

**THE PROFESSIONAL ATTITUDE OF PSYCHOLOGISTS TOWARDS THE
DEPRESSION OF PSYCHOLOGISTS**

Dianne Lawrence

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Department of Psychology

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DECLARATION

I, Dianne Lawrence, declare that the Doctorate of Psychology (Clinical Psychology) thesis entitled The Professional Attitude of Psychologists Towards the Depression of Psychologists is no more than 40,000* words in length, exclusive of tables, figures, appendices, references, and footnotes. This thesis contains no material that has been submitted previously, in whole or in part, for the award of any other academic degree or diploma. Except where otherwise indicated, this thesis is my own work.

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* While this thesis does go over the word limit, this declaration was enacted in November 2004, at which time this thesis was largely completed. It is also noted that the nature of this thesis, as a qualitative work, entails the incorporation of a large number of quotations from participants. In comparison to other forms of analysis, data is included in the text rather than being tabulated, and has artificially inflated the word count in the final chapters.

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ABSTRACT

The current thesis investigated the professional attitude of Psychologists towards the depression of Psychologists by conducting two phases of interviews with 14 Psychologists, designed and analysed according to the protocol of grounded theory. The aims of the current investigation were to gain an increased understanding of the experience and opinions of this cohort, and to develop theory based upon this information. Additional aims were to provide data that may inform further discussion, and thereby, to partly redress the gaps within the available literature about the depression of Psychologists. In the first phase of the current thesis, Psychologists who had themselves experienced depression were asked what they, as Psychologists, considered to be the important issues about their experience of depression. In the second phase, Psychologists who themselves had not experienced depression, were asked what they, as Psychologists, considered to be the important issues about the depression of those who were also Psychologists. Analysis of the data from both sets of interviews found four primary areas. These were firstly, the struggle or difficulties experienced by the depressed Psychologist, secondly, the attempts of the depressed Psychologist and his or her colleagues to make sense, or bring meaning to the experience, thirdly sensitivity, or the product of the experience of depression upon the personal and professional spheres of practice of an individual, and finally engagement, or responses towards the depression of Psychologists. It was hypothesised that an understanding of the experience of depression is a difficult struggle of which the depressed Psychologist seeks to make sense to effect personal and professional progress, and secondly, that the depression of Psychologist

colleagues demands a collegial response. As a result of these findings, recommendations were made in the areas of collegial and organization support for depressed Psychologists, as well as the need for increased measures of workplace advocacy. Specifically, it was recommended that efforts are made within the profession as a whole, as well as within professional organizations, workplaces, and training programs that are specific to Psychologists, that a supportive and preventative approach towards the depression of Psychologists be followed, which, rather than regulatory, is adaptive and flexible in philosophy, approach, and solutions, and does not enforce a particular viewpoint. It was also recommended that these resources be overseen, reviewed, and publicised, and that services should be highly respectful of privacy and confidentiality, as the decision as to whether or not to disclose having had depression is a personal one that is congruent with the philosophical constructs of each individual.

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INTRODUCTION

The high prevalence of depression has led to it being described as a National Health Priority Area by the Commonwealth and State Governments of Australia (Andrews, Hall, Teeson, & Henderson, 1999; Australian Institute of Health and Welfare, 2004; Commonwealth Department of Health and Aged Care, 1998, 2000; Hickie, 2000; The National Mental Health Plan Steering Committee, 2003). This is in keeping with international trends identified by bodies such as the World Health Organization (WHO), which has estimated that it will become the second largest contributor to the global burden of disease by 2020, an unwelcome increase upon its position as the fourth most significant disease burden in 1990 (WHO, 2000b, 2005). Although its devastating effects both on individuals and society are well documented (American Psychiatric Association [APS], 2000; Andrews, et al.; Hu, 2004; Tylee, Gastpar, Lepine, & Mendlewicz, 1999a, 1999b), and initiatives have been mobilised to research, intervene, and promote the awareness of depression (beyondblue, 2002, 2004, 2005; Dowrick et al., 1998; Paykel, Hart, & Priest, 1998), under-investigated areas still remain.

One sphere that has been neglected is the depression of Psychologists (Deary, Aguis, & Sadler, 1996; Siebert, 2001), despite the likelihood that this cohort will succumb to the condition with as much frequency as the general population (Collins & Parry-Jones, 2000; Cushway & Tyler, 1996; Farber, 1990; Miller, 1998; Reamer, 1992). As a result, there is an impoverished understanding about the way in which depression is experienced and perceived, and the issues that are of importance to this group can only be speculated upon. This thesis seeks to partly redress the imbalance, by developing theory about the professional attitude of Psychologists towards the

depression of Psychologists, and by providing data that may inform further discussion.

As the depression of Psychologists was not well serviced by research, inquiry for the current thesis was undertaken into additional areas so that suppositions about this cohort could be made. These areas included investigation into issues related to depression in general, as well as the ways in which the depression of other professionals who work in the mental health area have been addressed. This information is presented in chapters 1 to 4. Chapter 1 is concerned with the epistemology and epidemiology of depression; the condition is defined, its prevalence detailed within the general population as well as amongst mental health professionals, and ways in which this information can be categorised are described. In addition, issues to do with conceptual frameworks, and data comparison are critically discussed. In chapter 2, the aetiology of depression is discussed, and in chapter 3, the impact and outcome of being depressed are considered, with particular attention given to the physiological, psychological, sociological, and professional consequences of being depressed, as well as the issue of stigma. The possibility that there may positive outcomes to the experience of depression is also considered. Chapter 4 discusses the way in which depression has been addressed through government policy, by professional organizations, and by individuals who have experienced depression and have made considered decisions to publicly declare and/or describe that experience. These chapters are followed by a discussion of the methodology used, and of the results obtained from the current research.

CHAPTER ONE

EPISTEMOLOGY AND EPIDEMIOLOGY OF DEPRESSION

This chapter shall describe the current understanding of depression, as defined by the primary diagnostic manuals commonly in use. Statistics that indicate the general prevalence of depression, as well as its prevalence amongst mental health professionals in general, and Psychologists specifically, are presented in order to understand the context of the depression of Psychologists. The ways in which the data can be usefully organised are described, and this is followed by a critical discussion about the available data, as well as the conceptual frameworks that serve to make sense of the information about depression.

1.1 Definition of Depression

An understanding of depression can be obtained by reference to the two major diagnostic manuals available: the APS's Diagnostic and Statistical Manual of Mental Disorders, fourth edition with text revision (also known as the DSM-IV-TR), and the WHO's International Statistical Classification of Mental and Behavioural Disorders, tenth edition (the ICD-10) (APS, 2000; WHO, 1993).

In each of these manuals, as can be seen in Tables 1 and 2, depression is understood to refer a collection of somatic, cognitive, and emotional symptoms that present during the same two week period, and which cause clinically significant functional impairment (APS, 2000; WHO, 1993). The DSM-IV-TR classifies depression as having two core symptoms, namely, depressed mood and anhedonia, as well as additional symptoms that may include: increased or decreased changes in appetite, weight, sleeping pattern, and/or, psychomotor activity; feelings of

worthlessness or guilt; difficulty with concentration or decision making; suicidal ideation; and decreased energy. The ICD-10 also lists decreased energy as a third core symptom, and includes loss of confidence in the list of additional symptoms. In

Table 1

DSM-IV-TR Criteria for Major Depressive Episode

-
- A. Five (or more) of the following symptoms have been present during the same two-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.
- Note:** Do not include symptoms that are clearly due to a general medical condition or mood-congruent delusions or hallucinations.
- (1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.
 - (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by subjective account or observation made by others)
 - (3) significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite in nearly every day. **Note:** In children, consider failure to make expected weight gains.
 - (4) insomnia or hypersomnia nearly every day
 - (5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)
 - (6) fatigue or loss of energy nearly every day
 - (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach about being sick)
 - (8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)
 - (9) recurrent thoughts of death (not just fear of dying), recurrent suicide ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide
- B. The symptoms do not meet criteria for a Mixed Episode.
- C. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- D. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
- E. The symptoms are not better accounted for by Bereavement, i. e., after the loss of a loved one, the symptoms persist for longer than two months or are characterised by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.

The DSM-IV-TR describes additional depressive conditions, including Major Depressive Disorder and Dysthymic Disorder (APA, pp. 367-381).

From: DSM-IV-TR (APA, 2000, p. 356).

Table 2

*ICD-10 Criteria for Depression***F32 Depressive episode**

- G1. The depressive episode should last for at least two weeks.
- G2. There have been no hypomanic or manic symptoms sufficient to meet the criteria for hypomanic or manic episode at any time in the individual's life.
- G3. *Most commonly used exclusion clause.* The episode is not attributable to psychoactive substance use or to any organic mental disorder.

Somatic syndrome

Some depressive symptoms are widely regarded as having special clinical significance and are here called "somatic". In *The ICD-10*, the presence or absence of somatic syndrome is not specified for severe depressive episode, since it is presumed to be present in most cases. To qualify for the somatic syndrome, *four*, of the following symptoms should be present:

- (1) marked loss of interest or pleasure in activities that are normally pleasurable;
- (2) lack of emotional reactions to events or activities that normally produce an emotional response;
- (3) waking in the morning two or more hours before the usual time;
- (4) depression worse in the morning;
- (5) objective evidence of marked psychomotor retardation or agitation (remarked on or reported by other people);
- (6) marked loss of appetite;
- (7) weight loss (5% or more of body weight in the past month);
- (8) marked loss of libido.

F32.0 Mild depressive episode

- A. The general criteria for depressive episode (F32) must be met.
- B. At least two of the following three symptoms must be present:
 - (1) depressed mood to a degree that is definitely abnormal for the individual, present for most of the day and almost every day, largely uninfluenced by circumstance, and sustained for at least two weeks;
 - (2) loss of interest or pleasure in activities that are normally pleasurable;
 - (3) decreased energy or increased fatigability.
- C. An additional symptoms or symptoms from the following list should be present, to give a total of at least *four*:
 - (1) loss of confidence or self-esteem;
 - (2) unreasonable feelings of self-reproach or excessive and inappropriate guilt;
 - (3) recurrent thoughts of death or suicide, or any suicidal behaviour;
 - (4) complaints or evidence of diminished ability to think or concentrate, such as indecisiveness or vacillation;
 - (5) change in psychomotor activity, with agitation or retardation (either subjective or objective);
 - (6) sleep disturbance of any type;
 - (7) change in appetite (decrease or increase) with corresponding weight change.

The ICD-10 describes additional depressive conditions, including Moderate and Severe depressive episodes which are described in summary:

Moderate depressive episode:

General conditions for depressive episode, with at least two of the symptoms in criteria B, and additional symptoms from criteria C to a total of at least six symptoms.

Severe depressive episode:

General conditions for depressive episode, all three of the symptoms in criteria B, and additional symptoms from criteria C to a total of at least eight symptoms.

addition, it describes the “Somatic Syndrome”, a cluster of symptoms with which the sufferer may or may not present. Described in brief, these symptoms may be worse in the morning, and may include anhedonia; atypical lack of emotional reactions; psychomotor retardation or agitation; loss of appetite, weight, and/or libido; and early waking.

Both diagnostic manuals report that depression may be associated with other conditions, describe depressive conditions with variations of the symptomatology listed earlier, and further refine their classification of depression according to symptom severity, recurrence, and duration (APS, 2000; WHO, 1993). The current definitions of depression displace terminology that was formerly used to classify depression, but to which some researchers continue to refer (Silverstein, 2002). This includes factors that identify causation as a way in which to classify depression, such as the terms “reactive” or “exogenous” depression, where depression is understood to arise as a consequence of an event or experience, and “endogenous” depression, where no such event or experience is understood to exist (Colman, 2001; WHO, 1978).

1.2 Prevalence of Depression

Depression is recognised as a major cause of disability within the national and global community, and is variously estimated to currently affect from 121 to 340 million sufferers worldwide (Commonwealth Department of Health and Aged Care, 1998, 2000; Neighbour, 2000; WHO, 2004b, 2005). Data about the incidence of depression in Australia has been primarily sourced from Commonwealth Government organizations, with further interpretation and comparison of the information undertaken by other research groups (Andrews, et al., 1999; Australian Institute of

Health and Welfare, 2004; Commonwealth Department of Health and Aged Care, 1998, 2000). It is reported that about 6% of individuals will experience a depressive disorder in Australia, and that at any one time about 12% to 15% of Australian adults experience a significant measure of depressive symptomatology (Andrews et al.; Commonwealth Department of Health and Aged Care, 2000; Hickie et al., 2001b).

Information about the global prevalence of depression has been provided by organizations such as the WHO, as well as initiatives that include DEPRES I and II (Depression Research in European Society), the “European Union Initiative Into Depression”, and ODIN (the Outcomes of Depression International Network) (Dowrick et al., 1998; Gater et al., 1998; Prince et al., 1999a, 1999b; Tylee et al., 1999a, 1999b). Indicators of the incidence of depression vary between studies and population groups. Weissman and colleagues (1999) presented lifetime rates that varied from 1.5% in Taiwan to 19% in Beirut. American research indicated that the general population of that country had a 20% lifetime risk for the development of major depression or dysthymia (Preboth, 2000), and Dowrick and colleagues reported that depression affected 4.6% to 8.8% of the population in Europe at any one time. In keeping with the findings of the previously mentioned study of Weissman and colleagues, Chiu (2004) indicated that the incidence of depression in Asia was lower than in Europe, but ceded that the available data was of variable quality, with regards to recency and statistical standardisation. It was reported that Major Depressive Disorder (defined according to ICD-10 categorisation) was identified in 5.5% of the population of Singapore in one study, and at levels of 7.3% in another (Chiu; Fones, Kua, Ng, & Ko, 1998). The one-year prevalence rate for depression in China was reported to be from 1.7 to 2.5% (Chiu).

