

https://dspace.org/

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

Esterhuizen, Melanie Jane

2006-11-15T12:53:12Z
http://hdl.handle.net/10539/1744

Downloaded from a DSpace repository. https://dspace.org/

CHAPTER ONE – LITERATURE REVIEW

1. Introduction

This study was designed to investigate depression in clinical, counselling and educational psychologists in private practice. The existing literature and studies conducted on this subject have emerged predominantly out of the United States of America, the United Kingdom and Canada. It was felt by the researcher that an exploratory study done in a South African context may yield interesting comparisons with existing research, broaden the existing body of knowledge, and perhaps generate hypotheses for future research.

Ideas for the current research were gleaned from existing qualitative and quantitative studies. The literature review will focus on the relevant studies which make up this current body of knowledge. The following areas will be covered:

1.1 Depression - Impact, definition and result of distress and/or impairment

This section focuses on the reasons for studying depression in psychologists, and the complexity inherent in attempting to define depression and its intensity. The experience of depression as an expression of distress and/or impairment will also be considered.

1.2 Factors implicated in the aetiology of depression

The possible relationship between predisposing and precipitating factors which often culminate in a psychologist's experience of depression, are explored. The impact of this relationship on a psychologist's personal life and professional functioning is outlined.

1.3 Depression amongst female psychologists

The demands of professional functioning, the demands made within a woman's domestic context, and societies expectations of women are believed to increase a woman's risk of experiencing depression. This phenomenon is explored against the backdrop of general population statistics for depression.

1.4 Motivation for choosing psychology as a profession

This section explores the possible unconscious motivations for the selection of psychology as a profession. These unconscious motivations, which often predispose a psychologist to depression, are examined. The influence of the psychologist's family of origin is given particular attention.

1.5 The private practice context and its contribution

This section examines the contribution made by the particular circumstances of private practice to the psychologist's depression.

1.6 The impact of the nature of the therapeutic relationship

Along with private practice stressors, the difficulties inherent in the nature of the therapeutic relationship are central to this investigation of depression as experienced by psychologists. From the reciprocally generated transference and countertransference phenomena, to unrealistic expectations, depressed patients, projection of unbearable feelings, loss of therapeutic distance, isolation and interpersonal loss experienced through termination of the therapeutic relationship – there exist uniquely complex relationship dynamics which characterize the therapeutic work.

1.7 Psychologists seeking treatment

Some of the more frequently cited reasons for psychotherapists seeking treatment are discussed, along with a description of the types of treatment sought.

1.8 Self-Care Practices

This section explores the self-care patterns of psychologists and how this relates to effective and responsible professional functioning. Some of the risks around self-neglect are introduced and suggestions offered for improved self-care.

1.9 The Psychologist as 'Wounded Healer'

Finally, the importance of the psychologist's ability and willingness to integrate their own vulnerability and accept their 'woundedness' is proposed as the point of empathic connection to the suffering of the other.

Psychology - A Perilous Profession?

The process of psychotherapy flows in two directions, influencing the client but, also affecting the personal life of the clinician. From the perspective of the psychodynamic psychologist, whose theoretical orientation demands that they are attuned and open to patients and to the unconscious, the practice of psychology renders them particularly vulnerable to human problems, including depression of all forms (Heath, 1991). This vulnerability may not be as marked in practitioners who utilize theoretical orientations such as Cognitive Behavioural therapies where a goal focused 'tools' or 'cognitive conditioning strategy' approach is used, and there is less likelihood of the practitioner immersing himself or herself in the feelings generated by the client's experiential reality. However,

psychodynamic psychologists, precisely because they immerse themselves in the patient's internal world, may be more vulnerable to the empathic evocation of depressed feelings.

Laliotis and Grayson (1985, cited in Norman & Rosvall,1994), make the point that 'mental healthcare professionals are particularly vulnerable to psychological impairment by virtue of their profession, because not only are their stresses associated with around-the-clock client welfare responsibility, but also the omnipotent role of the professional often discourages help seeking' (p.451). With the stress inherent in the profession of psychology, unwillingness to seek personal treatment may well place a psychologist's mental health at risk.

In general, the work of a psychologist, according to Kottler (1993), can for better or for worse, be among the most spiritually fulfilling, as well as the most emotionally draining of human endeavours. As a result, the psychologist's vulnerability to depression is profound (Heath, 1991). Kottler (1993) states that studies reveal that approximately 10% of practicing psychologists are clinically depressed. For this reason research into psychologists' subjective experience of depression may yield useful information and contribute to an ethos of increased understanding and compassion.

1.1 Depression - Impact, definition and result of distress and/or impairment

Although research on the issue of depression among psychologists is sparse, the existing evidence suggests that rates of depression among psychologists may be substantially higher than that of the general population (Heath, 1991). According to the South African Depression & Anxiety Group as reported in *The Star* (26/2/2004), 'between 10 and 14% of the general population will experience depression at least once in their lives.' Dr Shaquir Salduker, media spokesman for the South African Society of Psychiatrists reports that an estimated 12 – 15% of our general population suffer from a mental disorder (*Sunday Tribune*, 7/4/2002). Persad, (1989, cited in Heath, 1991),

states that according to prevalence studies in various populations sampled around the world, 20% of the general population suffers from depressive symptoms. Also, the average age for a first diagnosed episode of major depression is approximately 40 years of age (www.health24.com). However, according to the National Institute of Mental Health, the onset of depression is occurring earlier in individuals born in more recent decades.

The study of depression among psychologists, in particular, is an important issue to address for a variety of reasons. Firstly, as noted by Sherman (1996), psychologists who are depressed may not be able to use their key skills effectively, which will hinder their therapeutic effectiveness. Thirty two percent of respondents to one survey reported having experienced depression to the extent that it interfered significantly with their work (Wood, Klein, Cross, Lammers, & Elliott, 1985). Another survey of practising psychologists indicated that approximately 60% thought that they had practised therapy when they were 'too distressed to be effective' (Pope, Tabachnick, & Keith-Spiegel, 1987). Secondly, impairment of professional functioning due to depression is important to address because of its impact on the profession and on the practitioner's colleagues (Schwebel, Skorina, & Schoener, 1994). According to Sherman (1996), highly publicized cases of therapist misconduct or impairment portray psychologists in an embarrassing light, harming the profession's reputation in the public eye. In addition, the pressure on colleagues to take action results in severe interpersonal distress between the impaired professional and his/her colleagues.

1.1.1 Depression – difficulties with definition

> The concept of depression is often loosely used to describe what may be a brief negative mood, feeling sad or low. It may also refer to a severe, incapacitating melancholy – a mood disturbance - described by an interrelated set of symptoms, or a more severe medically defined syndrome – a mood disorder. (Gotlib & Hammen, 1992, as cited in Rapmund 1995).

Many people have probably felt ‘down’ at times and so understand something about depression. Depression of mild intensity is a common human emotion and is usually the consequence of recent stress or loss. It is often difficult to distinguish between what Rapmund (1995) describes as mood disturbance (normal depression) and mood disorder (persistent and intense depression which is maladaptive). The boundary between the two is often not easy to identify. Heath (1991), describes how the American Psychiatric Association has attempted to address the complexity and confusion around the classification of depressive disorders by providing so-called ‘operational definitions’ for various types of depression. The operational definitions are descriptive rather than driven by psychodynamic understandings, and so do little to address the question of aetiology.

