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An investigation of Depression among clinical, counselling and educational psychologists in private practice

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CHAPTER FOUR – DISCUSSION

4.1 Introduction

The current research replicates some aspects of an existing American study conducted by Gilroy, Carroll and Murra (2001). The researcher felt that an exploratory study done in a South African context may yield interesting comparisons with this existing research, and perhaps generate hypotheses for future investigation. Using the existing American study as a point of reference, the researcher set out to explore how psychologists' depression affects clinical practice.

The current study deviated from the study cited above in the following ways:

- It attempted to explore how clinical practice impacts on psychologists' vulnerability to depression
- It attempted to explore psychologists' understanding of their depression, in particular, the predisposing, precipitating and maintaining factors.
- An attempt was made to establish the chronology of the depression experience in relation to the commencement of private practice
- It attempted to explore whether or not psychologists' patients fell into any particular diagnostic categories. The thinking behind this focus was that there may be something particular about the South African context that impacts on psychologists' depression, and this may be revealed through recurring patient presentation profiles.
- Furthermore, the research sought to investigate what psychologists perceived to be the most stressful aspects of their work.

- Finally, an investigation of current self-care trends amongst psychologists was included.

The discussion will first cover the quantitative findings, followed by comment on the qualitative findings of the study.

4.2 QUANTITATIVE DISCUSSION

This section covers the following variables which emerged from the quantitative responses of participants:

4.2.1 Marital Status

Of the total sample of psychologists who had experienced one or more depressive episodes, 84% were involved in an intimate relationship. Fifteen percent were single or divorced/separated. According to Kaplan and Sadock (1998), major depressive disorder occurs most often in people without close interpersonal relationships. The contradictory result found in this study may be due to sample bias and thus is not worthy of further investigation.

4.2.2 Children

Fifty eight percent of the sample of psychologists who had experienced one or more episodes of depression had children. Existing studies which examine the contribution of child bearing and child rearing to ones vulnerability to depression suggest that the financial, emotional and time-related demands required to raise children increase one's vulnerability to depression, especially women (Rapmund, 1985).

4.2.3 Years in Practice

There appeared to be no meaningful relationship between years in clinical practice and depression. Respondents who had experienced one or more episodes of depression reported being in private practice from between 6 months to 20 years. The mean number of years in private practice for the current sample was 7.15 years.

4.2.4 Age

The sample was not big enough to adequately assess the relationship between age and depression. The total respondents' ages fell between 27 years and 59 years and the mean age of respondents was 40 years.

4.2.5 Gender

Ninety two percent of the sample were women. This bias towards women may be due to a combination of many factors. These include the sampling method where respondents are purposively chosen by the researcher and a possible self-selection bias. Secondly, the fact that, according to Rosenthal and Rosnow (1991), women are more likely to volunteer for research. Thirdly, the twofold greater prevalence of depressive disorder in women than men (Paykel, 1991). Finally, according to the Health Professions Council of South Africa, 63% of the total psychologists registered in South Africa are women. Perhaps a study of depression amongst male psychologists would yield useful comparative data.

4.2.6 Psychology discipline

The division of psychologists into clinical, educational and counseling disciplines was not meaningful for this study. The sample was biased towards clinical psychologists due to the purposive sampling method selected. Overall, 69% of the respondents who reported having experienced one or more depressive episodes were clinical psychologists, 27% were educational psychologists and 4% were counseling psychologists.

4.2.7 Depression Experienced

Sixty three percent of the total respondents in the current study reported having experienced one or more depressive episodes. In Deutch's (1985) sample of psychologists, 57% reported depressive symptoms at some point in their professional lives. Gilroy, Carroll and Murra's (2001) study reported that 76% of their sample of female psychotherapists experienced some form of depression since beginning clinical practice.

It would appear that the incidence of depression among psychologists in this sample does not deviate significantly from depression reported in samples in other parts of the world. The counter-intuitive nature of this result suggests that future research should explore in greater depth the impact of working clinically in a context of high levels of criminal violence and trauma, such as that which characterizes South Africa.

