psychologists and female psychologists. No significant association was found ($\chi^2 (1) = 3.64$, $p = .056$).

Regarding any ethnicity and depressive symptom association, the frequencies of the depressive symptom(s) for European American psychologists and non-European American psychologists were compared since ethnic minorities are usually more likely to have mental illness compared to their European American counterparts (e.g., U.S. Department of Health and Human Services [USDHHS], 2001). The prevalence of depressive symptom(s) among European American psychologists was 69.5% and the prevalence of depressive symptom(s) among their counterpart of non-European psychologists was 63.6%. Although statistical tests were not immediately available due to the small number of non-European samples, this result seems to contradict common notions about the disparity between ethnic minorities and the majority. Further research should reveal the truth regarding this seeming contradiction.

**Survey Question 2.** The question was, “When you realized you were developing depressive symptom(s), what was your first reaction? (Please check all that apply.)” Possible responses were offered along with an “Other” response the participants used to fill in their own answers. This question addressed Research Question, “How do psychologists deal with their own depression?” Table 7 shows the results in the order of category frequency for the 218 respondents who answered “Yes” to Question 1.
Table 7

*First Reaction to Depressive Symptom(s)*

<table>
<thead>
<tr>
<th>First Reaction</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wanted to solve myself</td>
<td>82</td>
<td>37.6%</td>
</tr>
<tr>
<td>Sought diagnosis/treatment as soon as possible</td>
<td>38</td>
<td>17.4%</td>
</tr>
<tr>
<td>Didn’t want to acknowledge</td>
<td>8</td>
<td>3.7%</td>
</tr>
<tr>
<td>Wanted to hide it from others and Wanted to solve the problem myself</td>
<td>8</td>
<td>3.7%</td>
</tr>
<tr>
<td>Fear</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>Other(^a)</td>
<td>82</td>
<td>37.6%</td>
</tr>
</tbody>
</table>

*Note.* N = 218.

\(^a\)There were various answers (e.g., viewed as normal, talked to others, changed a job, angry).

**Survey Question 3.** The question was, “Have you ever sought psychiatric/psychological treatment for depressive symptom(s)?” This question also addressed Research Question 2.

Among 219 psychologists who responded to this question, 149 said, “Yes” (68.0 %) while 70 said, “No” (32.0 %). To examine the gender association regarding treatment seeking behavior, a chi-square test of independence was calculated. The result showed that female psychologists more frequently reported they sought treatment (Expected = 95.4, Observed = 104) than did male psychologists (Expected = 53.6, Observed = 45), \( \chi^2(1) = 6.81, p < .009 \).

To those who answered, “Yes” (149), the next question was further asked, “If yes, what was your diagnosis based on the DSM?” Among those who responded to this question (143), their diagnoses varied extensively. Nonetheless, the major diagnoses are presented in Table 8.
Table 8

*Diagnosis Based on the DSM*

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment disorder</td>
<td>36</td>
<td>25.2%</td>
</tr>
<tr>
<td>Major depressive disorder</td>
<td>28</td>
<td>19.6%</td>
</tr>
<tr>
<td>Dysthymic disorder</td>
<td>22</td>
<td>15.4%</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>5</td>
<td>3.5%</td>
</tr>
<tr>
<td>Depressive disorder not otherwise specified</td>
<td>5</td>
<td>3.5%</td>
</tr>
<tr>
<td>None</td>
<td>13</td>
<td>9.1%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>9</td>
<td>6.3%</td>
</tr>
<tr>
<td>Other&lt;sup&gt;a&lt;/sup&gt;</td>
<td>25</td>
<td>17.5%</td>
</tr>
</tbody>
</table>

*Note.* N = 143.

<sup>a</sup> Posttraumatic stress disorder, generalized anxiety disorder, panic disorder, bereavement, etc.

To those who answered, “No,” to the treatment sought questions (70), the next question was further asked, “Why did you not seek treatment? (Check all that apply.)” Table 9 summarizes the frequency of reasons for not seeking treatment in the order of category frequency based on 62 cases.
Table 9

Reason for Not Seeking Treatment

<table>
<thead>
<tr>
<th>Reason</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depressive symptoms went away after using appropriate coping skills (e.g., exercise, meditation).</td>
<td>24</td>
<td>38.7%</td>
</tr>
<tr>
<td>Depressive symptoms eventually went away.</td>
<td>11</td>
<td>17.7%</td>
</tr>
<tr>
<td>The combination of (1) and (2).</td>
<td>6</td>
<td>9.7%</td>
</tr>
<tr>
<td>The combination of (1) and, “I was concerned about confidentiality.”</td>
<td>2</td>
<td>3.2%</td>
</tr>
<tr>
<td>The combination of (1), (2) and the confidentiality concern.</td>
<td>2</td>
<td>3.2%</td>
</tr>
<tr>
<td>Other&lt;sup&gt;a&lt;/sup&gt;</td>
<td>17</td>
<td>27.4%</td>
</tr>
</tbody>
</table>

Note. N = 62.
<sup>a</sup>Among “Others,” two psychologists included the confidentiality concern.

Survey Question 4. The question was, “What was your first reaction when you were diagnosed with, or thought you could be diagnosed with a mental illness? (Please choose one.)” This question also addressed Research Question 2.

For those who responded to this question (N = 150), the results are summarized in Table 10.
Table 10

First Reaction to Mental Illness Diagnosis

<table>
<thead>
<tr>
<th>First Reaction</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>I accepted the diagnosis with relief, as liberating and validating.</td>
<td>49</td>
<td>32.7%</td>
</tr>
<tr>
<td>I accepted the diagnosis as a matter of fact.</td>
<td>35</td>
<td>23.3%</td>
</tr>
<tr>
<td>I accepted the diagnosis but implicitly questioned it.</td>
<td>16</td>
<td>10.7%</td>
</tr>
<tr>
<td>I accepted with unhappiness/grief/shame.</td>
<td>5</td>
<td>3.3%</td>
</tr>
<tr>
<td>I rejected the diagnosis as inappropriate.</td>
<td>4</td>
<td>2.7%</td>
</tr>
<tr>
<td>I accepted with relief and shame.</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Other(^a)</td>
<td>39</td>
<td>26.0%</td>
</tr>
</tbody>
</table>

Note. N = 150.
\(^a\) e.g., “Sought to understand it.” Collaborated in determining diagnosis.” “I wanted it to be temporary.”

Survey Question 5. The question was, “How long did you have depression before you received a diagnosis? (Please choose one.)” This question also addressed Research Question 2. For the 138 valid cases, Table 11 shows the result.

Table 11

Duration before Receiving a Diagnosis

<table>
<thead>
<tr>
<th>Duration</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 months</td>
<td>57</td>
<td>41.3%</td>
</tr>
<tr>
<td>More than 1 year</td>
<td>36</td>
<td>26.1%</td>
</tr>
<tr>
<td>3-6 months</td>
<td>28</td>
<td>20.3%</td>
</tr>
<tr>
<td>More than 6 months – 1 year</td>
<td>17</td>
<td>12.3%</td>
</tr>
</tbody>
</table>

Note. N = 138.
No significant gender difference was found regarding the waiting period before receiving a diagnosis ($\chi^2 (3) = 1.60, p = .660$).

**Survey Question 6.** The question was, “Who diagnosed you? (Please choose one).” This question also addressed Research Question 2. For the 146 valid responses, the results are shown in Table 12.

<table>
<thead>
<tr>
<th>Who diagnosed you?</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist</td>
<td>60</td>
<td>41.1%</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>31</td>
<td>21.2%</td>
</tr>
<tr>
<td>Self</td>
<td>30</td>
<td>20.5%</td>
</tr>
<tr>
<td>Physician</td>
<td>12</td>
<td>8.2%</td>
</tr>
<tr>
<td>MSW/LCSW</td>
<td>7</td>
<td>4.8%</td>
</tr>
<tr>
<td>Other$^a$</td>
<td>6</td>
<td>4.1%</td>
</tr>
</tbody>
</table>

*Note. N = 146.*

$^a$One response each: marriage family therapist, school counselor, LPC, master’s level clinician, psychoanalyst, and no one.

**Survey Question 7.** The question was, “Are/were you on medication(s) for your symptoms of depression?” This question also addressed Research Question 2.

Out of 150 valid responses, 57 (38.0%) responded “No” while 93 responded “Yes” (62.0%). Among the 93 who said, “Yes” on medication(s), the type of medication is shown in descending order of frequency in Table 13.
Table 13

Medication(s) for Symptoms of Depression

<table>
<thead>
<tr>
<th>Medication</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSRIs(^a)</td>
<td>43</td>
<td>46.2%</td>
</tr>
<tr>
<td>Multiple types of medications</td>
<td>25</td>
<td>26.9%</td>
</tr>
<tr>
<td>Name is not given</td>
<td>9</td>
<td>9.7%</td>
</tr>
<tr>
<td>New generation antidepressant(^b)</td>
<td>6</td>
<td>6.5%</td>
</tr>
<tr>
<td>Tricyclic</td>
<td>5</td>
<td>5.4%</td>
</tr>
<tr>
<td>Herbal (St. John’s wort)</td>
<td>2</td>
<td>2.2%</td>
</tr>
<tr>
<td>Other(^c)</td>
<td>3</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Note. N = 93.
\(^a\)Selective serotonin reuptake inhibitors
\(^b\)e.g., Wellbutrin, Remeron and trazodone
\(^c\)One of each: mood stabilizer, antianxiety, antidepressant

Survey Question 8. The question was, “How do/did you handle your professional life while having a depression issue? (Please choose one.)” This question addressed Research Question 3, “How do psychologists handle their professional life while having a depression issue?”

For the 149 valid responses, the categories and frequencies are shown in Table 14.
Table 14

Way of Handling Professional Life while having a Depression Issue

<table>
<thead>
<tr>
<th>Way of Handling Professional Life</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Just kept going as well as I could.</td>
<td>96</td>
<td>64.4%</td>
</tr>
<tr>
<td>Reduced overall schedule of activities including seeing clients for a period of time.</td>
<td>15</td>
<td>10.1%</td>
</tr>
<tr>
<td>Stopped seeing all clients for a period of time.</td>
<td>4</td>
<td>2.7%</td>
</tr>
<tr>
<td>Stopped seeing most severe/difficult clients for a period of time.</td>
<td>3</td>
<td>2.0%</td>
</tr>
<tr>
<td>Stopped other activities besides seeing clients for a period of time.</td>
<td>2</td>
<td>1.3%</td>
</tr>
<tr>
<td>Othera</td>
<td>29</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

Note. N = 149.
aAmong other answers, one psychologist stated he quit a job.

Survey Question 9. The question was, “Would you or did you feel any ethical concerns about having depression yourself as a mental health professional? (Please choose one.)” This question addressed Research Question 5, “Do psychologists feel any ethical concerns about having depression themselves as mental health professionals?”

For the 220 valid responses, the order by category and frequency is shown in Table 15.
Table 15

*Ethical Concerns about Having Depression as a Mental Health Professional*

<table>
<thead>
<tr>
<th>Ethical Concerns</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is ethical as a mental health professional to see clients while having</td>
<td>101</td>
<td>45.9%</td>
</tr>
<tr>
<td>depression as long as I am aware of my symptoms and limitations.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It depends on the severity (for example, whether or not I am receiving</td>
<td>73</td>
<td>33.2%</td>
</tr>
<tr>
<td>treatment).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>It is not ethical as a mental health professional to see clients while having</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>depression.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other&lt;sup&gt;a&lt;/sup&gt;</td>
<td>43</td>
<td>19.5%</td>
</tr>
</tbody>
</table>

Note. N = 220.

<sup>a</sup>e.g., “It is ethical with appropriate supervision.” “Mild depression does not negate high function, not an ethical issue.” “It depends on whether it diminished one’s therapeutic helpfulness.”

**Survey Question 10.** The question was, “How do you think that having depression relates to your professional competence? (Please choose one.)” This question addressed Research Question 4, “How do psychologists think that having depression relates to their professional competence?”

For the 218 valid responses, the responses are shown in descending order of frequency in Table 16. The most common response was, “As long as depression is mild or moderate, it does not greatly interfere with my professional competence.”
Table 16

Relationship between having Depression and Professional Competence

<table>
<thead>
<tr>
<th>Depression and Professional Competence</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>As long as depression is mild or moderate, it does not greatly interfere with my professional competence.</td>
<td>97</td>
<td>44.5%</td>
</tr>
<tr>
<td>Having depression enhances my professional competence since I can empathize with clients with depression.</td>
<td>59</td>
<td>27.1%</td>
</tr>
<tr>
<td>Having depression does not interfere with my professional competence.</td>
<td>20</td>
<td>9.2%</td>
</tr>
<tr>
<td>Having depression greatly interferes with my professional competence.</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other\textsuperscript{a}</td>
<td>40</td>
<td>18.3%</td>
</tr>
</tbody>
</table>

\textbf{Note.} N = 218.\\
\textsuperscript{a}e.g., “Having been depressed and seeking treatment and supervision greatly enhanced my competence.” “Depends on severity, treatment, and openness to feedback by supervisor or therapist plus type of clientele you see.” “…must be aware of transferences/countertransferences…”

**Survey Question 11.** The question was, “On the line below, please circle the number that best describes your personal experience of depression.” This question addressed Research Question 6, “What meanings do psychologists attach to having depression?”

For the 210 valid responses, the minimum was 1, the maximum was 10, and the mean was 7.21 (SD = 1.97) on a scale of 1 to 10. In the scale, 1 is, “I felt it was a stigma,” and 10 is, “I felt potential for meaning.” In other words, the psychologists in general perceived their experience of depression positively. Although the distribution was highly skewed to 10 (potential for meaning), nonetheless, 21 psychologists (10%) rated
it between 1 and 4 (less than the middle, closer to a stigma). Among them, two psychologists rated it as 1 and another two psychologists rated it as 2.

To see if any gender difference existed, an independent-samples $t$-test was calculated comparing the mean score of female psychologists to the mean score of male psychologists. No significant difference was found ($t(206) = -0.42, p > .05$). The mean of female psychologists ($M = 7.16$, $SD = 1.97$) was not significantly different from the mean of male psychologists ($M = 7.28$, $SD = 1.99$).

A Pearson correlation coefficient was calculated for the relationship between psychologists’ age and their rate of personal experience of depression. A weak positive correlation was found ($r(205) = .15, p = .030$), indicating a significant linear relationship between the two variables. Older psychologists tended to rate their experience of depression as more meaningful.