Statistics indicate that there is an almost consistently greater number of females effected by depression, a fact that is claimed to be “one of the most robust findings in psychiatric epidemiology” (APS, 2000; Astbury, 2001, p. 77; Cushway & Tyler, 1996; Gilroy, Carroll, & Murra, 2001; Whitney, Kusnir, & Dixie, 2002). In their study drawn from information provided by 15 centres across Europe and Asia, Gater and colleagues (1998) reported that of the worldwide percentage of people experiencing a current depressive episode, 12% were females, and 7.1% were males. The absence of a sex-by-centre effect was reported to discount local psychosocial effects that varied from one society to another; consequently, the results were claimed to be compatible with factors that had a similar final effect across cultures (Gater et al.). An inspection of the figures provided by these researchers indicated that the percentage rate for females varied from a high of 36.8% (in Santiago, Chile) to a low of 2.8% (in Nagasaki, Japan), compared with a male incidence rate that varied from 13.9% (in Manchester, England) to 2.3% (in Nagasaki, Japan). In a 12-month period in Australia, depressive disorders were reported to impact upon 7.4% of females, and 4.2% of males (Andrews et al., 1999; Chiu, 2004), and in the United Kingdom, depression was reported to affect 5.9% of females, and 4.2% of males at any one time (Ohayon, Priest, Guilleminault, & Caulet, 1999).

In addition to information about the occurrence of depression, the literature has also reported on the incidence of suicide, which may be a tragic consequence of depression (Graham et al., 2000; Rihmer, 2001). Jamison (2000) reports that there are complex contributory factors, including depression, that can “shatter” an individual’s capacity to manage; nevertheless, the “real reasons for suicide remain fugitive” (Jamison, p. 96). In 1998, suicide was ranked as the second cause of worldwide deaths for females aged between 15 to 44 years of age, and ranked fourth for males in the

same age group (Jamison). The Australian statistics for suicide indicate that within the classification of injury-related deaths in that country, suicide accounted for the largest proportion of deaths in 2002, with 2,320, or 29.7% of cases in that category (Australian Institute of Health and Welfare, 2004). Information was not available about the role of depression in these figures, but the same publication reported that mental or behavioural disorders accounted for 3,172 deaths in 2002.

1.3 The Depression of Mental Health Professionals

As well as reporting the occurrence of depression amongst the general population, the available literature has also provided a measure of information about its incidence amongst mental health professionals. In this section, data specifically concerning the overtly and covertly described occurrence of Psychologists' depression is tabulated and discussed, and comparison made to the occurrence of depression amongst other professionals who may also work in the area of mental health, such as Social Workers, Psychiatrists, and General Practitioners (GPs). Finally, areas that are suspected to contribute, and be subsequent, to the depression of Psychologists, are tabulated.

There has been limited research into the depression of Psychologists, as can be seen in the summary presented in Table 3. Additional research has also been conducted into the experience of other conditions such as burnout, stress, distress, and impairment, by Psychologists, and these findings are summarised in Table 4. It is understood that these latter conditions may be comorbid or concurrent with depression, and in some cases may utilise descriptive terms that allude to a state of depression without describing it as such.

In response to a questionnaire which had a 31% response rate, Gilroy and colleagues (2001) found that 76% of female Psychologists reported experiencing some sort of depressive illness subsequent to their commencement of clinical practice. In another American study, 84% of the Psychologists who responded to an anonymous questionnaire, stated that they had received therapy in the past, and of this number, 61% claimed to have been clinically depressed (Pope, & Tabachnick, 1994). Cushway and Tyler (1996) used the General Health Questionnaire (GHQ-28) to assess

Table 3

Research Investigating the Depression of Psychologists

Researchers	Group investigated	Research question	Research method	Data
Gilroy, Carroll, & Murra (2002)	Psychologists (Counselling Psychologists)	Experience and treatment of depression.	Preliminary survey. Self-report: voluntary pen and paper survey.	62% of respondents identified themselves as depressed. Impact of depression on clinical work: - Positive (empathy, more effective), - Negative (eg. reduced energy), - Neutral (eg. more willing to suggest medication).
Gilroy, Carroll, & Murra (2001)	Psychotherapists (female Psychologists)	Does depression affect clinical practice?	Self report: voluntary pen and paper questionnaire.	76% of respondents reported experiencing depression since beginning clinical practice. Impact of depression on clinical work: - Positive – 83% (eg. increased empathy, accuracy of assessment and diagnosis, sensitivity, compassion, insight, knowledge, patience) - Negative – 69% (eg. reduced energy, confidence), - No impact – 15% (eg. more willing to suggest medication), - More receptive to medication – 11%. Impact on collegial relationships (times mentioned): - No impact (45) - Improved (29) - Reduced (26), judged (16) - Isolated (37), reduced contact (26).
Pope & Tabachnick (1994)	Psychologists	Experience of therapy.	Self report: voluntary pen and paper survey	61% of 84% respondents who reported as having been in therapy had clinical depression

Table 4

Research Investigating Conditions of Psychologists That may Include Depression

Researchers	Group investigated	Condition	Investigation	Data
Miller (1998)	Psychotherapists	Burnout (including stress, trauma, and vicarious trauma).	---	Reduce risks through: - security, support, protocols. Assistance: - "decompression", organisational support, therapy, debriefing.
Sherman & Thelen (1998)	Psychologists	Distress and Professional Impairment.	Mail survey concerning work factors and life events.	Distress can impair professional function. Risk factors: - personal relationship problems, major personal illness/ injury, difficult clients. Protective factors: - non-work related activities, holidays.
Cushway & Tyler (1996)	Psychologists	Stress.	---	"Caseness" levels: - 29.4% (1994); 40% of Psychologists. Risk factors: - low job satisfaction and experience, few coping strategies, avoidance, internalised stressors, relationship problems, and being female.
Good, Thoreson, & Shaughnessy (1995)	Counselling Psychologists	Substance use and impairment.	Division 17 Health Practices Survey (including information to do with substance use, satisfaction with life, and work related strain).	A general disinclination to confront impaired colleagues. Current substance use was low-modest.
Farber (1990)	Psychotherapists (Psychologists)	Burnout.	---	2-6% of Psychotherapists are burnt out. Protective factor: - job satisfaction Risk factors: - inexperience, being institutionally based
Guy, Poelstra, & Stark (1989)	Psychologists	Personal Distress.	Psychotherapist Information Survey.	74.3% reported experiencing personal distress during the previous three years.
Raquepaw & Miller (1989)	Psychotherapists (Psychologists & Social Workers)	Burnout.	MBI and questionnaire.	An individual's <i>perception</i> of his/her workload was predictive of burnout.
Ackerley, Burnell, Holder, & Kurdek (1988)	Psychologists	Burnout.	Maslach Burnout Inventory (MBI), Psychologist's Burnout Inventory	39.9% experienced high levels of emotional exhaustion. 34.3% experiencing high levels of depersonalisation.

the status of British Clinical Psychologists. Even though the study's focus was upon the experience of stress, it was of interest to note that high levels of significant clinical disturbance were reported, and that the figure of 40% of effected participants was similar to the levels found amongst mental health Nurses. An earlier study by Farber (1990) indicated that 2% to 6% of Psychotherapists were burned out. The term Psychotherapist was understood by the reader to refer to Psychologists, and being burned out was operationalised as being exhausted, emotionally and/or physically depleted, professionally inattentive, irritable, disillusioned, and experiencing a loss of belief in one's effectiveness (Farber).

In addition to these figures on depression and related conditions, Ukens (1995) reported that male Psychologists had the highest suicide rates of any other profession in the United States of America. The reasons for this distressing statistic can be only speculated upon, and it is assumed that depression was a contributing factor.

In general, it has been found that people who work in the so-called caring professions are more at risk of stress than those who worked in product-orientated professions (Collins & Parry-Jones, 2000). Firth-Cozens (2003) reported levels of around 28% of stress within the health care professions, and compared this with stress levels of around 18% that are found within the general population. Similar to the situation for Psychologists, there appears to be limited research into the depression of Social Workers (Reamer, 1992). An unpublished PhD thesis reported levels of 22% for current depression, and 60% for lifetime rates amongst this cohort (Siebert, 2001). Elsewhere, Deary and colleagues (1996) stated that Psychiatrists had higher levels of work related emotional exhaustion and severe depression than Physicians and Surgeons. Possible stressors for this group were described as including exposure to client suicide and violence (factors which are elsewhere described as also being

associated with the practice of Psychology), as well as the reportedly stigmatised status of Psychiatry within the medical profession (Deary et al.; Guy, Brown, & Poelstra, 1990, 1992; Royal College of Psychiatrists, 2001b; Swearington, 1990).

The depression of GPs has been subject to ongoing investigation, and has been recognised as a potentially serious matter (Riley, 2004; Willcock, Daly, Tennant, & Allard, 2004). British GPs were found to be more depressed than other white-collar workers, with 38% scoring equal to, or above, the threshold for potential clinical depression (O'Conner, O'Conner, White, & Bundred, 2000). Rout (1999a, 1999b) found similar results for male, but not female, GPs. In the United States, 19.5% of female GPs were found to have a history of depression, a figure that was considered to be within general population norms (Frank & Dingle, 1999; Sonneck & Wagner, 1996). Stanton and Caan (2003) found that the most common reason for the early retirement for GPs was psychiatric, inclusive of depression. The general dissatisfaction of GPs with their profession was a repeated theme in the literature, and was attributed to factors that included work structure and characteristics, high levels of patient expectations, and a general lack of team support (Edwards, Kornacki, & Silverstein, 2002; Stanton, & Caan; Wall et al., 1997).

In addition to providing, and inferring, information about the incidence of depression amongst Psychologists, the available literature has also suggested areas that may specifically contribute to the depression of Psychologists. This information is summarised in Table 5. The areas that were suggested to potentiate the occurrence of depression in this cohort include the reasons for entering the profession of Psychology, possible character traits, workplace issues, and client stressors. This information informed areas of research interest, and is further discussed in the following chapters.

Table 5

Factors That may Contribute to the Depression of Psychologists

Area	General comment	Researcher/s
Factors contributing to depression/ Motivation for entering Psychology.	30% of Psychologists have a history of childhood physical or sexual abuse.	Pope and Feldman-Summers (1992).
Factors contributing to depression/ Motivation for entering Psychology.	69% of female mental health professionals have reported experiencing childhood trauma.	Elliot and Guy (1993).
Factors contributing to depression/ Motivation for entering Psychology.	Traumatic experiences, parental alcoholism, and taking on the role of a parent, correlate with a desire to enter the helping professions out of identification with the client, and the need to master adversity and/or heal one's self.	Elliot and Guy (1993), O'Conner (2001), Pope and Feldman-Summers (1992).
Factors contributing to depression/ Motivation for entering Psychology.	Therapists with a childhood history of abuse use increased levels of rescuing statements in response to disturbed clients. This history may adversely influence the capacity to be resilient.	Gustinella (1995).
Motivation for entering Psychology.	Therapists are trying to heal themselves, and compulsively give to others what they would like for themselves.	Bowlby (1977), Malan (1994).
Character traits.	A substantial proportion of Psychotherapists are characterologically depressive.	McWilliams (1994).
Profile of impaired health professionals.	The most common problems that precede intervention are marital and emotional difficulties.	Kartsavdakis, Gabbard, and Athey (2004).
Workplace and client stressors.	Psychology is an inherently stressful and emotionally demanding activity.	Cushway and Tyler (1996), Guy (2000), Guy and colleagues (1990, 1992).
Workplace and client stressors.	Workplace stressors are a workplace responsibility.	Collins and Parry-Jones (2000), Firth-Cozens (2003).

Finally, the available literature has indicated areas that are specifically related to the consequence of being a depressed Psychologist, and this information is summarised in Table 6. The areas encompass stigma avoidance, issues to do with disclosure, stigma from colleagues, reluctance to seek assistance, suicide, the response

of professional bodies, and ethical considerations. This information informed areas of research interest, and is expanded upon in the following chapters.

Table 6

Research Concerning Factors That may be Subsequent to the Depression of Psychologists

Area	General comment	Researcher/s
Stigma avoidance.	Less specific terminology may be being used to describe or infer the depression of Psychologists.	Farber (1990), Miller (1998), Sonneck and Wagner (1996).
Disclosure.	There is a "conspiracy of silence" about disclosing having been depressed.	Rogers and colleagues (2001).
Collegial stigma.	Psychologists who overcome difficulties such as childhood trauma feel they have been more successful than similarly afflicted colleagues.	O'Conner (2001).
Collegial stigma/ Disclosure.	Some depressed Psychologists may be reluctant to disclose matters to their colleagues due to concerns about potential stigmatisation.	Gilroy and colleagues (2001), Hutchinson and Bhugra (2000), Siebert (2001), Stromwall (2002).
Collegial stigma/ Intervention reluctance.	Some depressed Psychologists may avoid seeking treatment due to apprehension about being labelled as having a mental disorder.	Williams and Healy (2000).
Suicide.	There are high levels of suicide amongst male Psychologists.	Ukens (1995).
Association assistance for Psychologists.	In comparison to other groups, there has been a belated response to assist members within the profession of Psychology.	Barnett and Hillard (2001), Good, Thoreson and Shaughnessy (1995), Laloties and Grayson (1985).
Ethical considerations.	Expectations for Psychologist's professional standards and the protection of the public, described in the Psychologists Registration Act.	Victoria Government (2000).

1.4 Organization of Data

Researchers have organized the data that describes the incidence of depression in order to inform further research. In 1992, the World Bank instigated a project that used the available data about disabling sequelae, disability attributes, and mortality, so

as to estimate the global burden of disease (Andrews & Mathers, n.d.). This was evident of a shift of emphasis from rates of mortality to disability to provide information about health, that was motivated in part by a need to prioritise the use of finite health care resources (Homedes, 1995; Mathers, Vos, Stevenson, & Begg, 2000). As a result, information was obtained that enabled intervention effectiveness and efficiency to be measured and compared; responses to be formulated according to the effectiveness of health interventions, rather than the influence of traditions, individual idiosyncrasies, or pressure groups; and priorities for research, investment, and training made (Andrews & Mathers; Homedes; Mathers et al.). Following this investigation, the World Bank developed a measure in support of their aims, namely the Disability Adjusted Life Year (DALY) (World Bank, 1993).