4.2.8 Age of first depression

One of the unique aspects of the current study was the exploration of respondents' ages when experiencing their first depressive episode. Fifty seven percent of the current sample of respondents who reported experiencing one or more episodes of depression did so on or before the age of 22. In other words, over half of the sample of psychologists who reported having experienced a depressive episode did so many years before commencing private practice. According to Kaplan and Sadock (1998), the general population's mean age for onset of depression is 40 years. This finding highlights the possibility that individuals who have a predisposition to, or early experience of, depression are more likely to select a career in the helping professions such as psychology.

Studies conducted by Elliot and Guy (1993) have gone some way towards exploring the family environments of mental health professionals. They suggest that psychologists often come from families in which they suffered emotional distress. They may enter the profession, in part, to fulfil needs that were not met in childhood. Fussel and Bonney's (1990) study also offers a rough road map for conceptualizing the relationship between early experiences and their impact on career choice and effective clinical practice. Much of this exploration requires awareness of the influence of unconscious motivation. This is an area of research, which requires a psychodynamic conceptualization and a qualitative method capable of tapping into a reflexive mode of analysis. In such a mode, past behaviour and memories of motivating cognitive and emotional states are examined against current behaviour and current motivating emotional and cognitive states. The shifts that are identified consciously may then shed light on aspects of the

constant and evolving unconscious processes that are thought to drive past and current behaviours and emotional states.

The existing literature and the current study confirm that early onset of depression is a common phenomenon amongst individuals who select psychology as a career.

4.2.9 Client Hours per week

In the current study there appears to be no correlation between depression experienced and client hours worked per week. Although long after hours work was cited as a common stressor among respondents, 57% of the sample that had experienced one or more episodes of depression did so before starting private practice. With a larger randomised sample, a possible correlation may be revealed.

4.2.10 Most frequently occurring depressive symptoms

In the current study respondents were presented with a list of neurovegetative features defined by the atheoretical classification system of the DSM-IV-R, which are thought to identify the presence of a depressive episode. They were asked to identify which symptoms they experienced during their depressive episode.

It is important to consider that people may describe themselves as depressed without the incidence or experience of actual neurovegetative features. This has implications for future research. In order to distinguish between a mood disturbance and a mood disorder, descriptions need to be tightened and provision made for idiosyncratic depressive experience.

This was a unique aspect of the current study and revealed that most respondents who had experienced one or more episodes of depression reported experiencing fatigue/loss of energy and feelings of worthlessness and self-doubt most frequently. It may be interesting for further research to explore the general population symptom profile, and compare it to psychologists in clinical practice. This will assist understanding and treatment efforts.

4.2.11 Theoretical Orientation

Fifty eight percent of the total sample reported a psychodynamic theoretical orientation. This result is perhaps due to the purposive sampling method and the self-selection bias. Twenty six percent reported a mixed theoretical orientation, which included combinations of systems, psychodynamic, cognitive behavioural and transactional analytic theoretical approaches.

In the total sample of respondents reporting one or more episodes of depression, 61% identified their therapeutic approach as psychodynamic, and 19% identified a mixed/integrated therapeutic orientation.

It is possible that respondents who select a psychodynamic orientation are more likely to have experienced depression in their adolescence or early twenties, and identify relationships in their family of origin as contributing to their vulnerability to depression. An exploration of individual motives for selecting a particular theoretical orientation may be an interesting area for further research.

4.2.12 Treatment sought by respondents

In line with similar research, 84% of respondents who reported having experienced depression sought treatment. 80% of this group selected psychotherapy as their treatment of choice, and the most frequently cited reason was that psychotherapy helped them to understand the underlying causes. An interesting addition to this for future research may be an investigation of what factors influenced respondents' selection of their personal therapist. This may assist the profession to uncover the obstacles which hinder professionals seeking therapeutic help.

The majority (69%) of respondents did not receive a DSM-IV-R diagnosis. Of those who did receive a DSM-IV-R diagnosis (30%), 90% reported taking medication. It would appear that respondents who received a formal diagnosis were more likely to have been prescribed medication. Of the total sample of respondents who reported experiencing one or more episodes of depression, 46% took medication, often in combination with psychotherapy.