In addition, the search for the genetic underpinnings of depression continues unabated. It is thought that some forms of depression have a biological basis (Heath, 1991). This has blurred the boundaries between so-called reactive/neurotic depression (i.e. depression that result predominantly from loss), and endogenous depression (i.e. depression where there appears to be no precipitating external event or cause). Definitive treatment modalities for the different types of depression are also difficult to identify. According to Gotlib and Hammen (1992, cited in Rapmund, 1995), most depressive episodes are time-limited, the period of time depending on the nature and severity of the episode. Depression often recurs and may become chronic. It would appear that the strongest predictor of depression relates to the presence of previous episodes of depression (Lewinsohn, Hoberman & Rosenbaum, 1998, cited in Rapmund, 1995).

1.1.2 Depression – result of impairment or distress

Sherman (1996) makes the point that 'impairment' may be observed in a clinician's depressed mood, and may differ in severity depending on the individual's resilience and the precipitating event. In this study, 'impairment' or 'distress' is restricted to the specific experience of a depressive episode as operationally defined by the DSM-IV-R. The study also elicits psychologists' personal reports about their experience of depression, which includes self-perceived predisposing, precipitating, and maintaining factors, and the impact of the depression on their capacity to function professionally. The section that follows explores the idea of a relationship between a predisposition to depression and precipitating factors such as life crises and work stress. These interrelated factors, it has been found, appear to impact on professional functioning.

1.2 Factors implicated in the aetiology of depression

Some psychologists may enter the field with a predisposition to depression, and this may interact with work or life stressors to trigger a depressive episode. As Gerson (1996) points out, there are many adult crises that the therapist may encounter. Sussman (1992) notes that since the mid 1980's there has been a substantial increase in the focus on the impact of the psychologist's personal life on his/her professional functioning.

A psychologist's professional self is inevitably touched by his/her personal self. Each individual makes use of what has been wrought and fashioned from encounters with life – as children and as adults. Life crises ultimately shape and become part of our personalities. They contribute to the formation of our values and orientations to the world and others. The conflicts the practitioner carries from his/her background, and the sensitivity about these conflicts, shape the way the therapist views others who are suffering.

The wish to practise psychology may be unconsciously motivated by the need to deal with and make sense of the psychologist's inner wounds and unresolved conflicts. At the same time, emotional difficulties exhibited by therapists may result from the hardships of practicing their profession. According to Sherman (1996), the field of psychology has only recently begun to directly address the mental health of psychologists and its impact on therapeutic effectiveness. Ellis (1973) makes the observation that many renowned psychologists who developed influential models of psychotherapy described the therapist's mental health as the foundation of his/her work.

Sussman (1992) also reports that the influence of the psychologist's person on the therapeutic process remains a relatively neglected area of inquiry. The personality of those who attempt the 'impossible profession' of healing minds, he states, has been largely overlooked. Using the most basic tenet of the psychoanalytic approach to understanding human behaviour, that is, the understanding of unconscious motivations, this study gives emphasis to the importance of the therapist's subjective experience. This emphasis has been highlighted in this review, as most of the literature regarding depression among psychologists presupposes unconscious factors existing in, and impacting on relationships. As someone who has been trained in the psychodynamic tradition, this is a theoretical lens of choice, however, the researcher understands and appreciates that there are many practitioners who would not embrace this theoretical approach.

With the focus on the psychologist's subjective experience of depression, the current study explores the impact of the depression experience on career choice and professional functioning, and also the impact of clinical work on the individual's experience of depression.

Why do psychologist's personal lives and unconscious motivations matter? Automobile mechanics do not need to know why they chose to fix cars for a living, or how they are feeling whilst doing so. Why should psychologists be any different? To begin with, Sussman (1992) makes the observation that human interactions can be exceedingly complicated and multifaceted.

Secondly, introspection is unlikely to provide mechanics with a greater understanding of motor vehicles. It will, however, aid the clinician's understanding of themselves and their clients. A third distinction is that the psychologist generally uses no mechanical instruments, that is, it is the ***person*** of the psychologist that constitutes his or her primary tool. Therefore, the psychological state and makeup of the individual psychologist does impact, to a very large extent, on the effectiveness of the treatment process. Based on his research findings, Strupp (1958, cited in Sussman, 1992), concluded that "a therapist's personal influence outweighs the effects of particular techniques on treatment outcome" (p.6).

A predisposition to depression may interact with work or life stressors to trigger the occurrence of a depressive episode. According to Heath (1991) psychologists have been identified as a population at risk for depression due to the emotionally demanding nature of their professional roles and responsibilities.

Sherman (1996) reported that distress and impairment may be observed in the clinician's depressed or anxious mood, physical complaints, and feelings of confusion and helplessness. These studies summarize the difficulties encountered by health professionals, such as depression, marital-relational conflict and work-related problems, which can interfere with and impede professional functioning.

Work factors such as malpractice claims, moving the setting of one's private practice, and inadequate time for meeting obligations also increase the risk of depression. According to Sherman and Thelen (1998), a psychologist's ability to function adequately in terms of basic requirements of his/her role (e.g. punctuality, availability and conscientiousness) may be compromised when he/she is under significant stress at work. The adverse affects on the more subtle requirements of the psychologist's job, for example, the appropriate provision of empathy, are much more difficult to assess, but may be equally affected (Sherman & Thelen, 1998). According to Bermak (1977),

expectations of the psychologist to provide continuous empathy can be draining.

Given society's expectations of woman, along with the personal demands made in a domestic context and the demands of professional functioning, women appear to be more vulnerable to depression than men. The section which follows explores this phenomenon in greater detail.

1.3 Depression amongst female psychologists

Currently, most psychologists in South Africa are female. According to the Health Professions Council of South Africa (July 2005), of the total number of registered psychologists (5947), 63.6% are woman and 36.4% men.

Gilroy, Carroll and Murra (2001) claim that female psychologists are twice as vulnerable to experiencing depression. Research has indicated that depression is more prevalent in woman than men. The ratio of depressed women seeking help to depressed men seeking treatment is 2:1 (Webster, 1990; Paykel, 1991, cited in Rapmund, 1995). Women tend to seek help more frequently for their depression and are therefore more readily diagnosed (Rapmund, 1995). However, physiological shifts in the female reproductive system predispose women to depression, as well as contribute to the maintenance of depression (Rapmund, 1995). Pregnancy and childbirth may also contribute to female psychologists experiencing depression. Powerful psychological stressors also contribute to postnatal depression. A woman may experience a profound sense of loss when the baby is born. A shift of attention away from the mother to the baby, the responsibility of caring for the baby, and the shifts in her role from 'childless woman' to mother may also contribute. The impact of this shift on her husband, her mother, siblings and society often require major relationship readjustments. The shift from competent provider, with it's accompanying social status, to full-time mother may also threaten a woman's self-esteem. In the absence of consistent support, the birth of the baby often represents a long-term difficulty which can compromise a woman's coping skills, provoke a sense of hopelessness and

low self-esteem, all of which may develop into a more prolonged depressive illness (Rapmund, 1995).

