CHAPTER THREE – RESULTS

The results of this exploratory research will be presented quantitatively and qualitatively.

The initial quantitative analysis will be presented largely in tabular format for an easy-to-assimilate and clear indication of the more obvious characteristics, trends and divisions across the sample. In this way the reader is introduced to the sample and an informative ground is laid, which will serve to assist in the interpretation of the qualitative results which follow.

It is important to note, that because the sample is not randomly selected, it is therefore not representative of the population of psychologists in private practice.

3.1 A quantitative introduction to the sample

Of 890 registered psychologists in Greater Johannesburg, a sample of 90 was utilized for this investigation. A total of 41 questionnaires were returned which amounted to a 45% return rate.

The sample size delineates this study as exploratory research which makes use of survey methodology. Tentative inferences can therefore be drawn and possible trends identified, however generalizations to the broader population of psychologists cannot be made without qualification.

3.1.1 Table of one-way frequencies for marital status.

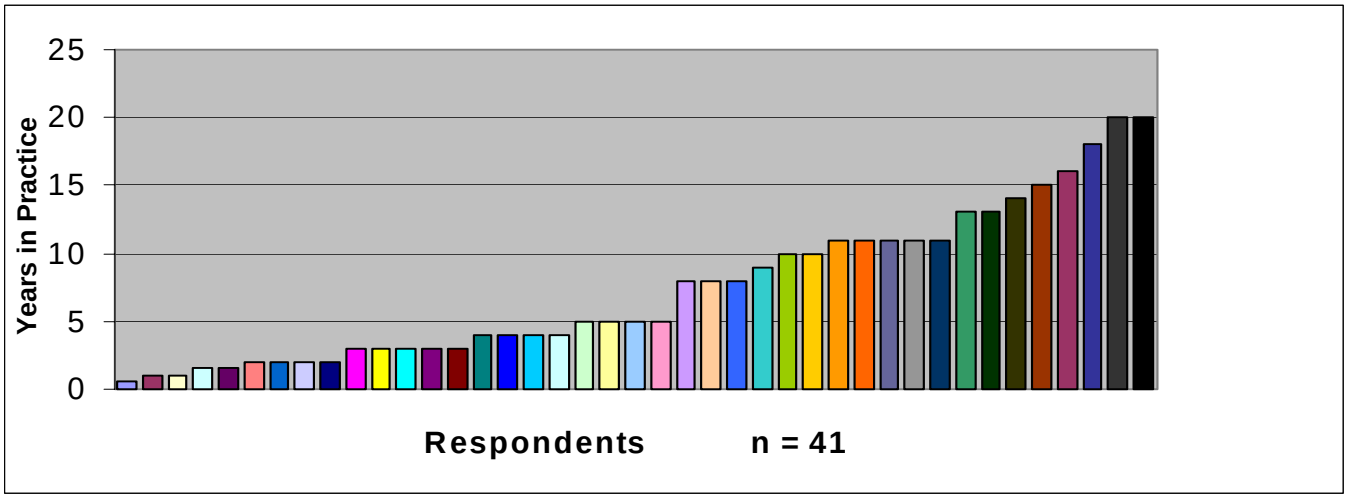
Of the total sample of 41 respondents, 22 (53.65%) reported being married, 12 (29.26%) were cohabiting, 4 (9.75%) were single and 3 (7.31%) were divorced or separated. It is interesting to note that according to Kaplan and Sadock (1998), major depressive disorder occurs most often in people without close interpersonal relationships or in those who are divorced or separated.

Amongst our sample, 64.70% of those in close interpersonal relationships reported having been depressed at least once in their lifetimes, and 57.14% of those who are single or divorced/separated reported being depressed at least once. Because our sample is a non-probability sample, this finding may not be meaningful.

Marital Status N = 41		
	Frequency	Percent
Married	22	53.65
Single	4	9.75
Cohabiting	12	29.26
Divorced/Separated	3	7.31

3.1.2 Graph of one-way frequencies - Years in Practice.

Respondents reported being in private practice from between 6 months to 20 years. The mean number of years in private practice was 7.48 years.



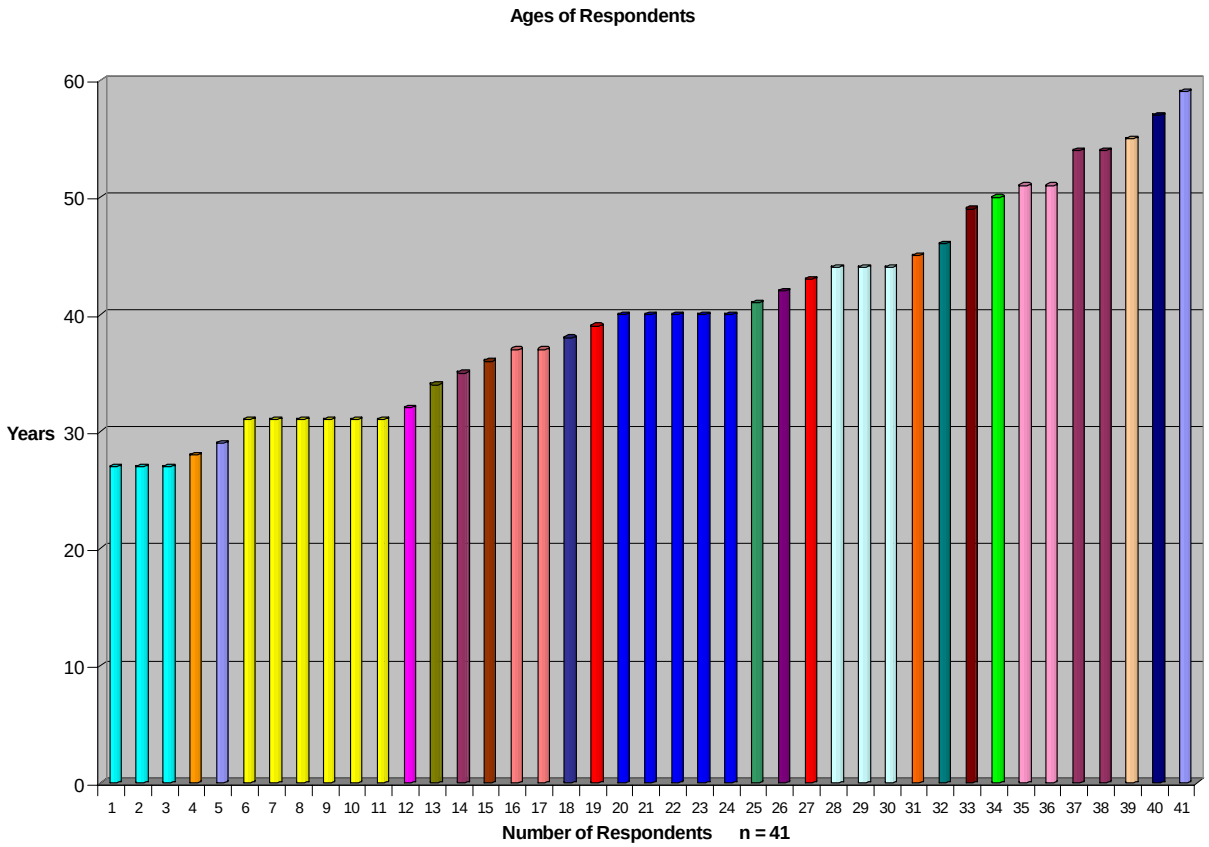
3.1.3 Table of one-way frequencies for number of children

Overall, 43.59% of respondents reported having no children, 21.95% reported having 1 child, 26.82 of the sample have 2 children, 4.87% reported having 3 children, and 2.43% reported having 5 children.

Number of Children N = 41	Frequency	Percent	Cumulative Percent
No Children	18	43.59	43.90
1 Child	9	21.95	65.85
2 Children	11	26.82	92.67
3 Children	2	4.87	97.54
5 Children	1	2.43	100.00%

3.1.4 Graph of one-way frequencies of respondents ages

Respondents' ages fall between 27 and 59. The mean age of the total number of respondents is 40.



3.1.5 Table of one-way frequencies for Gender.

Ninety two percent of the non-probability, purposive sample were women. This may be explained by a number of interacting factors. According to Rosenthal and Rosnow (1991, p.220), women are often more co-operative regarding completing questionnaires or responding to requests for volunteers. In addition, the self-selection bias may have impacted on the responses, in that woman who have experienced depression and are interested in the subject matter of the study are more likely to respond.

Furthermore, statistics provided by the Health Professions Council of South Africa reveal that 63% of psychologists in South Africa are women. According to Kaplan and Sadock (1998), an almost universal observation, independent of country or culture, is the twofold greater prevalence of major depressive disorder in women than in men. No trends can be inferred from this particular result as the sample was not randomly selected.

Gender N = 41	Frequency	Percent
Women	38	92.68
Men	3	7.32

3.1.6 Table of one-way frequencies for psychology discipline.

Of the total sample of 41 respondents, 30 (73.17%) were clinical psychologists, 2 (4.87%) were counselling psychologists and 9 (21.95%) were educational psychologists. The bias towards clinical psychologists can be accounted for by the purposive sampling method which was used for this exploratory study.

Apart from individually referred practitioners, the researcher approached members of reading groups and associated organisations to invite participation in the study. These groups appeared to be made up largely of clinical psychologists. It may be of greater use to this study, to amalgamate the different disciplines and simply refer to 'psychologists' in private practice.