4.2.13 Dominant syndromes seen in respondents' private practice

This was a unique aspect of the current study and although few participants (23%) responded to the question, it may be an interesting area for further research.

It is suggested that due to the psychodynamic emphasis on countertransference and transference relationship phenomena, psychologists who treat a number of depressed patients are more vulnerable to experiencing depression. This is alluded to by the results of a study conducted by Chiles (1974), where it was found that psychologists who committed suicide had a

significantly larger number of suicidal clients than the average therapist.

According to the results of the current study, the most frequent syndrome seen in respondents' private practice was reported to be depression. This may imply that exposure to depression can contribute to a therapist's depression due to his/her total immersion into the patient's emotional world. In other words, the daily encounters with unhappy and discouraged people may be a cumulative catalyst for a therapist's own depression.

4.2.14 Disclosure of depression experience to colleagues

In the current study, 88% of respondents who had spoken to their colleagues about their experience of depression reported positive, supportive and empathic responses. Compared to the study conducted by Gilroy, Carroll and Murra (2001) in the United States, where respondents appeared to more often withdraw from colleagues, feel judged by colleagues, and feel the need to hide their depression - a greater openness and acceptance may characterize collegial relationships in South Africa. This remains conjecture due to the non-experimental nature of the current study, but may prove to be an interesting area for future research.

One may also speculate that psychodynamic psychologists are possibly more open to self-disclosure. This may be because their theoretical understanding allows for consideration of countertransference, and therefore the contribution of the self to the therapeutic encounter. In other words, a psychodynamic theoretical orientation encourages regular examination of the self and emotional reactions to one's patients. This increases the need for disclosure in individual therapy, and disclosure within collegial relationships. In fact, the current research

proposes that establishing and maintaining collegial relationships where disclosure is possible, be seen as a vital source of support and an important self-care practice.

4.2.15 Theoretical orientations of respondents who reported not having experienced a depressive episode.

The results of the current study suggest that psychologists who use a mixed theoretical orientation are less likely to experience a depressive episode. It is thought that the use of theoretical approaches such as Cognitive Behavioural therapy provides the therapist with practical tools to offer patients. The therapy is solution focused which provides increased control and less anxiety and uncertainty for the therapist.

In addition, systems approaches do not place as much emphasis on the relationship between therapist and client. Rather, the focus is on complex circular interactions between the different parts of a system in which the therapist is just one part.

Psychodynamic approaches, because of their emphasis on the relationship between therapist and client, and the often unconscious processes influencing the relationship, are thought to place a greater strain on the therapist. This emphasis on the person of the therapist within the therapeutic encounter requires a high degree of emotional involvement and uncertainty, often increasing a therapist's vulnerability to self-doubt, anxiety, and depression.

4.3 QUALITATIVE DISCUSSION

The following section covers the results of a qualitative analysis which emerged from the subjective responses of participants:

4.3.1 Factors contributing to psychologists' depression

The findings of the current study serve to confirm many of the findings reported in the existing literature regarding possible contributions to psychologists' personal experience of depression.

The current study confirms the central contribution of a psychologist's early experience in their family of origin to their vulnerability to depression. Studies by Menninger (1957), Ford (1963), and Elliot and Guy (1993), all suggest that psychologists often come from families in which they suffered emotional distress as children. The current study supports this general trend and, in addition, identifies some of the life events that are more likely to trigger a depressive episode. A genetic predisposition to depression was identified by some participants as a contributing factor. The infrequent mention of possible genetic contributions may be due to the sample bias towards psychodynamic psychologists, who may be more likely to emphasize the interpersonal and unconscious origin of depression.

The current study explored the most stressful aspects of working as a psychologist. Many of these related to the context of private practice. Apart from anecdotal reports by Kottler (1993) and Bloomfield (1997), there appears to be very little research focused on the impact of private practice stressors. The most frequently cited stressors in the current research related to

private practice issues of earning per hour, extended after-hours work, the depleting nature of the work, exposure to trauma, uncertainty and isolation.

An interesting area of research may be the impact of the daily emotional (internal) and environmental (external) stressors of private practice on the therapist's state of mind. Such research may reveal ways in which contextual stressors may be reduced for greater therapeutic effectiveness.