A woman's psychosocial development also contributes to her greater vulnerability to depression. According to Herman (1983, p .503), despite changes in attitudes towards women, society does not sufficiently value the feminine qualities of 'inwardness, intangibility, sharing, receptivity and nurturance.' Society places too much emphasis on the masculine values of 'achievement, competition, things tangible, material success and aggression.' This, according to Rapmund (1995) serves to undermine women and increases their vulnerability to depression. The (male) culture prescribes the nurturing role to women, and yet shows disrespect for this role, which place women in a double bind. Women's healthy capacity for intimacy is often construed as a weakness (Jack, 1991, cited in Rapmund, 1995). It is important to consider the contribution of the South African context to women's vulnerability to depression. South Africa in the 21st Century is characterised by unemployment, shifting gender roles and family violence. It is women who most often absorb the stress in the family and provide emotional nurturance at a time when they are also vulnerable and need to be cared for emotionally (Rapmund, 1995).

According to Mausner and Steppacher (1973, as cited in Gilroy, Carroll & Murra, 2001), the rate of suicide among female psychologists and psychiatrists is three to four times that of women in the general population. Sherman and Thelen (1998) suggest the possibility that women experience depression more as a result of being overburdened with domestic responsibilities. They may also become entrapped by the 'superwoman phenomenon' where they feel they must perform each role perfectly, leaving them emotionally depleted and depressed. (Rasmussen & Guy,1989, as cited in Gilroy, Caroll & Murra, 2001). Gilroy et al (2001) suggest that female clinicians may receive more referrals for the more clinically challenging cases such as eating disorders and sexual abuse, which may also increase female psychologists' vulnerability to depression.

It is important to mention that many of the studies cited in this review include psychologists practising privately, as well as within public organisations. However, many of the work stressors such as feeling isolated due to the confidential nature of the work, physical inactivity, emotional fatigue, sparse recognition for accomplishments and one-way intimacy, affect practitioners similarly within the different practice sites.

In Deutsch's (1985) sample of 264 psychotherapists, 57% reported depressive symptoms at some point in their professional lives. Over 25% of the sample received psychotherapy for depression, and 11% were prescribed antidepressant medication. Pope and Tabachnick (1994) reported that 61% of their sample disclosed having experienced at least one episode of clinical depression. In the survey of female psychologists conducted by Gilroy, Carroll and Murra (2001), 76% reported experiencing some form of depression since beginning clinical practice.

Looney and colleagues (1980) surveyed 263 psychiatrists nationwide and reported that 73% had experienced moderate to incapacitating anxiety during their early years of professional practice, while 58% experienced serious depression. Deutch (1985), surveyed 264 psychologists representing various disciplines, and found that a majority of them had experienced significant personal problems, including relationship difficulties (82%), depression (57%), substance abuse (11%) and suicide attempts (2%).

Gilroy, Carrol and Murra (2002) conducted a preliminary survey in the United States, which focused on Counselling Psychologists' personal experiences of depression and the treatment thereof. This survey found that depression, anxiety, substance abuse and relationship dysfunction are just a few of the occupational risks associated with the practise of psychology. They go on to say that of these occupational risks, depression is the most common disorder among psychologists (Deutch, 1985; Mahoney,1997; Pope & Tabachnick, 1994).

Cooke (1999) conducted an in-depth exploration of the phenomenology of depression among practicing psychologists. Six psychologists, all women, were interviewed about their experiences of depression. This inquiry revealed the painful and often shrouded aspects of the wound of depression, which contributed significantly to drawing them to the profession, and which continues to sensitise them to their patients' suffering (Cook, 1999).

Although women appear to have a heightened sensitivity to the suffering of others, and perhaps a learned position of empathic attunement, unconscious motivations for selecting the profession appear to be similar for men and women (Racusin, Abromowitz & Winter, 1981). The following section explores these unconscious motivations, and how they often contain the seeds of a psychologist's vulnerability to depression.

1.4 Motivation for choosing psychology as a profession

What are the underlying motivations that provide the impetus for becoming a psychologist? Maeder (1989) suggests that psychologists are driven by their own emotional hunger. Freud theorized that a strong desire to help others stems from longings that are a consequence of childhood losses (Maeder,1989). Maeder also suggests that a host of less-than-selfless motives may enter into the choice of psychology as a profession: sublimated sexual curiosity, aggression, the problem-solving pleasure of resolving emotional confusions, and a voyeuristic fascination for the lives of others are also thought to contribute to this.

According to Sussman (1992), in one of the largest and most comprehensive studies on mental health professionals to date done by (Henry et al. 1971), the wish to resolve personal problems is an important, although initially unconscious motivation for becoming a therapist. The same conclusion was put forward by Kelly and Schneider (1976, cited in Sussman,1992), stating that the wish to become a therapist represents a repeated effort to overcome one's own pathology, with specific reference to deficient ego resources and identity development.

Menninger (1957) believed that the therapist's experience of emotional rejection in their families of origin often results in a wounded self-image. These experiences are then projected into their interest in lonely, eccentric and unloved people. Burton (1972, cited in Sussman,1992), agrees with Menninger and suggests that professional functioning serves to compensate for therapists' interpersonal conflicts derived from their families of origin. He goes on to say that early family experiences sensitize psychologists to emotional pain, as well as provide motivation for their vocational choice. Several studies support the notion that individuals who enter the mental health professions tend to have experienced a high level of emotional and interpersonal stress within their families of origin.

Ford (1963, cited in Racusin, Abromowitz & Winter,1981), reflecting on his experience with trainee psychologists, hypothesized that therapists undertake training to deal correctively with conflict arising out of early personal history. He cited a pattern of dominating mothers who were central to therapists' emotional and physical well being, and fathers who were passive and non-nurturing.

Racusin, Abromowitz and Winter (1981) suggest that lack of nurturance encountered by therapists in their families of origin generated feelings of helpless rage and ambivalence toward interpersonal intimacy. The choice of psychology as a career is seen as a defence against these feelings of helplessness by attempting to control intimacy. They report that in some families that are characterized by physical abuse, sensitivity to nuances of interpersonal functioning may have been necessitated out of fear for physical safety. This kind of empathic understanding is commonly considered to be a valuable therapeutic asset (Matarazzo, 1978).

Henry, Sims and Spray (1973) confirmed in their research that psychologists' family relationships were indeed stressful (for example, physical illness, difficulties in the expression of emotion and adolescent struggles over independence). This history appeared to foster interpersonal sensitivity and a

desire to understand human relationships. Harris' (1975) study of childhood recollections of a small sample of therapists also identified the existence of interpersonal stress in therapists' families. Particular reference was made to parents' perceived lack of emotional responsiveness. Harris believed that these childhood deprivations facilitate the psychologist's capacity to empathize with their patients, empathy being regarded as necessary for effective psychotherapy treatment.

According to Elliott and Guy (1993), although research on the childhood family environments of mental health professionals is relatively sparse, it suggests that psychologists often come from families in which they suffered emotional distress as children. They may enter the profession, in part, to fulfill needs for closeness and intimacy that were not met in childhood (Dryden & Spurling, 1989; Ford, 1963; Guy, Tamura, & Poelstra, 1989; Liaboe & Guy, 1987; Raskin, 1978). Racusin, Abromowitz and Winter (1981, cited in Elliot & Guy,1993) report that 100% of the psychologists in their sample had a member of their family of origin afflicted with physical and/or behavioural difficulties arising from psychogenic factors. Alcoholism, child abuse, or both, had occurred in over 50% of these families. Furthermore, 50% of the clinicians reported that their primary role in childhood had been to provide a parental function within the family. It has been postulated by Guy (1987), that the internalization of the caretaking role is a first step toward becoming a mental health professional. The concept of the "wounded healer" has been discussed by many authors who suggest that negative experiences in childhood enable psychologists to identify with the problems of their clients and to relate to them in an empathic manner (Elliott & Guy, 1993). However, if mental health workers enter the field in order to "heal wounds" or to resolve personal conflicts, this motivation might result in diminished effectiveness in their work with clients. The results of Elliot and Guy's (1993) study, suggest that 'women working in the mental health profession are more frequently traumatized as children, than women working in other fields' (p.89). In addition, female therapists appear to come from more chaotic families of origin. However, Elliot and Guy (1993) suggest that psychologists, unlike other professionals, are fortunate in that their psychological distress is more

likely to be addressed due to the opportunities for self-healing provided by the psychology profession.