Discipline N = 41	Frequency	Percent	Cumulative Percent
Clinical	30	73.17	73.17
Counselling	2	4.87	78.04
Educational	9	21.95	100.00

3.1.7 Table of one-way frequencies for depression experienced.

Out of the total sample of 41 respondents, 26 (63.41%) reported experiencing one or more depressive episodes. Fifteen respondents (36.58%) reported that they had not experienced a depressive episode.

It is interesting to note that according to Persad (1989, cited in Heath, 1991), prevalence studies in various populations sampled around the world, indicate that approximately 20% of the general population suffers from depressive symptoms.

According to the South African Depression & Anxiety Group, as reported in the The Star (26/2/2004), 'between 10 and 14% of the general population will experience depression at least once in their lives.'

Depression Experienced N = 41			
	Frequency	Percent	Cumulative Percent
Yes	26	63.41	63.41
No	15	36.58	100.00

3.1.8 Table of one-way frequencies for age of first depression

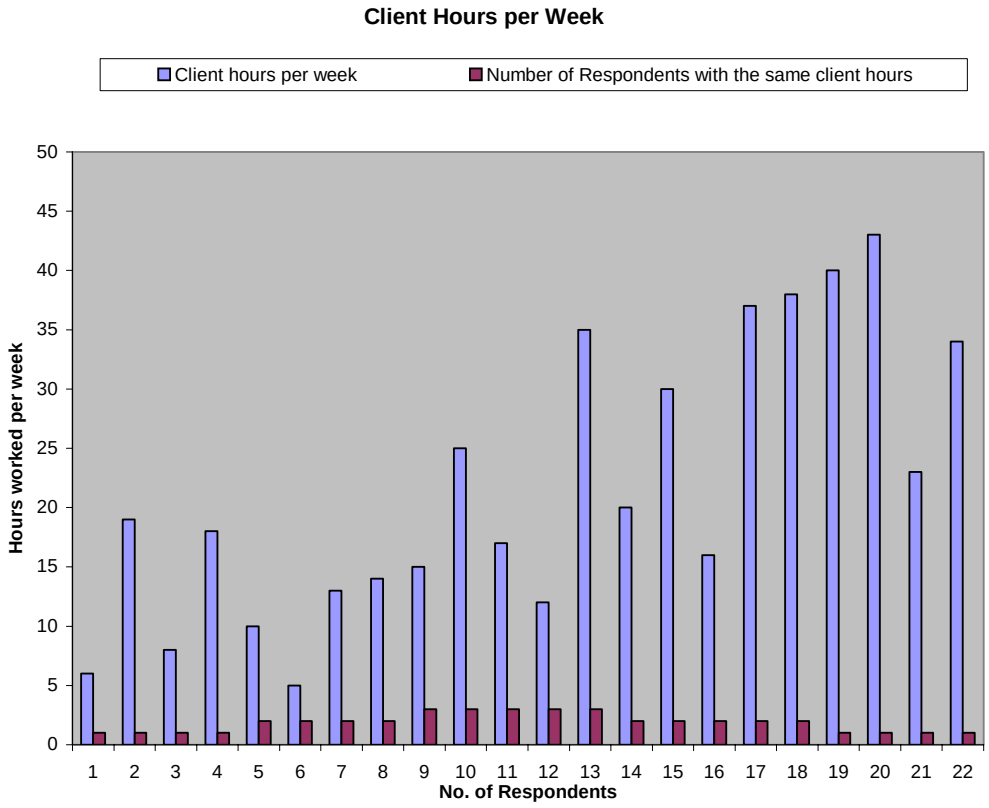
It is interesting to note that 61.56% of the sample experienced a depressive episode between the ages of 10 and 25. The most common age for onset of depression in the sample was 16 years.

According to Kaplan and Sadock (1998), the mean age of onset for major depressive disorder in the general population is approximately 40 years.

Depression First Experienced	**N = 26**		
Age	Frequency	Percent	Cumulative Percent
10 – 15	5	19.23	19.23
16 – 20	6	23.10	42.33
21 – 25	5	19.23	61.56
26 – 30	3	11.53	73.09
31 – 35	2	7.69	80.78
36 – 40	4	15.38	96.16
41 – 45	0	0	96.16
46 – 50	1	3.84	100.00

3.1.9 Graph of one-way frequencies of respondents' client hours per week

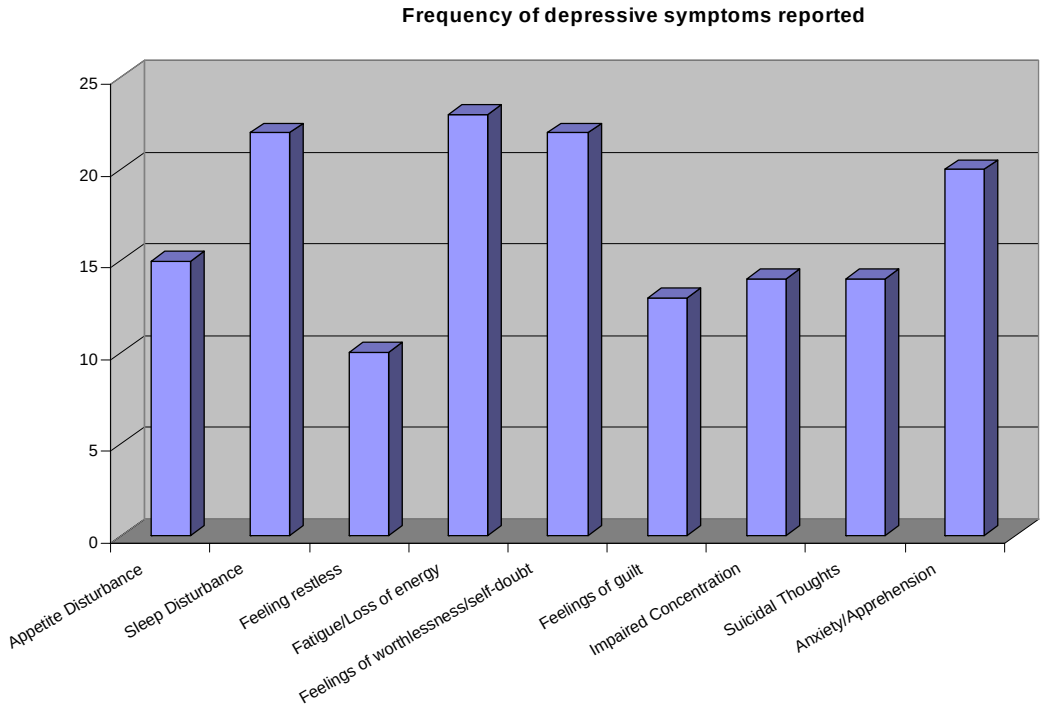
The number of client hours worked per week ranged between 5 and 43. The mean number of hours worked across the sample was 21.5 hours per week.



3.1.10 Graph of one-way frequencies of depressed respondents' most frequently occurring depressive symptoms.

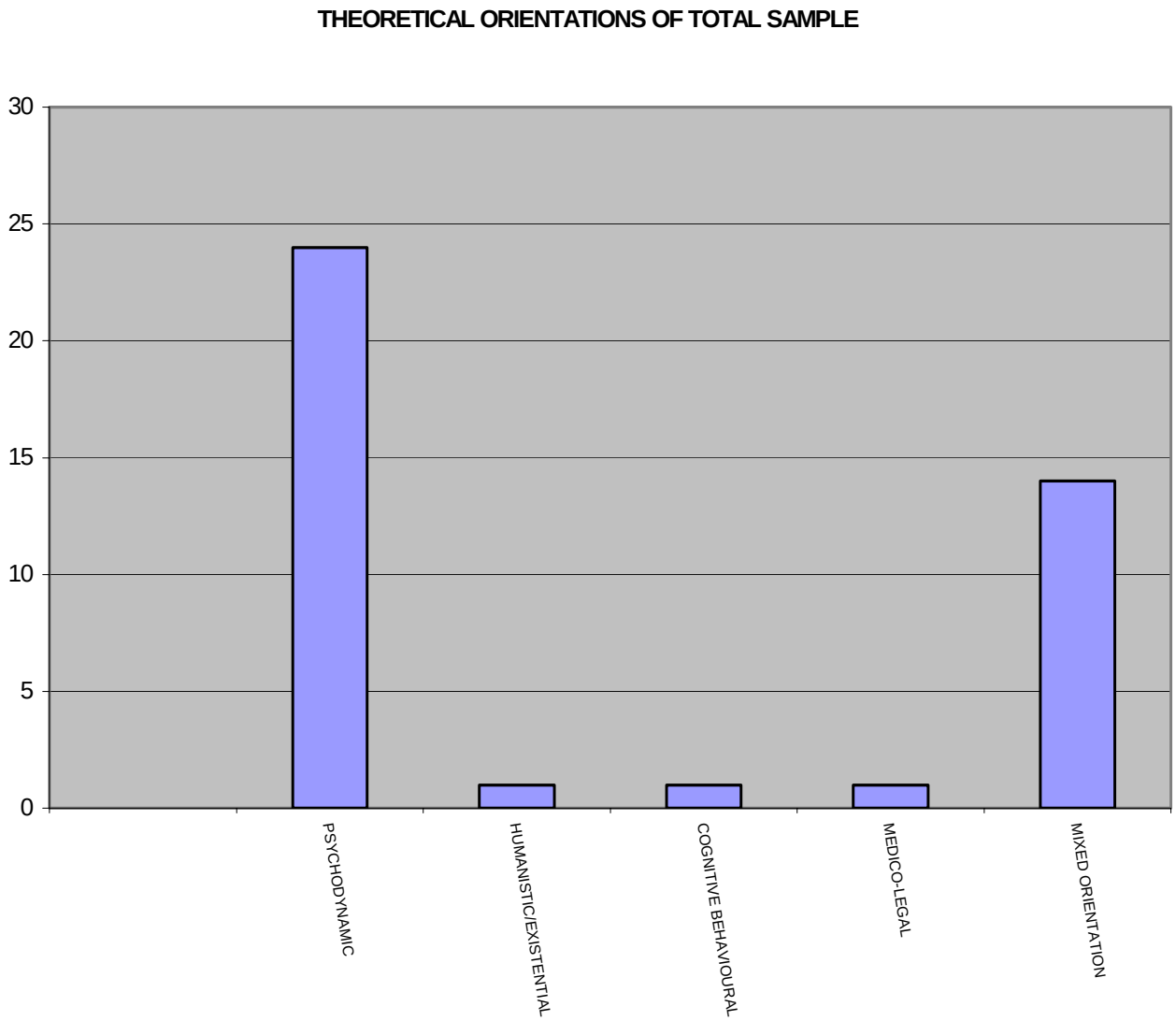
The symptoms specified were taken from the DSM-IV criteria for a major depressive episode. The episode must last for at least 2 weeks and at least four symptoms must be experienced, from a list that includes:

- 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



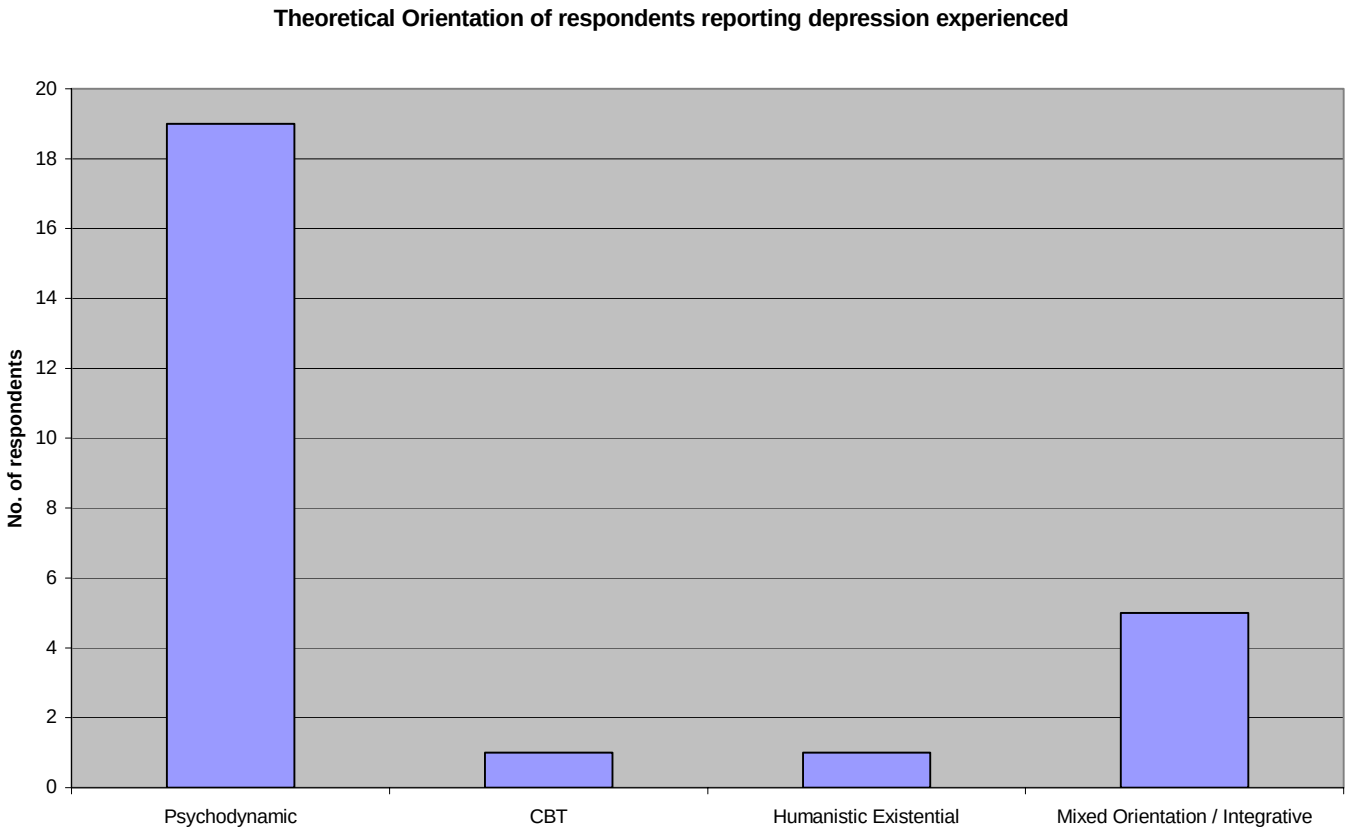
3.1.11 Graph of one-way frequencies of theoretical orientations for the total sample of depressed and non-depressed respondents.

Out of a total sample of 41 respondents, the two dominant theoretical orientations appeared to be psychodynamic (58.5%) and a mixed orientation (34.14%). Mixed Orientation included specific combinations of the following theoretical approaches: Systems Theory, Psychodynamic approaches, Cognitive Behavioural Therapy and Transactional Analysis. Respondents who reported an integrated theoretical approach are included under mixed theoretical orientation.



3.1.12 Graph of one-way frequencies of theoretical orientations for the total sample of respondents reporting depression experienced.

In comparison to the total sample, 73% of respondents who reported having experienced one or more depressive episodes described their theoretical orientation as psychodynamic, and 19% described a mixed/integrated theoretical orientation.



3.1.13 Table of one-way frequencies – Treatment sought by depressed respondents.

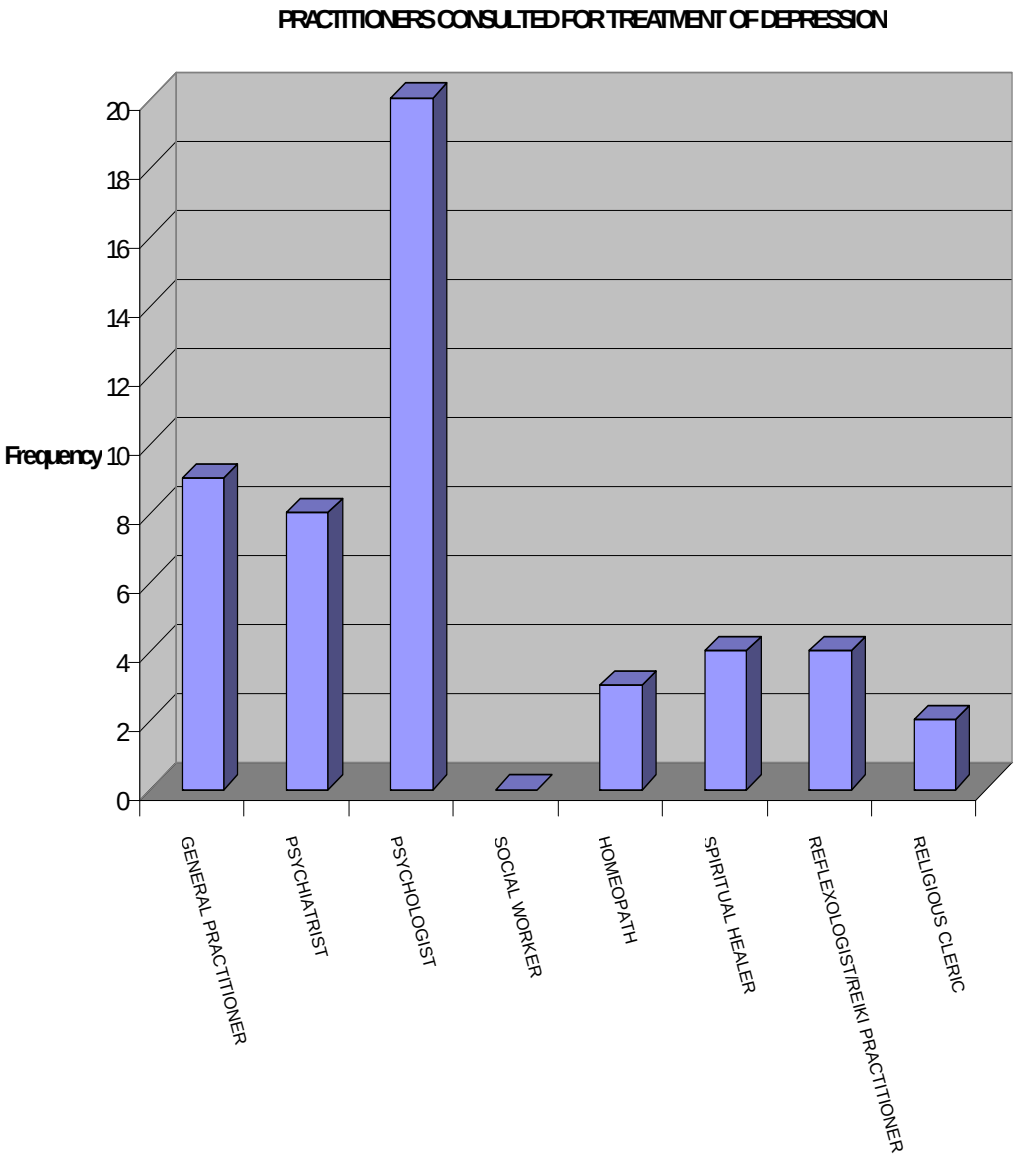
84.61% of respondents who reported having experienced depression, sought treatment. Only 15.38% of those having experienced depression did not seek treatment. Some of the reasons for not seeking treatment were:

- Foolish self-sufficiency
- Had previously been in psychotherapy
- Thought I could heal myself through self-help books
- Time would contribute to healing
- Remained quiet about symptoms, symptoms went largely unnoticed.