The DALY is described as a unit for measuring both the global burden of disease, and the effectiveness of health interventions, as indicated by reductions in the disease burden (Homedes, 1995; Hu, 2004; Murray, & Lopez, 1996; WHO, 2000a). It can be interpreted as a measure of the loss of one year of “healthy life”, and the burden of disease as a measure of the gap between the ideal state of a disease- and disability-free old age, and the reality of current health (Homedes; Mathers et al., 2000; WHO). The DALY is composed of two components, namely, years of life lost through premature mortality (YLL), and years lived with a disability (YLD), (Homedes; WHO). Despite the advantages of such a universal system, it has been acknowledged that it has inadequacies that include the selective inclusion of factors that compose the measure, and manipulation of information, (Homedes). In addition, despite its realism, some may find the language of cost-effectiveness in regard to health issues unsettling.

Nevertheless, this method has enabled the significance of depression as an area of priority to be clearly exhibited. As Mathers and colleagues (2000) pointed out, the inclusion of non-fatal health outcomes has created a significantly different picture of what was happening, when compared to that which was previously illustrated through the use of mortality statistics. Using the DALYs as a measure, these researchers reported that depression was the greatest contributor to the non-fatal disease burden in Australia, and that mental disorders in general were responsible for almost 30% of the non-fatal disease burden (Mathers et al.). Globally, depression has been identified to account for 4.5% of all DALYs, and it is estimated that in 2020 it will account for 5.7% of the DALYs (WHO, 2004c). The WHO has also provided data that describes the burden of disease caused by unipolar depression in six world zones that are inclusive of both under-developed and developed communities. Using DALYs measured in the 1000's, these figures ranged from 2,011 to 2,316 in Africa; from 898 to 5,863 in the Americas; from 2,897 to 17,671 in South-East Asia (an area which encompasses Indonesia in the south, and Bhutan in the north); from 2,598 to 4,117 in Europe (inclusive of the states of the former USSR); from 1,259 to 3,754 in the Eastern Mediterranean (extending from Morocco to Pakistan); and from 1,007 to 14,926 in the Western Pacific (inclusive of China, Australia, and the islands of the Pacific). The WHO acknowledged that some of these figures might differ from those provided by other countries, and attributed this to variations in rigor.

Using the YLDs to make a detailed comparison of the impact of depression on males and females, the WHO (2004a) reported that depression accounted for 18.6% of YLDs in females, almost three times greater than the next factor of iron-deficiency anaemia, at 6.4%. This compared with levels of depression of 13.9% YLDs for males. Similar measures were used in Victoria to prioritise areas of concern. It was revealed

that intimate partner violence was the leading contributor to death, disability, and illness in Victorian women aged between 15 and 44 years of age, and of the health outcomes that were attributable to intimate partner violence, depression, at 33%, was found to be the largest health burden (VicHealth, 2004). Similar methodology has also been used by other researchers, in recognition of the need for a global response to depression, and because the experience and consequences of depression are, indeed, a burden (Hickie, 2004b; Hu, 2004; Sartorius, 2004; Vos et al., 2004).

1.5 Cautions Associated with Definitions and Data

A number of considerations can be associated with an understanding of the definitions and data that have been described in the preceding sections. In this section, definitions are discussed according to their conceptual framework, and this is followed by a consideration of issues that are related to an assessment of the available data.

1.5.1 Conceptual Frameworks

The way in which a subject is defined can both indicate, and reinforce, perceptual bias. This section shall critically consider some of the arguments concerned with the description of depression specifically, and mental health concerns in general, and how these influence perceptions about those who experience depression. The areas to be discussed include defining depression, the focus of classification manuals upon categorisation, classification revision, symptom hierarchy, the choice of descriptors, and issues surrounding the usage of a medical model to describe psychological conditions.

Defining depression is not necessarily a straightforward process. Despite the ready availability of clinical definitions, the reality of depression may be understood in varying ways by different clinicians, individuals, and population groups, which in turn may differ from the ways in which those who have experienced depression may choose to describe it. For instance, some researchers have been critical of the lack of specificity of classification manuals, professional attitudes that exclude rather than include the client, as well as the disregard of alternate diagnostic considerations such as gender and culture (Kuyken, Brewen, Power, & Furnham, 1992; Rogers, May, & Oliver, 2001; Tharyan & Raghuthaman, 1999). In response to these criticisms, the DSM and ICD have made efforts to be gender sensitive and cross-culturally appropriate, principles that have also been applied to assessment instruments such as the Beck Depression Inventory (APS, 2000; Bonicatto, Dew, & Soria, 1998; WHO, 1993).

Despite these advances, the fundamental concepts underlying classification manuals have been rejected by some researchers, who oppose the categorisation as disordered states, of what they consider to be reasonable responses to the drama of human life. For example, Rowe (2002, ¶ 14) described the DSM as having:

Grown from a simple list of the forms of mental distress, which prevent an individual from living an ordinary life ... into a massive volume which classifies every kind of human behaviour as a mental disorder, whether or not it is a natural reaction to a situation in which a person finds himself.

Once having been made, classification is not necessarily a stable condition; clusters and definitions may adapt in response to societal pressure, or changes in perceived realities. This may provoke dissent from those opposed to change, and may bring into question the authenticity of previous and current categories, as well as the

philosophy upon which these were established (Greenwood, 2004; Parker, 2004). For example, in earlier editions of the ICD, the previously mentioned Somatic Syndrome was described as being “biological”, “vital”, “melancholic”, or “endogenomorphic”, and depression was classified as being either endogenous or psychogenic (i.e. neurotic or neurotic-reactive) in nature (WHO, 1978). In addition, due to disputes about the aetiology of depression, as well as ambiguity associated with the terms being used, depression was subsumed as an affective disorder. Thereby classification was separated from pathogenic or therapeutic implications. The DSM has also sought to be more therapeutically neutral (APS, 1987, 2000; Vetter et al., 2000; WHO, 1978, 1993).

Despite these classification changes, some researchers have continued to refer to earlier categories as a basis for research (Silverstein, 2002; Vetter et al., 2000); classification change has not always been associated with perceptual change. This may be illustrative of the continuing search for an understanding of depression, or may suggest other matters, such as an inherent dissatisfaction with the adequacy of current classification. For instance, Silverstein used terminology sourced from earlier editions of the ICD as the framework upon which to illustrate the presence of high numbers of female sufferers diagnosed with somatic depression, rather than the so-called pure, or endogenous, depression. The researcher argued that by changing the definition of depression to exclude somatic features, a group of symptoms that was described as being associated with psychosocial factors, the result would more accurately represent its prevalence, and the distribution of depression would be more evenly balanced between males and females. Although potentially offensive to individuals with different viewpoints about gender and depression, these findings may, instead, be indicative of the ongoing efforts of researchers to understand

depression, albeit using paradigms that reflect a philosophic construct that some would reject as invalid.

Some research has questioned the weighting of certain symptoms that compose a diagnosis of a depressive disorder. Vetter and colleagues (2000) argued against the changes made to the description of depression in the more recent edition of the ICD-10, and questioned the assumption that each symptom was of equal validity. They made the observation that, similar to the DSM, the ICD appeared to follow the principle that “symptoms of apparently different validity, such as those associated with melancholy, are equivalent and that diagnosis of a depressive episode should be based on simple counting” (Vetter et al., p. 160, WHO, 1993). It would appear that the researchers were arguing for a hierarchy of symptoms, and applied greater value to certain symptoms. Another challenge to symptom calibration was presented by Gater and colleagues (1998). They reported that by varying the number of symptoms required for a diagnosis of depression, the ratio of males to females could be changed, “thus, our findings may to some extent be the product of sex differences in the conceptualisation and reporting of symptoms ... rather than real differences in the rates” (Gater et al., p. 412). Another viewpoint was presented by Goldney, Fisher, Dal Grande and Taylor (2004). In their study of so-called subsyndromal depression in Australian communities, they found that individuals who had depressive experiences that were just below the threshold for the diagnosis of either major depression, minor depression, or dysthymia, experienced significant disruption to their quality of life that warranted clinical diagnostic consideration.

As well as the considerations given to the classification of depression in diagnostic manuals, it is also significant to an understanding of depression, to consider whether it should be described either as a mental health illness, or as a

mental health problem. This appears to be a complex issue for which there does not seem to be a straightforward answer in the literature, and one that suggests a number of implications.

The National Mental Health Plan for Australia differentiated between mental health illness and mental health problem by, firstly, clarifying the desirable condition of “mental health” as a “state of emotional and social well being in which the individual can cope with the normal stresses of life and achieve his or her potential” (Australian Health Ministers, 2003. p. 5). This state was understood to encompass the cognitive, emotional, and behavioural aspects of a person’s life, and to influence his or her capacity to work productively, contribute to the life of a community, interact socially and environmentally, and to have the potential to “optimise opportunities for development” (Australian Health Ministers, p. 35). The scope of this influence, and its regard for current conditions and future possibilities, appears to be compatible with the scope of functional impairment experienced by the sufferer of depression that is described by the DSM-IV-TR and the ICD10 (APS, 2000; WHO, 1993). The United Nations summed up mental health as being “a state of being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community” (WHO, 2004c, p. 10).

The National Mental Health Plan for Australia reported that mental health problems were as wide in their range of effects as mental illness (Australian Health Ministers, 2003). However, because they were less severe and of shorter duration, they were described as being less intrusive to the life of the sufferer, even though it was possible that at a later date they may develop into a mental illness. Mental health problems were described as the more common condition, and included responses that

may be “temporarily experienced as a reaction to life stressors” (Australian Health Ministers, p. 5).

The legal rights and needs of people suffering from mental health problems and illnesses were identified in the National Mental Health Plan, in keeping with the findings of other research (Australian Health Ministers, 2003; Ricci, Lee, & Chiu, 2004). The Health Plan used the term “illness” in order to emphasise that individuals with mental illnesses had “legitimate health care rights and needs” that were the same as those who had physical illnesses (Australian Health Ministers, p. 5). Of particular relevance to the current thesis was the conclusion that the rights and needs of people with mental health concerns were human rights issues that encompassed the areas of discrimination (in housing, law, employment, and education), as well as stigma (from the media, general public, and mental health services) (Australian Health Ministers, p. 5).

Some researchers have been critical of the use of a medical model to understand human psychology. The WHO (2002, p. 8) stated that the medical model viewed disability as “a feature of the person, directly caused by disease, trauma, or other health condition”, that required professional care to “correct” that problem. Consequently, dependence upon external expertise is legitimised by this model; physicians are given tacit authority to determine an individual’s health status (Karp, 1996, p. 173). Crooks (2001) was critical of the focus upon pathophysiology within the medical model, to the exclusion of the living processes of health, recovery, and dying. It was felt that in comparison to a Psychological perspective, which reportedly considered the individual holistically, the medical model focused upon disease-orientated aspects of health, which were defined according to preselected concepts. Bannister (in Rowe, 1978), and Littlewood (1996) pointed out that a medical model

was the product of 19th century thinking, with its general attempt to redefine experience, particularly within the growing discipline of Psychiatry which perceived mental disorders through a medical lens. “As the psychiatric notion of depression was elaborated, it tended to either look for physical cause rather than psychological meaning or at least to present the condition as intrinsically mysterious and impersonal.” (Bannister, cited in Rowe, p. xiv).

Part of the contemporary inheritance of using the medical model as a basis for understanding mental conditions was reported to be the tendency for sufferers of depression to be summed up with a label that pathologised their experience, rather than being acknowledged as persons who might be unhappy and distressed about something that was happening in their lives (Rowe, 2002, 2003). Other researchers argued that, as a result, pharmacological solutions might be sought at the expense of engendering positive changes, and that those who suffered from mental disorders were perceived according to their shortfalls rather than their abilities, an understanding incompatible with client empowerment (Fava, 2002; Gammel and Stoppard, 1999; Rowe, 1978; Stromwall, 2002).

Rowe (1999, ¶ 5) also questioned whether a model of the mind in terms of disease could “accurately reflect how we think, feel and act”; in comparison to a psychological perception, such a model was understood to be limited, as its preference was to pin down and categorise “the flux of human experience rather than to enter into it in the hope of understanding how another person perceives himself and his world” (Rowe, ¶ 30). Using one of the DSM symptoms of depression, guilt and worthlessness, Rowe (¶ 42) suggested that that it was:

Not a symptom but a logical outcome of a person’s way of seeing himself and his world. All depressed people struggle with universal and moral

issues. When such a person speaks of his guilt and worthlessness, to say in reply, “that’s just your illness talking” is both stupid and cruel.

In conclusion, the classification and definition of depression is not a clear-cut issue that is without potentially political implications. The elements that have been discussed are not only of academic interest, but also influence attitudes towards depression, and consequently, towards those who are suffering from it.

1.5.2 Data Interpretation

The literature has not always provided data that can be remain unquestioned. This section discusses data operationalisation and consistency, date of research compared to actual recency of data, the reported incidence of depression compared to its actual incidence, and challenges to standard statistical patterns.

Despite the usefulness of much of the available data, there have been some difficulties encountered when comparing the statistics provided in the literature. It has not been always clear how certain researchers operationalised depression, and the degree to which this was at variance between different research papers. Only some papers made reference to the diagnostic criteria that was used to classify the depressive condition being investigated (Chiu, 2004). In addition, report comparison was not facilitated by the preference for some researchers to present figures that indicated the lifelong prevalence of depression, whilst others referred to its current incidence. Indications of data recency may also be at odds with the date of the published research. At the time of writing the current report, the most recent data about the incidence of depression in Australia appeared to be the information provided by Andrews and colleagues (1999). This information was used as a basis for

findings by more recent researchers such as Chiu, and Mackinnon, Jorm, and Hickie (2004).