4.3.2 Contributions of the depression experience to choice of profession

The current study did not directly address the link between depressive experience and selection of psychology as a profession. However, it emerged from the data that participants themselves perceived a link between their experience of depression and how it had sensitized them to the suffering of others. This link has been well documented in the literature by researchers such as Menninger (1957), Racusin, Abromowitz and Winter (1981), Henry, Sims and Spray (1973), Guy (1987), and, Fussel and Bonney (1990). Menninger (1957) adroitly articulates this relationship when describing how "early family experiences sensitize psychologists to emotional pain, as well as provide motivation for their vocational choice" (p. 267).

Recent studies around attachment organisation and how this affects psychologists' approach to therapeutic work may assist psychologists by making conscious their individual style of attachment, care-giving behaviour and quality of close relationships. A useful area for future research may be a method of identifying the attachment styles of therapists. This would highlight the possible relationship risks inherent to these

styles, their impact on the therapeutic relationship, and the appropriate support required by supervision.

4.3.3 Effects of the experience of depression on the therapeutic encounter

The findings of the current study serve to confirm the findings made by Gilroy, Carroll and Murra (2001) regarding the ways in which respondents reported their depression experience having affected their clinical work. The responses to this question fell into two categories: a) positive impact, and b) negative impact. Unlike the abovementioned study, which reported that the majority of respondents indicated a positive impact, respondents in the current study presented a balance of both positive (49%) and negative (51%) consequences for their clinical work. The most frequently mentioned positive impact was that experience of depression made them more empathic, understanding, tolerant, and attuned to their patient's feelings. The most frequently mentioned negative impact reported by respondents was that they felt emotionally unavailable at times.

Respondents also expressed positive gains related to depression in their professional skill development. Unlike Gilroy, Carroll and Murra's (2001) findings, respondents referred to the way in which clinical work forces them to reflect on and process their vulnerability to depression. One respondent stated "it has helped me be more understanding and compassionate with myself, sparing me a more extreme emotional experience."

However, severely depressed therapists, faced with loss of patients and income, have to confront the ethical dilemma of continuing to practice when their depression has the potential to impair the quality of service they offer their patients.

The researcher would like to propose that trainee psychologists be well prepared for the possibility that their clinical work may increase their vulnerability to the experience of depression. Attempts should be made to destigmatize depression, as it is suggested here as being inherent to the human condition, especially under stressful circumstances. If a culture of tolerance and receptivity is promoted in our learning environments, psychologists' understanding and compassion for others and for themselves will be encouraged. Treatment will be sought without fear of stigmatization and, ultimately, this will improve therapeutic effectiveness.

4.3.4 Preferred self-care strategies

Existing research consistently highlights the stress that is inherent to the profession of psychology, and which can contribute to psychologists' vulnerability to depression. Unwillingness to seek assistance for their depression may place therapists at risk. Existing studies suggest that therapists are reluctant to seek help after their training ends (Sherman, 1996). However, results of the current study support the findings of Gilroy, Carroll and Murra (2001), who reported that the vast majority of respondents (85%) in their study sought therapy. 80% of respondents in the current study reported seeking treatment for depression from a psychologist. The most frequent reason given for this was that psychotherapy helped them to understand the underlying causes, rather than just treat the symptoms, of depression.

Future South African experimental research that examines the impact of parenthood, years in private practice, client hours per week, gender, race, religious affiliation and marital status on psychologists willingness to seek therapy, may provide a more

accurate picture of the obstacles psychologists experience in relation to responsible self-care.

Further research in this area could include exploring with therapists who have sought personal therapy, the perceived value of the therapeutic experience, and positive and negative experiences of their personal therapy.

The current study has highlighted the vital importance of ongoing personal therapy for psychologists in private practice. As a consequence, it is suggested that the Health Professions Council of South Africa's Code of Ethics, which governs the profession of psychology, include personal psychotherapy as a mandatory self-care practice for all practising psychologists. The researcher would like to make the point that the current Code of Ethics as applied to psychologists in South Africa provides a limited view of self-care. It focuses on self-care issues primarily as they relate to the welfare of patients. The welfare of the therapist is only mentioned as it relates to preventing impaired performance. South Africa requires a progressive Code of Ethics, which includes a preventative focus on self-care as it relates to the therapist's personal and professional well being.