**Survey Question 12.** The question was, “What, if anything, did you learn from your depression?” This question also addressed Research Question 6, “What meanings do psychologists attach to having depression?”

Of the 222 psychologists who answered “Yes” to Question 1, “Have you ever experienced depressive symptom(s)?” 191 responded to this question. (Thirty-one psychologists left this question blank.) Since this question was an open-ended one, their answers varied. After they were sorted out based on the similarity of the theme, the order of the major responses is shown in Table 17.
Table 17

*Things Learned from Experience of Depressive Symptom(s)*

<table>
<thead>
<tr>
<th>Things learned</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better understanding of clients</td>
<td>49</td>
</tr>
<tr>
<td>(empathy, compassion, etc.)</td>
<td></td>
</tr>
<tr>
<td>Importance of self-care</td>
<td>31</td>
</tr>
<tr>
<td>Importance of psychotherapy/treatment</td>
<td>26</td>
</tr>
<tr>
<td>Normality of having depression</td>
<td>24</td>
</tr>
<tr>
<td>Deeper insight into self (meaning of life, etc.)</td>
<td>20</td>
</tr>
<tr>
<td>Benefit of medication</td>
<td>13</td>
</tr>
<tr>
<td>Treatability of depression</td>
<td>12</td>
</tr>
<tr>
<td>Awareness of need to change</td>
<td>8</td>
</tr>
<tr>
<td>Importance of support system</td>
<td>7</td>
</tr>
<tr>
<td>Debilitating power of depression</td>
<td>7</td>
</tr>
<tr>
<td>Resiliency of human nature</td>
<td>5</td>
</tr>
</tbody>
</table>

Note. Some psychologists mentioned multiple themes. Therefore, the total number of responses exceeds the number of respondent psychologists (191).

The most frequently mentioned theme regarding what psychologists learned from their experience of depression was better understanding of clients through enhanced empathy and compassion. This theme is closely related to psychologists’ professional role of helping others. The other themes that emerged could have been mentioned by many lay people who have experienced depression. These themes suggest that psychologists gained greater awareness of the significance of certain factors when they themselves experienced depression. In other words, until they had a first-hand experience of depression, some participants may not have understood the nature of depression on a
personal level and they may have considered that they were exempt from having depression because of their professional skills and knowledge. One psychologist straightforwardly wrote, “That it [depression] is real and we cannot just shake it off.” Another psychologist wrote, “That even as a “professional” (my research area for dissertation was depression) who had done lots of therapy and personal growth work, I could still develop depression.”

Not surprisingly, many psychologists mentioned the importance of psychotherapy/treatment. One psychologist put it this way: “That therapy works(!).” Nonetheless, several psychologists expressed their suspicion of the effectiveness of psychotherapy. Three psychologists addressed this notion, mentioning that they did not do themselves what they told to their clients. One psychologist wrote, [It was hard to] “Practice what I preach to my clients to help myself.”

Among other responses, two psychologists mentioned the “humility” of having depression. One psychologist mentioned that a stigma about mental illness still exists even among professional psychological organizations as follows: “Most surprising: Denied health coverage by APA Insurance Co. for psychologists in private practice = stigma.” One psychologist mentioned the negative impact of clinical work as follows: “The impact of clinical practice (25+ years) can be quite debilitating.”

**Survey Question 13.** The question was, “What is your theoretical orientation? (Please indicate your primary orientation.)” This question, along with Survey Question 14, addressed Research Question 7, “Is there any relationship between psychologists’ theoretical orientation and their perception of depression?”
For the 220 valid responses, the rank order (except for “Other” responses) is shown in Table 18.

Table 18

<table>
<thead>
<tr>
<th>Theoretical Orientation</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive behavioral</td>
<td>68</td>
<td>30.9%</td>
</tr>
<tr>
<td>Eclectic/integrative</td>
<td>52</td>
<td>23.6%</td>
</tr>
<tr>
<td>Psychodynamic</td>
<td>35</td>
<td>15.9%</td>
</tr>
<tr>
<td>Multiple (more than two)</td>
<td>13</td>
<td>5.9%</td>
</tr>
<tr>
<td>Humanistic</td>
<td>11</td>
<td>5.0%</td>
</tr>
<tr>
<td>Cognitive and psychodynamic</td>
<td>5</td>
<td>2.3%</td>
</tr>
<tr>
<td>Systems</td>
<td>5</td>
<td>2.3%</td>
</tr>
<tr>
<td>Psychoanalytic</td>
<td>4</td>
<td>1.8%</td>
</tr>
<tr>
<td>Behavioral</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>Cognitive behavioral and systems</td>
<td>3</td>
<td>1.4%</td>
</tr>
<tr>
<td>Feminist</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Feminist and psychodynamic</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Psychoanalytic and psychodynamic</td>
<td>2</td>
<td>0.9%</td>
</tr>
<tr>
<td>Other (one response each)</td>
<td>15</td>
<td>6.8%</td>
</tr>
</tbody>
</table>

*Note. N = 220.

* Existential, eastern/Buddhist, evidence based, synthesis of sexual orientations, etc.

**Survey Question 14.** The question was, “Does your theoretical orientation relate to your perception of depression? (Please circle the response.)” This question addressed Research Question 7.

Of the 213 valid responses, 146 (68.5 %) said, “Yes,” while 67 (31.5 %) said, “No.” Of those who responded, “Yes” to this question, the following question, “In what
“way?” was asked. Out of 146, 137 provided their comments while 9 did not respond. Of the 67 who answered “No” to this question, five provided comments.

Among those psychologists who gave comments, four participants thought there was a general relationship between theoretical orientation and the perception of depression. That is, one psychologist commented, “[My theoretical orientation] gave me a model for how I felt and why.” However, most psychologists commented that there was a direct relationship between their specific theoretical orientation and their perception of depression. That is, they applied specific therapeutic techniques based on their theoretical orientation to treat their own depression. For example, a psychologist whose theoretical orientation is cognitive behavioral, commented, “thoughts impact feelings which impact behavior.” A psychologist whose approach is psychodynamic, commented on the “Emphasis on childhood origins and parental relationships.” A psychologist whose orientation is eclectic/integrative, commented, “I am more aware of the number of systems (family, environment, etc.) that influence the system.”

Although few, some psychologists commented that they did not necessarily use their theoretical orientation to view or treat their own depression. For example, a psychologist whose orientation is cognitive behavioral, commented, “I believed that depression can be attributed to irrational thoughts/beliefs, but in my case, my symptoms were brought on by stress at work.” Another psychologist, whose orientation is psychodynamic, commented, “Actually, although my orientation is psychodynamic, I was able to move through my depression using cognitive behavioral techniques, which I use in my practice as well.”
To sum, most psychologists saw their depression from the perspective of their theoretical orientation and then utilized therapeutic techniques that stemmed from it. In other words, their theoretical orientation appeared to be related to their perception of depression.

For some other psychologists’ responses according to their theoretical orientation (only major orientations were included), refer to Appendix F.

**Individual Interviews**

The summary of the nine psychologists’ answers to the five interview questions are as follows. (For all psychologists’ responses [partial transcripts], refer to Appendix G.)

**Question 1: What have you learned from depression?**

Although the psychologists’ responses to this question varied and they were mostly ambivalent (they expressed positive as well as negative aspects), most psychologists (eight out of nine) reported their experience of depression was positive, although the degree of reported positiveness varied. Only one psychologist responded her experience was rather neutral. She stated, “I’ve found that there’s a lot of biochemical associates with it” (female in her 50s). Nonetheless, most psychologists reported their experience of depression by using some positive descriptors. (Some psychologists used multiple adjectives or phrases to express what they learned from their experience of depression, therefore, the total number of psychologists’ responses could exceed nine.) Three psychologists mentioned that they became more “empathic.” Two mentioned that depression gave them new “insight;” one mentioned she learned “compassion,” while another mentioned she learned to be more “mindful.”
Four psychologists mentioned some of the negative aspects of depression. The psychologists described these negative aspects as, “very painful,” “how awful,” “how pervasive,” and “shame.” One psychologist who mentioned shame stated, “I’ve worked real hard over the years to get rid of the shame that goes with that,” although she also learned that depression is a physical/biological illness. One psychologist who described his experience as “very painful” stated that he has learned, “You can get out of it.” Another psychologist mentioned that she has learned that having a “social support system” such as friends, family and colleagues is critical.

One interesting thing was that one psychologist stated that her knowledge and clinical experience as a psychologist did not help her manage her depression better than a layperson. She stated this as follows:

No! I don’t think it [being a psychologist] helped me one bit! In fact, it wasn’t until my therapist pointed it out to me that it was like “oh yeah, that’s what this is.” So, no, I was as clueless as anybody else about my own experience. It didn’t help one bit. (Female in her 60s)

To conclude, most psychologists disclosed that having depression is a harsh experience; nonetheless, it enhanced both their personal and professional life.

**Question 2: How has the experience of depression affected your practice as a psychologist (e.g., your relationship with your clients and colleagues)?**

In this question, I was especially interested in psychologists’ relationships with their clients and colleagues since it would reveal how they managed their depression in the professional setting. I was also interested in the self-disclosure issue; that is, disclosure to their clients and to their colleagues. Disclosure to their clients could represent how psychologists handled ethical issues like that and disclosure to their colleagues could represent how they handled negative aspects of depression such as
stigma issues. However, in the actual interviews, I sometimes did not explicitly address these self-disclosure issues based on the flow of the interviews. Therefore, not all psychologists clearly responded to the issues.

First, regarding psychologists’ relationships with their clients, as they mentioned in Question 1, most psychologists stated that their experience of depression brought them “a more acute awareness,” “much greater empathy,” and helped them to “listen better,” be “more patient,” and “more attuned.”

Second, regarding psychologists’ self-disclosure to their clients, the responses varied across the spectrum of degree of self-disclosure from “zero” or a flat “no” to “very open.” Nonetheless, among those psychologists who explicitly responded to this question, the majority were very cautious about disclosing their experience of depression to their clients. One psychologist, who answered that she did not disclose it, mentioned that it is “a boundary issue,” (female in her 60s) while another psychologist mentioned it is “the judgment of the readiness of the client and not just to share for the sake of sharing” (male in his 60s).

However, one psychologist, who replied that she became “very open” about disclosing her experience, stated the reason as follows:

It has probably changed over time again, as I’ve been in practice working as a psychologist for almost 30 years. Initially, I guess there was more of a secret. As time has gone by, I’ve been able to think about it and experience it and live through it. I’ve seen it as an important tool. Now, when I see my clients, almost always in the first session, I identify that I have bipolar disorder and I have ADHD. That these are challenges that I’ve gone through, because I don’t want my clients to feel ashamed that they have illnesses that they might need to work through. So I’ve become very open. I’ve become a real advocate of being open about it. (Female in her 50s)
Here the psychologist emphasized that she intentionally discloses her mental illness to her clients in the beginning as a mental health “advocate” since she does not want her clients to “feel ashamed of” having mental illness.

Third, regarding the psychologists’ self-disclosure to their colleagues, their responses were generally negative. Only two psychologists clearly stated that they did not hide their experience of depression from their colleagues. One psychologist stated the reason why she did not hide it as, “We’re very close and they knew what was going on the whole time and they supported me” (female in her 60s). Another psychologist, who also stated he shares his experience of depression with his colleagues, said he does not think a taboo or stigma exists among psychologists to talk about their own mental illness (male in his 60s). Nonetheless these kinds of responses were a far minority. Other psychologists stated that they are very cautious about disclosing their experience of depression. One psychologist stated that it is “absolutely” taboo even now. He stated the reason as, “I would be afraid that people would stop giving me referrals, they would question my competence, they would question my ability to maintain the quality of practice, things like that” (male in his 60s). One psychologist admitted that she hesitates to disclose her experience of depression and mentioned the existence of stigma. But she also analyzed her hesitancy on a personal level as being because of “my own fear of competency” and “a projection of my own insecurities” (female in her 50s). One psychologist stated that she discloses her experience of depression to “only the person that I’ve chosen to trust” and analyzed the reason why psychologists, who are supposed to be experts on mental illness, still have a bias against having mental illness as follows:

I think part of that may be because we’re trained to be the experts and to help other people who are sick. That doesn’t include us. I mean, somewhere along the
way we lose that connection, that we’re part of the population. I mean, you know, I’ve had psychologists as clients, so we know they get sick, but, yeah, there’s a disconnect. (Female in her 60s)

To conclude, regarding the influence of their experience of depression on their clients, almost all the psychologists saw some positive elements in it. Nonetheless, the majority of them were very cautious about disclosing their experience of depression to their clients. The reasons were they were concerned about boundary issues and the therapeutic usefulness of disclosure. One psychologist, however, stated that she discloses her mental illness experience to her clients to help get rid of the shame that is often attached to mental illness. However, such an active “advocate” approach seems to be uncommon. Regarding the relationship with their colleagues, most psychologists were very cautious about disclosing their own experience of depression. They mentioned that because a stigma about having mental illness still exists among some psychologists, they were concerned about their reputation and future referrals.

**Question 3: How did the experience of depression affect your perception of mental disorders/illness?**

Four psychologists out of nine mentioned their experience of depression increased their awareness of some of the struggles regarding mental illness their clients might have by using the terms, “sensitivity,” “compassion,” and “flexibility.” The other five psychologists mentioned that it made them reconsider the etiology of mental illness by mostly referring to generic factors. Among them, two psychologists frankly stated that they learned psychologists are also prone to mental illness. One psychologist stated, “I think I didn’t really understand that [depression] viscerally until it was me. That it could happen to anybody. That it could happen to anyone and that there’s nothing special about me (laughs)” (female in her 60s). The other psychologist stated, “Of course I had the
intellectual understanding and what not. But it’s one thing to read about it, to see it, and to work with it. It’s another thing to experience it” (male in his 60s).

To conclude, all psychologists admitted their experience of depression enhanced their understanding of mental disorders and some psychologists honestly admitted they realized that they would also be prone to them.