Fussel and Bonney (1990), in their comparative study of childhood experiences of psychologists and physicists, put forward the point of view that emotional pain can be an asset to the psychologist. According to Gustafson (1986), psychologists who have experienced emotional pain are believed to understand better and respond more appropriately to the pain of their patients. The successful resolution of their own psychic pain engenders optimism and empathy in the therapist, which can in turn influence the therapeutic process positively. Overall, Fussel and Bonney's (1990) study found that compared to a group of physicists, psychologists reported a higher incidence of childhood trauma and emotional deprivation. Psychologists perceived themselves to have experienced more parent – child role inversion and were more likely to take on the role of caretaker. However, their study suggests that although the childhood of psychologists did involve pain, it may have enhanced, rather than diminished, their continuing interest in people. The study does not however, indicate the degree to which they have resolved the surrounding issues or describe the consequences of their pain. They suggest that what seems likely is that the resolution of childhood pain requires an ongoing struggle that continues well into their adult lives.

Leiper and Casares (2000) have recently investigated how the attachment organisation of psychologists influences their approach to therapeutic work. Attachment is defined as 'the propensity of human beings to make strong affectional bonds to particular others' (Bowlby, 1977, p. 201). According to Bowlby (1977), the attachment style of an individual is thought to be influenced by their initial experience of being cared for. These experiences are subsequently seen to determine that individual's own care-giving behaviour and the quality of their close relationships. These results suggest that insecurely attached psychologists may be more at risk of work stress and may need more support. It also suggests that this is a group, which may prove harder to support. Leiper and Casares' (2000) research also highlights the debate around the role of personal therapy as part of a psychologist's

training, and the role of supervision for support and helping them to make sense of the difficulties that they experience in their work.

Many theorists and studies have suggested that psychologists enter the profession as a consequence of earlier emotional pain and the influences of painful experiences in their family of origin (Menninger, 1957). The dynamics of this influencing process however, are still open to question. Some tentative suggestions have been made such as provided by Henry, Sims and Spray (1973), who suggest that, a stressful family history appears to foster interpersonal sensitivity and a desire to understand human relations. In a more recent study conducted by Fussel and Bonney (1990), a similar suggestion is offered where, although ambiguous communication and confusing childhood surroundings are thought to increase a psychologist's susceptibility for relationship problems, they may also stimulate his/her interest in people and encourage a curiosity as to why people act so strangely.

This tolerance for ambiguity also assists psychologists to follow calmly as patients present confusing and perplexing life events. It is important to highlight, that it is sometimes particular stressors in the work context that interact with an individual predisposition or vulnerability to precipitate a psychologist's depressive episode.

1.5 The private practice context and its contribution

Heath (1991) makes the point, that it is easy to assert that the mental health field attracts people who are already casualties themselves. However, it is necessary to consider the possibility that the stresses of clinical practice, especially in the context of private practice, affect practitioners in a profound way.

Kottler (1993) describes the psychologist as providing a safe and private haven for people to resolve their underlying problems. Psychologists swear allegiance to their profession's code of conduct with regard to privileged

communication in order to protect the client's right to privacy, confidentiality and dignity. Due to the communicative restrictions of confidentiality, in a moment of crisis there is very often no one to talk things over with outside of the formally scheduled supervision times. In the case of an emergency such as sudden illness or a death in the family, the therapist cannot rely on others to cancel his/her appointments with patients. Furthermore, there is little opportunity during the day for formal or informal discussions with colleagues, and therefore it is not easy to get feedback on one's work. As Goldberg (1992, p.92) describes it, without discussions, case conferences and exchanges with colleagues, it can feel like a 'psychological desert'. Guy (1987) describes the isolation of a psychologist's work as all encompassing. Physically, client and therapist are separated from the outside world, ensconced in a soundproof chamber. The telephone is not answered, the door is not opened and interruptions are not tolerated during sessions. In between sessions, notes are taken, paperwork is attended to, ablutions performed and there is little time for interaction with anyone (Kottler, 1993).

Bloomfield (1997) describes how in private practice there is usually no secretary to take messages, make appointments, or change sessions if necessary. All this has to be done by the therapists themselves. Time pressures head the list of private practice stressors. These are typically, seven or eight consecutive appointments with ten minute breaks in between. During the ten minute break, bodily functions must be attended to and phone calls returned (Nash, Norcross, & Prochaska, 1984). In addition, working in a one-person practice can be lonely (Bloomfield, 1997). There is also the risk and fear of violent patients. Psychologists are undoubtedly vulnerable when working on their own with nobody else on the premises (Bloomfield, 1997). According to Goldberg (1986), clinical situations, which potentially hold the greatest distress, are when clients come to us in acute suffering and despair, threatening to end their lives. Handling a client, who is suicidal, evokes considerable anxiety and feelings of helplessness in the therapist. It would seem that no matter how hard psychologists work to preserve professional detachment, the tendency to carry patients inside one when they walk out of the door, is great. Kottler (1993), points out that it is not surprising that

patients become significant in a psychologist's life and mind when week after week is spent discussing the private, and often distressing details of their lives.

Psychologists spend eight to ten hours per day in the same chair, in the same room, being exposed to the intense emotions of a few individuals. Full concentration and attention must be given to each individual patient and this can cause considerable physical and emotional strain. According to Bellack and Faithorn (1981, as cited in Kottler,1993), psychologists experience greater risks of lower back pain and circulatory and metabolic disorders than the population at large. It is hard to sit still for so long. It becomes tiring to just sit, listen, talk and think. Kottler (1993), describes the combination of remaining 'immobile and attentive' as extremely draining. As Coltart (1994) puts it, "there is also a good deal of emotional strain in having to contain our own feelings, no matter what is thrown at us, and of continually offering ourselves to the inner suffering of other people in the hope that there is something we give which may be of therapeutic aid to other people" (p.94).

Another factor concerns the fact that, in the United States in particular, it is becoming harder for recently qualified people to get referrals in private practice. This, according to Bloomfield (1997) is because there has been a decline in the number of people seeking psychotherapy, partly because of the variety of psychological treatments now available. Furthermore, psychotherapy has not had very good publicity from the media for some time.

Another area of extreme stress for the therapist in private practice are issues relating to payment (Bloomfield, 1997). Setting a fee, which suits the needs of both patient and psychologist, is a complex task. Since the relationship is a central part of the therapeutic process, the feeling that it is like 'buying friendship,' which is a common feeling among patients, may create resistance within the client regarding payment. These feelings have to be addressed, and often psychologists struggle with irrational feelings of guilt about charging for their service (Bloomfield, 1997).

Psychologists are placed in an unenviable position by the perceptions of themselves as neither missionaries nor business persons. Kottler (1993), describes how at times therapists feel guilty about being paid for doing nothing, and other times feel angry about being unappreciated and underpaid. Furthermore, no amount of money can compensate for the intensity, emotional turmoil, conflict and frustration encountered when working with particularly difficult clients.