The incidence of depression may be greater than that indicated by the data because General Practitioners (GPs), to whom clients usually first refer, may be under-recognising, and therefore under-reporting its presence (Hickie et al., 2001b; Lecrubier, 1998; Rogers et al., 2001). It has also been suggested that as many as 50% of individuals with depression may not present to their GP, or other professionals, for reasons that include the potentially negative implications of having this condition (Andrews et al., 1999). A later American study emphasised this fact, and reported that almost 60% of those with severe mental illness, inclusive of depression, received no specialty care over a 12 month period (McAlpine & Mechanic, 2000). These factors not only question the accuracy of the statistics about depression, but importantly, indicate that a number of depressed people are not being treated, at great cost to their potential as fully functioning human beings.

In addition, for cultural, social, and political reasons, some people groups may be reluctant to admit to being depressed, may describe it in ways that differ to standard diagnostic terms, or may not have access to diagnostic and intervention procedures that would record its occurrence (APS, 2000; Chiu, 2004; WHO, 1993, 2004a). The WHO (2004a) reported that suicide was the leading cause of death of young women in some parts of rural China, and the negative impact of rapid social change upon such things as interpersonal networks and identity was implicated as a likely contributing factor by Phillips, Lui, and Zhang (1999). As previously noted, the factors that contribute to depression are complex, nevertheless it is wondered whether depression preceded the suicide of these women, and whether inattention towards their psychological needs contributed to their deaths. It is also wondered if neglect of

these, and similar behaviour patterns or expressions of distress, are being recognised or described as depressive behaviours within some cultures, even when it has been reported that high levels of depression exist in some areas. For example, the phrase “thinking too much” was reported as being commonly used by women in Ghana to describe their experience of depression, and a study in Zimbabwe put a figure on the current levels of depression within a cohort of low-income women at 18% (Astbury, 2001; Broadhead & Abas, 1998; Patel, Simunyu, & Gwanzura, 1995).

Different populations may present data that may challenge accepted statistical patterns, and in doing so, provoke further questioning. For example, as previously noted, it is generally accepted that a greater number of females are affected by depression than males, and a body of literature has been built upon this information (Crooks, 2001; Hurst, 1999; Schreiber, 2001). However, these facts were challenged by the results of a study into the depression of students at an American college, where males and females were found to have similar levels of depression (Alloy et al., 2000; Nolen-Hoeksema, 1990). Although more recent data continues to support the argument that females suffer from unacceptably high levels of depression, contradictory research has provided an impetus for further investigation into why this may be so. Astbury (2001, p. 79) has reported that “gender bias has skewed the research agenda”, which has led to undue scrutiny into supposed correlations between reproductive functioning and mental health. However, more recent research has indicated that the relation between these factors is mediated or disappears when psychosocial factors are accounted for (Astbury).

An awareness of the irregularities and biases that may skew data and its interpretation also inform the literature that has explored the depression of Psychologists and other mental health professionals.

1.6 Suppositions About the Depression of Psychologists

Although it is likely that the incidence of depression amongst Psychologists is similar to that of other mental health professionals, it is not possible to state this with confidence because the available data is incomplete. It could be argued that Psychologists are less likely to experience depression because their professional expertise in therapeutic processes may be protective, but it may also be argued that they are more vulnerable to depression because of their exposure to client distress. However, the main purpose of the current thesis is not to quantify the incidence of depression amongst Psychologists, except where it may elucidate the primary focus of issues surrounding its experience, both by those who suffer from it, and from those who have not experienced it, so that informed theory can be developed.

The lack of information available about the experience of depression in Psychologists may be related to the stigma associated with having a mental health illness. For this reason, it is possible that the depression of Psychologists has been inferred by the use of less specific terminology such as “burnt out” (or “burnout”), “distressed”, or “impaired” (Farber, 1990; Miller, 1998; Sonneck & Wagner, 1996). Elsewhere, Schattner, Davidson, and Serry (2004) clearly delineated the terminology used in regard to medical practitioners. “Impaired” indicated mental illness or substance misuse; “troubled” indicated significant levels of stress; and “dissatisfied” referred to individuals who did not have a mental health problem, but might be at risk for problems in the future.

Miller (1998, p. 137) discussed the “compassion fatigue”, or burnout, of Psychologists, however, later research differentiated between burnout and depression; it was reported that burnout could lead to depression, and the latter was distinguished by the characteristic of having “given up” (Brenninkmeyer, Van Yperen, & Buunk,

2001, p. 879). In that light, burnout may more likely be used to refer to incidences where there was stress or overwork. It may be interpreted by some as a positive feature of a diligent employee, and consequently, not perceived as a factor that could contribute to ill health, and not reported as such. Similar features have been described in Japan as Karoshi (death from overwork), where it has been related to depression, somatization, and suicide (Nakagawa & Sugita, 1994). The term distressed may be indicative of a state of temporary emotional imbalance, akin to The National Mental Health Plan for Australia's definition of a mental health problem (Australian Health Ministers, 2003). It may be that impairment is used to indicate an interference with competence, and may have legal implications that are relevant to professional policies (Swearington, 1990).

The definition of depression and an understanding of its epistemology and epidemiology, provides a basis upon which the depression of Psychologists can be explored further. The next chapter shall discuss the complex question of the aetiology of depression.

CHAPTER TWO

AETIOLOGY OF DEPRESSION

A considerable body of research has investigated the aetiology of depression from the earliest days of the development of psychological theory, constructed upon an awareness of its enormous personal and economic cost (Australian Institute of Health and Welfare, 2004; Freud, 1917/1985; WHO, 2004b). Nevertheless, the answer as to why individuals become depressed has not been clearly explicated, or been able to be attributed to one major factor, more than likely because human beings, and the lives they lead, are complex (Brown, 1998, 2002; Goldstein & Rosselli, 2003). It is of value to explore what the literature has to report about the causes of depression, as perceptions about the reasons for an individual's depression can shape the attitudes of the sufferer towards their illness, as well as the attitudes of those who are not depressed towards the sufferer. Hence, the depressed Psychologist is also subject to the influence of attributions for his or her condition.

This section classifies the aetiology of depression into three main areas: biological, environmental, and psychological. It is acknowledged that few factors can be attributed to only one area, and that some issues, such as gender, could be discussed separately. Following a discussion about multifactorial contributions to depression, these three areas are discussed in turn, and finally, issues directly related to the practice of Psychology such as personal attributes and the demands of the profession, are considered.

2.1 The Multifactorial Aetiology of Depression

The Australian Institute of Health and Welfare (2003, 2004) and the WHO

(2001, 2002, 2003, 2004b) have developed policy guidelines that are based upon the conclusion that the aetiology of depression is multifactorial. In addition, depression has been found to be frequently comorbid or concurrent with other conditions (Herbert, 1997).

In order to further understand the prevalence of depression in Australia, Andrews and colleagues (1999) correlated depression with gender, age, marital status, education, employment, and living arrangements (Henderson, Andrews, & Hall, 2000). It was reported that higher levels of depression were associated with mid-life males; females between 18 to 24 years of age; males and females who had separated or divorced; males and females who had never married (especially males); individuals who had not completed secondary school; unemployment and under-employment (or part-time work); and living alone. No significant relationship was found between depression and the elderly who lived in the community (rather than in specialised accommodation), country of birth, or between rural and urban populations. Using data from the aforementioned research, as well as the National Health Survey 2001 (produced by the Australian Bureau of Statistics), Mackinnon and colleagues (2004) sought to formulate information from which a national depression index for Australia could be developed. Making allowance for gender, employment status, and income, they found that index values were higher for young people, females, the unemployed, and those who were socioeconomically disadvantaged.

So as to inform the focus of health policy, the Australian Institute of Health and Welfare (2004) reported modifiable and non-modifiable risk factors for depression, a number of which were also recognised as being common to other health priority areas. Modifiable risk factors were identified as poverty, unemployment, conflict, poor parenting practices, child abuse, exposure to adverse life events, being a carer of those

with chronic physical or mental disorders, older age, and residential care. Non-modifiable risk factors were identified as having a family history of depression, being a female, the period of adolescence, high trait anxiety and pre-existing anxiety disorders, and temperament (such as reacting negatively to stressors, having negative thought patterns, and utilising an avoidant coping style).

The WHO (2004b, p. 39) reported that the onset and recurrence of depression was "influenced by a wide range of malleable risk and protective factors at different stages of the lifespan from as early as infancy". In that report, depression-specific risk factors were identified as parental depression, and depressogenic cognitions; generic risk factors were identified as inadequate parenting, child abuse and neglect, stressful life events, and bullying; and finally, protective factors were identified as having a sense of mastery, self-esteem, self-efficacy, stress resistance, and social support.

2.2 Biological Causes of Depression

The research suggests that a number of biological determinates may cause, contribute towards, or be subsequent to the experience of depression. Broadly, these include the dysregulation of the serotonin, norepinephrine, dopamine, acetylcholine, and gamma-aminobutyric acid neurotransmitter systems; neuropeptide alterations, such as corticotrophin-releasing hormone; and hormonal disturbances, such as elevated glucocorticoid secretion, or reduced growth hormone, thyroid-stimulating hormone, and prolactin responses (APS, 2000; Preboth, 2000). In addition, physiological changes have been observed such as changes in cerebral blood flow, and structure (APS; Drevets, 1998; WHO, 2000b). Depression may also be a consequence of medication, substance use, or medical conditions directly or indirectly associated with cerebral insult such as stroke, epilepsy, or diabetes (APS; Preboth).

Research into the biological causes of depression has also pointed to other factors of interest. Campbell and MacQueen (2004) related the memory impairment commonly associated with depression to the central role of the hippocampus in depression. Both Sibille and colleagues (2004), and Kendler and colleagues (1995) attributed depression to genetic and environmental factors. Kendler and colleagues proposed that a genetic predisposition altered individual sensitivity to the negative effects of stressful life events.

It is reported that the attribution of depression as an illness with a biological cause, provides an explanation that can reduce a sense of personal responsibility for being depressed, on the part of the sufferer, as well as those who are not depressed (Lewis, 1995). Goldstein and Rosselli (2003) also found that endorsement of the biological model was associated with decreased stigma, as well as an increased sense of empowerment. Schreiber and Hartrick (2002, p. 98) described the relief of a woman after being told that her depression was due to biomedical causes; in response she stated, "it's not my fault. I didn't do this to myself". This contrasted with the findings of Hood, Egan, Gridley, and Brew (1999), who reported that some participants in their study interpreted the need for medication, the treatment solution of the biological model, as evidence of personal failure. Schreiber and Hartrick also reported that although some individuals attributed less self-blame, the same explanation did not necessarily minimise the negative perceptions of others. It was found that labelling with a cause could paradoxically reinforce stigma as it accentuated the sufferer's deviation from the norm. They added that a biological attribution could also "objectify" or "de-contextualise" depression, thereby diverting the depressed individual away from an exploration of the complexity of the factors involved in their experience of the condition (Schreiber & Hartrick, p. 100).

2.3 Environmental Causes of Depression

Environmental, rather than the term social, has been selected to describe this category because it is suggestive of a broader range of factors, some of which may be thought of as only partly environmental. This includes issues related to gender, a categorisation which may be interpreted by some as provocative, as attribution of cause demands specific interventions. For example, if the depression of women is perceived to be a biological problem, then the solution would involve a biological approach such as medication, but if the depression of women is understood to be environmental, the required response would be more far-reaching. The WHO's (2002) description of the social model partly describes what an intervention for this attribution would involve; the social model, which sees disability as "a socially-created problem" rather than an attribute of an individual, "demands a political response, since the problem is created by an unaccommodating physical environment brought about by attitudes and other features of the social environment" (WHO, p. 9). Areas that are considered in this section include economic factors, status, negative life events, sense of self, stress, social resources, evolutionary reasons, and gender issues.

Depression is more common amongst the economically vulnerable, and those perceived to be of lower social rank (WHO, 2000b, 2004a). Negative and threatening life events have been related to the occurrence of depression at a later time (Oatley, & Bolton, 1985; WHO, 2000b). Penza, Heim, and Nemeroff (2003) found that events such as abuse and trauma caused permanent physiological maladaptions, and were risk factors for the development of psychopathology such as depression and anxiety, subsequent to exposure to additional stress. In addition, chronic difficulties may challenge accustomed roles through which a sense of selfhood and purpose is gained (Oatley, & Bolton; WHO, 2000b). Patton, Coffey, Posterino, Carlin, and Bowes

(2003) found that single negative events brought a five-fold elevated risk of depression, and multiple events were associated with an almost eight-fold higher risk. In addition, negative life events may interact with internal factors that can moderate or exacerbate the likelihood of the occurrence of depression (Brown, 1998).

Stress has been recognised as a predictor of depression (Collins & Parry-Jones, 2000). Kendler, Karkowski, and Prescott (1999, p. 83) found that exposure to stressful life events was influenced by genetic factors, and provided evidence of individuals who “select[ed] themselves into high risk environments”. Van Praag (2004) also related genetic factors to stress and depression. It was found that changes in 5-hydroxytryptamine and stress hormones that were produced in response to stress, significantly mimicked the changes that also occur in these systems as a result of depression. Cronkite, Moos, Twohey, Cohen, and Swindle (1998) investigated depression within the context of life circumstances and personal resources. They found that negative correlates were related with having more life stressors, fewer social resources, being less easy going, and by the use of avoidance coping.