**Question 4: What meaning do you personally attach to depression? For example, do you see depression as having any value, or being meaningful in your life?**

All nine psychologists stated they found some meaning and/or value in their experience of depression. However, finding meaning may not be unusual since, as one psychologist stated, “It’s like any other life experience” (male in his 60s). The contents of the meaning and values varied among the participants. Two psychologists mentioned that depression was “a signal” that reminded one something was not working (male in his 50s and male in his 60s). One psychologist mentioned that depression is “certainly part of my [self] identity” (male in his 60s). One other psychologist termed it a “self-examination, which is very ugly” (female in her 50s). However, two psychologists stated that they did not want to have such an experience. One psychologist stated, “Yes. Looking back on it, it was valuable and meaningful, for sure. But, when you’re right up against it, no. I’d rather not have such a valuable experience. I’d rather be ignorant” (female in her 60s). The other psychologist stated, “That I probably would not have gotten to that same level of skill and ability without the depression, but again, I think if I would have got a chance to choose, I would have chosen a life without the depression” (female in her 60s). These statements may reveal how painful the experience of depression was.
To sum, all the psychologists admitted some meaning and/or values in their experience of depression. However, an interesting thing is it did not mean they actually highly valued it.

**Question 5: What else would you like to tell me about your experience with depression and its effects on your work?**

Since this question was a supplemental one, not all the psychologists responded. (One psychologist did not address this question.) Responses to this question also often overlapped previous responses. For example, one psychologist mentioned the importance of having a support system (female in her 50s) while another mentioned the importance of listening skill (female in her 60s).

However, some psychologists pointed out new aspects. One psychologist stated her childhood experience of depression made her enjoy working with people with depression since she feels, “how magnificent it is to watch a human being who is suffering every day, come alive and lose their suffering” (female in her 60s). Two psychologists mentioned the relationship between the nature of a psychologist’s work and depression. One psychologist stated that it is hard to believe that psychologists have not experienced depression because “the work itself, not just the profession, but even to study it brings you back to self-examination” (male in his 60s). Another psychologist mentioned the physical and psychological toll of having depression as well as its benefit. She concluded, “Psychology, as a clinician, is difficult enough to handle emotionally without having an illness like this” (female in her 50s).

To sum, it was repeatedly stated that the experience of depression had a significant impact on psychologists’ personal life and on their professional life as well. In addition, some psychologists even speculated that the nature of their clinical work itself
might contribute to the occurrence of depression.
Chapter Five: Discussion

In contrast to research on depression in the general population, research on depression among psychologists has received little attention. However, psychologists, as members of one of the major groups of mental health care professionals, may also experience depression. It was the purpose of this study to focus more attention on this topic since psychologists’ own mental health could potentially affect their clients’ mental health. Included in this investigation were issues of competency and ethical concerns of doing clinical work while depressed. The current research examined the prevalence of depression among psychologists in Colorado, and then examined how psychologists dealt with their own depression, their concerns for competency and ethics, and the existential meaning of depression. Interviews with nine volunteers from the original sample were also conducted. A discussion of the findings, limitations of the study, and suggestions for future research were addressed.

Demographic Information

First, regarding the demographic data, the respondents’ data were compared to those of their counterparts in three divisions of the APA. This comparison was made in order to determine how similar the current data were to national data. This information is important in regard to the possible generalizability of conclusions drawn from this sample of psychologists in the state of Colorado. To compare the current data, membership statistics of three APA divisions out of the APA’s 56 divisions were chosen: Division 12 (Society of Clinical Psychology), Division 17 (Society of Counseling
Psychology), and Division 42 (Psychologists in Independent Practice; APA, 2010). These three divisions were chosen because these organizations were most closely related to the current population of licensed psychologists. Licensed psychologists are usually engaged in clinical work and the memberships of the three divisions are likely involved at some level in clinical practice. One caution is that some psychologists may belong to more than one division, and therefore memberships may overlap.

Regarding age, the mean age of members in the three APA divisions ranged from 57.8 years old to 62.2 years old and the grand mean was 61.0 years old while the mean of the current study was 54.1 years old (SD =11.1). Results of a single-sample t test indicated that the mean age of the sample was significantly younger than the grand mean age of the three APA division members ($t(9) = –11.224, p < .001$). The reason the current sample is younger than the national data is not clear. However, it will be discussed later in relation to the academic degrees.

Regarding gender, the percentage of male members in each of the three organizations ranged between 53.8 % and 63.9 % with a grand mean of 59.8 %. In the current study the percentage of males in the sample was 39.7 %. The percentages of female members in the three organizations ranged between 36.1 % and 46.2 %, and the grand mean was 40.2 %. In the current study, the percentage of females was 60.3 %. Thus, in the current sample the proportion of males to females is opposite the proportion found in the three APA divisions. The reason is not clear.

Regarding ethnicity, the percentage of European American (White) members in the three divisions ranged between 75.9 % and 90.1 % with a grand mean of 85.6 %. In the current study 90.4 % of the sample was European American (White). Although the
The current sample is at the high end of the range, it is not greatly deviated from the national sample represented by the three divisions. It appears the largest percentage of psychologists, in general, are European Americans.

Regarding the academic degree, the current data showed that 64.3% had a Ph.D., 31% had a Psy.D., and 4% had an Ed.D. The current data showed far more Psy.D. holders among the Colorado psychologists compared to the national data of the three APA divisions, in which the percentages of the Psy.D. holders ranged between 1.4% and 9.3%. Since the Psy.D. degree was introduced as a clinical-oriented option of the traditional research-oriented Ph.D. degree about three decades ago (Norcross, Karpiak, & Santoro, 2005), it is far newer compared to the Ph.D. degree. It may be interpreted that Colorado attracts more clinically oriented psychologists than research oriented psychologists. Since the Psy.D. program at the University of Denver was developed in 1976 (University of Denver, 2010) and was one of the earliest in the country (Norcross, Castle, Sayette, & Mayne, 2004), it may be that Colorado has a history of Psy.D. graduates who have remained in Colorado to practice. They may be relatively young compared to Ph.D. holders. This possible age disparity was observed in the current sample (the mean age of Psy.D. holders was 50.4 years old and the mean age of Ph.D. holders was 55.1 years old). This age disparity may reflect that the current sample is younger than the three APA national data.

Regarding psychologists’ direct client contact hours, about two-thirds were more than 10 hours per week. Since this did not include other hours such as paperwork and administrative work, this may reflect that most psychologists have a heavy caseload. The three APA divisions did not provide this information.
Regarding years in clinical practice, nearly half (46%) had worked more than 20 years. This is not surprising, since, as mentioned previously, the mean age of the psychologists was 54.1 years. The three APA divisions did not provide this information.

Regarding employment setting, approximately half (49.7%) of the psychologists in the sample were in private practice. This percentage was much higher than in the Society of Clinical Psychology (36.4%) and the Society of Counseling Psychology (18.1%). The data for Psychologists in Independent Practice (Division 42) was excluded since it had a much higher rate of private practitioners for obvious reasons. Although the exact reason for the discrepancy between the present sample and national data is not clear, one explanation is that private practitioners were more likely to be interested in depression issues since they tend to work independently and therefore may not have much of an official support system. Another possibility is that the sample was drawn from the database of licensed clinical psychologists in Colorado (DORA), which is composed largely of individuals in private practice.

**Research Questions**

This section will discuss the results of the research questions for this study in the context of other research and broader literature.

**Question 1.** How prevalent is depressive symptom(s)/depression among psychologists in Colorado who respond to the survey?

**Question 2.** How do psychologists deal with their own depression?

**Question 3.** How do psychologists handle their professional life while having a depression issue?
Question 4. How do psychologists think that having depression relates to their professional competence?

Question 5. Do psychologists feel any ethical concerns about having depression themselves as mental health professionals?

Question 6. What meanings do psychologists attach to having depression?

Question 7. Is there any relationship between psychologists’ theoretical orientation and their perception of depression?

Research Question 1. “How prevalent is depressive symptom(s)/depression among psychologists in Colorado who respond to the survey?” (Includes Survey Question 1).

Survey Question 1 in the questionnaire indicated that approximately 69% of the participants answered “Yes” to the question about if they have experienced depressive symptom(s). This figure (69%) was similar to three previous studies that asked about the experience of depression among psychologists. Three previous studies found percentages of 61% (Pope & Tabchnick, 1994), 76% and 62% (Gilroy et al., 2001, 2002, respectively). The results of the current study confirm that the prevalence of depression among psychologists is basically consistent across the United States because although each of the four studies targeted a different psychologist population, the results were similar. The oldest study among the three (Pope and Tabchnick, 1994) targeted psychologists who belonged to APA Division 12 (Clinical Psychology), 17 (Counseling Psychology) and 42 (Psychologists in Independent Practice). Their findings showed that 61% of respondents reported at least one episode of clinical depression. The second study (Gilroy et al., 2001) addressed female psychologists who belonged to the Association of
Women in Psychology (AWP). Among the respondents, 76% of them reported that they had experienced some form of depression since beginning clinical practice. The third study (Gilroy et al., 2002) surveyed counseling psychologists who belonged to APA Division 17 (Counseling Psychology). Their result showed that 62% of respondents reported being depressed at some time.

The percentages of these four surveys of psychologists (61–76%) were compared to available reports of depression in the general population. Results revealed that the prevalence among psychologists was much higher than that reported in some available statistics on depression in the general population: (a) approximately 9.5% of the US population (AARP, 2010), and (b) almost 20% of the U.S. population (Gotlib & Hammen, 2002). Kessler and Wang (2008) reported a higher estimated lifetime prevalence of depression (46.4%). However, this figure included the prevalence not only of depression but also of other mental disorders such as anxiety disorders and substance disorders. Therefore, the actual prevalence of depression would be much lower. This discrepancy in the prevalence of depression between psychologists and the general population raises several questions. For example, are psychologists more prone to depression than the general population, or are they just more aware of symptoms or more willing to acknowledge them?

In the present study, it is possible that the incidence of depression was skewed because those psychologists who were interested in depression (especially those who had experienced depression) were more likely to respond to the questionnaire. Another possible explanation is that the profession itself triggers depression. Comments made by some psychologists during the individual interviews seemed to confirm this. For
example, one psychologist stated that it is hard for him to believe that psychologists have not experienced depression because the work itself brings them back to self-examination. Another psychologist mentioned that being a psychologist is difficult enough to handle emotionally without having an illness [depression] like this. This notion that depression or distress stems from the nature of a psychologist’s work is actually not uncommon.

Kilburg (1986) pointed out:

Professionals [psychologists] can be their own worst enemies. Trained to be independent, creative, assertive, competitive, and hard driving, they do not readily acknowledge that they are in trouble or need assistance. (p. 25)

Another potential source of the discrepancy might be related to the definition of depression in each study, which might vary from general unhappiness to a DSM diagnosis of depression. The limitation of the methodology (relying on self-report) further contributes to many possible explanations. For all these reasons, generalization of the current study should be approached with caution.

Research Question 2. “How do psychologists deal with their own depression?”

(Includes Survey Questions 2 – 7).

Survey Question 2 asked about the first reactions when the psychologists realized they were developing depressive symptom(s). Results indicated that more than one-third (37.6%) of the psychologists who reported that they have experienced depressive symptom(s) wanted to solve the depressive symptom(s) themselves. This figure was twice as high as the percentage of responses related to seeking diagnosis/treatment (17.4%). This may be interpreted as a sign of the expertise that psychologists believe they have. In other words, they may consider that they are able to handle depression themselves. Another explanation may be that they are embarrassed about having
depression and would rather handle it themselves than let another professional know of their depression.

Survey Question 3 asked whether or not participants sought psychiatric/psychological treatment. In response to this survey question, more than two-thirds (68.0 %) of the participants reported seeking treatment while one-third (32.0 %) did not.

It is interesting to note that the two-thirds of the sample who eventually sought treatment is a much higher figure than the 17.4 % who indicated they would seek treatment as a first reaction in response to Survey Question 2 above. It is possible that even though many respondents initially tried to solve their depression by themselves, eventually they sought treatment. However, this treatment-seeking ratio (68.0 %) is still lower than the ratio (87.7 %) that was reported in Mahoney’s (1997) study on psychotherapy practitioners regarding handling their personal problems. Nonetheless, the discrepancy can be explained as being due to the difference in the samples between the two studies. While in the current study all the samples were psychologists, who are all doctoral level, in Mahoney’s study, the majority (54 %) were non-doctoral practitioners and it was found that non-doctoral therapists were more likely to report being in therapy than their doctoral counterparts. Therefore, the current result suggests that psychologists are more likely to manage their own problems by themselves than are other psychotherapists.

On the other hand, the 32 % of the sample who reportedly did not seek treatment is similar to the percentage (37.6 %) of those who initially said they wanted to solve their depression themselves (see responses to Survey Question 2 above).
For individuals who sought treatment, a further question was asked about diagnosis. The three most common diagnoses were adjustment disorder, major depressive disorder, and dysthymic disorder, in this order. This result was generally similar to those of two previous studies (Gilroy et al., 2001, 2002) where the three most common diagnoses were the same but the order was slightly different. For example, in the 2001 study by Gilroy et al., the order was adjustment disorder, dysthymia (dysthymic disorder), and major depressive disorder. In their 2002 study, the order was dysthymia (dysthymic disorder), adjustment disorder, and major depressive disorder. Other diagnoses such as bipolar disorder were far less common. One interesting result of the current study was that adjustment disorder was most common (25.2 %). Generally, major depressive disorder is the most prevalent mental disorder in the lifetime (16.6 %; Kessler & Wang, 2008). The current study indicates that many psychologists considered that specific stressor(s) were the cause of their depression.

For the third of the psychologists who did not seek treatment, Survey Question 3 asked the reason for this decision. The most common reason given was that depressive symptoms went away after using appropriate coping skills (38.7 %). This may not be surprising since, as mental health care professionals, psychologists have generally acquired appropriate coping skills to handle their own mental health. Nonetheless, at the same time, six psychologists (9.8 %) mentioned a concern about confidentiality as a reason they did not seek treatment. These respondents may have been concerned about boundary issues or loss of anonymity (Kaslow, 1986), knowing that the professional community is very small in some ways and that they might come in contact with their
therapist at professional meetings or workshops. If they live in a small community, they may even share a social life.

To sum, although the majority of the participants thought they could manage to handle depression by using their own expertise or by seeking the help of another professional, still some participants did not seek help due to concerns about confidentiality, which further implies concerns about seeking psychological help (e.g., seeking psychotherapy is a sign of failure, especially as a psychologist). This confidentiality concern will be further examined in Survey Question 4.

Survey Question 4 asked how psychologists reacted when they were diagnosed or recognized that they had depressive symptoms. The most common response was to accept the diagnosis positively. The second highest response was to accept the diagnosis objectively as “a matter of fact.” These results are probably due to psychologists’ familiarity with depression and their knowledge about mental illness since they themselves diagnose their clients. Nonetheless, some psychologists responded to the diagnosis with unhappiness, grief or shame. This attitude toward their own diagnosis was also expressed during individual interviews. Most of the nine interviewed psychologists stated that they were very cautious about disclosing their experience of depression due to their concern for their reputation, loss of referrals, etc. One psychologist explicitly stated that disclosing his experience of depression to his colleagues was “absolutely” taboo, even now.