Treatment Sought N = 26		
	Frequency	Percent
Yes	22	84.61
No	4	15.38

3.1.14 Graph of one-way frequencies – Type of practitioner consulted for treatment.

The most frequently consulted practitioner by psychologists in the sample were psychologists (80%). The most frequently sited reason for this was that psychotherapy helped individuals to understand the underlying factors for their feelings.



3.1.15 Table of one-way frequencies – DSM IV-R diagnoses given when treatment for depression sought.

The majority of respondents who reported having experienced a depressive episode did not receive a DSM-IV diagnosis (69.23%). However, 30.75% of the sample did receive a DSM diagnosis, the breakdown of which is outlined below:

DSM Diagnoses N = 26		
	Frequency	Percent
Major Depressive Disorder (one episode)	3	11.53
Major Depressive Disorder (more than one episode)	2	7.70
Adjustment Disorder with depressed mood	1	3.84
Dysthymia (Chronic ongoing depression)	1	3.84
Generalised Anxiety Disorder	1	3.84
No Diagnoses	18	69.23

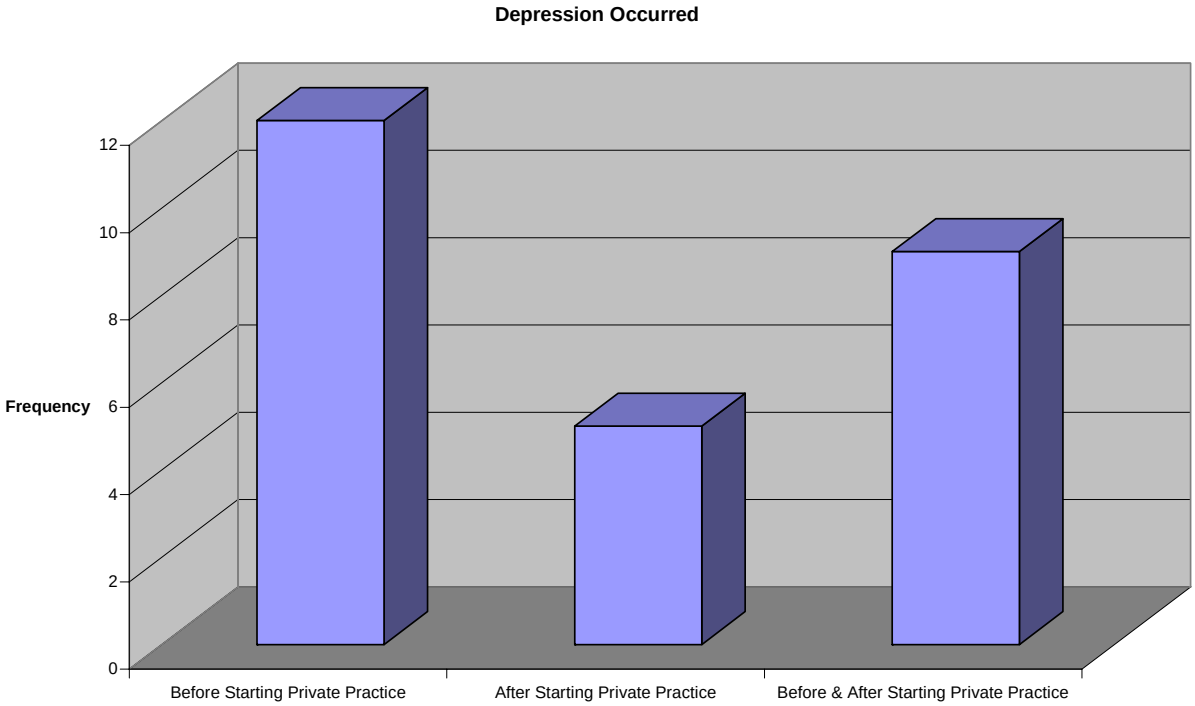
3.1.16 Table of one-way frequencies – Medication taken to relieve depressive symptoms.

Of those respondents who had experienced depression, 46.15% reported having taken medication and 53.84% did not take medication.

Medication Taken N = 26			
	Frequency	Percent	Cumulative Percent
Yes	12	46.15	46.15
No	14	53.84	100.00

3.1.17 Graph of one-way frequencies – Depression occurred before starting private practice, after starting private practice and both before and after starting private practice.

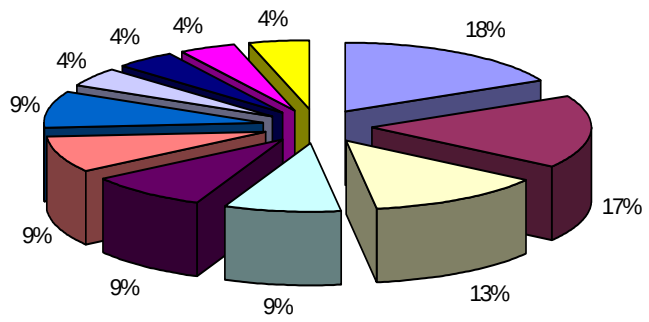
It is interesting to note that the majority of respondents who reported having experienced depression, did so before starting private practice. The question that arises out of this finding is, could their be a link between early onset of depression and vocational choice. More simply stated, 'Does an early experience of depression make it more likely that an individual will select psychology as his/her profession or line of study.

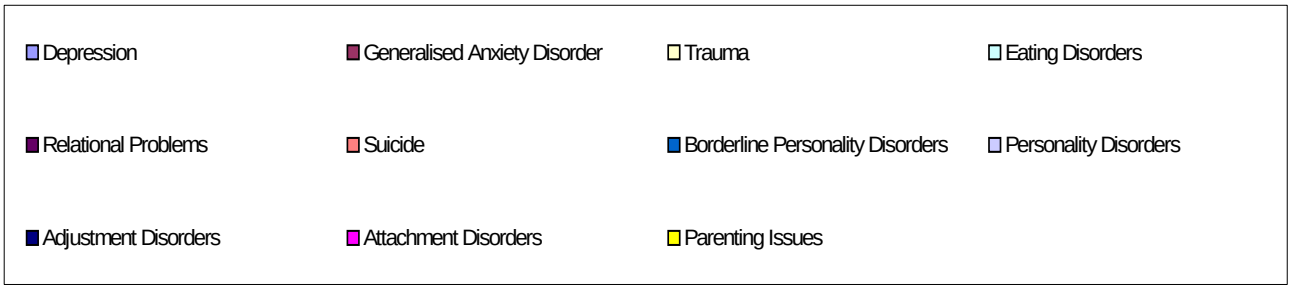


3.1.18 Chart of one-way frequencies – Dominant syndromes seen in respondents ' private practice.

Only six respondents indicated that their patients fell into particular diagnostic categories. The dominant syndromes and the frequency of their occurrence are indicated below:

Dominant patient syndromes outlined by six respondents





3.1.19 Table of one-way frequencies – Disclosure regarding depression experience to colleagues.

Out of the total respondents who had experienced depression, 88.46% reported that they had spoken to colleagues about their experience. The remaining 11.54% cited the following reasons for not speaking to colleagues as:

- ‘As a recent graduate, it hasn’t been appropriate, as yet, to speak to my colleagues. I certainly wouldn’t hide my experience, should the conversation allow self-disclosure.

- ‘I have recovered. Hasn’t impacted on current functioning’

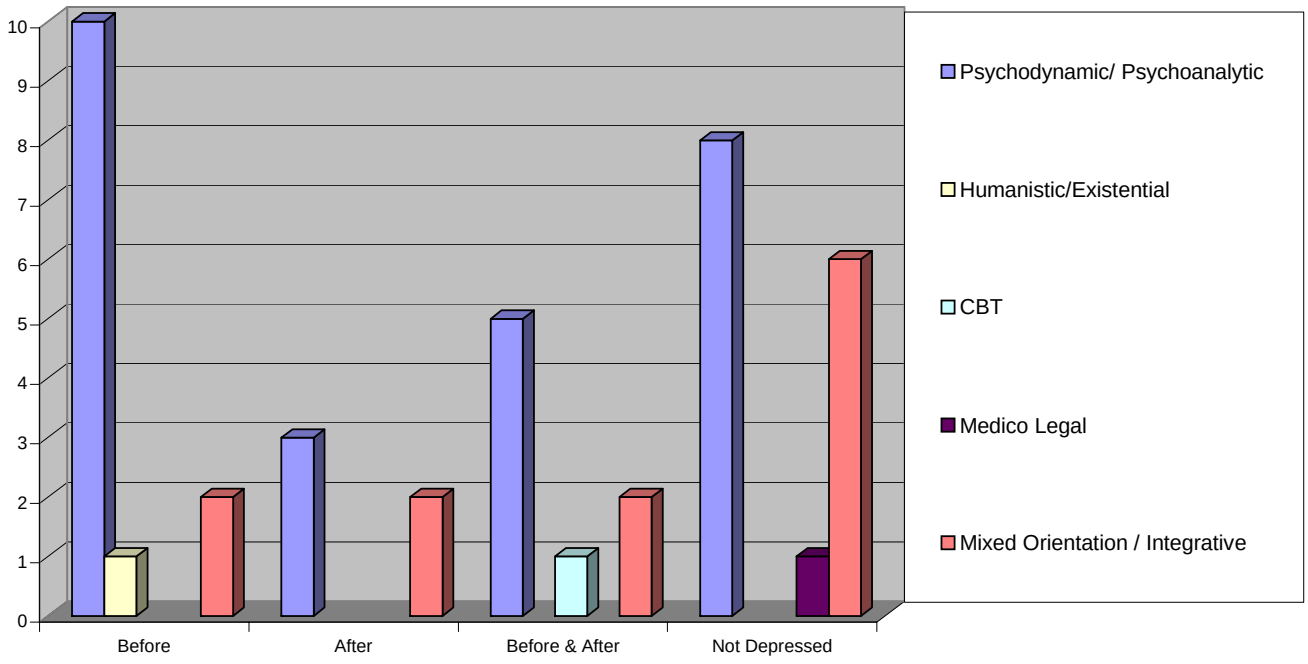
- ‘Do not experience depressive symptoms currently’