Cushway and Tyler (1996) identified a model of risk factors that mediated between stressors and outcomes. They related psychological well-being with high job satisfaction; the use of a wide range of coping strategies; the ability to externalise and objectify stressors (in other words, stressors were attributed as being “not my fault” or “partly my fault”); high levels of job experience; quality relationships with partner or significant other; and being male (except in cases where the work entailed dealing with violent clients) (Cushway & Tyler, p. 146). Psychological distress was associated with the reverse of these conditions. It was concluded that coping was “ultimately an individual affair”, and talking to work colleagues and friends, exercise, and leisure

activities, were suggested as methods that could assist in reducing stress levels (Cushway & Tyler, p. 147).

Disruptions in social relatedness have been attributed as causative, and not only the consequence of, depression. Seligman attributed depression to the rise of Western-style individualism that following the Second World War. He supported this by describing the emphasis placed upon encouraging the development of self-esteem, or feeling good about one's self, rather than stressing good "commerce" with the world, or a healthy balance between commitment to the self and the common good (McCrossin, 2002, ¶ 13; Seligman, 1990). Elsewhere, a study that attempted to find correlates between depression and the five-factor traits of personality, instead concluded that depression was related to "miscalibrations" of social interactions (Finch & Graziano, 2001, p. 44).

Another perspective was presented by Paul Watson and Daniel Nettle in a radio discussion about the possibility of an evolutionary purpose for depression (Mitchell, 2004). Amongst other matters, Watson suggested that lower, sub-malignant, levels of depression served a social planning function by enabling a sober ruminative state that was not biased by optimistic thinking. It was proposed elsewhere that depression functioned as a means to navigate complex social problems (Cline-Brown & Watson, 2003; Watson & Andrews, 2002). Hagen (2005, p. 119) described depression as a method of bargaining, with "adaptation triggered by social costs that functions to compel social investment and change". Social support benefits such as concern, support, and decreased aggression directed towards the sufferer were identified as responses towards the outward symptoms of depression, notably a plummet in so-called productivity.

The literature provided a number of explanations for the higher number of women who suffer from depression. Nolen-Hoeksema and Jackson (2001) investigated rumination in response to stress as a predictor of depression. It was found that females ruminated more than males, and it was concluded that this was a socialised response that was related to the greater sense of powerlessness of women. Using a twin study, Bierut and colleagues (1999) found that depression aggregated in families and was best explained by shared genetic factors and unshared family environment; the data indicated that there were stronger genetic influences in its development in females. This finding was challenged by WHO's (2004a, pp. 14-15) research which found "considerable cross-cultural variability in the magnitude of the male: female ratio" that brought into question the so-called simplistic assumptions of biological or hormonal explanations. Greater exposure to stressors such as negative life events was thought to be a more likely reason (WHO).

Whitney and colleagues (2002) argued that more women suffered from depression because of their cumulative exposure to certain predisposing factors. These elements were categorised into three major areas: biological, psychosocial, and artefact (or diagnostic and cultural biases). The researchers also stated that women's occupations and roles tended to be less valued than those of men, that women had a tendency to self blame, that society tended to "sanction" their roles as being of low status, and women felt as if they had little control over their environment (Whitney et al., p. 21). Another study revealed a 40% correlation between the development of clinical depression in women within a 14-month follow-up period, and one or two vulnerability factors (namely, negative evaluation of self, or negative close relationships) (Bifulco, Brown, Moran, Ball, & Campbell, 1998). Kuyken and Brewen (1994) investigated stress and coping in depressed females; it was found that less

planful problem solving and more escape-avoidance was utilised by females when faced with stressful events.

Jack (1992, 1999) devised a theory, *Silencing the Self*, in order to explain and describe depression in women. In summary, Jack (1999, p. 100) found that “actively silencing the self leads to the inward experience of a divided self, the condition of self-alienation”. This was typified by stopping certain thoughts, words and/or actions, which led to an outer appearance of passivity and dependence. Jack argued that the focus of previous researchers upon women’s supposed passive coping style, was erroneous, because cognitive activity (namely, self-monitoring and self-inhibition) was required for this type of behaviour. Jack (1992, p. 98) developed a scale to measure these “gender specific schemas”, using four key dimensions. These were: having an externalised self-perception; perceiving care as self-sacrifice (or, putting the needs of others first); silencing the self (in order to avoid conflict); and the divided self (thereby presenting an outer compliant self in order to live up to feminine role imperatives).

The high prevalence of women suffering from depression is relevant to the current investigation into Psychologists and depression due to the larger proportion of female, compared to male, Psychologists (with numbers confirmed by personal communication with a representative of Psychologists Registration Board of Victoria, P. Gloster, February 2, 2007, and qualitatively confirmed by a representative of the Australian Psychological Society, L. Bender, February 5, 2007).

Some researchers have expressed concern that depression is devalued as a condition because of a perception that it is primarily a women’s disorder. McMullen (1999) argued that the seriousness of depression was minimised because it was associated with a so-called deficient (and therefore female) self. This has implications

for the depressed female mental health professional, who must not only deal with additional stressors which exist because she operates as a female within the professional role, but also, if she makes known her experience of depression, she makes public pronouncement of her so-called inherent and unavoidable inadequacies (Sonneck & Wagner, 1996).

Research into gender issues has not only followed standard quantitative practice, but also utilised qualitative approaches in order to obtain data that may be more insightful (Crooks, 2001; Schreiber, 1998). As a result, the central research figures were the source, as well as the pattern, through which different ways of understanding depression were obtained, thereby enriching the data available about depression. In addition, some researchers have made methodological choices that challenge models of theory that they perceived were limited by societal attitudes and diagnostic constraints (Crooks; Schreiber, 1998, 2001; Stoppard, 1999). In a qualitative study, Hurst (1999) found that women who had experienced depression felt demoralised and had a sense of being betrayed. Amongst the participants of the study, the researcher found that depression was caused by being betrayed, or namely, by being abused, disrespected, and left. This event led to feelings of being left out of the world, and led to being demoralised, or, in other words, feeling that they were not worthy of love, and that there was nothing they could do to change things, and nothing was ever going to get better. Finally, being demoralised was understood to be self-perpetuating, and reflected a lack of belief in one's value as well as the potential to exert control over one's circumstances.

Other qualitative research has provided additional information about the experience of depression. Whitney and colleagues (2002) proposed a model of work-life balance in order to better understand the social context of depression in women.

Schreiber (2001) described three major categories that were considered important by women who had experienced depression, namely, internal dialogue, the impact of violence, and lastly, oppression and the marginalisation of women's experiences.

Hood and colleagues (1999, p. 46) found that women "displayed a sense of personal responsibility for both the occurrence and management of their depression".

Broadhead and Abas (1998) identified a sense of humiliation and/or entrapment as central to the women in their study, and subsequent to marital crises, premature death, family illness, and severe financial difficulties. Elsewhere, the lived experience of elderly women was described as a descending spiral, where mutual experiences provided a type of "background music" which they understood to confirm their sense of worthlessness, and contributed to a loss of respect (Hedelin & Jonsson, 2003).

Schreiber, Stern, and Wilson (2000) identified "being strong" as a core factor that women of a particular cultural group used to manage the symptoms of depression. It was speculated by the researchers that such response may further induce depression, and thereby impede recovery.

The WHO (2004a) summarised the factors that contributed to higher levels of female depression as being a lack of educational and occupational opportunities, economic difficulties, being victims of violence, intimate partner violence, and the consequences of child sexual abuse. VicHealth (2004) reported that the causes within the context of Victoria were complex, and included cultural, social and economic factors, and in particular, the unequal distribution of power and resources between men and women. It was concluded that the issue was better addressed within the context of a human rights, legal and health framework (VicHealth).

There is no doubt that the experience of females is minimised within society, and the previously mentioned research has attempted to address this imbalance. It is

of interest that the voice of the depressed male does not appear to have been investigated in similarly challenging ways (Cochran & Rabinowitz, 2000), even though some researchers may argue that the male voice has been well pronounced within the forums traditionally available for research and commentary. It may be that the factors that appeared to have inhibited the expression of the male experience of depression are not related to social opportunity, but are located within men themselves. Efforts have been made to encourage them to speak about depression, and to recognise its symptoms by using male role models such as respected sporting figures to publicly discuss their experience of depression (beyondblue, 2005; Fuller, 2005; Ker & Nader, 2004). In addition, internet connections such as The Black Dog, an Irish initiative, promoted forums and support networks specifically for men, and anonymous assistance was available for professional groups such as medical practitioners (Doctors' Health Advisory Service, 2005; The Black Dog, n.d.; The Doctors' SupportLine Website, n.d.).

2.4 Psychological Causes of Depression

An overview of hypotheses that attempt to explain the occurrence of depression indicates diverse points of view. Despite, or perhaps because of their diversity, they have contributed to an increased understanding of depression. The areas that are discussed in this section include personality factors and cognitive styles, coping strategies, and schools of psychological thought.

In direct contrast with perceptions of the biological cause of depression, Goldstein and Rosselli (2003) reported that endorsement of the psychological model was associated with increased levels of stigma, as well as an increased belief that sufferers could help themselves. Other researchers reported that the challenges

associated with psychological attributions were too much for some clients. The sufferer of depression may have less incentive to pursue treatment programs that involve cognitive or life-style changes rather than pharmaceutical interventions (Gammel & Stoppard, 1999; Schreiber & Hartrick, 2002; Vetter et al., 2000), and others may feel that the source of the problem, and its management, exceeded their personal capacity to intervene (Schreiber & Hartrick).

In order to predict the likelihood of depression, a number of factors associated with personality have been investigated (Deary et al., 1996; Finch & Graziano, 2001). The positive impact of a sense of subjective well being upon the environment has been reported (Bradburn & Caplovitz, 1965; WHO, 2004c), as well as that of perfectionism. Rice, Ashby, and Slaney (1998) reported a relationship between perfectionism, self-esteem, and depression. It was understood to be multidimensional; no relationship between so-called adaptive perfectionism and depression was found, but the researchers associated maladaptive perfectionism with both low self-esteem and higher levels of depression (Rice et al.). Enns, Cox, Sareen, and Freeman (2001) also reported a positive relationship between depression and maladaptive perfectionism in their sample of medical students.

Cognitive styles have also been found to influence the occurrence of depression. Beck focused upon current life events and their relationship to depression, and proposed that symptoms of depression were the consequence of specific negative cognitive patterns (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961). Specific human requirements were related to depression, namely sociotrophic (i.e. dependency) or autonomy (i.e. achievement) needs, and also identified certain dimensions of personality with depression (Blatt, 1999; Street, Sheeran, & Orbell, 1999). Seligman developed his behaviour theory of learned hopelessness to explain

depression (McCrossin, 2002; Street et al.). At a later stage, he included attributional style as well as hopelessness, and expanded his views to include a social context in order to explain the contemporary prevalence of depression (McCrossin; Seligman, 1990; Street et al.). He stated that depression was a disorder of the individual, and that it was increasingly prevalent because of the lack of so-called larger beliefs to fall back upon in times of crisis (Seligman). Other researchers demonstrated that negative cognitive styles were vulnerability factors for the development of depression (Alloy et al., 2000), and that rumination was predictive of both becoming, and remaining, depressed (Nolen-Hoeksema, & Jackson, 2001).

Ways of managing times of difficulty have also been subject to research. Otto and colleagues (1997) reported that less adaptive coping strategies were applied during periods of mood disturbance, or depression, and linked these strategies to a stress-depression-stress cycle that resulted in increased levels of stress. In addition, Lewis (1995) indicated that depressed individuals had an extensive sense of inadequacy, and McWilliams (1999, p. 190) reported that this permeated social relationships, with some carrying “the inner conviction that their badness will alienate anyone who gets to know them well”. Conversely, optimists have been found to have better coping mechanisms such as acceptance and acceptance of reality, and reliance on personal growth (Scheier & Carver, 1992; WHO, 2004c), and the capacity to develop resilience and cope with adversity, has been found to reduce levels of depression (WHO).

In addition, schools of psychological thought have also provided explanations as to the aetiology of depression. Street and colleagues (1999) integrated 27 of these theories in order to obtain global explanations about the condition. The researchers selected theories that were “traditionally segregated”, and identified 99 factors from

which four poles of influence were drawn (Street et al., p. 177). These poles were summarised as cognitive bias –v- social reinforcement of self, and social relations –v- goal pursuit. “Cognitive bias” referred to the areas of information bias, self-attributions, and self-schemas. It indicated the manner in which information was selectively processed, with the result that a negative self-view developed. “Social reinforcement of self” referred to the areas of individual and environmental factors, and indicated the manner in which social behaviours and pursuit of social goals resulted in a lack of positive self-reinforcement. “Social relations” referred to the areas of social support, social interaction, and isolation, and indicated a lack of positive social support, and the need to be part of social groups. Finally, “goal pursuit” referred to the areas of failure, self-esteem, and commitment to unrealistic goals. It indicated the value of goal pursuit and achievement (Street et al.).

The seminal work of Freud on depression continues to inform psychoanalytic and psychodynamic therapists today (Freud, 1917/1985). He used the term melancholia to describe what is understood today as depression, and differentiated it from grief and mourning. He stated that during periods of grief, the external world was experienced as being diminished in some specific way, and this was contrasted with depression, where part of the self was perceived as lost or damaged (Freud; McWilliams, 1994, p. 229). As a result of this perception, there was a real sense of premature loss and grieving, and as the self had identified with the lost object, the individual directed his or her anger inwards (Freud; Gabbard, 2000; Malan, 1994; Street et al., 1999). This was likened by McWilliams (p. 230) as a sort of “sadism against the self”, with the end result being a profound loss of self-esteem, self-reproach, and guilt (Gabbard). In other words, the individual “represents his ego to us as worthless, incapable of any achievement and morally despicable; he reproaches

himself, vilifies himself and expects to be cast out and punished” (Freud, p. 51). Rowe succinctly expressed a similar perspective during a recent radio interview. Whilst discussing the cause of depression she stated, “when we suffer a loss, the natural response is to feel sad. But if you blame yourself for that loss, then you turn natural sadness into depression” (Thompson, 2004).