This attitude toward depression raises the question of whether some psychologists have a stigma about having mental illness, even though they are supposed to educate lay
people about mental illness, or whether they may have considered themselves to be impervious to the condition.

One explanation could be that the general public still attaches a stigma to mental illness and psychologists are not free from such a social attitude. Research has found that the stigma of mental illness still exists despite a decades-long campaign for its destigmatization by various organizations such as NAMI (e.g., Martin, Pescosolido, & Tuch, 2000). Dingfelder (2009) concluded, “Americans may be as suspicious of people with mental illness as ever” (p. 56). Half of the current sample was in private practice and those psychologists may have been particularly concerned about their reputation related to their mental illness. In addition, the stigma of mental illness seems to also exist among mental health professionals (e.g., Hinshaw, 2008). In a study by Godredsen (2004), more than half of the mental health professionals reported being negatively treated by their colleagues after they self-disclosed their experience of mental illness to them. Therefore, it may not be unreasonable that some of the current participants perceived the diagnosis of depression negatively.

Survey Question 5 asked how long it took to receive a diagnosis. The result indicated that most psychologists (nearly three-quarters) received a diagnosis within one year. However, the rest (one-quarter) of the sample waited for more than one year to receive a diagnosis. Although it is not clear about the reason behind this, it could be that those psychologists who waited might have been afraid of receiving a diagnosis. Further research is needed to learn more about this issue.

Survey Question 6 asked who diagnosed their depression. The two most common answers were psychologists and psychiatrists. The third most common response was self-
diagnosis. This is not surprising since psychologists are themselves mental health professionals.

Survey Question 7 asked what medications psychologists took to treat depression. Responses indicated overwhelmingly that they took antidepressants. However, it is notable that nearly one out of three (26.9%) responded they had taken multiple medications. This may reflect the fact that psychopharmacological treatment can be somewhat “trial and error” in terms of its efficacy for different individuals. Another interesting thing is that two psychologists reported they used an herb (St. John’s wort), which is rather controversial regarding its scientific efficacy.

Research Question 3. “How do psychologists handle their professional life while having a depression issue?” (Includes Survey Question 8).

Survey Question 8 asked psychologists how they dealt with depression regarding their professional life. An overwhelming majority (64.4%) responded that they kept going as well as they could. One participant reported he quit his job as a psychologist; however, very few reported stopping work, even temporarily. This phenomenon can be interpreted in several ways. One interpretation is that two-thirds of the respondents felt they were capable of doing their clinical work even with depression. Another explanation is that some psychologists may not have thought about their capability as a psychologist and just kept going. A third explanation is rather practical. Some psychologists may have been concerned about their financial situation and kept going. Although no psychologist explicitly stated this financial concern, considering that half of the psychologists were in private practice, this could be a reason.
Research Question 4. “How do psychologists think that having depression relates to their professional competence?” (Includes Survey Question 10).

Survey Question 10 asked psychologists’ opinions about their professional competence while experiencing depression. About 45% of the responding psychologists said that as long as the depression is mild or moderate, it does not greatly interfere with their professional competence. About 27% responded that having depression enhances their professional competence and about 9% responded that having depression does not interfere with their professional competence. Only two (0.9%) responded that having depression greatly interferes with their professional competence. This result shows that an overwhelming majority of the psychologists (81%) thought having depression does not really interfere with their professional competence. On the contrary, nearly one-third of them think that such an experience even enhances their professional competence.

However, this positive attitude toward experiencing depression can be interpreted as revealing their lack of understanding of depression. In other words, until psychologists themselves have experienced depression, they may not have fully understood people with depression. This could be true since three out of the nine interviewed psychologists admitted that they did not think or expect they suffered from depression. One psychologist stated, “…I don’t think it [psychological knowledge or clinical experience] helped me one bit! In fact, it wasn’t until my therapist pointed it [depression] out to me that it was like “oh yeah, that’s what this is.” So, no, I was as clueless as anybody else about my own experience…” (female in her 60s). One interviewed psychologists explicitly stated, “…because we’re trained to be the experts and to help other people who are sick. That does not include us“(female in her 60s).
Good, Khairallah, and Mintz (2009) argued that psychologists tend to fall into dualistic perspectives of wellness and impairment. That is, psychologists, as experts in mental health, tend to view themselves psychologically healthy while others are troubled. The current results may reflect that psychologists tend to think they are immune to depression because of their extensive training and knowledge about mental health.

Smith and Moss (2009), after reviewing literature on the impairment of psychologists, pointed out it may be due to lack of training that focuses on self-analysis.

Since all of the nine interviewed psychologists were either in their fifties or sixties and no younger psychologists were included, the current situation of training psychologists would be different from that in those psychologists’ days. In addition, the APA started working on psychologists’ mental health three decades ago (Kilburg, 1986) and the necessity of training psychologists as clients was advocated (Thoreson, 1986). However, in their article in 2009, Smith and Moss pointed out that psychologists’ impairment or wellness has not yet been a major issue in academia, in national professional organizations such as the APA, or in those at the state level, which is quite contrary to physicians’ training. Smith and Moss also pointed out that psychologist impairment programs are declining. Therefore, regarding supporting psychologists’ mental health, the situation does not seem to have improved much. This is ironical since the importance of self-awareness through such means as Freud’s self-analysis has a long history in psychology.

To sum, regarding the relationship between having depression and professional competence, there is a deficit of clinical training about psychologists’ own self-care and there is an insufficient support system for distressed or impaired psychologists.
Research Question 5. “Do psychologists feel any ethical concerns about having depression themselves as mental health professionals?” (Includes Survey Question 9).

Survey Question 9 asked psychologists’ ethical concerns as mental health professionals when experiencing depression. Nearly half (45.9%) of the psychologists responded that it is ethical as long as psychologists are aware of their depressive symptoms and limitations. The second most common response was that it depends on the severity of the depressive symptoms (33.2%). Very few psychologists (1.4%, n = 3) responded it was unethical to see clients while experiencing depression. It appears that many psychologists rely on their own internal standard to determine whether or not they should work as a clinician when depressed. In other words, the respondents were confident in their own assessment of themselves. However, this attitude could be dangerous. The reason is that while psychologists’ self-awareness regarding the degree of their impairment is important (Canter et al., 1994; Orr, 1997, O’Connor, 2001), distressed psychologists may not be able to objectively assess their clinical capability (Kitchener, 2000; Smith & Moss, 2009; Williams et al., 2010).

However, the interviewed psychologists were careful with how to relate to their clients in clinical settings. When asked if they disclosed their experience of depression to their clients, only one out of seven psychologists answered yes. Other psychologists’ answers were either flatly “No” or very cautious, depending on the situation. Their main concern was whether the self-disclosure crossed therapist/client boundaries, that is, if they used the sessions for their own therapy, not the clients’. Even the psychologist who said yes she discloses the information, mentioned that she is always aware that self-
Disclosure is for the benefit of the client, not for her own need. She also stated that she discloses her experience of depression to help her clients not feel ashamed of having depression. Therefore, in actual clinical settings, psychologists seem to be very careful about the influence of their depression on their clients. It is interesting to note that none of the interviewed psychologists explicitly mentioned civil and criminal liability related to impaired practice.

To sum, although psychologists seem to be very careful about ethical issues related to their clinical practice while having depression, further precautions which are not reliant on psychologists’ own self-evaluation, such as objective assessment by their colleagues of the degree of distress, need to be implemented, since distressed psychologists could directly affect their clients’ well-being.

**Research Question 6. “What meanings do psychologists attach to having depression?” (Includes Survey Questions 11 and 12).**

Survey Question 11 asked psychologists to rate their experience of depression on a scale ranging from 1 (“I felt it was a stigma.”) to 10 (“I felt potential for meaning.”) The mean of the responding psychologists was 7.21 (SD = 1.97), suggesting that the respondents generally rated their experience of depression favorably, as having potential for meaning. Twenty-one psychologists (10 %) rated their experience between 1 and 4, at the lower end of the scale, closer to a stigma. Among them, two psychologists rated it as 1 (least favorable) and another two rated it as 2. An interesting thing is that an age-related factor seems to exist regarding psychologists’ rating. A weak positive correlation ($r(205) = .15, p < .05$) was found between psychologists’ age and their rating of their personal experience of depression. In other words, older psychologists tended to rate their
experience of depression as having more potential for meaning than did younger psychologists.

Survey Question 12. To further explore the meaning of their experience, Survey Question 12 asked psychologists to describe what they learned from their depression. Since it was an open-ended question, the responses varied greatly. However, the most frequently mentioned theme was better understanding of clients through enhanced empathy and compassion. In other words, many psychologists associated the meaning of having depression directly with their clinical work. However, the rest of the themes that emerged could have been mentioned by many lay people who have experienced depression, as well. For example, the second most frequently mentioned theme was the importance of self-care and the third was the importance of psychotherapy/treatment. These results suggest that psychologists are not much different from the general population regarding learning from their experience of depression. This result may not be surprising, since it reveals that psychologists have the same vulnerability as lay people. However, it also reveals that psychologists, who are supposed to educate lay people, are sometimes themselves not well educated about depression, and perhaps find it difficult to apply what they know to themselves. This can be true since the fourth most frequently mentioned theme was the normality of having depression. One psychologist wrote, [It was surprising] “That even as a “professional” (my research area for dissertation was depression) who had done lots of therapy and personal growth work, I could still develop depression.” Some psychologists mentioned the debilitating power of depression. Such responses introduce the possibility that some psychologists do not really understand the
personal effects of depression. In fact, some psychologists did not seem to understand it until they themselves had experienced depression.

In addition, there appeared to be a disparity between their attitude towards their clients and their attitude towards themselves. In other words, sometimes they did not do themselves what they told to their clients. One psychologist wrote, “[It was hard to] practice what I preach to my clients to help myself.” Combined with the previously mentioned notions—that they were exempt from having depression or that psychologists were not prone to depression—this disparity suggests that some psychologists may not fully trust or believe in their own clinical work (what they are doing).


Survey Question 13 asked psychologists’ theoretical orientation. Although their orientations ranged widely, the three most common responses were: cognitive behavioral, eclectic/integrative, and psychodynamic, in that order. This result is similar to the current trend among psychologists (Prochaska & Norcross, 2007). Therefore, the current sample is considered to represent the general theoretical trend of psychologists.

Survey Question 14 asked psychologists about the relationship between their theoretical orientation and their perception of depression. The original question was:

“Does your theoretical orientation relate to your perception of depression? (Please circle the response.)

Yes In what way?_____________________________________________________
No
The overwhelming majority (68.5 %) of the psychologists’ responses showed there was a relationship between their theoretical orientation and their perception of depression. For example, psychologists whose theoretical orientation was cognitive behavioral emphasized the impact of thoughts on depression. Psychologists whose approach was psychodynamic emphasized the impact of childhood experiences on depression, while psychologists whose orientation was eclectic/integrative mentioned the impact of various factors (e.g., biological, environmental and relational) on depression. This result seems understandable because psychologists’ theoretical orientation gives them a framework for how to approach psychological problems. Therefore, it was surprising that about 30 % of the responding psychologists responded that there was no relationship between their theoretical orientation and perception of depression. Unfortunately, no further follow-up question regarding their response was asked. However, some speculations are possible. Although few, some psychologists left comments that they did not necessarily use their theoretical orientation to view or treat their own depression. For example, a psychologist whose orientation was cognitive behavioral, commented, “I believed that depression can be attributed to irrational thoughts/beliefs, but in my case, my symptoms were brought on by stress at work.” This statement suggests that although psychologists have a general framework based on their theoretical orientation to approach psychological problems, they also recognize the uniqueness and idiosyncrasy of real problems.

Norcross (2000), after reviewing four studies, did not find differences between psychotherapists’ own self-change strategies and their theoretical orientation. Norcross concluded that psychotherapists become more pragmatic and eclectic when confronting
their own distress. Therefore, the current result may be interpreted as that some psychologists become more pragmatic when treating their own psychological issues.

Gender Differences

There were no gender differences found in this sample on any of the survey questions except one (see Footnote 4). For example, a gender difference in the frequency of the experience of depressive symptom(s) was not observed ($\chi^2 (1) = 3.64, p = .056$). The only exception was treatment-seeking behavior. More female psychologists reported they sought treatment than did their male counterparts ($\chi^2 (1) = 6.81, p = .009$).

These results raise an interesting question. First, while many studies have found that women report a higher rate of depression than men (e.g., Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993; Noble, 2005; Nolen-Hoeksema, 1990; Sadock & Sadock, 2003), the current study did not find such a tendency. This disparity may be related to different characteristics between psychologists and the general population. In the general population, fewer men than women tend to seek help for psychological problems (Vessey & Howard, 1993). It may be due to the current cultural norm of masculinity, prohibiting men from expressing psychological vulnerability (Cochran &Rabinowitz, 1996), and/or a stigma about mental illness. Therefore, in the general population, depression among men might be under-reported (reporting bias). However, this self-report bias was not supported by using the third-person report, which also found a higher rate of depression among women than men (Kendler, Davis, & Kessler, 1997).

Footnote 4: To examine gender differences, a chi-square test of independence was used. However, many comparisons were not available because they did not satisfy one of the necessary assumptions, which is that no more than 20% of the categories should have expected frequencies of less than 5 (Cronk, 2004).
Kessler (2000) concluded that biological factors (e.g., sex hormones), subtle socialization experiences, and gender-role-related experiences could be plausible explanations.

In the current sample, males were as likely to report their depression as females. It may be due to their expertise in mental health. Nonetheless, even among psychologists, in a previous study females reported depression more often than males (Gilroy et al., 2002). A plausible explanation for why the current sample is different from previous studies is not immediately available.

Next, regarding treatment-seeking behavior, the result of the current sample indicated a higher rate of treatment seeking behavior among women compared to men. This result supports the previous findings (e.g., Pope & Tabchnick, 1994; Vessey & Howard, 1993). This indicates that it is culturally acceptable for females to seek psychological help and it has less social stigma compared to men, which include male psychologists.