In addition to the difficulties inherent to the private practice context, the therapeutic relationship is considered to be a central concern in contemporary psychology. From concepts like reciprocally generated transference and countertransference phenomena, the projection of unbearable feelings on to the practitioner, abandonment rage and termination – there are many uniquely difficult aspects inherent to the therapeutic relationship, which have the potential to increase a psychologist's vulnerability to depression. Aspects of the therapeutic relationship within a psychodynamic paradigm will be discussed in the following section.

1.6 The impact of the nature of the therapeutic relationship

The individual therapeutic situation involves a complex and multidetermined interaction between two individuals. Historically, the focus has predominantly been on the dynamics and motivations of just one of the collaborators in the therapeutic process, that is, the patient. However, to the extent that the psychologist is regarded as a participant and engaged in an emotional relationship with the patient, the psychologist's experiences, traits and strivings must be considered crucial (Sussman, 1992).

In a 1929 paper entitled "The Psychology of the Psychotherapist," Edward Glover (cited in Sussman,1992), comments as follows:

> *'A cursory glance at the syllabus of any representative body of psychologists is sufficient to remind us how rarely psychotherapists inflict on themselves the discipline of self-examination. Papers on the*

subject matter of clinical investigation are as plentiful as blackberries, but only once in a while is the instrument of investigation, the psychotherapist himself, subjected to purposive scrutiny.' [p.1]

Sussman (1992), suggests that Freud set an example that few psychologists live up to. He subjected himself to intense self-scrutiny, bravely attempting to disclose the workings of his own unconscious thought processes, as well as his pathological tendencies. Refusing to set himself above those distressed individuals who sought his help, Freud applied the same model of neurosis to studying his own psyche as he did to those of his patients. It was Freud's honest self-appraisal that enabled him to balance his concept of transference with the complementary notion of countertransference (Sussmann, 1992). It is important that the psychologist be aware of his/her own countertransference experiences, and to be able to differentiate his/her own issues from that of the patient. Countertransference experiences are defined by Heimann (1950, cited in Sussman, 1992), as "all the psychologist's emotional responses to the patient, both conscious and unconscious."

Strean (1988) makes the point that when faced with a personal crisis, some psychologists find it difficult to undergo their own psychotherapy and take on the patient role in order to explore their issues and countertransference reactions. Fleischer and Wissler (1985) suggest that one of the reasons for this is a psychologist's strong wish to collude with the patient's need for and idealization of perfection and omniscience in the therapist. This results in excessive and unrealistic expectations about one's capacities as a psychologist.

Racker (1953, cited in Sussman, 1992, p.314) astutely likened the status of countertransference to that of "a child of whom the parents are ashamed." Sussman (1992) describes how more recently, there has been an increased focus on the interpersonal and bilateral nature of the analytic process, as reflected in the attention given to such concepts as the therapeutic alliance (Zetzel, 1956), the working alliance (Greenson, 1967), and the importance of the psychologist's countertransference. Although there are many

psychologists who work within theoretical frameworks which do not emphasize psychodynamic concepts, such as transference and countertransference, whatever treatment they offer implies an emphasis on a relationship or working alliance. By entering into a client's worldview within this relationship, it is improbable that the process will leave the practitioner unaffected.

Currently, the psychodynamic concepts of transference and countertransference are viewed as reciprocally generating and interpenetrating each other (Greenberg & Mitchell,1983, cited in Sussman, 1992). Clarkson and Pokorny (1994) describe how in the transference, infantile relationship dynamics are experienced with a strong sensation of immediacy. The psychologist comes to represent significant people from the patient's past and the patient's perception of the psychologist, and his/her behaviour can be severely distorted. Consequently, when the transference is negative, the psychologist has to receive and contain projected hostile feelings, verbal attacks, constant criticism and rejection of all interpretations. Even for psychologists who practice alternative types of therapy, which do not make use of the psychodynamic understandings of transference, being the receptacle of hostility and contempt is emotionally taxing.

1.6.1 The negative impact of the therapeutic relationship

In addition to the peculiar and relentless strains of the private practice setting referred to earlier, a major stress for the psychologist is dealing with depressed patients. The patient's depression may be reactive to a particular life crisis or reactive to both effective, and ineffective therapeutic work (Heath, 1991). In other words, the patient may be depressed because the therapy is not working, or because the therapy is working and he/she is starting to deal with very difficult emotions. There can be no doubt that therapeutic work is draining and sometimes leads to feelings of despondency and depression. In a collection of essays written by nineteen mental health workers who had experienced major depression, Rippere and Williams (1985) noted that three quarters of

them were able to recover and return to work. Most resolved to carry more realistic expectations of what was within their capacity. According to Deutsch (1985), a low sense of self-efficacy often leaves many psychologists frustrated and full of self-doubt about their competence and effectiveness.

Deutsch (1985) makes the point that psychologist's irrational beliefs, such as "I must be totally competent and able to help everyone," add to their vulnerability to depression when expectations are not met. Sometimes, according to Freudenberger (1990), psychologists become so absorbed in their clients' welfare that they become distant from their own psychological well-being, producing negative effects on their own physical and mental health and ability to practice.

In the study conducted by Gilroy, Carroll and Murra (2001), many clinicians related examples of negative work consequences of their depression, including being unable to maintain their focus, memory problems, fatigue and lack of energy and motivation for therapeutic work.

Frustration with the work may also emerge due to the slow and erratic nature of psychotherapy (Bermak, 1977; Wood et al., 1985). Psychologists often become demoralized when they do not see major improvements in their clients (Millon, Million, & Antoni, 1986).

In addition, some theorists argue that client contact can result in psychopathology. For example, Jung (1966) described this process as 'unconscious infection.' Here the process of doing therapy can reactivate the psychologist's early memories and feelings, stirring up painful issues for the psychologist (Farber, 1985). Certain types of client's have been described as particularly depleting for therapists. According to one study, therapists who committed suicide had a significantly larger number of suicidal clients than the average therapist (Chiles, 1974).

Unlike physicians who can wear masks and gloves to protect against infection, the psychologist does not have easy access to protective 'devices.' He/she must be fully present to patients who are almost always in pain, often emotionally demanding, hostile, depressed, or otherwise dysfunctional (Chessick, 1978). Heath (1991), states that sometimes it is regarded as a therapeutic necessity to be caught in a patient's turbulence (p.69). This is an accepted notion amongst most psychologists, as it is felt that there is a need to empathically immerse oneself in a patient's internal and external world, in order to really understand their suffering.

According to Heath (1991), psychologists are exposed to a wide spectrum of depressed clients in the course of their work, and it is easy to introject some of the emotion unwittingly, and then experience depression without recognizing where it has come from. Denying that the patient is evoking feelings in oneself is, in itself, diagnostic. 'Manic defenses of triumph, control, derision of the patient, and omnipotence about the therapeutic work may be valuable diagnostic signs of what is happening in the patient' (p.95).

Farber's (1993) survey reports that psychologists' emotional depletion hinders their ability to be genuine, spontaneous, and comfortable with non-mental health professionals or friends. Inevitably, clinical work affects psychologists' interpersonal relationships. Many psychologists do not seem able to shut off the therapeutic stance, to function in a healthy way with other people, on an equal power, equal in vulnerability basis(Cray & Cray, 1977; Guy & Liaboe, 1985; Maeder, 1989).