Finally, two other views which have informed psychological theory from a developmental perspective, include the work of Klein and Bowlby. Klein described two basic groups of anxieties and defences, the second of which, the depressive position, was considered to be the more developmentally advanced (Steiner, 1992). She stated that in this position, the individual’s relationship with the object, or the other, was typified by a sense of developing ambivalence, dependence, and concern, and as a result, feelings of loss, guilt, and mourning were experienced (Fonagy, Gergely, Jurist, & Target, 2002; Steiner; Street et al., 1999). Bowlby concentrated upon early parent-child interactions, or attachment, and their effect on subsequent personality development and vulnerability. He likened depression to mourning, and related it to attachment loss, either in the past or in the present (Blatt, 1999; Street et al.).

2.5 Psychological Practice and Aetiology of Depression

It has been speculated that both the nature of Psychologists and the nature of the profession of Psychology can contribute towards the depression of Psychologists. In addition to these factors, in an attempt to gain a profile of a cohort of “impaired” health professionals that included Psychologists, Kartsavdakakis, Gabbard, and Athey (2004) found that the most common difficulties that preceded intervention were marital and emotional difficulties. As well, Cushway and Tyler (1996) reported that

the largest factor implicated in the stress of Clinician Psychologists was their sense of professional self-doubt, which was also found to be a generally significant factor amongst workers in the mental health area.

Researchers have indicated the influence of developmental influences upon the disposition of Psychologists. Pope and Feldman-Summers (1992) reported that 30% of Psychologists indicated having experienced a history of childhood abuse (physical or sexual), and Elliot and Guy (1993) found that 69% of female mental health professionals reported having experienced trauma in childhood, in comparison with levels of 49% in a control group. Traumatic experiences, as well as problems associated with parental alcoholism, and taking on the role of a parent, have been correlated with a subsequent desire to enter the helping professions out of identification with the client, and the need or opportunity to master adversity and/or heal one's self (Elliot & Guy; O'Conner, 2001; Pope & Feldman-Summers). Gustinella (1995) found that therapists who had a childhood history of abuse demonstrated increased levels of rescuing statements in response to disturbed clients. Psychotherapists whose personal histories contained issues that remained unresolved, were found to be more vulnerable to stress, alienation and depression (Wesley, 1994). A background of abuse may influence the therapist's capacity to be resilient when confronted with certain stressors during the practice of their profession, and may influence the therapeutic conduct of interventions (Gustinella).

Certain character traits have also been reported in Psychologists. McWilliams (1994 pp. 228-229) stated that:

A substantial proportion of psychotherapists are characterologically depressive. We naturally empathize with sadness, we understand wounds to self-esteem, we seek closeness and resist loss, and we ascribe our

therapeutic successes to our patients' efforts and our failure to our personal limitations.

Elsewhere, McWilliams (2004, p. 148) reported that a therapist's impassioned stance was likely to indicate a stance that "either normalises their own dispositions or compensates for the limitations of their character type. In either case, they seem to be trying to heal themselves." With philosophical reference to Bowlby's description of "compulsive care giving", Malan described the so-called healing profession syndrome (Bowlby, 1977; Malan, 1994). This manner of professional relating was attributed to an "over-compensation" against the inherent conflict between "needs" (of one's self) and "demands" (of others); in other words, the healing professional "compulsively gives to others what he would like to have for himself" (Malan, p. 139). As a consequence, it was possible that the needs of "others" (or, the needs of the Psychologist's client) could be misinterpreted as demands, and this response could lead to a sense of guilt on the part of the healing professional, followed by resentment, then depression. "The individual devotes his life to giving to others the care and concern he would like to have for himself. He then frequently comes to treatment when he breaks down into depression, accompanied by conscious resentment about the demands being made on him." (Malan, p. 131).

The profession of Psychology has been described as having inherent stressors related to client and workplace issues. Guy and colleagues (1990, 1992) found that nearly 40% of their sample of Psychologists had been attacked by their clients as many as 20 times during their careers, with nearly 23% of these assaults resulting in physical injury to the clinician. Cushway and Tyler (1996, p. 147) reported that "conducting therapy is an inherently stressful and emotionally demanding activity" due to the high levels of emotional engagement required, and practice can be

depleting (Guy, 2000). Consequently, it was recommended that Psychologists should attend to their self-care, and seek professional and personal support, as well as good supervision. The nature of the workplace has been reported as significantly contributing to the depression of Psychologists, through the creation of a stressful and unsupportive environment. “Stress is not just a personal problem located in individuals, but ‘an indicator of the ineffectiveness of work environments, systems and practices’ ” (Pottage & Evans, cited by Collins & Parry-Jones, 2000, p. 790). Firth-Cozens (2003) attributed the stress of health care professionals to workplace, rather than individual, issues. Consequently, the management of potential stressors within the environment should be viewed as “a normal part of management, and an essential part of patient safety” (Firth-Cozens, p. 671).

The general aetiology of depression is multifactorial, and complex; a number of attributions are not easily categorized into one or another area. The depression of Psychologists is additionally attributed to factors that are related to presumed features of personality exhibited by individuals who are attracted to the profession, factors which are exacerbated by practicing in a stressful and difficult line of work. The next chapter shall discuss the various ways in which depression impacts upon the individual and their realm of interaction.

CHAPTER THREE

THE IMPACT OF DEPRESSION

Depression not only affects an individual, but also their productive contribution and optimal participation as a family member, member of a community, and employee or employer (APS, 2000; Andrews et al., 1999; WHO, 1993). The somatic, cognitive, and emotional symptoms of depression have been described in chapter 1, and are listed in Tables one and two (APS; WHO). This chapter shall discuss the research into a number of the effects of the diagnostic symptoms of depression. This is followed by a discussion about issues to do with stigma, the perception that the experience of depression can herald an opportunity for personal growth, experiential descriptions of depression, and finally, how the experience of depression influences the professional role of the Psychologist.

3.1 The Impact of the Diagnostic Symptoms of Depression

The somatic symptoms of depression have been described by a number of researchers (Beck et al., 1961; Tylee et al., 1999a, 1999b), and include significant weight loss or gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy (APS, 2000). Researchers have correlated features of depression, as well as distressing circumstances that are identified as risk factors for depression, with somatization. Terre, Poston, Forevt, St. Jeor, and Horrigan (2004) found that self-reported symptoms of current depressed mood and low internal locus of control were significantly linked to somatic complaints. The expected finding, that family-of-origin functioning predicted adult somatic complaints was not detected in this research. Elsewhere, somatic symptoms were correlated with perceptions of

gender role (Caceres-Dalmau, 2004); anxious somatic depression in young Latina women was identified as a factor of their perceptions of their mothers' marianismo (or traditional gender role) ideology. The distress of depressed divorced women who lived in a traditional Bedouin-Arab society, was identified with symptoms of somatization by Al-Krenawi and Graham (2004). It was reported that, in comparison with married and single women, these divorced women experienced more somatization, loneliness, paranoid ideation, obsessive-compulsion, depression, anxiety, phobic anxiety, psychoticism, and family problems, and less self-esteem, and satisfaction with life.

Cognitive symptoms such as a diminished ability to think or concentrate, or indecisiveness, have been associated with depression (APS, 2000). In support of this, Outram, Murphy, and Cockburn (2004) reported that as many as 51% of depressed individuals may have memory impairment. More specific research found that depression adversely influenced the immediate recall of new information, as well as the total amount of acquisition, but did not affect the retrieval and retention of information (Basso & Bornstein, 1999; Kizilbash, Vanderploeg, & Curtiss, 2002). Kizilbash and colleagues also reported that the retrieval of newly learnt information was adversely influenced when anxiety occurred concurrently with depression. The researchers expressed concern about the long-term functioning of depressed individuals (with or without symptoms of anxiety), and whether it was possible that they might exhibit increasing levels of cognitive impairment in the future. In their study of cognitive impairment that did not specifically focused on memory, Miller, Faustman, Moses, and Csemansky (1991) did not find any significant difference in cognitive functioning between depressed and non-depressed participants. As a result, they cautioned against the assumption that individuals had cognitive difficulties when

they exhibited depressive symptomatology, or that non-symptomatic individuals were free of cognitive deficits.

Emotional symptoms such as depressed mood, loss of interest or pleasure, feelings of worthlessness or inappropriate guilt, and recurrent thoughts of death or suicidal ideation, have also been identified with depression (APS, 2000). Instruments such as the Short Depression-Happiness Scale have been designed to measure the presence or absence of well being in depression (Joseph, Linley, Harwood, Lewis, & McCollam, 2004). Research into the responsiveness of depressed individuals to emotional stimuli has found reduced levels of responsiveness to positive, but not negative, stimuli (Dunn, Dalgleish, Lawrence, Cusack, & Ogilvie, 2004). The same researchers also indicated that there were significant differences in response to positive images, namely, decreased levels of happiness, increased sadness, and reduced levels of arousal.

The behaviour and perceptions of the depressed individual can impinge upon social relationships and work participation, and thereby further exacerbate depressive symptoms by decreasing the opportunity for social support (Outram et al., 2004; Wildes, Harkness, Simons, 2002). Park, Wilson, and Lee, (2004) reported that social support at work was directly related to high job control, low depression, and high job performance. In addition, the intimacy of marital and family relationships could be disrupted, as depression was reported to be associated with reduced levels of couple engagement, communication, and satisfaction (Goldney et al., 2004; Hurst, 1999; Rix et al., 1999), and other “intense and persistent” pressures (Highet, McNair, Davenport, & Hickie, 2004, p. S8). Finally, the depressed individual might experience a loss of a sense of self that had formerly been constructed upon social relationships (Lewis, 1995).

3.2 The Impact of Stigma

Stigma is often an unfortunate social and personal consequence of depression. It is understood to refer to the experience of being stigmatised, as well as feelings, such as shame and fear, that may be induced in response to episodes of stigma (Asbring, & Narvanen, 2002). Miller and Kaiser (2001) conceptualised stigma according to a model of stress and coping. Schreiber and Hartrick (2002, p. 97) used a social constructivist model in order to understand the stigma of depressed women, and reported that the stigmatised individual or group was discerned as “deviant” from the norm, and was subject to sanctioning. The researchers concluded that social control determined that which was acceptable or shameful, and consequently, that which was devalued (Schreiber & Hartrick). In this way, a social bias (or problem) was attributed to the individual, and thereby became the individual’s problem, and reinforced perceptions of stigma (Link, Mirotznik, & Cullin, 1991).

The consequences of stigma are complex, and are related to societal exclusion, and include the resultant attributes taken up by those who are stigmatised (Angermeyer & Matschinger, 1996, 2003, 2004; Asbring & Narvanen, 2002; Schreiber & Hartrick, 2002). Stigmatised individuals can mimic the personal incompetence they have been labelled with, identifying with a “spoiled” social identity that consequently brings disqualification from total social acceptance (Hutchinson & Bhugra 2000, p. 234; Link et al., 1991). Attributions of moral deficit were described by Asbring and Narvanen in their study of women with a chronic disability. It was reported that the veracity and moral character of sufferers was questioned, their status psychologised, and their problem categorised as fictitious, delegitimised, and deprecated as a women’s complaint. Rosen (2003) compared attitudes towards psychiatric stigma in so-called developed and developing countries.

As well as negative responses, it was found that both groups assisted people with mental health conditions in different ways. The support offered in developed countries included educative and media strategies, whereas that offered in the rural areas of developing countries included greater social inclusion, communal involvement, and a valued work role. It was also observed that family members were not excluded because of issues related to social embarrassment.

3.3 The Impact of Depression Upon Personal Growth

Despite the dire experience and consequences of depression, the literature has also suggested that the experience of depression could potentiate growth, although introspection may be deliberately avoided by some individuals, and may not be a useful therapeutic option at a particular time in a person's stage of development (Bettelheim, 1991). In a recorded forum, Martin Seligman stated that he understood there to be an inherent purpose behind the experience of negative feelings, and consequently, that it was not advantageous to stifle these experiences (McCrossin, 2002). It was felt that feeling sad or depressed "tells us we've lost something", and that this brought with it the potential for the development of persistence, contrary to the "insidious" effects of the self-esteem movement, which tended to "cushion" dysphoria (McCrossin).

Depression could also be perceived as a type of awakening to a, sometimes painful, grim reality (Steiner, 1992; Street et al., 1999). Dorothy Rowe (1978, p. 270) cited from the correspondence of an acquaintance, an unnamed Psychiatrist, who described the experience of depression:

I have experienced a far better, truer understanding of myself. I have become nearer to my feelings. I have felt the sense of having been re-

created. ... Depression ... is an experience that brings great misery and causes a great waste of time, but it can be, if one is fortunate, a source of personal wisdom and worth more than a hundred philosophies.

Rowe (2002, ¶ 16) later enlarged upon this, and related concepts, when she advised upon ways that depressed individuals could regain control over their lives, and stated that “recovery is simply the gaining of wisdom”. This was reiterated in a later radio interview, when she commented that depression could afford a place of retreat within which one could learn, and thereby attain wisdom (Thompson, 2004).

3.4 Experiential Descriptions of the Impact of Depression

Rich insights about the experience of depression can be obtained by listening to the voice of the individual who is familiar with the condition. There is an increasing body of literature which seeks to explain and/or describe this experience by the use of qualitative methodology (Crooks, 2001; Hight, McNair, Thompson, Davenport, & Hickie, 2004; Jack, 1999; McNair, Hight, Hickie, & Davenport, 2002; Stoppard, 1999; Swearington, 1990), as well as personal narratives (Endler, 1982; Groom, Hickie, & Davenport, 2003; Jamison, 1995; Leibrich, 1997; Styron, 1991; Wolpert, 2001). In this way, data about the personal experience of participants is obtained, and used to describe this experience, and/or to formulate theory, so as to expand the collective understanding of depression, and an appreciation of the depressive experience.