Limitation of the Study

First, the operational definition of depression was not stringent in the current study. Although depression and depressive symptom(s) were used interchangeably in the current study, some research participants may have understood it differently. In addition, the definition of depression varied greatly in previous studies, therefore, exact comparison with them was difficult. Second, the current study was based on self-report. While self-report is considered a good tool to explore respondents’ subjective experience, its reliability may need to be confirmed by some other objective measurement. Third, the sample of the current study consisted only of psychologists who resided in the state of
Colorado. Therefore, although some results differed from those found in previous studies using national data, generalization needs to be made very cautiously.

**Suggestions for Future Research**

First, a stringent operational definition of depression needs to be implemented for more reliable comparison studies. Second, the reliability of psychologists’ self-reports on their competency and ethical behavior needs to be examined with other objective evaluations. One possible approach is to utilize psychologists’ colleagues and clients for the evaluation of the psychologists’ situation. Third, the relationship between psychologists’ previous experience of self-analysis (personal therapy) and the prevalence of depression needs to be examined to find a way to enhance their mental health. Fourth, the influence of cultural factors such as ethnicity on psychologists’ depression needs to be further explored.
References


Appendix A

Questionnaire about Experiences of Depression among Psychologists

Note: This brief questionnaire will take only about 10 minutes to answer. In order for your responses to be anonymous, please do not write your name or any personally identifying information on the questionnaire when you return it.

Q 1. Have you ever experienced depressive symptom (s)?
   _____ Yes   _____ No → Move to the Demographic questions (page 4).

Q 2. When you realized you were developing depressive symptom (s), what was your first reaction? (Please check all that apply.)
   _____ Fear
   _____ Wanted to hide it from others
   _____ Did not want to acknowledge my depressive state
   _____ Wanted to solve the problem myself
   _____ Sought diagnosis/treatment as soon as possible.
   _____ Other (specify) ___________________________

Q 3. Have you ever sought psychiatric/psychological treatment for depressive symptom (s)?
   _____ Yes   _____ No

If yes, what was your diagnosis based on the DSM?
________________________________________________________________________

If yes, proceed to Q 4.

If no, why did you not seek treatment? (Check all that apply.)

_____ Depressive symptoms eventually went away.
_____ Depressive symptoms went away after using appropriate coping skills (e.g. exercise, meditation).
_____ There was no acceptable therapist nearby.
I was concerned about confidentiality.
Other (briefly explain ________________________________)

If no, move to Q 9 (skip Q 4 – Q8).

Q 4. What was your first reaction when you were diagnosed with, or thought you could be diagnosed with a mental illness? (Please choose one.)

I accepted the diagnosis with relief, as liberating and validating.
I accepted the diagnosis but implicitly questioned it.
I rejected the diagnosis as inappropriate.
Other (briefly explain ________________________________)

Q 5. How long did you have depression before you received a diagnosis? (Please choose one.)

less than 3 months
3 – 6 months
more than 6 months – 1 year
more than 1 year (specify how many years __________)

Q 6. Who diagnosed you? (Please choose one.)

physician
psychiatrist
psychologist
self
other (please specify ____________)

Q 7. Are/were you on medication (s) for your symptoms of depression?

Yes (specify ________________________________)
No

Q 8. How do/did you handle your professional life while having a depression issue? (Please choose one.)

Stopped seeing all clients for a period of time.
Stopped seeing most severe/difficult clients for a period of time.
Stopped other activities besides seeing clients for a period of time.
_____ Reduced overall schedule of activities including seeing clients for a period of time.
_____ Just kept going as well as I could.
_____ Other (briefly explain ________________________________ )

Q 9. Would you or did you feel any ethical concerns about having depression yourself as a mental health professional? (Please choose one.)

_____ It is not ethical as a mental health professional to see clients while having depression.
_____ It is ethical as a mental health professional to see clients while having depression as long as I am aware of my symptoms and limitations.
_____ It depends on the severity (for example, whether or not I am receiving treatment).
_____ Other (briefly explain____________________________ )

Q 10. How do you think that having depression relates to your professional competence? (Please choose one.)

_____ Having depression greatly interferes with my professional competence.
_____ As long as depression is mild or moderate, it does not greatly interfere with my professional competence.
_____ Having depression does not interfere with my professional competence.
_____ Having depression enhances my professional competence since I can empathize with clients with depression.
_____ Other (briefly explain____________________________ )

Q 11. On the line below, please circle the number that best describes your personal experience of depression.

I felt it was a stigma  1       2       3        4        5        6       7        8        9        10  I felt potential for meaning

Q 12. What, if anything, did you learn from your depression?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
Q 13. What is your theoretical orientation? (Please indicate your primary orientation)

- Behavioral
- Cognitive Behavioral
- Eclectic/Integrative
- Existential
- Feminist
- Gestalt
- Humanistic
- Psychoanalytic
- Psychodynamic
- Systems
- Other (briefly explain __________________ )

Q 14. Does your theoretical orientation relate to your perception of depression? (Please circle the response.)

Yes    In what way? ______________________________

No

Demographic questions

1. Age: ______

2. Gender: _____ Female
- Male

3. Ethnicity:
   - African American
   - Asian American
   - European American
   - Hispanic/Latino(a)
   - Native American
   - Multiracial
   - Other _____________

4. Marital status:
   - Married
   - Single
   - Divorced
   - Widowed
   - Partnered
   - Other _______________
5. Academic degree:

_____ Ph.D.
_____ Psy.D.
_____ Ed.D.
_____ Other ____________________

6. Number of direct client contact hours per week:

_____ 10 or less hours
_____ 11-20 hours
_____ 21-40 hours
_____ 41 or more hours

7. Number of years in full or part-time clinical practice (post-degree):

_____ 1-5 years
_____ 6-10 years
_____ 11-20 years
_____ 21-30 years
_____ 31 or more years

8. Employment setting (please choose one):

_____ Community Mental Health Center
_____ Hospital
_____ Correctional Facility
_____ University Counseling Center
_____ Private Practice
_____ University
_____ Other ____________________

Thank you for participating in this research project!!

PS: If you are willing to participate in an in-depth interview about the personal meaning of having depression, please contact me by email (amurata@du.edu). The first six participants who respond to an invitation to a follow-up survey will be contacted and I will explain the interviewing process. I will respond to all other emails as well.
The guiding questions for the interview will be:

1. What have you learned from depression?
2. How has the experience of depression affected your practice as a psychologist (e.g. your relationship with your clients and colleagues)?
3. How did the experience of depression affect your perception of mental disorders/illness?
4. What meaning do you personally attach to depression? For example, do you see depression as having any value, or being meaningful in your life?
5. What else would you like to tell me about your experience with depression and its effects on your work?
Appendix B

Interview questions:

1. What have you learned from depression?
2. How has the experience of depression affected your practice as a psychologist (e.g., your relationship with your clients and colleagues)?
3. How did the experience of depression affect your perception of mental disorders/illness?
4. What meaning do you personally attach to depression? For example, do you see depression as having any value, or being meaningful in your life?
5. What else would you like to tell me about your experience with depression and its effects on your work?
Appendix C

An invitation to participate in a survey project

My name is Aki Murata. I am a Japanese Ph.D. student in Counseling Psychology at the University of Denver. As I wrote you a couple of days ago, I am writing this letter to invite you to participate in a survey project that partially fulfills my doctoral degree requirements.

My survey topic is “Experiences of depression among psychologists.” I myself have experienced severe depression, and as a future psychologist, I am keenly interested in how psychologists have experienced and perceived this issue.

I have attached a questionnaire. It is self-explanatory and it will take less than 10 minutes to answer. But if you feel uneasy answering any of the questions, you can simply skip a question or stop responding. You have no obligation to return your answers. Participation in this project is strictly voluntary.

I am especially concerned about confidentiality. Your responses will be anonymous (so please do not put your name in any place). The data will be statistically analyzed as a group. However, if you are willing to be contacted for a further follow-up interview, which will explore this topic in more depth (in person), please provide your contact information in your reply. I will later contact you to explain the interviewing process. There are five interview questions and you can find them at the end of the questionnaire.

Regarding informed consent, your return of the questionnaire is considered to imply your consent to participate in this project.

You can reach me either by phone: 303-782-4887 or email: amurata@du.edu. This project is supervised by my dissertation advisor, Dr. Cynthia McRae, Morgridge College of Education, University of Denver, Denver, CO 80208, phone: 303-871-2475, email: cmrca@du.edu.

This survey project has been approved by the Institutional Review Board for the Protection of Human Subjects at the University of Denver. If you have any concerns or complaints about how you were treated during this project, please contact Dr. Susan Sadler, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-3454, or Sylk Sotto-Santiago, Office of Sponsored Programs at 303-871-4052 or write to either at the University of Denver, Office of Sponsored Programs, 2199 S. University Blvd, Denver, CO 80208-2121.

Thank you for considering participation in this survey project.

Sincerely,
Aki Murata
Ph.D. student in Counseling Psychology, University of Denver
Appendix D

INFORMED CONSENT

Research topic: Experiences of Depression among Psychologists

You are invited to participate in a study that will explore the experiences of depression among psychologists. Your name was randomly selected from the public domain list of licensed psychologists provided by the State Department of Regulatory Agencies (DORA).

This study is being conducted to fulfill the requirements of my Ph.D. dissertation. The study is conducted by me, Aki Murata, M.S.. I can be reached at 303-782-4887 by phone or amurata@du.edu by email. This project is supervised by my dissertation chair, Dr. Cynthia McRae, Counseling Psychology Program, Morgridge College of Education, University of Denver, Denver, CO 80208, phone: 303-871-2475, email: cmcrae@du.edu.

Answering the questionnaire should take about 10 minutes of your time. Participation will involve responding to 14 questions about your experiences of depression. Participation in this research is strictly voluntary. The risk associated with answering the questionnaire is considered minimal. Nonetheless, there might be a slight possibility that you may begin to feel discomfort or anxiety due to the nature of the questions. If this occurs, you may discontinue answering the questionnaire at any time. We respect your right to choose not to answer any questions that may make you feel uncomfortable. Refusal to participate or withdrawal from participation will involve no penalty or loss of benefits to which you are otherwise entitled.

Your returned questionnaire will be kept in a locked filing cabinet. Only the researcher will have access to your individual data and the data is identified by participant number only and will not be associated with personally identifying information. After the study has concluded, the entire questionnaire will be shredded. This is done to protect the confidentiality of your responses.

This study is anonymous in nature. The information that is collected will be analyzed statistically as group data only. Therefore, in order to make sure your responses to be anonymous, please do not put your name any place on the questionnaire.

However, if you are willing to be contacted for a further follow-up interview which will explore this topic in more depth (in person), please provide your contact information in your reply or feel free to email me at amurata@du.edu. I will later contact you to explain the interviewing process. There are five interview questions and you can find them at the end of the questionnaire.
Regarding informed consent, the return of your questionnaire is considered to imply consent to participate in this project. Nonetheless I recommend keeping this page for your records.

If you have any concerns or complaints about how you were treated during the interview, please contact Susan Sadler, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-3454, or Sylk Sotto-Santiago, Office of Research and Sponsored Programs at 303-871-4052 or write to either at the University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121.
Appendix E

INFORMED CONSENT

Research topic: Experiences of Depression among Psychologists

You are invited to participate in an interview study that will explore the experiences of depression among psychologists. It is a follow-up study of the questionnaire study that you have already participated in. This study is being conducted to fulfill the requirements of my Ph.D. dissertation. The study is conducted by me, Aki Murata. I can be reached at 303-782-4887 by phone or amurata@du.edu by email. This research is supervised by my dissertation chair, Dr. Cynthia McRae, Counseling Psychology Program, Morgridge College of Education, University of Denver, Denver, CO 80208, phone: 303-871-2475, email: cmcrae@du.

The interview would take about 30 minutes to an hour of your time and would be audio taped using a voice recorder. Participation will involve responding to five questions about your experience of depression (please see the attachment). Participation in this project is strictly voluntary. There might be a possibility that you may begin to feel discomfort or anxious due to the nature of the questions. If this occurs, you may discontinue the interview at any time. We respect your right to choose not to answer any questions that may make you feel uncomfortable. Refusal to participate or withdrawal from participation will involve no penalty or loss of benefits to which you are otherwise entitled.

The interview is planned one-time only. However, if necessary and you agree, there may be a second interview, which will take the same amount of time.

The audio tapes of the interview will be stored in a locked filing cabinet. The audio tapes will then be transcribed. Hard copies of the transcripts will be kept in a locked filing cabinet. Only the researcher will have access to your individual data and the data is identified by participant number only and will not be associated with personally identifying information. After the study has concluded, all interviews and transcripts will be deleted or shredded in the case of the paper copies of the transcripts. This is done to protect the confidentiality of your responses. In addition, any reports generated as a result of this study will use only two pieces of general demographic information (age range and gender). No other specific demographic information is used, to protect your anonymity. However, if you do not want to disclose any demographic information about yourself, I respect your decision and will follow your request.

Nonetheless, should any information contained in this study be the subject of a court order or lawful subpoena, the University of Denver might not be able to avoid compliance with the order or subpoena. Although no questions in this interview address it, we are required by law to tell you that if information is revealed concerning suicide,
homicide, or child abuse and neglect, it is required by law that this be reported to the proper authorities.

If you have any concerns or complaints about how you were treated during the interview, please contact Susan Sadler, Chair, Institutional Review Board for the Protection of Human Subjects, at 303-871-3454, or Sylk Sotto-Santiago, Office of Research and Sponsored Programs at 303-871-4052 or write to either at the University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121.

You may keep this page for your records. Please sign the below if you understand and agree to the above. If you do not understand any part of the above statement, please ask the researcher any questions you have.

I have read and understood the foregoing descriptions of the study called Experience of Depression among Psychologists. I have asked for and received a satisfactory explanation of any language that I did not fully understand. I agree to participate in this study, and I understand that I may withdraw my consent at any time. I have received a copy of this consent form.

Signature _____________________ Date __________________

I would like a summary of the results of this study to be mailed to me at the following postal or email address:

Signature _____________________ Date __________________

Address:

Email address
Appendix F

Some other psychologists’ responses according to their theoretical orientation

1. Cognitive behavioral

a. Depression stems in part from early-developing concepts about one’s self and social environment.

b. Individuals can learn to take control.

c. You don’t have to spend a lot of time figuring out the “why?” – You spend your precious energy on “how do I get out of here?!”

d. Our belief system plays an important role in our emotions.

e. I became more aware of how my negative and irrational thinking affected my behaviors and view of the world. Applying more positive ways of thinking and countering negative thoughts helped me have hope and lessened the detrimental affects on my work interactions.

f. Thought drives behaviors.

g. I am a strong believer that our feelings can be improved by controlling/observing our thoughts. Certainly, much depression is biological and genetic, needing medication. But I advocate looking at the positives in one’s life, and feeling thankful for life’s gifts…along with medication when necessary.

h. Thoughts, feelings and behaviors are all interconnected and I need to watch my thoughts and reframe pessimistic thoughts associated with depression.

i. I view it as false thought patterns paired with poor/unhelpful behavior choices, often on top of a biological disposition…not character weakness.

j. [I] recognized the meaning I was making of my life experience at that time impacted my perception/definition of self (failure) and impacted my mood.

k. Change in thinking (perception) helped me a lot.