The current study also attempted a tentative exploration of the willingness of psychologists to disclose their experience of depression to their colleagues. Existing studies conducted by Sherman (1996); Kramen-Kahn and Hansen (1998), highlight the importance of congenial collegial relationships which provide support and help to reduce professional conflicts. This finding is confirmed by the current study, however further research with a representative sample of psychologists may provide interesting information on the quality of, and changes to, collegial

relationships as a result of disclosure regarding experiences of depression.

In addition to the above, the current study included an investigation of current self-care practices. The most frequent self-care practices cited in the study were physical exercise, social activity, supervision, and personal therapy. Future research in the area of self-care would be usefully directed at exploring psychologists' attitudes to:

- A professional program designed to assist practising psychologists who are psychologically impaired
- Mandatory personal psychotherapy for practising psychologists
- Disclosing a colleague's impaired mental health to the Health Professions Council of South Africa

4.3.5 Transcending Woundedness

The current study confirms findings in the existing literature (Gilroy, Carroll & Murra, 2001), which indicate that psychologists' perceived experience of depression assists them to better understand the patient's experience of depression. In other words, it is the personal experience of woundedness which enables the psychologist to understand the patient's pain, and which informs sensitive clinical practice.

There are many examples in the literature, for example Remen, May, Young and Berland (1985) of individuals who have used traumatic personal struggles to empower others. In so doing, they have experienced the healing provided by finding meaning in, and mastery over, the experience. The results of the current study suggest that it may not always be an advantage for

psychologists to have experienced depression. Clinical practice may be adversely affected and the profession's reputation compromised. However, what is advantageous to clinical practice is if the depression has been recognised, confronted, successfully understood and resolved. It is here where personal therapy and self-care practices are vital in order to help integrate the experience and restore the psychologist's capacity to function effectively.

Although depressions differ in severity and duration, most are characterised by common experiences such as low self-esteem, indecision, feelings of helplessness and irritability. These experiences, regardless of their severity, provide a basis for understanding something about depression. This experience of depression or time-limited depressive feelings, can increase a psychologist's sensitivity and empathic attunement, and may improve the application of professional skills. Future research, which explores the translation of personal experience into professional skills, may further consolidate this link.

In addition, a study which attempts to establish whether afflicted psychologists have worked through their depression or not, would be a useful avenue of exploration.

4.4 Implications for Future Research

4.4.1 Methodological Implications

- The self-report instrument should be tested thoroughly to eliminate leading questions and ambiguous questions. A thorough pilot study should be conducted to ensure that the self-report instrument elicits the information that is required to fully address the research questions. In the current research, the nature of the questionnaire was a limitation as

it included a leading question, an ambiguous question and omitted questions with a greater focus on current experience.

- A larger random sample of psychologists should be selected and mailed to ensure a greater degree of generalisability

- A follow up mailing could be built in to the research methodology to elicit a higher response rate.

- Questions that could be included to improve the usefulness of the research are:

  - Are you currently depressed?
  - Are you currently in psychotherapy?
  - What is the theoretical orientation of your therapist?
  - What were the reasons for selecting your particular therapist?
  - Why did you select the treatment you did?
  - What was happening in your life when you experienced your first depressive episode?
  - How do you understand your current depression?
  - Do you feel that individual psychotherapy should be mandatory for all practising psychologists? If yes, why? If no, why?

4.4.2 Practical Implications

- Training programs should include a process which encourages reflection on individual understandings of the possible connection between childhood experiences and the selection of psychotherapy as a profession. This would promote self-awareness and insight into potential blind spots

and areas of vulnerability which may negatively affect clinical practise.

- Psychologists' attitudes to consulting a psychiatrist could be explored, and the working relationships between psychologists and psychiatrists be investigated. This may promote greater understanding of a multidisciplinary approach to depression. It also opens an exploration of the possible historical antipathy between the professions, which may contribute to a reluctance to draw on either psychiatric help or psychotherapeutic help, whichever is perceived to be the competing profession.