In addition, the endless cycle of introducing oneself to new patients, conducting the intense work of psychotherapy, and finally, terminating the relationship, may also leave a psychic scar on the therapist (Bermak, 1977; Guy & Liaboe, 1985; Will, 1979). The repeated loss of

all contact with individuals with whom the psychologist has shared an intimate relationship, may create considerable feelings of sadness and abandonment. If this experience is generalized to their personal lives, the psychologist may become reluctant to engage in intimate relationships. This, in turn, may increase their sense of isolation and loneliness.

Depressed patients commonly communicate their depression to their psychologists through projective identification. Projective identification is defined by Klein (1952, cited in Heath, 1991), as a part of the self, or whole self which is projected into another person. The aim of this may be to get rid of unwanted feelings, to possess or control the other, to attack or to avoid separation. Furthermore, the psychologist is attentive, empathic, attuned, open and therefore more vulnerable to absorbing the patient's depressed feelings. In addition, sometimes personal life experiences of psychologists, such as marital problems, divorce, illness/death of a family member, legal problems, financial problems and mental illness, make them especially susceptible to the depressive symptoms created by particular patients (Heath, 1991).

Negative influences in therapeutic work include increased stresses when therapists' boundaries are permeable, feelings of isolation and aloneness (Freudenburger, 1986, cited in Thoreson, Miller & Krauskopf, 1988), and a defensive emphasis on intellectualization at the expense of emotion and spontaneity (Farber, 1985). Farber (1985) found that although overall private practice clinical psychologists are satisfied with their work, 2% - 6% feel greatly affected by work-induced stress. The prevalence of problem drinking in the sample fell within the range of 6% - 9%. These problem drinkers reported a high incidence of depression, anxiety and suicidal ideation (more than 70%) and actual suicide attempts (24%) at the peak of their drinking (Thoreson, Miller & Krauskopf, 1988). The data in this study suggest that when a psychologist reports a problem with his/her marriage or relationship, it is likely that in addition to feelings of loneliness and depression, problems

with alcohol use may be present. It was thought that within the sample was a small group of psychologists who were struggling with more serious issues such as depression or major anxiety (Thoreson, Miller & Krauskopf, 1988).

1.6.2 The positive impact of the therapeutic relationship

On a more positive note, the practice of psychotherapy can help to mitigate a psychologist's vulnerability to depression. Zur (2005), describes how the practice of psychotherapy can also promote a psychologist's sense of wellness and confidence in interpersonal functioning. Therapeutic practice is likely to sensitize psychologists to a wide range of human feelings and behaviours (Farber & Heifetz, 1981; Guy & Lieboe, 1985). Psychologists can become knowledgeable about their own unconscious motivations and drives, and this may subsequently promote their personal growth. Farber's survey (1983) concludes that the primary effects of therapeutic practice are increased psychological mindedness, self-awareness and a greater appreciation of human diversity. He also contends, that the majority of psychologists felt they had a deeper understanding of and tolerance for other people.

In the study conducted by Gilroy, Carroll and Murra (2001), at least half of the respondents reported that their experience of depression had had a positive impact. As a result of their personal struggles, women in this study described: a) 'enhanced empathy with depressed clients' b) 'more patience and tolerance when progress in therapy is slow,' c) 'a heightened appreciation for how difficult therapy can be' d) 'greater faith in the therapeutic process' (p.26).

In a survey conducted by Wood, Klein, Cross, Lammers, and Elliot (1985), 32.3% of respondents reported having experienced depression to the extent that it interfered with their work. According to Thoreson, Miller and Krauskopf (1989), the hazards and benefits of psychotherapeutic work have been well documented. On the positive

side, the studies suggest that psychologists experience an increase in self-awareness and self-assurance, and lower levels of job-related stresses and concerns when compared to academicians (Boice & Myers, 1987, as cited in Thoreson, Miller & Krauskopf,1988). Also, when psychologists are able to maintain personal boundaries they tend to be less affected by stressful client behaviour (Hellman et al, 1987 cited in Thoreson, Miller & Krauskopf, 1988).

Holt and Luborsky (1958) refer to the practise of therapy as initiating positive changes in a psychologist's sense of self, greater self-insight and the ability to form more mature social relationships. In Thoreson, Miller and Krauskopf's (1988) study, they described psychologists in their sample as reporting high levels of satisfaction with their profession and life situations. Women emerged as more dissatisfied with interpersonal and family relationships, and, in addition reported more depression. However, this may be due to the fact that traditionally girls and women are taught to disclose their difficulties with more clarity and more frequency.

According to Kottler (1993), those psychologists who make personal growth a major life priority will usually seek greater self-awareness and clarity by entering into their own treatment. However, according to Deutsch (1985), there is a marked reluctance of many psychologists to seek therapy for themselves. Just like so many clients, it seems as if asking for help is seen as a sign of weakness or failure. At present, the research done on help-seeking behaviours among psychologists in the United States of America has revealed a reluctance by psychologists to seek therapy. The idea persists among professionals that psychologists should have 'a high level of psychological wellness' (Norman & Rosvall, 1994, p.450). According to Kottler (1993), the psychologist's resistance to self-examination with the same critical, diagnostic eye that they would direct toward a client amounts to hypocrisy. He posits that if psychologists do not genuinely believe that the therapeutic tools of their profession can work on themselves, then they have no business

practising them on anyone else. The duel experience of being both therapist and patient is explored in the section which follows.

1.7 Psychologists seeking treatment

It is interesting to note that as Freud's understanding of countertransference increased over time, his growing respect for the complexity of the mental processes and the tendency for resistances to result in distortion within self-analysis resulted in a theoretical shift. According to Fussel and Bonney (1990), Freud reversed his earlier belief that self-analysis was sufficient, asserting instead that a training analysis must be conducted by another psychologist. This point of view has led one major organisation of psychologists to include personal psychotherapy as a prerequisite for membership (American Academy of Psychotherapists, 1986).

There appears to be a stigma within the profession against therapist self-disclosure, not only in relation to clients, with whom such a prohibition can often be justified, but also in relation to students and colleagues, with whom it usually cannot. Sherman (1996) makes the point that highly publicized cases of therapist misconduct often portray psychologists in an embarrassing light, which harms the field's reputation in the public eye. Podyrygula (1994, cited in Sherman,1996) takes a controversial stand by describing impairment as inevitable, in that all psychologists will be psychologically impaired at least once over the course of their careers.

The value of psychotherapy for the psychologist has long been exhorted (Freud, 1937, Fromm-Reichmann, 1950). For practitioners, psychotherapy is prescribed to alleviate the emotional stresses inherent in their work (English, 1976; Katz & Rosen, 1978), especially when countertransference problems compromise the psychologist's capacity to empathize. Furthermore, a psychologist's difficulties around overidentification with, or dependence upon patients for self-esteem regulation, can be successfully worked on in a personal treatment experience.

According to Pope and Tabachnick (1994), relatively little research information exists about the types of problems that may have prompted psychologists to seek therapy. As late as 1986, Millon, Millon and Antoni noted that "there is no systematic data specifying which variants of psychopathology are most prevalent among psychologists" (p.119). Norcross and Prochaska (1983) report that out of 750 members of the American Psychological Association, over 65% of clinical psychologists and over 80% of psychotherapists have experienced personal therapy sometime during their lives.

Guy, Stark and Poelstra (1988) in their survey conducted in the United States, found that only 18% of 318 practicing psychologists "never received any form of personal psychotherapy at any time" (p.475). One of the surprising findings of this survey was the degree to which participants reported suffering from unhappiness and depression. A majority (61%) reported that they had experienced at least one episode of what they would characterize as clinical depression. Over one out of four (29%) disclosed that they had felt suicidal and almost 4% reported having made at least one suicide attempt.