2. Eclectic/integrative

a. All people adapt, adjust, and do the best they can.

b. Each person who seeks treatment is a unique individual and will respond most favorably to a unique treatment approach. A knowledge of theoretical, medical, psychological, cognitive, and spiritual factors is essential.
c. Look for causes/origins of depression in family origin wounds/deficits—understanding then processing (somatic experiencing, EMDR, etc.) can heal a great deal.

d. Related to individual authenticity, social support, and existential concerns.

e. I understand the relationship of cognitions, shaped in early childhood, combined with neurophysiology + stress management/mindfulness to symptoms of depression.

f. Depression is many faceted, which can lead to different approaches.

g. …each person must discover what “works” for them in terms of healing/coping, etc. [There is] No “one” right way.

h. I’m very spiritual and saw depression as god’s way of getting my attention to make changes.

i. [I now] View predisposition, precursors, and maintainers of depression in multidimensional way.

j. I see historical, biological, and interpersonal factors contributing to my mood, as well as habits or patterns of thinking.

k. A strong understanding of neuroscience and development is necessary to enhance the interpersonal and intrapsychic psychotherapeutic effectiveness.

3. Psychodynamic

a. I see childhood experiences as influencing adult perceptions of life events and adult perceptions coupled with biological triggers determining aspects of one’s depression.

b. I can see how dysthymia and long term losses arose from my parents’ relational limitations.

c. Yes. We can learn from all life experiences if we practice self-awareness, increased consciousness and reflection, process emotions, integrated experiences. It is less important the experience (depression, anxiety, sexual abuse, eating disorder, etc.) than how we process it and that we process it.

d. I will look at underpinnings, long-term patterns, etc., rather than just a medical/biological perspective. Also, I put more of a focus on the process, relational and dynamic aspects of depression than other clinicians might.

e. Insight = relief.
4. Humanistic

   a. Being understood and accepted are healing factors.

   b. It is an experience that needs attention and understanding. It is a doorway to deeper meaning/purpose and self-evolution.

   c. It [depression] could be transformed into a growth experience.

   d. [Theory] Assisted me in “depathologizing” my depression.

   e. Integrating the complexity of each individual and learning problem solving.

5. Systems

   a. [This theory] Increases my awareness of contextual variables influencing me.

   b. It informs my own understanding of the causes and possible solutions to all mental illness. I tend to look initially and primarily to a person’s overall context for problems. Slowly moving inward to more neurological or genetic sources only when other sources are accounted for.
Appendix G

Nine psychologists’ responses [partial transcripts] to five interview questions

Note: “Q” means the interviewer (current researcher) and “A” means the interviewee (psychologist).

Question 1: What have you learned from depression?

Responses

Psychologist 1 (female in her 60s)

Well, seeing this as a question, the top priority, the main thing, the overarching thing is compassion. Also, in terms of the psychodynamics that a person who is depressed may have, there’s very little that I hear from depressed people that I haven’t experienced myself, so that, in addition to compassion, there’s extra knowledge of what it’s like to live with this every day and to struggle with it and to suffer with it. In fact, sometimes I can almost think ahead of my patient. Because I am familiar with the map of depression, what it’s like, I can anticipate other things they may experience and not even be able to articulate yet or preconscious.

Psychologist 2 (male in his 50s)

So one thing I’ve learned is to be more mindful or more watchful of my state before it kind of got to a more serious problem. I think that’s the big one. Second, I think I’ve learned, that as the primary care giver in the family, I can try to pass those responsibilities around, instead of trying to do it all myself. That’s been a good lesson.

Psychologist 3 (male in his 60s)

I have a firsthand experience, not having been depressed before, that you can have significant depression associated with a medical procedure. It gave me a new insight into some of [my clients’ concerns], too, because I think sometimes we’re not holistic as practitioners.

Psychologist 4 (female in her 50s)

I’ve found that there’s a lot of biochemical associates with it. And I feel if one does not reach out and talk and check out one’s ideas, I think some very troubling thoughts can become associated with depression. And I think, between the physiological reactions as well as the troubling thoughts, people tend to withdraw. And if you don’t check out your ideas and you don’t start getting out more, and stay in physical decent shape, I think that’s a very bad combination, where somebody withers away both physically, cognitively, as well as spiritually. And that can happen very readily.
**Psychologist 5 (male in his 60s)**

I’ve learned that it’s a very painful thing. I’ve learned that, on a mild level, it’s hard to recognize. It’s easy to blame life’s circumstances without really seeing what it’s all about. I’ve learned that I don’t want that to ever happen again. And I’ve learned that you can get out of it. You can move past it. I’ve also learned that it can be lifelong. And I’ve learned that there’s hope. Yeah, you really can move past it, with the right treatment, with the right medication, it’s a manageable thing. And I’ve learned that a social support system is, for me at least, it’s critical.

**Psychologist 6 (female in her 60s)**

A. …One thing that I learned is, first of all, how awful it is. I had been working with people for a long time, as a psychologist, and I thought that I had a lot of empathy for people with mood disorders, but I had no idea. I had no idea how debilitating it can be. And especially the unbidden suicidal thoughts. I thought that was so curious that they would just come. And so I learned how powerful depression or any kind of mood disorder can be to a person. So I learned that. What else did I learn? So I think I had more empathy as a result, than I did before….

Q. You said at that time you were already a psychologist, practicing for a while, right?

A. Yep!

Q. Okay, so your accumulated psychological knowledge or clinical experience helped somehow managing depression compared to the ordinary layperson, laypeople?

A. No! I don’t think it helped me one bit! In fact, it wasn’t until my therapist pointed it out to me that it was like “oh yeah, that’s what this is.” So, no, I was as clueless as anybody else about my own experience. It didn’t help one bit. I knew that. Yep, nope, it didn’t help at all.

**Psychologist 7 (male in his 60s)**

Well. It’s quite different when you experience it and when you read about it or see it in film. So, I think having experienced it, I think, gave me greater insight, and with that insight, I would say, came a deepened empathic response and I think also a more comfortable, more facile ability to develop treatment strategies. And I think it made the treatment more credible.

**Psychologist 8 (female in her 50s)**

I’ve learned that it’s a physical illness. Not to just treat it as someone’s unhappy. That it has a far more profound effect on the body. On thinking, socially and emotionally. That it’s truly a biological illness, at least in many people. And it needs to be treated with that same sort of respect. And that it is a disability. And I accept that maybe I can’t see as
many clients as another psychologist could. Or maybe I get fatigued earlier. And so I try
to kind of forgive myself for having an illness that I have no control over. It’s not my
fault. And I’ve worked real hard over the years to get rid of the shame that goes with that.
And I think I’ve done a pretty good job of that. That it really is not my fault, it does not
change who I am as a person. If anything, it makes me a better clinician, more empathic,
better able to really support just how much suffering there is involved in that, in a way
that provides not only validation for the experience, but hope for how you work your way
through that. How you survive and how you make a life for yourself even though you
have these illnesses.

**Psychologist 9 (female in her 60s)**

I think the thing that is hard to learn when you go to school and get educated in
psychology. If you haven’t had anything, either in the family or experienced it, the
progression, the process that the person goes through in terms of, you know, from okay to
whatever, whether it’s depression or anything else. It’s that process that just sometimes is
so subtle. And the other thing that I’ve always been curious about is why so many people
are in such denial about mental illness, in terms of themselves, why so many people
won’t go and get help. I think part of it’s the stigma, obviously, but part of it, I think, you
know, like, I never thought about myself as being depressed in high school. I had a better
sense that I was getting depressed when I was in therapy, but I still wasn’t thinking
depression. I was just thinking, you know, I’m overwhelmed with all the trauma stuff.
And so, it’s, you know, that process that you go through that I think was interesting for
me to observe firsthand and also, how pervasive the illness is. I mean, it just affects
everything.

**Question 2. How has the experience of depression affected your practice as a
psychologist (e.g., your relationship with your clients and colleagues)?**

**Psychologist 1 (female in her 60s)**

*(Self-disclosure to clients and colleagues)*

Q. I’m interested in…you tried to hide your depression from other people as a student or
practitioner?

A. No. My small practice, at that time I was doing domestic violence. And it was a
different population, so it didn’t enter into it because it was domestic violence. And then
in my doctoral program, I don’t remember people asking me if I was depressed/ I
certainly didn’t wear a tee-shirt that said Depressed Person. I wasn’t hiding it, neither was
I advertising it.
Psychologist 2 (male in his 50s)

(Self-disclosure to clients)

Q. …I’m wondering how much you disclosed yourself, your depression, to your clients.

A. Zero.

Q. Zero. Okay.

A. Zero. I do self disclose periodically, as it relates to the issue of my patient, because I have had a divorce and maybe someone’s here before a divorce and I say, when I went through it, here’s the steps of grief or adjustment I went through. But I not once made disclosure to my patients about my own depression. I protected that, kept it private.

(Self-disclosure to colleagues)

Q. Then the next question is, your relationship with your colleagues as a psychologist.

A. I would say there was probably zero impact on my relationships in this building. There are five mental health professionals. We might cross paths at the coffee pot, but there is not much interface. And so, I would safely say the blue mood I was going through would have (a) been unnoticed by my colleagues and (b) that we’re in private practice and don’t work for an agency, we wouldn’t have to be in meetings together where they would witness my mood. So, we’re so independent with our private practice. There wouldn’t be an impact on my colleagues.

Q. So you didn’t tell anybody about your psychological situation?

A. My wife knew. I didn’t seek treatment. My children didn’t know. Maybe a friend. I might have said, “Oh, I’m having a rough time.” Probably that. But, it kind of took care of itself.

Psychologist 3 (male in his 60s)

Answer to the self-disclosure to clients was not available.

(Self-disclosure to colleagues)

Q. Yes. Okay. Focused on that question, the relationship with colleagues, other psychologists. Do you think mental illness or mental disorder in general, not specifically just focused on depression, it’s kind of a stigma?

A. Yes, you’re right.

Q. Even among mental health professions?
A. Yes. You haven’t seen too many people who have been candid in coming out about their depression. You know, it’s interesting, in the history of this country, those in the past few years who have said anything about their depression have been looked at differently. I remember there was someone, I can’t remember his name, running for the presidency, who said, “I was depressed” and everybody said, “We can’t have him as a candidate.” Very often, with any disorder, there’s this spokesperson, somebody who is in the media who is comfortable to come out. You know, like they have, what is his name, the guy who’s on, it’s a kind of a quiz show and he has OCD, he doesn’t touch people. I’m trying to remember who that is. In any case, he’s very popular, he’s very charismatic, he say’s, “I have OCD. I have concerns about germs. I have concerns about infection and contamination.” So he’s actually popularized, “I won’t shake hands with anybody.” He does this, fist bump. So he speaks for this. Not so many people speak for depression. Not so many.

Psychologist 4 (female in her 50s)

(Self-disclosure to clients)

Q. Regarding the relationship with your clients, how far did you disclose your experience of depression?

A. Probably not. Oh gosh, and I’ve been seeing the same clients for years. If somebody were to ask me if I’ve ever been depressed, I think I’d be candid about that. I wouldn’t say, “And why are you asking me that question?” I think maybe a time or two I’ve alluded to that. I don’t get into, in depth, my own experiences, but I think, if I were to be asked, I’d acknowledge it. I’d just say, “I can sympathize with what you’re going through. It’s just pretty ugly and very taxing, and not fun.”

Q. I believe self-disclosure is related to your theoretical orientation. So, basically, you don’t think, self disclosure is not so useful?

A. I think if a client were to say, “I feel totally alone” or “I feel totally like there’s something wrong with me” I think I would get into some self-disclosure. If a client just felt, like, very alienated, you know, there’s something very, very wrong with them, I think it would be okay to self-disclose.

(Self-disclosure to colleagues)

Q. Next, your relationship with your colleagues. Do you think talking about mental illness in general or specifically depression, is kind of like still a taboo even among psychologists or mental health care providers or professionals?

A. I think it’s becoming less a taboo. I really do. Because, I’m just trying to think who’s disclosed to me they’re on antidepressants. I’ve had a supervisor tell me once he was taking Paxil and I’ve had some very close friends, of course close friends are going to
disclose that. I’ve been surprised at some people who’ve told me they’re on antidepressants. I think the taboo is a lot reduced.

Q. But still, somehow, it is.

A. I think there’s a little bit. I think there’s a little bit of taboo. I think people are careful about who they share it with.

**Psychologist 5 (male in his 60s)**

**Answer to the self-disclosure to clients was not available.**

**(Self-disclosure to colleagues)**

Q. Actually, in terms of the relationship with your colleagues, what’s my intention, I’m somehow wondering, even among mental health care professionals, especially among psychologists, talking about or disclosing depression is kind of like a taboo or..?

A. Yes, absolutely.

Q. Still?

A. Yeah. Yes. Even now. Except to just a few people that I’m very close to.

Q. If so, why? Is there somehow a stigma attached to it?

A. Yes. I would be afraid that people would stop giving me referrals, they would question my competence, they would question my ability to maintain the quality of practice, things like that.

**Psychologist 6 (female in her 60s)**

**Answer to the self-disclosure to clients was not available.**

**(Self-disclosure to colleagues)**

Q. Okay, actually, it’s related again with you’re relationship with your colleagues. My question is, the psychologist is one of the most experienced mental health care professionals, but I wonder if some kind of taboo or stigma exists if psychologists themselves suffer from mental illness. Of course that includes depression. For example, do you remember, at that time when you suffered from depression, did you talk to your colleagues or did you disclose that?

A. Yes, I did.

Q. Oh, really? Okay.
A. We’re very close and they knew what was going on the whole time and they supported me. They rallied around me. They were great.

Q. So you didn’t try to hide that?

A. No, I didn’t. I didn’t try to hide it. I was very upfront about it, with my colleagues. I wasn’t upfront about it with my clients, because it was supposed to be about them and not about me, but I did refer clients away because of it and I think some of them didn’t understand because I didn’t explain why. I just said generic, like, “I’m not in a position to be able to see clients right now.” They thought I was sick.