- Psychologists' attitudes should be elicited towards a code of ethics which includes mandatory personal therapy for all practising psychologists

- A quantitative comparison of rates of depression between psychologists from different theoretical orientations could be investigated. This may reveal that some theoretical orientations increase a practitioner's vulnerability to depression, whereas others, or a combination of others, may act to protect the practitioner from depression.

- Training programs for intern psychologists should include an emphasis on self-care and the potential hazards associated with the practice of psychology.

CHAPTER FIVE – CONCLUSION

The aim of the present study was to investigate depression in clinical, counselling and educational psychologists in private practice. The study replicated, in part, a study conducted in the United States and made use of relevant aspects of its design. In addition, the current study elaborated on this existing structure and added unique areas of inquiry.

In concluding this study, we return to the original research questions to ensure that the research objectives have been met. It is important however, to remind the reader that generalizations to the population of psychologists in South Africa based on the results of this research cannot be made due to methodological limitations which have been discussed.

In brief, this study reveals that depression amongst psychologists may occur at a much higher rate (63% in the current study) than the general population (an estimated 20%). Psychologists appear to have a significant vulnerability to depression. It was found that psychologists do seek treatment and most often seek psychotherapeutic help as it helps psychologists to explore the underlying reasons for their feelings, instead of merely treating the symptoms. However, there were a number of respondents who felt that medication was also beneficial and, at times, assisted the process of exploration.

Respondents reported that their vulnerability to depression was related to a number of factors such as life crises, genetic factors, and family relationships – all of which often precede the choice of psychology as a profession. Many respondents appeared to understand the experience of depression as fostering a sensitivity to pain in others, contributing to their career choice, and enabling more empathic clinical practice. However, this positive interpretation was balanced by respondents' acknowledgement of how clinical work can contribute to depression and reduce therapeutic effectiveness.

Both the negative and positive impact of depression on their professional activity was reported. In addition, the results of the current study suggest that psychodynamic psychologists may be more vulnerable to depression. Also, although respondents reported engaging in a variety of self-care practices, there appears to be a need for an increase in self-care practices to help mitigate the effects of depression, personally and professionally.

The current study has addressed the research questions and highlighted a number of potential areas for future research. Methodological and practical implications have been considered. Finally, the researcher would like to suggest that once the limitations of the questionnaire design have been addressed, and resources found for a national mail survey using random sampling, the current study, if repeated, may provide increasingly useful information contributing to the efficacy of clinical practice and integrity of the profession.

Finally, it is important to highlight that the perspective towards depression adopted by this research, is influenced by the urgency of the times. This urgency dictates that depression is most often perceived as a mood disturbance or disorder which needs to be treated in order to facilitate the ongoing healthy functioning of the individual. In closing perhaps it is thought provoking to acknowledge that there exist many other perspectives such as that articulated by Moore (1992):

> ***'What if 'depression' were simply a state of being, neither good nor bad, something the soul does in its own good time and for its own good reasons? What if it were simply one of the planets that circle the sun?' (p.140).***

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Appendix I

University of the Witwatersrand

Psychology – School of Human & Community Development

LETTERHEAD

11 April 2005

Dear Psychologist

My name is Melanie Esterhuizen and I am studying towards a Masters degree in Clinical Psychology at the University of the Witwatersrand. As part of my studies I am conducting a research project through the University of the Witwatersrand – School of Human & Community Development.

> The aim of the study is to investigate depression in clinical, counselling and educational psychologists in private practice. I would like to invite you to participate in this study, which will make a valuable contribution to the growing body of South African research.

To date there seem to have been no studies conducted to investigate depression among psychologists in private practice in South Africa. Research done in the United States provides evidence that psychologists are a population at risk for depression and depressive symptoms.

> *Your participation in this research is entirely voluntary. The attached questionnaire does not require any identifying details thereby ensuring your complete anonymity. It should take approximately 30 minutes to complete. The pre-addressed, stamped envelope will help to facilitate the return of the completed questionnaire. It would be greatly appreciated if you would complete the attached questionnaire, and return it in the stamped, pre-addressed envelope by no later than 31 May2005.*

Your participation will help to ensure that this research yields useful results, relevant to South African psychologists. Should you be interested in the results of this study, you can contact me for a summary of the findings approximately six months after you have submitted your questionnaire.