Disclosure to Colleagues N = 26		
	Frequency	Percent
Yes	23	88.46
No	3	11.54

3.1.20 Theoretical Orientations of respondents versus depression occurring before, after or before & after starting private practice

The graph below provides an overview of the relationship between respondents' theoretical orientation and the occurrence of their depression. The results may suggest that a psychodynamic theoretical orientation may be more frequently selected when an individual has experienced early onset of depression. Conversely, psychodynamic therapists may be more vulnerable to depression due to a greater emphasis on working within the transference. Also, a mixed theoretical orientation may prove to be a protective factor against depression. Being a non-probability sample, no inferences can be made to the broader population of psychologists in private practice. However, this may be a useful area for further research.

DEPRESSION OCCURANCE VS THEORETICAL ORIENTATION

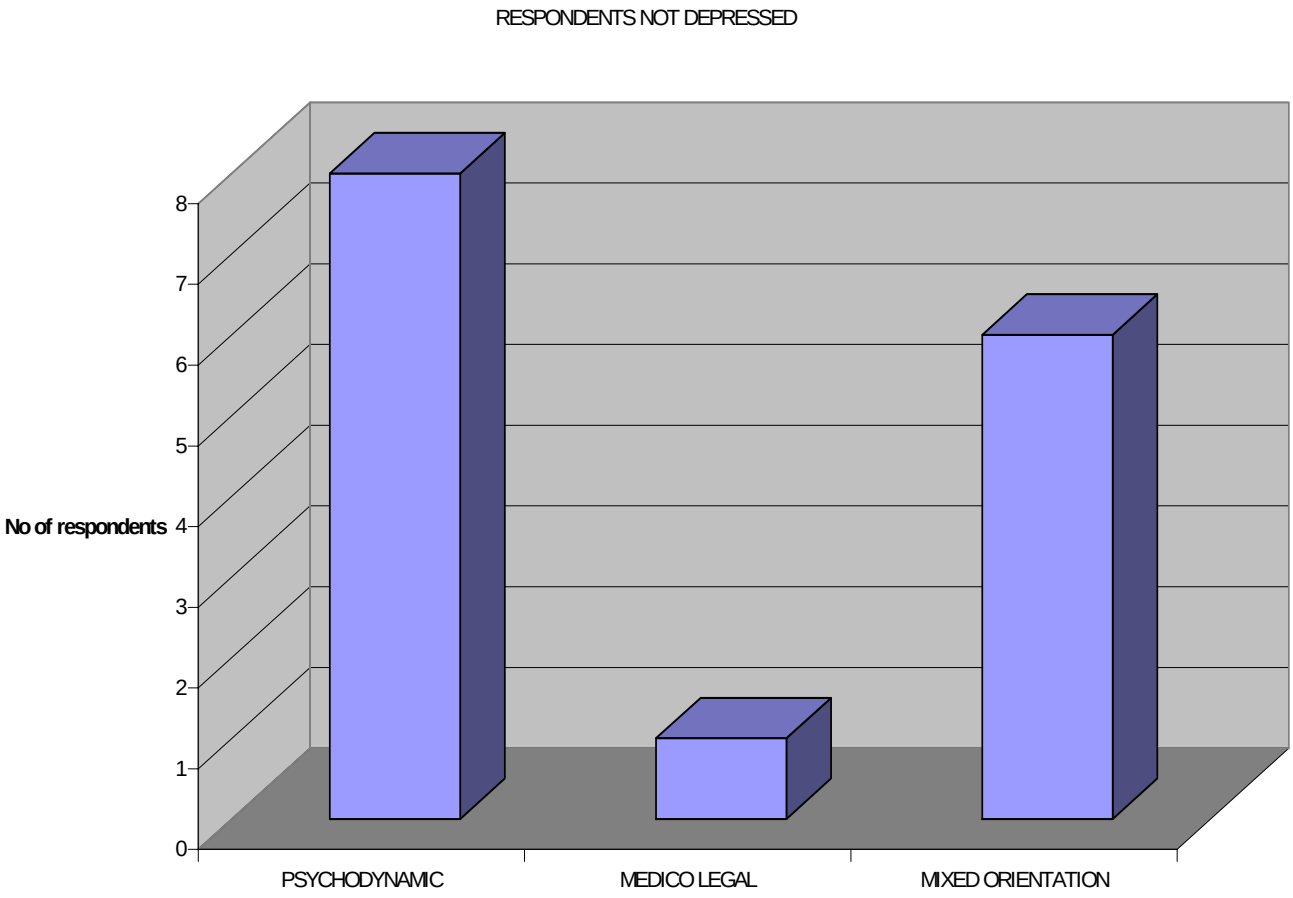


3.1.21 Theoretical Orientations of respondents who have NOT experienced a depressive episode.

It is interesting to note that the respondents who reported not having experienced a depressive episode appear more likely to use a mixed / integrative theoretical orientation to inform their work. For the purposes of this study, an integrative theoretical approach includes what the researcher describes as a mixed orientation. Mixed orientations were reported as including the following combinations:

1) Transactional Analysis & Cognitive Behavioural Therapy
2) Self psychology & Relational Psychoanalytic, Intersubjective
3) Cognitive Behavioural Therapy & psychodynamic therapy
4) Systems Theory & Integrative theories
5) Psychoanalytic conceptualization but eclectic in technique
6) Integrative & psychodynamic (self psychology/attachment theory) orientation

Again, because this is a non-probability sample, no inferences can be made to a broader population. However, this may be a useful area for further research.


RESPONDENTS NOT DEPRESSED
No of respondents
0
1
2
3
4
5
6
7
8
PSYCHODYNAMIC
MEDICO LEGAL
MIXED ORIENTATION

3.2 A Qualitative Analysis

After examination of all the responses to the open-ended questions, it became clear that a dynamic relationship between the selection of psychology as a career and depression, does exist. This relationship was explored using a nonemergent design, i.e. data was collected and then analysed (Maykut & Morehouse, 1994). As the design of this research is both descriptive and exploratory, the aim was to analyse and interpret the data in a way that makes use of existing theory and literature, but with a greater emphasis on presenting the current reality of the participants of the research. The following section explores the qualitative or 'insider perspective' which emerged out of the data.

The questions put to respondents elicited the following themes:

- *Theme 1:* **Possible causes and contributions to psychologists' personal experience of depression**
- *Theme 2:* **Contributions of the depression experience to the choice of the profession of psychology**
- *Theme 3:* **Effects of the experience of depression on the therapeutic endeavour (Positive & Negative)**
- *Theme 4:* **Preferred protective strategies**
- *Theme 5:* **Transcending Woundedness – The wounded healer within the therapeutic relationship.**

Within these broad overarching themes, a number of subthemes emerged.

THEME 1:

3.2.1 CONTRIBUTIONS TO PSYCHOLOGISTS' PERSONAL EXPERIENCE OF DEPRESSION

Respondents' understanding of the precipitants of their depression, or contributions to their vulnerability to depression, vary. On close examination of the responses given in this exploratory study, the following sub themes emerged:

a) Family of Origin
b) Genetic Predisposition
c) Precipitants – Other
d) Context of Private Practice

a) Family of origin

Respondents very often sited the particular circumstances of their family of origin as having a direct impact on their suffering. Of the total respondents who had experienced one or more depressive episodes, 62% mentioned the contribution of family relationships to their depression, such as the impact of a depressed mother, losing a parent, feeling displaced by a sibling and the separation of the marital couple. The following are some of the understandings offered:

Subject 18: *'Stems from losing a parental figure at an early age with subsequent less availability of other parent who was burdened, stressed etc. Feel that as a result I tend to be vulnerable to depression at times of separation and loss.'*

Subject 8: *'I consider family environment factors important to my own tendency to depression. As the fifth child, I felt a lot of pressure (self-imposed) to be 'okay', responsible and mature, possibly prematurely. These feelings were not expressed, and with childhood and adolescent struggles, I tended to deal with these in isolation.'*

Subject 1*: 'Although physically well cared for, there was not much emphasis on psychological 'holding and containing' in my family of origin.'*

Subject 2*: 'Early childhood trauma/abuse; Lack of early and ongoing adequate emotional understanding and support from primary care-givers; Consequent unresolved anger; Unstable self-esteem; Insecurity.'*

Subject 39: *'I feel that the way I was parented as a child, together with my temperament caused most of my emotional difficulties. My parents were very young. My mother herself had very poor parenting and I was a very emotional and sensitive child who they were not able to understand because of their social situation. They were also financially constrained and both worked fulltime. I had conduct difficulties, acted out sexually and was sexually molested – never told my parents and eventually became depressed.'*

Subject 5*: 'Loss and the precursors in infancy and the experience of loss in adulthood.' 'End of a relationship evoked earlier, probably primary experience of loss in early childhood – in this instance, displacement by sibling when I was just 2 and probably compounded by 'loss' of mother due to postnatal depression.'*