(Self-disclosure to clients)

Q. But you didn’t tell or disclose your experience of depression to your client, right?

A. No.

Q. I just wonder why?

A. Good question. I didn’t want them taking care of me, and a lot of clients, especially women, want to take care of you.

Q. So it’s more like a boundary issue.

A. It was like a boundary issue, yeah. Some of them thought I was sick, thought maybe I had breast cancer or something. Rumors were going around, I found out later, that I was ill. Well, yeah, I was ill, with depression. So there was a boundary issue around that. I think that’s why I didn’t feel any taboo or any problem with disclosing it, in general. I disclosed it to my friends, I disclosed it to my parents, my family. I didn’t have a problem with that.

Q. I think it’s also related with your theoretical orientation, because, based on some theoretical orientation they disclose, actually, self disclosure is sometimes very therapeutic.

A. Yes.

Q. So, may I ask you your theoretical orientation?

A. Yeah. I was just going to say that because I think it does have to do with one’s theoretical orientation. I was trained very humanistically, and so the relationship is the primary thing and it still is in my work, although I’ve incorporated a lot of different things into my work. And so I think that that helped. Or maybe people that are attracted to humanistic psychology tend to be more self-disclosurist. I don’t know. I didn’t have a problem with that. So, yeah, I do think that it might be related, whereas if I were the kind
of therapist who is the expert, I think it would be much harder for a therapist like that to disclose, just even in their private life.

Q. Okay. One more question in terms of the relationship with your colleagues. Generally speaking, do you think some kind of taboo or stigma exists, even among psychologists, like disclosing, talking about their own mental illness or even depression? Your environment seems very, I’m not sure if it’s exceptional or not, so I’m just asking, generally speaking?

A. I know what you’re getting at. Yeah. Among the counseling psychologists, the therapists that I know, and I know just about everybody in town, I think, for the most part, we’re a pretty touchy-feely group. I think we’re pretty warm and accepting and I don’t think it would be a taboo. But there are other kinds of psychologists you know, that do research and teach and do all these other things. Maybe work in the schools that I don’t know. And maybe there would be more of a taboo regarding them, but in my experience with the people I can think of, the ones that I know, I don’t think so. And I’ve been around this area for a real long time.

**Psychologist 7 (male in his 60s)**

**(Self-disclosure to clients)**

Q. Okay. First, the relationship with your clients. You mentioned your experience of depression makes it easier to talk about depression, which means, I’m just wondering, how much did you talk about your experience of depression with your client, how much did you disclose?

A. I didn’t share my experience. I was able to say things like, “Many people experience what you’re going through and it wouldn’t surprise me if you were experiencing this. Do you experience this?” “Tell me about how you were sleeping before you experienced this depression. Tell me, how are you sleeping now?” “How is your appetite now? Is this the way it was before?” And then I could say things like, “Well, don’t be surprised if it stays this way for a while.” And “One of our goals is to restore your appetite. That’s something for you to watch and monitor.” But I was speaking, not only from textbook experiencing but also from my own personal experience.

Q. Okay. You didn’t disclose your experience to your clients. My next question, actually, is why? Because, based on the theoretical orientation, some psychologists actually somehow are encouraged to disclose their experience. So, if you didn’t disclose, why?

A. The rule of thumb was not to disclose. That’s not to say that I never did. Particularly if the client would say things like, “You could never understand this” or “Nobody knows what I’m going through” or things like that. Then I would. But I wouldn’t just volunteer it.
Q. Because sometimes it’s considered therapeutic, right? Self disclosure is somehow therapeutic but it’s also related to the boundary issues.

A. Well, for me, the test was, how will this facilitate treatment? If it was my judgment that it would facilitate the treatment, then I had no problem with it. There are many situations, in my opinion, where disclosure does not facilitate the treatment. And, in fact, in some situations, disclosure can pre-empt treatment. So I think that that’s a very important judgment.

Q. So, based on your professional judgment.

A. Yes. The judgment of the readiness of the client and not just to share for the sake of sharing, but how will this sharing help the client realize that they’re not weird or weak or what have you. And that functioning people have experienced depression and because they’re depressed and experiencing this, that doesn’t mean that it’s going to be that way all the time.

(Self-disclosure to colleagues)

Q. Then after you became a psychologist, a couple of years later. At that time, did you talk about your experience of depression to your colleagues or not? I mean share the experience with other people.

A. Yes. Yeah. We did that. Yeah, that was not uncommon. Yeah. It was. They shared with me and I shared with them. So, yeah.

Q. Why I am asking you this question is somehow I am wondering, the psychologist, the mental health care provider, especially psychologists, they are, I think, the most knowledgeable people about mental illness or mental disorder, but still, I was wondering if there is still some kind of taboo or stigma that exists to talk about their own mental illness.

A. I did not experience that.

Q. But how about generally speaking, what do you think? Such stigma or taboo still exists or not?

A. I don’t think so.

Q. No? Okay.

A. I think far less so than it used to be. And you know, when I was in a community mental health setting and it was not uncommon, I can think of psychiatrists that were working there and psychologists that were working there that often talked about being depressed.
Psychologist 8 (female in her 50s)

(Self-disclosure to clients)

It has probably changed over time again, as I’ve been in practice working as a psychologist for almost 30 years. Initially, I guess there was more of a secret. As time has gone by, I’ve gotten more…been able to think about it and experience it and live through it. I’ve seen it as an important tool. Now, when I see my clients, almost always in the first session, I identify that I have bipolar disorder and I have ADHD. That these are challenges that I’ve gone through, because I don’t want my clients to feel ashamed that they have illnesses that they might need to work through. So I’ve become very open. I’ve become a real advocate of being open about it. I’m very open with my friends about it. I think with my colleagues I still tend to be a little more secretive about it. I don’t know why, because they should understand better than anyone. But I still fear being judged about my competence because I have depression. And it’s really pathetic that, in our own profession, I would still continue to have that kind of concern.

Q. Okay. What’s your relationship with your clients? You said, in your first session, in the intake you disclose your experience of mental illness. But I think, it seems there are two approaches. Some psychologists don’t disclose themselves at all. They say they try to be objective.

A. A blank wall, yes.

Q. So I think it’s related to each psychologist’s theoretical orientation.

A. I agree.

Q. What is your theoretical orientation?

A. It’s very eclectic. I went through developmental psychology in the PhD program before I went through the clinical psychology program. That had definitely a developmental perspective. I have a strong family, a strong cognitive-behavioral background, I still do a lot of (unintelligible) and worse type of analytic type of thing. So it’s a very collective approach of Sullivan. I probably disclose and have much more of an interpersonal relationship with my clients than many counselors might be comfortable with. And that works really well for me. I have good outcomes with my clients.

Q. Some psychologists, somehow, who hesitate to disclose themselves to their clients, their personal experience sometimes they say somehow it crosses a boundary.

A. Yes. And that’s a question that I’m always aware of, but anytime I disclose something, it’s for the benefit of the client, not for my own need. That’s how I try to keep that. And I make it very obvious that this is for your benefit, not because I need support or I need help or I need to be understood. That it’s about, that we’re, I have the perspective that we’re working as a team and you’re not my friend but, at the same time, I’m a human
being, I have experiences. You’re a human being. And I’ve learned from some of my experiences. And I think that that’s been a valuable tool to use. I know that’s different from the orientation of many counselors.

(Self-disclosure to colleagues)

Q. And the second, your relationship with your colleagues as a psychologist. So you said somehow you hesitate to tell them about your personal experience. So, it’s one of my research interests. I think psychologists, in a way, are the most knowledgeable, experienced mental health care providers but still, you said, why you hesitate to disclose yourself means once you did, some people doubt your competency?

A. Right, right. And I think that’s probably a projection onto them about my own fear of competency. That I think most people really would, most psychologists or counselors would understand and might respect me as opposed to judge me. In fact, that’s been my experience. That my disclosure with the colleagues that I have, you know, they have issues and problems and things, too, and they actually feel validated in their concerns, and they admire that I’m open and that I have enough self esteem and ego strength to be able to do that. So, I think it’s a projection. And that fear of competency or of being evaluated, I think it’s more childhood oriented, fears and concern. And maybe there’s just more at stake, you know it’s like being popular in high school. You don’t want to show any of your weaknesses. So I think that’s more of a projection of my own insecurities.

Q. But, generally speaking, do you think there’s still somehow a stigma or taboo about talking about their own mental health experiences?

A. I do. I think there is a stigma. I think there is. One of the things that still bothers me is to go to a psychiatrist in my community. You know, how are they going to evaluate me and what’s that going to do to my reputation. Maybe particularly with, this is kind of a prejudicial comment, but I think maybe the psychiatrists, they’re still more trained in the blank wall and nonhumanistic kind of approach, that there is a greater sense of, maybe, judgment. With psychologists, I think that’s not quite as much of a concern, at least for me. There seems to be a more give and take kind of relationship with other psychologists. Then again, I don’t go to see other psychologists, I see psychiatrists. Yeah. I’m sure there’s still a stigma.

Psychologist 9 (female in her 60s)

(Self-disclosure to clients)

Q. I think you mentioned competence as a psychologist. I’m interested in terms of self-disclosure, the relationship with your client. What do you think about self-disclosure in terms of your experiencing depression. Do you disclose your experience to your client sometimes or..?
A. I do, but it’s not across the board. It depends upon the situation and it depends upon the client. And I never go into details. For example, sometimes, like if I have a rape client, depending on how the session’s going, if it sounds like it would make a connection, where she could open up better or he could open up better, then I will share that I had been raped and here’s how I handled it. Here’s how I got through it. There’s hope that you can get through this. Yes, I’ve had depression related to something similar but, yeah, I’m not going to go into the details. And I don’t share across the board with everybody. It really depends upon whether it’s gonna be therapeutic or not. For some people it is, for some it’s not.

Q. So it’s based on whether it’s therapeutic or not, right?

A. Umhm.

(Self-disclosure to colleagues)

Q. Okay. Thank you. Also the second, your relationship with your colleagues, you mentioned denial and also the trauma. How about, do you tell your colleagues about your experiencing depression?

A. Only the person that I’ve chosen to trust. I don’t tell all my colleagues. I have one person who knows my history. She knows my history. And I’m comfortable talking to her and I trust her opinion and I trust that she’ll be honest with me, and vice versa. What comes out in terms of the group, staff, is just really, again, it’s one of those things that sort of depends on the situation. None of them know my history, my complete history. Most of them know that I was in the, at the University of Texas during the shooting, because that came up in relation to Columbine one day, and I felt comfortable enough to share that. But that’s it. I just shared that I had been there. And that three of my friends were killed that day. That’s all

Q. My assumption is, psychologists are well educated, most educated about mental illness but still somehow they have a bias against having mental illness?

A. Again, I think part of that may be because we’re trained to be the experts and to help other people who are sick. That doesn’t include us. I mean, somewhere along the way we lose that connection, that we’re part of the population. I mean, you know, I’ve had psychologists as clients, so we know they get sick, but, yeah, there’s a disconnect. Physicians are the same way. Nurses are the same way. We have this disconnect. And part of it may be due to training and part of it may be due to just the bias of our society. Japanese do, too. They don’t accept mental illness very well. It’s changing, but slowly.
Question 3. How did the experience of depression affect your perception of mental disorders/illness?

Psychologist 1 (female in her 60s)

I think that I’ve always been more Eastern mind than Western mind in how I perceived it because, from the start, even as I child, I look at depression as not always what it seems or not necessarily what we’re told about what happens. I know the orthodoxy of what we’re all told in the TV ads and all that stuff and I knew that in my own case it was things are not always as they seem, and so my approach to mental illness was that we’re told what we need to do to help people. Maybe yes and maybe no, so it gave me additional flexibility in my perceptions. I’m not somebody who follows the recipe book chapter and verse. I’m a person who … The way my thinking processes are, are always more global and more outside of the rigid orthodoxy. I will follow whatever I think is truth for a particular patient.

Psychologist 2 (male in his 50s)

Well, I think what it did, having experienced the burden of sadness, grief, or being overwhelmed, I think the simple answer would be, it helped me be more compassionate to my patients to have gone through what they reported to me. It’s like, it adds another meaning to, quote – unquote, “I know what you mean.” ‘Cause then you can say to yourself “yeah, me, too” but without saying, “me, too.” But it adds a certain sort of empathy and compassion to their experience and it opened my eyes to how overwhelming life can be to patients, from my own feeling.

Psychologist 3 (male in his 60s)

I think I explained that but I think increased sensitivity. Another thing, too, is, you grow up. It’s a male psychology. It’s a male psychology. You’ll be not dependent. You’ll be, like in this state, a cowboy. You’ll be very independent. You’ll be help rejecting. It’s how you’re socialized. You shouldn’t be crying. Don’t feel that way. You shouldn’t be feeling this way, if you’re upset, it may be a disorder of will. And I think that that’s all… I grew up with that. And so, my perception was that there must be a gender difference. And I’ve learned there must be a gender difference. The women, I think, not all, get together and talk to one another about their feelings. They don’t feel uncomfortable about that and are more likely to come to services.

Psychologist 4 (female in her 50s)

Well, my own experience let me know that people can be depressed either by fate or choices, and sometimes genetic predisposition. I think it did help me to understand that in some ways it can be a natural response to very bad circumstances and that, if I were ever having a tiny bit of judgmentalness in me, I don’t anymore, not after my own experiences with depression. And I also feel that, if somebody is having some struggles, professional help can make a world of difference. I guess that’s all….  

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I think that people generally have a biological predisposition towards it and given the right circumstances the depressive reaction is going to occur. And I think that sometimes people have such a strong biological component that, no matter what their circumstances, they are going to be depressed.

Psychologist 5 (male in his 60s)

I think it gave me the sense that it’s manageable, that it can be temporary or it can be long lasting. I think it gave me the perception of – you know, this is not, I mean you learn this in school but social environment, family environment. When I was in graduate school, there was a big discussion is personality nature-nurture. As I understand it, the research now everybody has pretty much agreed it’s half and half. And so I see it as half and half. I see that a lot of it is environmentally induced and a lot of it is biologically induced. And that’s probably one of the things that’s really helpful to understand. And so I am much more prone to recommend medication than a lot of psychologists. And when I tell people about medication, see if it works. If you experience a significant difference, stay on it, if you’re just saying, “eh, I’m not so sure,” then don’t. But I really encourage people to try it. As I say, I’m probably more oriented that way. At least a lot of my colleagues. Again, I don’t know what people do so much, anymore.