Should you have any questions or concerns please feel free to contact me. Thank you for your time.

Yours sincerely

Melanie J Esterhuizen
Student Researcher
Cell No: 082 227 8205
Tel: (011) 803-7774
Melkaj@telkomsa.net

Appendix II

PSYCHOLOGIST DEPRESSION QUESTIONNAIRE

Please complete the following:

Age: ☐

Gender: M ☐ F ☐

Marital Status: Married ☐ Single ☐ Cohabiting ☐

Divorced/Separated ☐

Number of children: ☐

Number of years in practice: ☐

Clinical ☐
Counseling ☐
Educational ☐

Number of client hours per week: ☐

Theoretical Orientation: ……

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1. Have you ever personally experienced a depressive episode/s where for at least 2 weeks your mood was sad and depressed and you were not able to find pleasure in your usual activities?

   Yes ☐ If **yes**, please answer questions **2 to 20**

   No ☐ If **no**, please skip questions 2 to 18 and answer questions number **19 & 20**.

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2. During this depressive episode, please indicate which of the following symptoms you experienced?

   ☐ Appetite disturbance (weight loss or gain)

   ☐ Sleep disturbance (Insomnia or hypersomnia)

   ☐ Feeling restless (psychomotor agitation)

   ☐ Fatigue / loss of energy

☐ Feelings of worthlessness / self-doubt

☐ Feelings of guilt

☐ Impaired concentration

☐ Recurrent thoughts about death and/or suicide

☐ Anxiety / Apprehension

3. How old were you when you first experienced symptoms of depression? ……

4. Have you ever sought treatment for your symptoms of depression?

Yes ☐ **No** ☐

5. Please circle any of the following caregivers whom you have approached for help with your depression (you may circle more than one letter):

a. General Practitioner
b. Psychiatrist
c. Psychologist
d. Social Worker
e. Homeopath
f. Spiritual Healer
g. Reflexologist / Reiki Practitioner
h. Religious Cleric
i. I have never gone to a professional
j. Other (please describe) ……..

……

6. If you answered **yes to question 4**, what kind of treatment did you find most useful and why?

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7. If you answered **no to question 4**, what were the factors which contributed to you not seeking treatment?

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……..

8. During your treatment have you ever received any DSM diagnosis? If so, please indicate which one:

☐ Major Depressive Disorder (one episode)

☐ Major Depressive Disorder (more than one episode)

☐ Adjustment Disorder with depressed mood

☐ Cyclothymia (frequent periods of depressed mood and hypermania)

☐ Dysthymia (chronic ongoing depression)

☐ Bipolar Disorder (mixed manic and depressive episodes)

☐ Other DSM diagnoses (please specify): ……

……

9. Did you take any medication as part of your treatment?

Yes ☐ **No** ☐

10. If **yes**, did you find this helpful?

……

……

11. Did your depression/s occur:

☐ Before beginning your private practice

☐ After beginning your private practice

☐ Before and after beginning private practice

12. Do most of your patients fall into a particular diagnostic category e.g. trauma, eating disorders, generalised anxiety etc?

Yes ☐ **No** ☐

13. If **yes**, please indicate the dominant syndromes:

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14. Please describe in as much detail as possible, ways in which your depression may have affected your work with your clients?

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15. Has there been anything helpful that has emerged out of your experience of depression with regard to your work?

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16. Please describe in as much detail as possible how you understand your depression (i.e. predisposing, precipitating and maintaining factors, etc.)

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17. Do you feel that your work as a Psychologist is a contributing factor to your depression? If so, in what way?

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18. Have you spoken to any Psychologist about your depression?

Yes ☐ **No** ☐

If **yes**, please describe the response of these colleagues?

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If **no**, what are the reasons for choosing not to speak to your colleagues?

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19. What aspects of your work as a Psychologist do you find particularly stressful?

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20. What are some of the self-care practices that you regularly engage in?

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Thank you for your time. Please place this completed questionnaire in the stamped envelope provided and mail it off before the deadline date. Your support is greatly appreciated.

Appendix III

MindMap