Using qualitative methodology that included data sourced from meetings, focus groups, written feedback, and website interactions, McNair and colleagues (2002) discerned a number of themes. These include the consequences of stigma, lack of awareness of depression as an illness, unmet needs in healthcare settings, and

discrimination in the workplace. Comments from the participants about the stigmatic responses of others included, “physical illness happens to me, but depression is perceived to be a weakness within me”, and, “anything to do with the mind is about who you are – that promotes the stigma” (McNair et al., ¶ 32). Other descriptions that provided insight about the experience of depression included the comments of a participant about how the difficulty of the experience was compounded by the insensitive responses of others:

It is common to hear people say: “You look fine! What’s your problem! Do something!” Have those people ever looked into the eyes of the sufferers, dull and lacklustre? Do they see a smile or a tear? No. They save their compassion for the physically afflicted. (McNair et al., ¶ 6).

In their attempts to describe their experience of depression, many authors have stated that it was impossible to describe, and that previous attempts at classification had been inadequate. William Styron (1991, p. 7) described his experience of depression as being “so mysteriously painful and elusive in the way it becomes known to the self – to the mediating intellect – as to verge close to being beyond description”. He also cited the experience of William James, “it is a positive and active anguish, a sort of psychological neuralgia wholly unknown to normal life” (Styron, p. 17). Styron also questioned the adequateness of the word “depression” to describe his experience of being depressed. In keeping with the historic precedence of Freud (1917/1985), Styron felt that “melancholia” was more appropriate and evocative than the often ill-understood and misused term of “depression”, which he considered to be “a true wimp of a word for such a major illness” (Styron, p. 37).

Others have not only written about the difficulty of describing their phenomenology, but also of discerning the substance of their experience. “How far do

our feelings take their colour from the dive underground? I mean what is the reality of my feeling?” (Virginia Woolf, cited by Jamison, 1995, p. 68). Other descriptions of the subjective experience of depression included the comments of an unnamed Psychiatrist who wrote, “I was exquisitely vulnerable: like feeling I was made of glass”, and later, “I have lived then in blackness, grief, vulnerability and despair. Time itself changed” (Rowe, 1978, p. 270). Styron (1991, p. 5, p. 13, p. 26) described his “dank joylessness”, and his sense that his mind was “dissolving”, as if he was experiencing an “insidious meltdown”. Wolpert (2001, p. xv) described depression as:

The worst experience of my life. More terrible than watching my wife die of cancer. ... I was in a state that bears no resemblance to anything I had experienced before. ... I could not think properly. Let alone work, and wanted to remain curled up in bed all day. ... The future was hopeless. I was convinced that I would never work again or recover. There was the strong fear that I might go mad.

Sometimes, narrative may not provide sufficient imagery to describe an experience. When an unnamed woman cited by Rowe (1978, p. 8) was asked how she would paint depression, she described it as, “all sort of clinkery, burnt-away nothingness, [with] no life, nothing colourful in it at all, no colour or anything like that”. Like others before her, Leibrich (1997, p. 41, 44), used poetry to describe her experience of disempowerment, isolation, and stigmatisation, perhaps to remind herself of her identity that was larger than stereotypical labelling. “My illness is not me. ... I am a human being who thinks and feels. So I have times of joy – and times of despair.” Rowe (p. 8), made use of a number of literary citations to convey an understanding of what depression felt like to the sufferer, including that of the 19th century academic, Gerald Manley Hopkins:

I am gall, I am heartburn. God's most deep decree
bitter would have me taste: my taste was me;
bones built in me, flesh filled, blood brimmed the curse.
Selfyeast of spirit a dull dough sours. I see
the lost are like this, and their scourge to be
as I am mine, their sweating selves; but worse.

3.5 The Impact of Depression Upon the Role of the Psychologist

In common with the general populace, depressed Psychologists experience somatic, cognitive, and emotional symptomatology. In addition, their experience of depression shapes their professional practice in both positive and negative ways, and collegial relationships may be influenced.

Gilroy and colleagues (2001, p. 23) reported that depressed Psychologists felt that their depression had “no impact at all on [their] clinical work”, and listed positive consequences of having been depressed in the past. This included increased levels of empathy, the ability to conduct more accurate assessments and diagnoses, less fear of client anger, increased sensitivity to client depression, increased compassion, greater insight into client's experiences, an increased knowledge base, and increased levels of patience and understanding (Gilroy et al., p. 22).

Not all the effects of having experienced depression in the past were reported as positive. Some Psychologists were unable to market their practice, and exhibited poor organization and decision-making skills, poor session planning, decreased levels of energy, lack of confidence, difficulty in maintaining concentration, reduced levels of enthusiasm, a reduced ability to be emotionally present, problems with fatigue and memory, and poorly judged social interactions; as a result, clinicians cut back on their

working hours, cancelled appointments with clients, or took leave of absence for a period of time (Compton, 1999; Coyne, Gallo, Klinkman, & Calarco, 1998; Gilroy et al., 2001; Martin, Blum, Beach, & Roman, 1996; Thomas, Goudemand, & Rousseaux, 1998). Similar results were found in a study of depressed Social Workers; 52% of participants reported negative consequences in the conduct of their professional practice that could be directly attributed to having been depressed (Siebert, 2001).

The majority of Psychologists reported that being depressed did not unduly impact their collegial relationships, and in some cases even improved professional relationships (Gilroy et al., 2001). Some Psychologists may be more critical of colleagues whom they perceive to have less successfully dealt with distressing personal histories; O’Conner (2001) reported that Psychologists who had overcome past difficulties such as childhood trauma, felt that they had been more successful in this respect than similarly afflicted colleagues. Some depressed Psychologists may be reluctant to disclose their condition to their professional peers because of concerns about potential stigmatisation (Gilroy et al.; Hutchinson & Bhugra, 2000; Siebert, 2001; Stromwall, 2002). For example, one group of Psychologists reported that they felt that they were being judged and avoided following their revelation of having had a depressive illness, and they felt that there was “negative stigma attached to being a professional in distress” (Gilroy et al., p. 26). It is surmised that the fear of stigma has contributed to a so-called conspiracy of silence about a condition that “hovers on the borders of social legitimacy” (Rogers et al., 2001, p. 331; Sonneck & Wagner, 1996), and apprehension about being labelled as having a mental disorder may prevent some depressed Psychologists from seeking treatment (Williams & Healy, 2000).

Professional subgroups may hold biased preconceptions about other subgroups, and this may facilitate stigma. For example, Psychiatrists were described as an

ongoing subject of fascination and derision by other medical professionals (Swearington, 1990). They were thought of as emotionally unstable and unclear thinkers, and the profession was described as unscientific, imprecise, ineffective, and low in status (Royal College of Psychiatrists, 2001b, p, 19). It may be that some areas of psychological practice have similarly biased opinions about other areas.

The change of role to one of dependency within the mental health system may be a challenge to the depressed Psychologist. As a result of their change in status from that of health care expert to patient or client, they may find themselves in what is perceived to be an excessively vulnerable position, with the associated issues of a potential loss of perceived power and autonomy (Fisher, 1994; Foucault, 1961/1988; Gilroy et al., 2001; Leibrich, 1997). The WHO (2000b) identified being in roles with comparative less power and autonomy with increased likelihood of depression. Conversely, Double (1996) reported that having a sense of personal control was associated with greater social skills, increased attention spans, perseverance in the face of hard tasks, increased likelihood of success and optimism, as well as reduced levels of anxiety, stress, and depression. Consequently, it may be that the perceived loss of perceived control by the depressed Psychologist has the potential to be further damaged by insensitive treatment approaches, or merely by the need to seek help.

The impact of depression is broad ranging. As well as being as vulnerable as the general population to the impact of depression, the Psychologist is also confronted with issues that are related to having a mental illness whilst working in the area of mental health. The next chapter shall investigate the ways in which the impact and effects of depression have been addressed.

CHAPTER FOUR

ADDRESSING DEPRESSION

In an attempt to reduce the individual and corporate burden of depression, it has been addressed by a range of means. This chapter investigates international and local policy development, the response of professional organizations towards the mental illness of its members, the ways that depression has been openly addressed through use of the media and public disclosure, and finally, the ways in which depression has been addressed through prevention programs and interventions.

4.1 Addressing Depression Through Policy Development

An awareness of the breadth of factors that contribute to health and disability has been the impetus behind the frameworks that have guided policy formation. The WHO developed the International Classification of Functioning, Disability and Health (ICF), designed to be used in partnership with the ICD, earlier discussed in regard to the classification and description of depression (Australian Institute of Health and Welfare, 2003; WHO, 1993, 2001, 2002, 2003). Rather than disability, the ICF describes health and functioning within a social framework, and formally measures interactions between health conditions, and contextual factors that encompass environmental and personal areas (WHO, 2003). Consequently, levels of health and wellbeing, disease and disability, are described as being influenced by a complex number of determinants, and mental health conditions such as depression are perceived to be part of a larger whole. (Australian Institute of Health and Welfare).

Elsewhere, the WHO (2004b) made recommendations for the promotion of mental health practice, and the implementation of programs. It was advised that

projects should be mindful of evidence of effectiveness, principles of prudence, cultural appropriateness and acceptability, financial and personnel requirements, levels of technological sophistication and infrastructure requirements, overall yield and benefit, and the potential for large-scale application (WHO, p. 57).

In Australia, government led initiatives have been directed towards depression as a component of mental health problems in general (Andrews et al., 1999; Commonwealth Department of Health and Aged Care, 1998, 2000; Whiteford, Buckingham, & Manderscheid, 2002). The most recent five year plan (2003-2008) established priority areas that were agreed to by each state health minister, enabling the co-ordination of mental health care approaches and services at a national level (Australian Health Ministers, 2003). Aims agreed upon were to facilitate mental health; to prevent the development of mental illness; to reduce its impact on individuals, families and the community; and to assure the rights of people with mental illness. Priority areas were identified as the improvement of levels of mental health, service responsiveness, safety and quality, innovation and sustainability, and finally, accountability (Australian Health Ministers; The National Mental Health Plan Steering Committee, 2003).

Government policy has not been without its critics. The Mental Health Council of Australia established itself “as the peak independent advisory group to the Federal Minister”, with the aim of auditing mental health reform in Australia (Groom et al., 2003; Hickie & Groom, 2004, p. 124; Mental Health Council of Australia, n.d.). The council called for greater federal and state accountability, and was critical that the National Mental Health Plan of 2003-2008 did not include research, innovation, or sustainability in its list of 34 desirable outcomes. It identified the need for “real” increased levels of monetary investment; intent, accountability, and national

leadership; ongoing review; and sustained innovation (Hickie & Groom, p. 124).

Elsewhere, it was reported that key mental health issues were the grossly unmet need for basic mental health service; the grossly inadequate growth in expenditure on basic services; restricted access to existing services; ongoing human rights abuses and neglect; and the increasing demand for mental health care (Groom et al.).

4.2 Addressing Depression Through Professional Organizations

A number of professional organizations have addressed the depression of their members by attending to the needs of affected individuals, as well as professional issues such as public safety, and the maintenance of professional standards. As it would appear that attention to the needs of Psychologists has been a more recent phenomenon, it is considered following a discussion of what has been done for medical practitioners with mental health concerns, as well as for Psychologists in countries other than Australia.

In the United Kingdom, assistance for so-called “sick” doctors commenced in the 1970’s, at which time the Association for Anaesthetists set up the first service for its members following “much-publicised” suicides (Oxley, 2004, p. 388). Services for Doctors were initially provided through the National Health Service, but as confidentiality has been questioned, independent groups such as the National Counselling Service for Sick Doctors (2004), and The Doctors’ SupportLine (n.d.), have been established. Professional Colleges offer some support, but the focus of the Medical Association is more upon patient safety rather than the provision of counselling (National Counselling Service for Sick Doctors; Oxley; The Doctors’ SupportLine). Despite these efforts, responses were criticised for their inconsistency and inadequacy; as recently as 2003, Stanton and Caan described the need for a

collegial response towards their fellow medical practitioners, and stated, “we owe a duty of care to our colleagues ... at present we are letting them down” (Stanton & Caan, 2003, p. 97). Elsewhere it was suggested that in order to create an “anti-prejudice” climate, stigmatising attitudes should be regarded as a form of professional misconduct (Royal College of Psychiatrists, 2001b, p. 26).

In Canada, doctors’ health initiatives include the Canadian Physician Health Network, and the Centre for Physician Health and Wellbeing, which has the aim of not only assisting medical practitioners, but also their families (Puddester, 2004). In the United States of America, programs to assist medical practitioners commenced around the early 70’s, and thereafter developed in most states (Brown & Schneidman, 2004). Reportedly, the focus of most of these groups is evaluation and monitoring, rather than care, and the recent move to “outsource” some programs to the private sector has introduced concerns about ongoing confidentiality (Brown & Schneidman). Perhaps in response to this concern, independent support groups have been established such as The Institute for the Study of Health and Illness (n.d.), and Physician Recovery Networks (Schattner et al., 2004).

The Victorian Doctors’ Health Program was established by the Medical Practitioners Board of Victoria, in association with the Australian Medical Association; its focus is the treatment and referral of members, and apparently the primary psychiatric problem for which doctors seek assistance is depression (Schattner et al., 2004; Warhaft, 2004; Wilhelm & Reid, 2004). In New South Wales, the Impaired Registrants Panel was established in order to assess the capacity of referred medical practitioners to function, whilst protecting the public interest (Schattner et al.). Independent support is available from the Doctors’ Health Advisory Service, which provides telephone and internet support, as well as self-care

workshops (Doctors' Health Advisory Service, 2005; Hetzel, 2004). In addition, the Royal Australian and New Zealand College of Psychiatrists provides support services for its members (Schattner et al.).