Psychologist 6 (female in her 60s)

In general. Um. I think that it helped me to understand, I think, just how much people suffer. That they can look fine, and act fine, and appear to be okay, and be suffering tremendously. I think I didn’t really understand that viscerally until it was me. That it could happen to anybody. That it could happen to anyone and that there’s nothing special about me. (Laughs) And that was kind of reassuring, in a way, to know that. You know, it’s like you’re just part of the human race.

Psychologist 7 (male in his 60s)

You know, I’m sure that it did, but I guess if anything, what comes to mind is the belief that no one was exempt from a mental disorder or a mental illness and it increased my curiosity. As a result, I think I may have read more research studies than I would have. Yeah, I would say it demystified it for me. Of course I had the intellectual understanding and what not. But it’s one thing to read about it, to see it, and to work with it. It’s another thing to experience it.

Psychologist 8 (female in her 50s)

…So there’s a lot of psychopathology, mental illness, in my family. So I’ve had a lot of first hand experience. Again, I think that, as a psychologist. It’s much easier to kind of identify with my clients, with the problems they have with their families, with childhood abuse, different coping mechanisms. Not only my own experience towards my own depression, but watching the mental illness within my family has given me a wealth of
information in terms of working with my clients. So I see it as almost normal. Again, which may make it easier to relate with many people.

**Psychologist 9 (female in her 60s)**

(Shes talked about her experience of encountering a shooting incident at college while she was studying at library.)

How pervasive the stuff is and how subtle it can be, to me that’s one of the things that, it’s helped me to understand why patients come in the way they do. Either, my wife said I should come, or they come in when they’re so far down, because they’ve waited so long, because they’ve been in denial. Or they come in scared to death. They don’t know what’s happening. And I want to have a lot more compassion for that. I actively seek that kind of information in terms of how they got here and what are their fears and I try to build up a little hope in the first session. And I share that with them. These things can come on and other people may see it before we do, you know. That’s been one of my real insights, I think, and that’s helped me in terms of my clients, too.

**Question 4. What meaning do you personally attach to depression? For example, do you see depression as having any value, or being meaningful in your life?**

**Psychologist 1 (female in her 60s)**

As far as psychodynamics, the attribution of meaning to human experience is huge in terms of our experience of depression. What depression means to me is it’s an imbalance in the relationship between a person and himself. That’s what depression means to me. And the more I practice, the more clear it is to me that depression has never been and couldn’t be less neurochemical, however, in a mind-body sense, when a person bathes their entire self, including their body, in sadness, for long enough, being depressed, yes, everything in their body accommodates that and changes because of it, including the neurochemicals, as a result, not as a cause. So, that what my experience and what depression means to me is more and more, I get it. That it is a disconnect between the person and the relationship, their relationship with themselves.

**Psychologist 2 (male in his 50s)**

Well, as a mental health professional, first, I’m rather accepting of people’s problems and my own and so I don’t stigmatize the difficulty, either for my patients or for myself. That’s part of being in the field, as a practitioner, in terms of open minded, number one. I think I would attach a personal meaning as sort of a message to me, “hey, look, something is wrong here,” a signal that something needs to be different to be happy, kind of like a wake up call. Some of my patients come in and they might have a divorce or lose their job. Those are wake up calls. And I think that I don’t attach any stigma, any particular negative valence to the issue of my own depression, but more of, “what do I need?” More of a signal that something’s wrong here and I need to act on it. So, I need to, kind of, fix the problem in some way. Other than that, it would be more of a message that
something needs to change. It’s like, there is a need for some change to feel better, to not be so overwhelmed.

**Psychologist 3 (male in his 60s)**

I think it has meaning. It’s like any other life experience. So you take the life experience for what it is and you try to integrate that into other life experiences and that becomes part of yourself. So this is one way to think about an identity, is borrowing bits and pieces of other people, existentially, and kind of stitching them together – your mother, your father, the aunts and uncles, your culture, all of it. But also your life experience. If part of your life experience is depression, you use that somehow.

**Psychologist 4 (female in her 50s)**

I think when one is depressed, they’re very detached, they’re very into what’s going on in their own head. I don’t want to say it’s sort of an induced introverted state but I do feel, when somebody is seriously depressed, that is a time for a lot of reflection and sometimes it can be a time of very ugly self examination. Sometimes I think when somebody is extremely depressed, I think it’s so painful that the pain can promote them to make some changes. I think it can have a positive effect.

**Psychologist 5 (male in his 60s)**

Yeah, that’s an interesting question because it’s certainly part of my identity and at the end of the day, most people like their identity and who they are, at least I do. And so it partly defines who I am. And before, I probably would have said, “Do I really want to give this up? Maybe not.” It helps, I think, with creativity. I think it helps with being sensitive, I think it helps with seeing some depth to people, some understanding. So I really do think there is some meaning and value.

**Psychologist 6 (female in her 60s)**

I think that the depression had a lot of value and it was very meaningful to me in terms of what I said before about feeling I’m no different from anyone else, I am just as likely to be pummeled by life’s events as anyone else, I’m not special, which I like. I like not being special. And it made me a better therapist, as I said before, and I’m really pretty sure of that. And it also made me very aware of how fragile our lives are. That we’re all sort of hanging by a little thread, in a way, and when life happens, things get pulled out from under you, anyone could, and would, suffer from that. That life is a very fragile thing. I don’t walk around feeling that way, but I’m aware of that….

I think it depends on when you ask. During that time, no way! I’m glad it’s over. I don’t want to have another one. I hope I don’t. I know I could, but I hope I don’t. I would rather I never got depressed, sure. But the fact that I did, I think I’ve tried to glean every, wring every ounce of meaning that I could find out of that experience. And I think I did….
Yes. Looking back on it, it was valuable and meaningful, for sure. But, when you’re right up against it, no. I’d rather not have such a valuable experience. I’d rather be ignorant.

**Psychologist 7 (male in his 60s)**

For me, depression represents a loss of ability. And, for me, in working with depression, the question is, what is it that this person can’t do - Okay? - that they were able to do before the depression and what is it that they are unable to do that if they could do they wouldn’t be depressed? So that’s how I’m approaching depression. As a loss in ability and, in a different sense, a loss in power. So personally, for me, one of my goals is to promote the enhancement of an individual’s ability to do, speaking generally, whatever it is that they see themselves as being able to do and do well. Okay? And, for me personally, well, I’ll put it this way, I don’t court depression. It feels lousy. And it’s just an inability to take advantage of opportunities that I or another person ordinarily would be able to take advantage of, because the depression is disruptive. Now, does it have any value? Yeah. Depression signals. It signals a threat, it signals a fear, and it indicates that something is not working the way it ought to be working with the person. Now in a clinical depression, that’s a little different. And in a situational depression, of course that’s a little different. I don’t know if I’m answering your question does it have any value.

**Psychologist 8 (female in her 50s)**

I think, with depression, I think it’s a very introspective kind of illness, particularly with anxiety attached and that. You think a lot, because you’re trying to figure out how to get out of this. And so you’re analyzing this and analyzing that and you’re looking at relationships and you’re trying to figure things out. How do I escape from this suffering, from this misery? And so I think that there is a lot of knowledge that’s acquired in interpersonal relationships, in emotional functioning, in stress management, and in coping mechanisms that just come from trying to get through this illness. I don’t know if I would say it was worth it. You know, if I had a choice I’d rather be less wise and have had a happier life. It’s made me, I think, a very good clinician. And so there’s a lot of reward that comes from knowing that you’re making a difference in other people’s lives and seeing them grow and seeing them change. That I probably would not have gotten to that same level of skill and ability without the depression, but again, I think if I would have got a chance to choose, I would have chosen a life without the depression.

**Psychologist 9 (female in her 60s)**

I wasn’t sure if it has any specific meaning. I think that, in terms of its value, I’d put it out there with every other life experience. Partly by losing my dad so young, I had a difficult time in school. I know at that time I became very aware of a lot of the kids’ what I call superficiality. I had gone through something very severe and in an instant it changed the way I saw my life, whereas a lot of those kids had never experienced anything difficult and everything was still happy-go-lucky. I think there’s an old saying somewhere around the world that you can’t appreciate joy until you’ve had sadness, or
something to that effect. That’s, I guess, the way I put it. Every pain, every trauma, every
down kind of part of life is a way of helping you learn to be grateful for the upsides of
life. You appreciate the highs better. Does that make sense?

**Question 5. What else would you like to tell me about your experience with
depression and its effects on your work?**

**Psychologist 1 (female in her 60s)**

A. Was it worth it, to go through what I went through during childhood and being
depressed? No. Am I grateful that I experienced it, my experiences and getting rid of
depression, being able to help people? You betcha. Would I voluntarily go back and do it
all over again? Because of what my childhood was like, I would tell you in all honesty,
no. I wouldn’t want to do it all over again. But am I grateful that what I made out of it
was the ability to turn things around for people? You betcha.

Q. So you really enjoy working with people with depression?

A. Oh, enjoy is way too pallid a word, it’s just way too small a word. You can’t imagine
how magnificent it is to watch a human being who is suffering every day, come alive and
lose their suffering. There’s nothing else like it.

**Psychologist 2 (male in his 50s)**

Well, what I would say is that I have found for myself trying to do my job while I was
depressed was very much of a struggle. This business is hard work, anyway, and it was
amplified not feeling like talking. And this is a talk business. If I was a dentist and didn’t
want to look in a mouth, I would be in trouble. And so it was hard to keep doing my daily
work while I was struggling with myself, with my own mood. It takes a fair amount of
focus and energy to keep tuned in to a client and I kind of didn’t have the focus and
didn’t have the energy to keep going for a 45 minute appointment sometimes. That made
it tough and when it started to remit, it was like, “wow, I think I can do my job now.”
And so, I think that that would be the biggest issue, and the second issue would be to
learn ways to take care of myself. Maybe recreation, maybe exercise, maybe
communicate more, maybe let my family know versus be silent and just fix it on my own.
Some men, some people, kind of say, “Oh, I can handle this myself.” So it’s also a
message that I’ve learned that it’s okay to be vulnerable, and I think that I struggle with,
you know, opening up, even though I’m a counselor. We’re not immune from not talking.
That would be some good lessons for myself about stress management and coping with
depression.

**Psychologist 3 (male in his 60s)**

Having come through this, you use this in a good way. You can even use the experience
of working through having depression, in a good way. I tell kids the more you can talk to
other kids, the more you’ll find that they understand something about this, too. Especially
teenagers. And they always say, “oh, I couldn’t say anything like that” and I say, “Well, try it out”. A boy tells another boy, “You know, I was depressed there, for a while”. “When I was (unintelligible) and self-injurious, I was thinking ‘I’ll hurt myself’” and the friend says, “I did that, too.” So there’s kind of a comfort in sharing.

**Psychologist 4 (female in her 50s)**

A. Now, as I said, I work primarily with soldiers, and sometimes I do see soldiers with circumstances that would be very depressing and I always ask about vegetative signs and possible symptoms that could be going on. I’m amazed at how some individuals can have the same circumstances and a certain portion of them do not react to it and a certain portion do. (Unintelligible)

Q. Of course, each person’s different, unique. Even in the same stressful situation some people experience depression, other people don’t. What do you think makes the difference?

A. I think factors that make a difference include the level of support network that he has, the biochemical predisposition,

**Psychologist 5 (male in his 60s)**

The other thing I would say, it has helped me understand and appreciate when family members are going through this. For instance, my wife has had depression. I have a son who has significant depression at times, although he’s getting better. But he will go three or four days without getting out of bed. I’ve never experienced that. I’ve always been able to push past that. I think it gives me a greater appreciation of people, not just patients, but seeing it as a normal part of many people’s condition.

**Psychologist 6 (female in her 60s)**

I think I said this before but this is really the big thing for me. Is being really willing to set aside my own perceptions and trying to just really listen to what my clients are telling me about their experience, whether it’s depression, anxiety, their mother, their parents, whatever it is, to just really listen. And I’m listening specifically for what is the meaning of this for them and what can we do with that that’s going to be meaningful for them. And I don’t think that I would be, I tend to be, before this, I would make snap judgments about what people thought or felt or meant or what they did. I would make these very facile judgments or decisions. I don’t do that any more. At least I don’t think I do

Q. So you said you tried to find the meaning behind…?

A. I tried to help them find the meaning. And I’m listening for it. I’m listening for it. So I don’t do as much talking as I used to.
Psychologist 7 (male in his 60s)

A. Well, it’s hard for me to believe that there’s a psychologist that hasn’t experienced depression.

Q. Why? Is it somehow related to the profession?

A. Yeah. I mean the work itself, not just the profession, but even to study it brings you back to self-examination. I quite frankly believe that the person in this society that has not experienced depression is a rarity. I don’t buy the statistic that one out of every ten.

Q. Okay. Actually, somehow they are more like underestimated.

A. Well, I find it very difficult to believe or to understand how a person can go through this society and not at some point experience something, particularly depression.

Q. So as you said, depression’s kind of a very natural reaction.

A. Yes. It’s a reaction to a loss.

A. …Well, my orientation, I don’t know. I would say that my training is eclectic. I’ll just leave it at that. It’s eclectic.

Q. So you more like explore the meaning of the experience?

A. Yeah. I want to know what it means to them. I want them to see that, I want to appraise the level of guilt that they have internalized. I want to appraise the level of shame that might go with the depression. And I want to help them dissolve those emotions. I also want to help them see themselves when they were functional, so that they can work with the sense that that’s not gone forever. Depression is a state.

Psychologist 8 (female in her 50s)

…And there was a period of time that I had to take off work and not do that. But I do think that if you’re able to, if you honestly take a look, work through your issues diligently. Work on finding the right psychiatrist, finding the right medication, finding the right therapist, and really do your work, that not only can you continue and do the work, but it’s very healing for yourself as well as giving you stronger skills as a clinician. However, there is a cost. I do feel, as much as I enjoy my work, and as rewarding as it is, as much satisfaction as I find from it, I do think that it takes a tremendous toll on me physically and that it is exhausting. Maybe in some way the quality of life has declined a little bit. As a result of carrying that burden on top of having a disability. Maybe without the depression maybe I could do this work and have it not have such an impact in terms of energy drain. Psychology, as a clinician, is difficult enough to handle emotionally without having an illness like this.
Psychologist 9 (female in her 60s)
Not applicable (no answer to this question).