It would seem that most of the respondents' understandings of their depression are linked to less than optimal experiences within their family of origin. Overall, the experiences described in this study center around lack of maternal care, the presence of family conflict and violence, marital discord, emotional deprivation, affectionless parental care, divorce, bereavement and alcoholism. It would appear that these childhood experiences have required a protracted psychological struggle, one that has continued well into adulthood.

b) Genetic Predisposition

Also identified was the contribution of a genetic predisposition to their suffering. Twenty three percent of the total of respondents who had experienced one or more depressive episodes, reported the possible contribution of a genetic predisposition to depression. The following comments highlight this understanding:

Subject 17: *'Genetic loading – paternal aunts x 3 (Bipolar Mood disorder); Maternal great grandmother (Bipolar Mood Disorder); Undiagnosed Major Depression in father.'*

Subject 11: *'Genetic predisposition precipitated by life stressors at 18 years, did not know what it was… untreated for 20 years!! Had numerous episodes which maintained/reinforced the illness.'*

Subject 20: *'Strong genetic basis – both parents and maternal grandparent have had Major Depressive Disorder.'*

A few respondents in the sample cited a genetic vulnerability to depression. However, most of these respondents acknowledged that their genetic vulnerability to depression usually lay dormant until activated by a stressful life event.

c) Precipitants - Other

Respondents' understanding of the precipitants and contributors to their depression, or vulnerability to depression, include internal and external events. Of the respondents who reported having experienced one or more depressive episode/s, 65% cited a stressful life event as one of the contributing factors to their experience of depression. Some of these events are described by respondents below:

Death

Subject 18*: Death of a parent ;* ***Subject 4:*** *'Death of a grandmother, miscarriages' ;* ***Subject 20:*** *'Sibling death.'*
Subject 20: *'Holocaust Background.'*

Loss

Subject 35*: 'Abandonment' ;* ***Subject 3:*** *'A psychodynamic history of repeated loss and trauma' ;* ***Subject 5****: 'End of a relationship' ;*
Subject 17*: Divorce*

Work Stress

Subject 19*: Not taking sufficient time out' ;* ***Subject 16:*** *'Work can contribute to being depressed' ;* ***Subject 12:*** *'Depression occurs if I am particularly overworked & tired.'*

Lack of Support

Subject 15: *'Few support structures, felt to be ultra-independent' ;*
Subject 7: *'Absence of a supportive father to my unborn child';*
Subject 16: *'Lack of support is a maintaining factor.'*

An individuals unique temperament, combined with less than optimal life experiences impacts on the developing personality and often results in a personality structure which is vulnerable to depression. This is suggested by the following understandings offered by some of the respondents:

Individual Personality

Subject 19: '*Personality traits' ;* ***Subject 2:*** *'Unstable self-esteem, unresolved anger and insecurity' ;* ***Subject 3:*** *'Life events trigger the worst episodes when linked to my dynamics.'*
Subject 9: *'Development of a false-self'*

Stressful internal and external events and each respondent's unique vulnerablity to these events contribute to the experience and understanding of a depressive episode. It would appear from our results that most events linked to depression are associated with loss. Also, with the above examples in mind we can see that depression can be cumulative and often triggered by apparently small, insignificant events. It would appear that the absence of social support, in itself, increases the risk of depression. For example, the loss of a spouse increases vulnerability to depression. However, social support which provides intimacy and the opportunity to share ones emotional pain, can act as protective factor against depression.

d) Context of Private Practice

Professionals in private practice are subject to stressors associated with being self-employed. However, in addition to these general stressors, psychologists in private practice appear to grapple with a unique set of difficulties which they often feel exacerbates their vulnerability to depression. The following are summaries of comments made by respondents about the difficulties of being a psychologist in private practice:

Client Related Stressors

Respondents report a tendency to absorb the pain and sadness felt by their patient. This is alluded to by respondents when they talk about the effect of dealing with "'trauma work and severe depression'(subject 12). Feelings of helplessness around patient's issues of social and financial deprivation were mentioned, as well as the frustration of working with patients who are not well suited to therapy. A commonly mentioned difficulty amongst respondents was the sustained emotional restraint which is required to do psychotherapeutic work in the face of clients who are non-compliant and act out their difficulties, rather than talking about and trying to understand them.

Therapist Related Stressors

In the words of one of the respondents, 'being a container can be exhausting' (subject 11). The projected thoughts and emotions of patients have to be apprehended, understood, interpreted and gradually and carefully given back to the patient by the therapist. This is an active process requiring therapists' constant emotional and mental vigilance. This was often cited by respondents as a particularly stressful aspect of the work and described by one respondent as 'long hours of emotionally digesting peoples experiences.'

Also the 'one-sided' nature of the therapeutic relationship is mentioned as particularly stressful. This is demonstrated by the daily expectation that the therapist be attentive and immobile for many consecutive hours while he/she processes a patient's often extreme emotions, despite what the therapist is feeling or going through in his/her personal life. This hourly focus is reported to be draining and depleting. High expectations from the public, combined with very little or no feedback about their work, appears to leave many respondents feeling anxious and uncertain about their interventions. These feelings are exacerbated by the isolation that respondents report when working in private practice. As one of the respondents poignantly states, 'the aloneness is hard to bear sometimes' (Subject 15).

Time Related Stressors

Not making enough time for the self seems to be a common struggle for most respondents. With long hours of one-sided interaction, respondents identified that taking breaks and having regular holidays was essential. Many respondents felt overwhelmed by the long hours, the endless paperwork and overwhelming routine tasks that have to be done to keep their practice running smoothly. The volatility of private practice appeared to be a common area of anxiety

for respondents as they report never knowing whether to keep taking on new patients in case referrals should dry up. As one respondent described it,'the financial seduction of seeing too many people leads to burnout. Earning per hour makes it difficult to turn down referrals and take sufficient leave' (Subject 1).

Financial Stressors

Many respondents described the stress of financial insecurity in particular. It was generally felt by respondents that they have no control over their income. This uncertainty around their financial situation often makes it very difficult to take needed breaks. As one respondent put it, 'no work, no pay – taking a break is costly' (Subject 5). In addition to this, respondents report feelings of fear and resentment towards their patients when they do not pay, or do not pay on time. Liasing with medical aids and debt collection is unpleasant and stressful.

Summary – Theme 1

Respondents understandings of the precipitants of their depression, or contributions to their vulnerability to depression centered around difficulties experienced in their family of origin, possible genetic contributors, the impact of internal and external events on an individual's life, and the unique stresses which accompany working in the context of private practice. Each respondent presented a unique constellation of the above mentioned contributors.

THEME 2:

3.2.2 CONTRIBUTIONS OF THE DEPRESSION EXPERIENCE TO CHOICE OF PROFESSION

The experience of depression, especially at an early age, appears to sensitise an individual to emotional pain in others. This focus on feelings and the impact of relationships appears to become a feature of many of the

respondent's personality styles. This comes to play an important part in an individuals' choice of profession. This conscious understanding of the links between an individual's personal vulnerability, or woundedness, and the way their role as a psychologist unfolded, and how they use this understanding in their work, is thought to indicate a high degree of self-understanding and insight into their internal world.

a) **Self-understanding and Insight**

Self-understanding and insight is noticeable in the links articulated by a number of respondents between an individual's personal vulnerability to depression, and the way their professional role unfolded. Comments such as 'it made me more psychologically minded… more focused on feelings and relationships' provide clear examples of this link. This is further illustrated by the following statements:

Subject 5*: 'I am pretty sure that my apparent 'choice' of career as a psychologist was determined by the defences employed all that time to keep 'loss' at bay. Looking after vulnerability and pain in the other – until confronted it in myself.'*

Subject 10: *'I think a predisposition/propensity to depression led me to psychology – to help me understand what was happening to me!'*

Subject 36: *'I have a complex history and am grateful for that in many ways – but it makes me vulnerable and emotionally permeable. It is partly why I do the work I do. I still struggle to shake the behaviours that leave me feeling bad about myself. And I remain permeable to my clients – makes for effective work at a level.'*

Subject 17: *'Helped me to choose my professional career.'*

b) **The language of self-understanding**

An individual's ability to reflect on his/her own vulnerabilities and how they have influenced his/her choices and behaviour is thought to indicate a high level of self-understanding and insight. In addition, the language used by respondents to describe their experience of depression, may indicate a more textured and insightful understanding of the experience of depression:

Subject 5: *' My depression lasted 1 year – an appropriate period to grieve and resolve issues through a process of mourning. 'Presently often sad, but not "depressed".' 'Would consider that the seminal depressive episode of my life – who knows though what the future holds – subsequent losses have not precipitated "depression."*

Subject 14: *'Not clinically depressed but have experienced the emotional downs that many do.' 'How depressed I feel and for how long is usually determined by how readily I admit to myself and others how I am feeling. 'It is human to have mood fluctuations – a DSM IV category can pathologise and turn the experience into something else.'*

Subject 15: *'Work contributes towards me feeling 'low' a lot of the time.'*

Summary – Theme 2

An experience of depression very often seems to initiate a process of introspection and self-discovery in the individual sufferer. This process is, more often than not, aimed at mastering the uncomfortable feelings and attempting to understand their origins. This experience of depression appears to foster a sensitivity towards depression in others, and a desire to assist others by drawing on personal experience. As a result, it would appear that an experience of depression is one of the factors which may draw an individual to the profession.

In addition, the language used by respondents who have experienced depression often indicates a nuanced and textured understanding of the differing shades or severities of depression. This appears to assist respondents when working with their patients.