Deutsch (1985) found that a significant proportion of her sample of psychologists were hesitant to seek therapy because of professional complications, including difficulty in finding a therapist whom they did not already know from either a professional or personal context. The literature seems to indicate that there are fierce internal and external forces opposing the mature practising psychologist's return to therapy (McCarley, 1975). It is reported by Norman and Rosvall (1994) however, that women are significantly more likely to indicate a willingness to seek personal therapy than men.

Some important findings emerged from Guy, Stark and Poelstra's (1989) survey. Firstly, it is suggested that training programs may need to pay much more attention to clinical depression as a phenomenon that most psychologists are likely to experience at least once. Psychologists need the

assurance that such experiences (that is, experiencing clinical depression) does not imply that one must seek another career. More importantly, training programs should discuss how to fulfill the ethical responsibility of refraining from undertaking therapeutic activity when they know that their personal problems are likely to lead to harm.

A large majority (86%) of participants who had been in therapy found it helpful (Pope & Tabachnick, 1994). The most frequently mentioned benefit (26%) was not the accomplishment of a specific behavioural goal, but rather an increase in self-awareness or self-knowledge. Interestingly, the third most frequently mentioned benefit was that therapy improved participants' skills as psychologists, that is, "they learned what is was like to be a patient and what sorts of interventions seemed to be helpful or useless" (Pope & Tabachnick, 1994, p.256).

According to Sherman (1996), a variety of reasons for psychologists' under-utilization of therapy exist, including: 'lack of an available therapist, fear of exposure, financial limitations (Deutsch, 1985), a sense of invulnerability, and the therapist's tendency to equate personal problems with incompetence (Skorina, 1982). If psychologists choose to deny their difficulties and not seek therapeutic assistance, they are frequently able to hide their depression. In private practice, work is often unmonitored and depression is often only noticed after it has had a major indirect toll on many clients.

Guy, Poelstra and Stark (1989) undertook a study to examine the impact of personal distress on clinical competence and patient care. Although more than one third of respondents reported that their personal problems decreased the quality of the care they provided to their patients, it was those whose practice consisted primarily of individual psychotherapy patients where the decrease was particularly noted. This was thought to be the result of the intensity of individual therapy, which made psychologists' emotional impairment more noticeable.

An inevitable aspect of the treatment of psychologists is the process of examining their choice of professional career during their own treatment (Fleischer & Wissler, 1985). Compared to unconscious motivations, conscious motives for entering the profession are less of a risk to the therapeutic interaction because, by definition, they do not function outside of awareness. This would apply to psychologists' awareness of being depressed. According to Sherman (1996), psychologists' awareness of their own issues seems essential due to the potentially negative effects of impairment on care of clients.

The psychologist, because of the unique conditions of his/her work, is at times prevented by his/her own suffering from discerning a patient's situation correctly, and this may hinder treatment. One such hindrance, it is argued, could be the presence of a depressive episode. Another equally important hindrance could be a motivation of which the therapist is unaware for entering the profession. Fussel and Bonney (1990) make the point that if unresolved, "the painful aspects of the childhoods of psychotherapists could restrict the development of empathic skills in two ways: the first, by encouraging avoidance of the patient's psychic pain, and the second involves caretaking and identification or enmeshment with the patient" (p. 511).

The study conducted by Guy, Poelstra and Stark (1989), raised concerns about the possible reason why individuals tend to deny the impact of their distress on the treatment they provide. Older psychologists and psychologists reporting personal problems with substance abuse were most likely to deny that their distress resulted in inadequate patient care. It is also interesting to note that those who reported providing inadequate patient care tended to temporarily take a break and/or use self-help groups, without including more individually focused treatments. Whether any of these interventions were successful in restoring the impaired clinician to adequate levels of competency is unknown.

In the study done by Katsavdakis, Gabbard and Athey (2004), the three most commonly cited problems among health professionals (psychiatrists,

psychologists and social workers) were marital problems, suicidal ideation/behaviour and work problems, which included irresponsible behaviour. It was also found that health professionals who seek treatment are most often referred to treatment by a therapist rather than disciplinary agencies. They are also more likely to have difficulties centered around interpersonal, relational and emotional concerns than around substance abuse. This is consistent with previous research findings (Pope & Tabachnick, 1994; Sherman & Thelan, 1998), suggesting that relationship problems and depression-related symptoms, particularly suicidal ideation, were important factors leading to psychologists' distress.

It is clear that individual therapy treatment for psychologists assists in increasing self-awareness, self-esteem, improving therapeutic skills and providing a better understanding of relationships. This, as previously discussed, helps to reduce the negative impact of a psychologist's depression on his/her professional functioning. However, this is one aspect of responsible self-care. There are many other aspects which need to be incorporated in order to prevent and manage depression in psychologists.

1.8 Self-Care Practices

Psychologists tend to focus on others' problems and consistently fail to attend to their own needs. This neglect, according to Zur (1993), has led to an extremely high rate of alcoholism, depression and suicide among psychologists. Mahoney (1997) studied the personal problems and self-care patterns of psychologists. He found that less than half the sample of psychologists reported emotional exhaustion (often referred to as burnout), and one third reported anxious or depressive episodes over the previous year. In the realm of self-care:

> "half of the respondents reported practising meditation or prayer, and three out of four engaged in regular physical exercise. Pleasure reading, vacations, hobbies, and artistic pursuits were pursued by more than 80% of the sample. More than 40% reported doing volunteer work, and 1 out of 5 kept a personal diary. Personal therapy had been experienced by a large majority of these practitioners, and

> they generally rated it as a helpful or very helpful undertaking. Three out of four engaged in physical exercise and almost as many reported getting together with peers for feedback and support of their professional activities" (p.16).

Self-care is one method of preventing and treating a psychologist's depression. As such, according to Porter (1995), self-care is part of ethical practice. Knutsen (1977), makes the point that in psychological treatment, one's emotional state closely relates to one's efficacy. Effective therapy is possible only when one is emotionally stable, physically alert, and open to the awareness of one's own feelings as well as those of the client (Whitfield, 1980).

Self-care, is one method of attending to psychologists' personal needs in order to provide effective therapy. Porter (1995), makes the point that emotional unavailability may result from lack of therapist self-care, and may interfere with the empathic connection between therapist and client.

Faunce (1990) states that therapists are more likely to violate boundaries when they have not met their own needs. Poor therapist self-care is associated with a greater risk of ethical breaches due to increased personal vulnerability, reduced self-monitoring and poorer judgement (Keith-Spiegel & Koocher, 1985). Poor self-care can result in a range of boundary violations, from being overly friendly, to isolation, poor judgement, grandiosity, self-deception and an increased risk of getting one's needs met through the therapeutic relationship, including sexual exploitation (Porter, 1995).

Many psychologists do take a variety of steps to avoid professional impairment related to depression. Guy et al. (1989) found that 70% of the clinicians acknowledging their distress took some form of corrective action in response. Interventions reported included: individual psychotherapy, marital or family therapy, reduction of case loads, taking a leave of absence from work, attendance of self-help groups, and the use of medication and hospitalization.

Emerging consistently from the literature reviewed on psychologists' personal experiences of depression is the belief that prevention lies in establishing a professional ethos in which self-care is viewed as a moral imperative (Carrol, Gilroy & Murra, 1999).