THEME 3:

3.2.3 POSITIVE EFFECTS OF THE EXPERIENCE OF DEPRESSION ON THE THERAPEUTIC ENCOUNTER

The experience of depression appears to impact both positively and negatively on the therapist and the therapeutic encounter. The positive impact of the personal experience of depression is revealed under the following sub themes:

a) Experiential impact on the therapeutic relationship
b) Improved therapeutic techniques
c) Self healing

Responses to questions 14, 15 and 17 were qualitatively analysed and are selectively illustrated, to deepen our understanding of how personal experiences of depression can positively inform the work of psychologists.

a) Experiential impact on the therapeutic relationship

It appears that having a personal experience of depression assists a therapist to enter the internal world of a patient and really feel what he/she is feeling. The ability to truly understand another person's feelings is the basis of the therapeutic exchange. In total, 49% of the responses reported a positive impact. Some examples of this reported experience are as follows:

Subject 8: *'Greater insight and sensitivity towards the 'dark cloud' and debilitation of depression.'*

Subject 20: *'Helps me to tune into my patients in a very empathic way.' 'My depression has not affected my work adversely… attunement beneficial to my work and to helping patients feel understood.'*

Subject 6: *'Understand in a very real way that dark space which they feel themselves to be in'.*

Subject 10: *'More empathic, understanding, curious, more hopeful for their improvement.'*

Overall, when respondents were asked how their depression affects their work, they reported increased empathy, greater tolerance, an understanding of the hopelessness felt by their clients, greater insight and humility and an understanding of the depths of pain that one can recover from.

b) **<u>Improved Professional Skills</u>**

A personal experience of depression sensitises therapists to the needs of their clients – often in a very practical way. Being able to read the signs presented by their patients more efficiently, skills and techniques honed through personal experience are applied with greater confidence for the effective management of depression. These improved professional skills are described below:

Subject 15: *'More sensitive to clients presenting with symptoms of depression.*

Subject 9: *'Importance of matching or 'mirroring' patients mood/tone. Being able to sit with helplessness without feeling the need to 'take*

on' patients mood/tone etc. Not energetically trying to come up with solutions that are too exhausting for the patient to think about.'

Subject 20: *'It has helped me to understand, experientially what it means to feel depressed.' 'Helped me to know when to refer for medication.'*

Subject 11: *'Good at diagnosing depression and refer them for meds immediately… then work on psychological issues.'*

Subject 5: *'The lived experience informs my capacity to sense the client's feelings and 'tolerate', 'hold', 'understand', 'receive' the client's distress more fully.'*

Subject 18: *Increased empathy and identifying factors which help in managing depression.'*

c) **<u>Self Healing</u>**

It would appear that working as a psychotherapist often helps a therapist to process and understand their personal experience of depression more thoroughly. This is clearly illustrated by the following responses:

Subject 14: *'Work has helped spare me a serious clinical depression… afforded my life a sense of meaning and purpose that buffers against existential despair.' 'Helped me to explore my own living and reason for being – maturing me as a human being.' 'It has helped me be more understanding and compassionate with myself sparing me a more extreme emotional experience.'*

Subject 18: *'Experience and insight gained has helped me manage my depression more effectively.' 'Self-esteem and job satisfaction mitigate against depression.'*

Subject 1*: 'Providing holding & containing for others provides opportunities for self-healing.' Work seems to alleviate depression in me.' 'Helped me to be a better psychologist.'*

Subject 9: *'Forces me to be more in touch with myself… so depression dissipates.'*

Subject 2: *'Helps me to continually understand and process my predisposition to depression.'*

Respondents appear to acknowledge how the work with depressed patients forces them to rigorously monitor their depression, to be more in touch with themselves, which in turn appears to dissipate their depression.

3.2.4 NEGATIVE EFFECTS OF THE EXPERIENCE OF DEPRESSION ON THE THERAPEUTIC ENCOUNTER

Fifty one percent of the responses indicated that therapists thought that their depression may have had a negative impact on their work. The negative impact of the personal experience of depression on the therapist, and on the therapeutic encounter is revealed using the following conceptual structure:

a) Experiential impact on the therapeutic relationship

b) Countertransference and Projective Identification

c) Defensive Strategies

a) Experiential impact on the therapeutic relationship

Responses to open-ended questions were qualitatively analysed. Pertinent responses are presented to deepen our understanding of how a personal experience of depression can negatively affect the therapist, and consequently, the therapeutic encounter.

Subject 2: *'Defensively failing to empathize fully with their depression.' 'Failure to recognize the severity of destructive dynamics.' 'Lack of adequate emotional availability.'*

Subject 16: *'I felt I was less available to my clients – emotionally and practically i.e. returning phone calls.'*

Subject 8: *'The intensity of the work… continuous grappling with trauma and pain.' 'Times of personal loss and fatigue – often at the end of the year have been more difficult.' 'Work was a great struggle and effort.'*

Subject 3: *'Clients become aware of my sadness and respond to it.' 'An increased sense of helplessness.' 'I may have blunted affect and struggle to pick up on finer cues.'*

Subject 36: *'Endlessly tired and unable to remember the details they bring.'*

When depressed, respondents reported feeling less available to their patients, both emotionally and practically. There were concerns expressed regarding transmitting their depressed feelings to their clients. Many respondents described a loss of motivation, energy, cognitive sharpness and general fatigue. These feelings appear to have made it hard to hold patients.

b) Countertransference and Projective Identification

It would appear that therapist's are often permeable to the articulated and unarticulated feelings of their clients. In this way, negative and depressed emotion can be evoked in the therapist, as he/she attempts to understand the internal feeling world of the client. Evidence for this is provided by the following responses:

Subject 11: *'Work can be stressful – all the pain and agony can trigger my own pain.'*

Subject 9: *'My own sense of hopelessness must have unconsciously added to patients own and vice versa.'*

Subject 11: *'Countertransference issues take the form of depression at times.' 'Notice/feel their depression more easily.'*

Subject 20: *'Work of a psychotherapist is very draining and I believe I take in the negative/depressing projections of patients.' 'Certain patients' histories and lives are depressing.' 'Being exposed to negative projections, angry, destructive patients.'*

It seems clear that respondents' feelings of depression are triggered by certain patients. At times these feelings occur when psychologists are working too hard and have a number of patients who are extremely depressed. This renders professionals vulnerable to absorbing their patient's depression. Monitoring the boundaries of responsibility becomes difficult and a patient's verbal attacks and projective identification penetrate with greater ease. Also, feelings of projected hopelessness and despair appear to be evoked, or find greater resonance within the therapist when he/she is struggling with depression.

c) Defensive Strategies

Amongst the responses given, there appeared to be some defensive strategies used, perhaps to minimize the impact of depression on the therapeutic work, and/or to minimise the impact of the work on an individual's vulnerability to depression. Some of these defences may reveal strategies such as denial, splitting, intellectualization, rationalization, and projection.

Subject 8: *'I don't think I have been so depressed that it has compromised my work.'*

Subject 20: *'I feel better when I work as the work is all encompassing and I am able to move out of my own state of mind and enter the internal world of my patients.'*

Subject 9: *'Manic defences e.g. work. 'Denial of emotional pain.' 'Strong outer presentation of being in control and happy, masking inner distress.'*

Subject 12: *'I am not particularly predisposed to depression. The period of depression, or depressed mood was reactive to a traumatic personal experience and manifested toward the end of the year after a long period with a heavy psychotherapy load and insufficient time out. It reoccurs for a period of days if I am particularly overworked and tired.'*

Some respondents appear to be reticent to expose their vulnerability regarding their experience of depression and its impact on their clinical work. This somewhat defensive stance is revealed when respondents appeared to minimize their experience of depression, intellectualize it, or use it to avoid dealing with their own feelings of depression.

Summary – Theme 3

Overall, the impact of respondents' depression on their clinical practice appears to be both positive and negative. Most respondents report that they are more sensitively attuned to the patient's depression by being attuned to the experience of depression in him/herself.

THEME 4:

3.2.5 PREFERRED PROTECTIVE STRATEGIES

With an understanding of the potentially negative impact of their depression, or vulnerability to depression on the therapeutic relationship, therapists take active steps to protect themselves and their clients/patients. These preferred protective strategies can be thought of as belonging to one of three categories:

a) Therapist as patient

b) Collegial Support

c) Self-care

The following are some of the preferred protective strategies, and reasons for their selection, which have been outlined by respondents:

a) Therapist as patient

Personal therapy is regarded by many respondents as the treatment of choice for depression, and an important aspect of self-care. Although other practitioners are sought, such as psychiatrists, general practitioners and spiritual healers, psychotherapy appears to provide psychotherapists with greater understanding of the underlying issues contributing to their struggle with depression. Eighty percent of the sample of respondents who had experienced a depressive episode sought help from a psychotherapist. The following responses reveal this treatment preference:

Subject 16: *'Allowed me to vent and ask for help rather than only give out help.'*

Subject 6: *'Helped me gain insight into reasons why.' 'GP put me on to an antidepressant which helped too.'*

Subject 1:*'Made most sense to understand feelings/symptoms and their current and past contexts.' 'Personal therapy has made me aware of 'what was missed' and lowered my defenses.'*

Subject 2: *'Psychotherapy… a means to understand & work through the depression.' 'Provided support.'*

Subject 14: *'Understanding the underlying factors for my feelings.'*

Respondents appear to place great value on a treatment which assists them in their understanding of the underlying issues that fuel depression. Many respondents described how insight into the precipitants of their depression helped them to address causes, not symptoms. It was also suggested that therapy provides an opportunity for obtaining early missed experiences. Many respondents also mentioned the importance of medication prescribed by either a general practitioner or a psychiatrist, and the importance of the role of support provided by psychotherapy.