It is interesting to note that the Professional Board for psychology in South Africa's (Health Professions Council of South Africa) – Ethical Code of Professional Conduct does not mandate basic self-care practices such as personal therapy and supervision. The inclusion of self-care issues by the Feminist Therapy Code of Ethics, exemplifies the proactive, educational and preventative ethical approach feminist therapists have advocated (Rave & Larsen, 1995). It is the only code of ethics that specifically focuses on self-care as it relates to the well being of the therapist. In this way, self-care is not just a method of preventing work impairment, but is a way to improve the overall therapeutic environment (Wityk, 2002).

Although the curricula in professional psychology programmes in South Africa may mandate courses in ethical and professional issues, there appears to be a need for self-care education regarding the risk factors such as burnout, compassion fatigue, depression and professional impairment. Also, there appears to be a need for an increased focus on a psychology student's unconscious motives for selecting the profession of psychology during training. As more and more psychologists acknowledge the mutual-influence process of therapy, it is anticipated that psychologists may begin to feel less vulnerable about disclosing or seeking help for mental health problems such as depression. In the section that follows, the importance of a psychologist's conscious awareness and acknowledgement of his/her vulnerability to mental health problems - the wound of depression in particular - is explored.

1.9 The psychologist as "Wounded Healer"

Very often the psychologist is seen as immune from that which he or she heals. Indeed, many patients trust the ability of the clinician to heal only to

the extent that he or she is immune. According to Remen, May, Young and Berland (1985), in older healing practices such as shamanism, woundedness is seen not as evidence of vulnerability, but as the mark of knowledge. As described by Halifax (1982, cited in Gilhar, p.84, 2004), "the wound validates the healer's ability to move between the worlds – that is, the world of the well and the world of the ill, for it is in the bridging of these worlds that the healing power lies." It is the woundedness of the healer which enables him or her to understand the patient, and which informs the wise and healing action. We cannot heal it seems, unless we acknowledge our woundedness.

According to Grosch and Olsen (1994), psychologists can be affirmed by doing therapeutic work, but only when that work is a mature expression of themselves rather than an attempt to prop up a needy and insecure self. This affirmation or fulfillment is a form of self-transcendence, a reaching beyond the self. By leaving behind a positive legacy from their pain, psychologists are able to find meaning in their struggle by sharing their insight with others.

Greenson (1962) contends that the urge to understand a patient originates in the desire to get inside another human being. According to Sussman (1992, p. 143), 'analysts empathy enables them to re-establish contact with a lost love object, the patient they have yet to understand.' It may be in part an attempt at restitution for the loss of contact with a significant person. This loss of contact may have left an emotional wound. This seems to be borne out by Greenson (1967) who stated that, in his experience, 'the best empathizers seem to be those analysts who have a tendency to depressions (p. 383).

Kottler (1993), succinctly describes the experience of facing ones woundedness in the immediacy of the therapeutic relationship… 'It is important to remember that whenever we enter a room with another life in great torment, we will find no escape from our own despair. And we will find no way to hold down the elation we feel as a witness to another person's transformation – just as we are the catalyst for our own' (p.255).

True healers, according to Knight, by virtue of coping with their own suffering, and remaining fully aware of their own vulnerabilities, become 'pilgrims with others on the path to healing' (1986, cited in Grosch & Olsen, 1994, p.45). There is much evidence in the literature to support the belief that healing comes through the wounded life. However, it is important to reiterate the point that accepting oneself as a wounded healer is not enough to help others heal. It is as practitioners learn to integrate the more vulnerable parts of themselves, and actively manage their woundedness, that they become much less likely to hold onto elaborate and grandiose defenses.

Finally, it seems clear that a psychologist's vulnerability to depression is a bridge to his/her client's emotional vulnerability, and the basis of his/her sensitivity, compassion and responsiveness to the suffering of others. It is also, at the same time, potentially, a wound which is activated by painful stress and self-doubt. A personal experience of depression is one of many wounds that seem to deepen a therapist's understanding of the human condition.

By working with and using a deeply subjective understanding of our ourselves, we have the most potent human instrument available for understanding and responding to the hurt and suffering of our fellow beings. However, psychologists must guard against denying their vulnerability. For as Goldberg (1986) has articulated it, "no matter how intelligent, well-trained, experienced, caring and well-meaning we are as professionals, we are, at the same time, merely human, host to the same fears, depressions, ambitions and temptations of those we treat. We can be no more than that and no less, if we are to meaningfully treat those who petition us with their suffering" (p.34).

Summary

The above literature review attempts to alert the reader to the hazards inherent to the practice of psychotherapy, particularly if one selects a psychodynamic or interpersonal theoretical approach. These approaches

appear to demand an openness to the patient's unconscious conflicts and an immersion in the patient's feeling world. Psychologists are seen to have a profound vulnerability to depression, it is thought, because of the stress inherent in the profession, and the perception that if a psychologist seeks psychological help, they may not be fit to practice.

Rates of depression in the general population versus rates of depression amongst psychologists were presented. The importance of the study of depression among psychologists is outlined for such reasons as the potential harm it can do to the profession's reputation in the public eye if it is not addressed. Definitions of depression were considered, especially in terms of severity, and possible precipitants. Depression was further defined for the purposes of this study as an expression of distress and/or impairment.

An in-depth discussion of factors implicated in the aetiology of depression in psychologists was presented, with emphasis on the contribution made by life crises, work stress and a psychologist's individual predisposition to depression. Being a woman and a psychologist appears to increase an individual's risk for depression, and the possible reasons for this were presented. Many studies investigating the different aspects contributing to a psychologist's vulnerability to depression were introduced. It appears that the seeds of depression may be found in the unconscious motivations for selecting psychology as a profession. Unconscious motivations for entering the profession are argued to be most often embedded in painful experiences in the psychologist's family of origin.

The literature review includes an examination of the unique contribution made to a psychologist's vulnerability to depression by the working context of private practice. This unique contribution covers, among many others, factors such as sitting immobile in one place all day, the financial uncertainty of running a private practice and the impact of working in isolation. In addition to the aforementioned stressors, the uniquely difficult aspects inherent to the therapeutic relationship, such as countertransference, transference, the one-sided nature of the relationship, the psychologist's empathic immersion in a

patient's pain, and the eventual termination of the therapeutic relationship were discussed. These difficult aspects of the therapeutic relationship are balanced by the positive, mitigating factors, which appear to act as a buffer against depression.

Psychologists' willingness to seek treatment for depression is proposed as an ethical responsibility, and the impact of a psychologist's personal distress on clinical competence is considered. Self-care practices are proposed as a way of both preventing and treating depression in psychologists. The consequences of neglecting self-care practices are discussed, and the South African Health Professions Council Code of Ethical Conduct is criticized for not mandating personal therapy or supervision for all practitioners. It is suggested that greater self-care will protect psychologists from depression, and as the mutual influence process of therapy is acknowledged, psychologists may begin to feel less vulnerable about disclosing their personal struggle with depression and more comfortable seeking help.

The conscious awareness, integration and active management of the wound of depression are proposed as important safeguards for effective therapy. A personal experience of depression is suggested as one of the many wounds that has the potential to deepen a psychologist's understanding of the human condition, and inform effective healing action.

In essence, depression in psychologists is thought to be both a risk to therapeutic effectiveness, especially if it is untreated and unacknowledged, and a potential bridge to understanding the suffering of others.