b) Collegial Support

Regular contact with colleagues who are doing the same type of work seems to be an essential aspect of support and self-care. Respondents appear to feel comfortable sharing their struggle regarding their depression with their colleagues. This mutual disclosure may have an important protective role to play in a profession often described as 'isolated', and is revealed through the following responses:

Subject 1: *'Colleagues very understanding and receptive… a common problem.'*

Subject 20: *'Mostly empathic and supportive… one or two very defended colleagues have distanced themselves from me and my depression.' 'Not enough collegial support.'*

Subject 14: *'Many of my colleagues feel the same way… in part our depressed mood stems from the emotional strain of the work.'*

Subject 36: *'They often experience it themselves – it's a fairly normal thing – work is often sad and draining.'*

In general, colleagues are seen to be a very important source of support. There appears to be very little concern about stigma and possible judgements made about self-disclosure. The emphasis seems to be on the relief and greater intimacy that mutual disclosure brings among colleagues. There appear to be indications that there is an awareness of possible distress amongst colleagues.

c) Self-care

In the final question respondents were asked what kinds of self-care practices they engaged in as a way of preventing and managing their vulnerability to depression. Their responses can be divided into five descriptive categories:

- **Bold face type indicates most frequently cited self-care strategies employed by respondents in the category outlined.**

Physical (30%)

Gym/Exercise (Walks/Running/Yoga/Tai Chi/Pilates/Swimming)

Nurturing the physical body: Massage/pedicures/Good Diet/Adequate sleep/Less alcohol

Gardening

Medication when needed/Regular check ups/medication reviews

Acupuncture

Social (11%)

Socializing/Contact with friends/Peers/ Active social life

Professional (26%)

Regular Supervision

Individual Psychotherapy

Reading Group/Workshops/Peer Supervision

Time Out (21%)

Taking long breaks/Taking regular holidays/Limiting working hours each week/Not overworking

Being alone in nature/Time on my own/Uncluttered quiet evenings / Commit to a spiritual path / Daily meditation / Devotional practices/Screening patients / Limiting trauma work

Intellectual (11%)

Reading outside the field/magazines/novels

Movies/TV/Creative Arts

Hobbies/Playing a musical instrument

Ensuring variety in work e.g.lecturing, medico-legal work

It is interesting to note that every respondent reported making some effort to practice self-care as a balance to their professional lives. This perhaps highlights a widely accepted belief that the quality of care provided to others can be compromised if self-care is neglected.

Summary – Theme 4

Overall, when seeking treatment most respondents appear to have confidence in the process of psychotherapy as a treatment of choice for their depression. The most frequently cited reason for this was that psychotherapy addresses causes and underlying issues rather than focusing exclusively on symptoms. In addition, talking to colleagues about their experience of depression is seen by respondents as a vitally important source of support. Finally, self-care practices are reported to be consciously utilized by respondents.

THEME 5:

3.2.6 TRANSCENDING WOUNDEDNESS

It is thought that having an emotional wound sensitises one to others who are in emotional pain. In coming together in an attempt to help someone else manage their emotional struggle, therapists may be helped to understand their own suffering better. It may make one feel important or needed, or it may be that it is simply rewarding and life-affirming to help people who are in distress.

It would appear that a therapist's individual woundedness can be put to work with benefits to both patient, and therapist. Through careful management and self-reflection therapists' experience of depression can sensitize them to help others to transcend their individual and collective woundedness. The following comments made by respondents reveal aspects of this process:

> ***Subject 18:*** *'Stems from losing a parental figure at an early age with subsequent less availability of other parent who was burdened, stressed etc. As a result I tend to be vulnerable to depression at times of separation and loss. My depression has been a positive influence in terms of increasing empathy towards clients and identifying factors which may be helpful in managing depression.'*

Subject 5: *'When I have greater access to emotions around loss & separation, then I am more sensitively in touch with my client's feeling world. The lived experience informs my capacity to sense the client's feelings and to 'tolerate,' 'hold,' understand,' 'receive' the client's distress more fully.'*

Subject 3: *My experience of depression gives me a capacity to understand the depths of pain that one can recover from and hence the ability to hold onto hope of recovery for others.'*

Subject 6: *'I am able to empathize with their feeling and understanding in a very real way that dark space which they feel themselves to be in, and their sense of hopelessness of ever coming out of it.'*

Subject 39: *'I think the difficulties I went through emotionally as a young child/adolescent/young adult, have helped me to empathize with various age groups. I was not a great parent – but today have a very good relationship with my children. I can therefore understand difficulties with parenting / children and be helpful.'*

Subject 7: *My depression was hormonal and psychological and related to a pregnancy and the absence of a supportive father.' I am thus, more empathic towards clients / children who as mothers or whose mothers suffered from depression.'*

Subject 9: *'Being able to 'sit' with helplessness, without feeling the need to 'take on' a patients symptoms and change/remedy them. A realization of the importance of 'matching' or mirroring patients mood/tone etc. For example, not energetically trying to come up with solutions that are just too exhausting for patient to think about – thereby failing to 'hear' the patient – or understand their distress.'*

Subject 20: *'My depression has helped me to work with patients better in that I empathically understand the depth of their desperation. Also it has helped me to know when to refer for medication and to take patient's experience of depression very seriously, as many patients feel that others don't understand their state of mind.*

Summary – Theme 5

It would appear that respondent's personal experience of depression may have fostered within the individual a unique sensitivity to different aspects of the depression experience. This sensitivity appears to have an important impact on the way each individual approaches the practice of psychotherapy.

3.2.7 General Summary of Results

The results outlined in this chapter are analysed and presented both quantitatively and qualitatively. The initial quantitative section provides an introduction to the profile of the sample. The qualitative section offers the reader an in-depth, textured understanding of respondent's subjective experience of depression.

The quantitative results cover the following univariate and bivariate analyses:

- Marital Status – Univariate analysis
- Years in Practice – Univariate analysis
- Number of children – Univariate analysis
- Ages of respondents – Univariate analysis
- Gender – Univariate analysis
- Psychology discipline – Univariate analysis
- Depression experienced – Univariate analysis
- Age of first depression – Univariate analysis
- Client hours per week – Univariate analysis
- Most frequently occuring depressive symptoms – Univariate analysis

- Theoretical orientations – Univariate analysis
- Theoretical orientations (depression reported) – Univariate analysis
- Treatment sought – Univariate analysis
- Type of practitioner consulted – Univariate analysis
- DSM-IV-R diagnoses given – Univariate analysis
- Medication taken – Univariate analysis
- Depression occuring before, after or before & after starting private practice – Bivariate analysis
- Dominant syndromes in respondents private practice – Univariate analysis
- Disclosure of depression to colleages – Univariate analysis
- Theoretical orientations and depression occurring before, after or before & after starting private practice – Bivariate analysis
- Respondents not depressed and theoretical orientation – Bivariate analysis

The qualitative results present the current subjective reality of the respondents under five overarching themes:

1 **Possible causes & contributions to psychologists personal experience of depression**

Under this theme, four sub themes were identified:

a) Family of Origin
b) Genetic Predisposition
c) Precipitants – other
d) Context of private practice

Respondents' understandings of the precipitants of their depression, or contributions to their vulnerability to depression centered around difficulties experienced in their family of origin, possible genetic contributors, the impact of internal and external events on an individual's life, and the unique stresses which accompany working in the context of private practice. Each respondent presented a unique constellation of the above mentioned contributors.

2 **The contributions of the depression experience to the choice of the profession of**

Under this theme, a sub theme was identified:

a) Self-understanding and insight
b) The language of self-understanding

An experience of depression very often seems to initiate a process of introspection and self-discovery in the individual sufferer. This process is, more often than not, aimed at mastering the uncomfortable feelings and attempting to understand their origins. This experience of depression appears to foster a sensitivity towards depression in others, and a desire to assist others by drawing on personal experience. As a result, it would appear that an experience of depression is one of the factors which may draw an individual to the profession.

In addition, the language used by respondents who have experienced depression often indicates a nuanced and textured understanding of the differing shades or severities of depression. This appears to assist respondents when working with their patients.

3 **Positive effects of the experience of depression on the therapeutic encounter**

Under this theme, three sub themes were identified:

a) Experiential impact on the therapeutic relationship
b) Improved therapeutic techniques
c) Self-healing

Negative effects of the experience of depression on the therapeutic encounter

Under this theme, three sub themes were identified:

d) Experiential impact on the therapeutic relationship
e) Countertransference and Projective Identification
f) Defensive strategies

Overall, the impact of respondents' depression on their clinical practice appears to be both positive and negative. Most psychologists report that they are more sensitively attuned to patients' depression by being attuned to the experience of depression in themselves.

4 Preferred Protective Strategies

Under this theme, three sub themes were identified:

a) Therapist as Patient
b) Collegial Support
c) Self-care

Overall, when seeking treatment most respondents appeared to have confidence in the process of psychotherapy as a treatment of choice for their depression. The most frequently cited reason for this was that psychotherapy addresses causes and underlying issues rather than focusing exclusively on symptoms. In addition, talking to colleagues about their experience of depression is seen by respondents as a vitally important source of support. Finally, self-care practices are reported to be consciously utilized by respondents.

5 Transcending Woundedness

It would appear that respondents' personal experience of depression may have fostered within the individual, a unique sensitivity to different aspects of the depression experience. This sensitivity appears to have an meaningful impact on the way each individual approaches the practice of psychotherapy.