In the area of Psychology, the American Psychological Association established an advisory committee concerning the so-called impaired Psychologist in 1981, about 10 years after similar moves for medical practitioners. As a result, a self-help group was established, and 11 years following this, issues associated with depressed Psychologists were addressed in its ethical principles (Barnett & Hillard, 2001; Good, Thoreson, & Shaughnessy, 1995; Laliotis & Grayson, 1985). Criticism was directed at the belated response; Barnett and Hillard (p. 205) reported that "the profession of psychology has not responded as quickly to the difficulties of distressed and impaired psychologists", and recommended that the initiative of other groups in the areas of prevention, identification, and the treatment of need, was followed. Members also had variable understanding about the support available from professional organizations (Floyd & Myszka, 1998).

Information about the provisions made for depressed Psychologists in Victoria was obtained from the Psychologists Registration Board of Victoria, the Australian Psychological Society, and the Victorian Psychologists Association. It would appear that at this stage formal support is yet to be established.

Of relevance to the exploration of the depression of Psychologists in the current thesis, and the possibility that depression may impact upon professional practice, is a reading of the Psychologists Registration Act, 2000, which, amongst other matters, describes the expectations for Psychologist's professional standards and the protection of the public (Victoria Government, 2000). The Psychologists Registration Board of Victoria, as part of its role in the regulation of the profession of Psychology in

Victoria, oversees complaints against Psychologists, and assesses the impact of these complaints upon practice (Psychologists Registration Board of Victoria, 2003, 2004). The annual reports of 2003 and 2004 of this organization, indicate an absence of complaints about the health status of Psychologists and its influence upon their standard of practice (Psychologists Registration Board of Victoria).

4.3 Openly Addressing Depression

Public awareness of depression has been addressed in the training of mental health professionals, by the use of the media, and through the public testimony of respected figures. A need to openly discuss depression upon a basis of knowledge has activated many of these moves.

In recognition that the experience of depression may be a common reality within the profession of Psychology, Pope and Tabachnick (1994) recommend that training programs should teach that any Psychologist might experience clinical depression at least once. It was argued that this would provide “assurance that such experiences are not inherently discordant with their professional identity” (Pope & Tabachnick, p. 255). Elsewhere it was reported that, in common with some other universities, medical students at Monash had been taught stress-management techniques as part of their coursework (Schattner et al., 2004).

Lee (2004) was critical of the reportedly inadequate training about depression within undergraduate medical programs in eight Asia Pacific nations. This is a significant matter as GPs are frequently the first professionals with whom the sufferer of depression may confide, a fact that was enumerated by Goldney and colleagues (2004) to be as many as 70% of depressed individuals. Poor training of GPs may contribute to future diagnostic, and therefore treatment, shortfalls (Hickie et al.,

2001b; Lecrubier, 1998; Lee; Rogers et al., 2001). In addition to addressing student training, the knowledge base of GPs about depression was also being updated through professional development programs such as SPHERE (Structured Problem Solving and Cognitive Therapy for Depression) (beyondblue, 2005; Hickie, 2000; Hickie et al., 2001a).

The use of the media as a means of disseminating information about depression has been an issue that has caused some dissent amongst mental health professionals. Some would argue that the media has not always prized accuracy, and has distorted public understanding about mental illness issues by “dehumanisation” and “sensationalism” (Salter, 2003, p.123; Salter, & Byrne, 2000; Persaud, 2000). Nairn, Coverdale, and Claasen (2001) reported that newspaper stories about mental illness were frequently stigmatising and more negative than that provided by source material. These researchers discerned four main themes in the media, namely human rights issues, vulnerability, the risk of dangerousness and threat, and stories about individuals and/or their mental health condition. Elsewhere, using a research base that was not limited to the print media, Brunton (1997) found that individuals with mental health issues were commonly stereotyped as rebellious free spirits, homicidal maniacs, or female seductresses. As a result of these and other observations, Salter recommended that the profession of Psychiatry should develop a greater understanding of the operations of the media, with the ultimate aim of facilitating more accurate portrayal of issues associated with mental illness.

A number of public figures have publicly revealed their experience of depression in order to normalise public perceptions, inform, and hopefully reduce stigma. Beyondblue’s interactive website has presented the personal experience of Australian public figures such as the actors Rachel Griffiths and Garry McDonald

(beyondblue, 2005). Similarly, following a sensitive series about male depression and suicide, The Age newspaper published a front page article concerning a respected footballer who had disclosed his depression to his colleagues (Ker & Nader, 2004). This was followed by further articles which combined human interest as well as information about depression, such as the depression and recovery of another footballer, a personal account of post natal depression, and the depression and suicide of a male staff member (Fuller, 2005, Henstrom, 2005; Waldon, 2005). Elsewhere, Associate Professor Meg Smith, of the University of Western Sydney, and president of the New South Wales Association for Mental Health Inc., discussed her experience with bi-polar disorder on radio and television (Cohen, 2004; Swan, 1999), and a female GP published an account of her experience of depression in the Medical Journal of Australia (Tolhurst, 2004).

In New Zealand, Julie Leibrich, the then Commissioner of the New Zealand Mental Health Commission, discussed her experience with depression during an address to the Royal Australian and New Zealand College of Psychiatrists (Leibrich, 1997). Her aim was to facilitate increased dialogue, and to assist her audience in understanding mental illness from the point of view of the sufferer. In the United Kingdom, the musician, Adam Ant, discussed his problems with bi-polar disorder in a television documentary, and was cited on the Changing minds website, as wanting to encourage “more famous people to talk openly about their experiences of mental health problems” (Royal College of Psychiatrists, 2004a).

The American author and Psychologist, Kay Redfield Jamison (1995), has also written frankly about her experience with bi-polar disorder. In an Australian radio interview she stated that openness about such conditions was of value. She said, “I think it’s important that people talk openly about mental illness ... It’s bad enough to

have a terrible mental illness without feeling as though you can't talk about it.”

(Doogue, 2001, ¶ 9). In an earlier television interview, Jamison discussed some of the difficulties associated with disclosure:

I encourage people to think long and hard before they do so because people still have a lot of attitudes that are awful. There's a lot to be said for being open and I think ... the problems with the stigma of mental illness is the professionals haven't spoken openly, so people don't know there are a lot of people out there are doing well in work and having great personal lives. ... When people keep quiet about it, then people have no idea how successful people can be. (O'Brien, 2000, ¶ 66-67).

4.4 Addressing Depression Through Prevention Programs

Depression has been addressed by using a variety of strategies in a number of countries. Program commonalities include addressing the areas of education, intervention, research, stigma, and discrimination. This section will discuss a limited array of examples in the United Kingdom, Europe, Asia and the Pacific, and finally, national and regional programs in Australia.

In the United Kingdom, the Royal College of Psychiatrists has specifically addressed depression, as well as mental health issues in general. In 1992 the college launched a five-year national campaign, “Defeat Depression”, with the aims of educating GPs and other health professionals about the recognition and management of depression; stigma reduction; and educating the general public about depression, treatment availability, and the importance of early intervention (Royal College of Psychiatrists, 2004b). A 5% to 10% improved positive attitude towards depression was reported as a consequence of this initiative (Paykel et al., 1998). Nevertheless,

there still appears to be room for improvement; 25% of the respondents in a later survey continued to endorse statements that people with depression were dangerous to others, and 20% felt that depressed people could pull themselves together (Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000). Other current initiatives by the Royal College of Psychiatrists includes “Changing Minds: every family in the land” (which is aimed at increasing awareness, and reducing stigma, of mental health issues in general), and the broadly distributed “Help is at Hand” pamphlet series (which includes such titles as “Men Behaving Sadly”, and “Depression in the Workplace”) (Crisp, n.d.; Royal College of Psychiatrists, 2001a, 2004b; Timms, Briscoe, Hart, Cohen, & McClure, 2004).

Elsewhere in Europe, Angermeyer and Matschinger (2004) reported that despite a number of efforts, public attitudes towards depression had varied little in the last decade. Although a sense of pity towards sufferers of depression had apparently increased, levels of public fear and social distancing still remained. In other research, it was found that people who were more familiar with mental illnesses in general, tended to be more prosocial towards those who had a mental disorder (Angermeyer & Matschinger, 1996).

An initiative to reduce the social and economic burdens of depression in Asia, SEBoD, commenced in 2003, with the expressed goals of addressing barriers to early diagnosis and treatment, education, and the reduction of stigma for both individuals and their families (Sartorius, 2004; Hickie, 2004c). Elsewhere in Asia and the Pacific, similar aims motivated the “Defeat Depression” project in Hong Kong, and “Mind your Mind” in Singapore, which was focused upon the so-called minor mental health issues, including depression (Leung & Cheung, 2004; Yeo, 2004). Tanaka, Ogawa, Inadomi, Kikuchi, and Ohta (2003) reported on a Japanese community educational

program that had been established in response to government directives to inform about mental health issues in general. A scale was developed in order to determine program effectiveness, and it was found that there was a general, but not significant, improvement in positive attitudes towards mental health issues. One participant stated that as a result of participating in the program, “I now recognise that the illness is due to impairment of the brain and treatment using drugs is effective” (Tanaka et al., p. 601). However, the long-term effects of the program may be brought into question, as the instrument appeared to be administered immediately following its completion. “Like Minds, Like Mine” was developed in New Zealand in order to counter the stigma and discrimination associated with mental illness, and included the direct involvement and participation of individuals who had a mental illness (Vaughan & Hansen, 2004). As a consequence of the program, it was found that there was a significant increase in the awareness of mental health issues, and individuals who had a mental illness reported having an increased sense of social acceptance (Vaughan, 2004; Vaughan & Hansen). The reported positive effects appear to be congruent with research elsewhere which observed that individuals with mental health concerns increasing perceived, or asserted, themselves as “experts” about the details of their condition (Bolzan, Smith, Mears, & Ansiewicz, 2001). This was in contrast to the more passive role of being merely a “consumer” of mental health services (Bolzan et al.).

Beyondblue, an Australian national depression initiative, was established in order to focus upon the de-stigmatisation of depression by increasing community awareness; support consumer and carer advocacy; promote prevention and early intervention; provide training; and promote research (Hickie, 2000, 2004a; Hickie et al., 2001a, 2001b). It was reported that few other countries had attempted such a

coordinated approach towards depression (Hickie, 2004a, 2004b; Hickie & Groom, 2004). Recent perusal of the beyondblue website indicates that its brief has apparently extended to include anxiety, and substance-use related disorders, presumably because of their comorbidity and concurrence with depression (beyondblue, 2002, 2004, 2005). The initiative is composed of a diverse number of programs, that currently includes blueVoices, for consumer and carers; Ybblue, which focuses upon the depression of young people; postnatal Depression; research; media liaison; and SPHERE, a national depression project aimed at increasing the diagnostic and treatment skill base of GPs (beyondblue, 2005; Hickie, 2000; Hickie et al., 2001a, 2001b). In 2002, Hight, Hickie, and Davenport (2002) reported that mental health campaigns in Australia were yet to achieve meaningful changes; they found that although mental health was generally not perceived to be a major health issue, depression was recognised as the major mental health problem. Two years later, Hickie (2004a) reported upon the positive impact of beyondblue following the first three years of its operation, in the areas of increasing depression awareness, and reducing stigma and major social barriers. A later evaluation reported that, despite progress, systemic and societal change was still required (Pirkis et al., 2005). A program designed to facilitate the skills of GPs in the area of common psychiatric problems in general, Better Outcomes in Mental Health Care (BOiMHC) also reported high levels of interest from the target group (Hickie, Pirkis, Blashki, Groom, & Davenport, 2004).

Elsewhere in Australia, local organizations that focus on depression include the Black Dog Institute, which is associated with the University of New South Wales, and Sydney's Prince of Wales Hospital (Robinson, 2002; Robotham, 2002). Apparently it operates in the areas of education, research, and clinical service, including

telepsychiatry, a second-opinion consultation service for rural and remote area health professionals (Black Dog Institute, n.d.). Other depression-focused groups include The Centre for Mental Health Research (2005), and the Clinical Research Unit for Anxiety and Depression (Crufad, 2004). The former group emanates from the Australian National University, and produces such things as BluePages, accessed by the internet, and provides information and communication opportunities through a bulletin board, the BlueBoard (The Centre for Mental Health Research). The latter group was developed by the University of New South Wales school of Psychiatry, Sydney's St. Vincent's Hospital, and the WHO's Collaborating Centre; it is reportedly involved with research, and the WHO with epidemiology and health policy (Crufad). It is not certain whether these groups duplicate services, and it is also unclear whether the need for research support formalised their instigation.

4.5 Addressing Depression Through Interventions

General principles that guide successful interventions for depressed individuals are presented by the WHO, and a number of professional organizations. The WHO has recognised the value of prevention as well as intervention, the importance of tackling problems across the lifespan, and recommended three grades of interventions (WHO, 2004a, 2004b). Recommendations for the first group, "universal interventions", included the strengthening of protective factors such as school-based programs, exercise programs for the elderly, efforts to reduce child abuse and neglect, and bullying. The second group, "selective interventions", included suggestions for training parents in behavioural child rearing strategies, programs for the children and families of depressed individuals, the elderly, refugees and those exposed to war trauma, and attention to coping with major life events such as death or divorce,

unemployment, economic instability and poverty. The final group, “indicated programs”, recommended working with individuals with depressive symptoms but no disorder, group support, education, cognitive-behavioural groups, self-help materials, mass-media, internet, light therapy, and comorbid conditions such as anxiety disorders (WHO, 2004b). The same publication reported that approaches which utilised relevant recommendations had successfully reduced the incidence of depression by levels of about 11%.

The APS (Australian Psychological Society, 2003a) has provided information for members concerning recommended interventions for depression. This information has been graded according to research rigor, and accordingly, level I recommendations were made for Cognitive Behavioural Therapy (CBT), and level II recommendations were made for Interpersonal Therapy (IPT). Similar research has been undertaken by the Royal Australian and New Zealand College of Psychiatrists, and made available on its website for member use (Ellis, Hickie, & Smith, 2003). Ellis and colleagues summarised this research and its recommendations for CBT and IPT approaches, and pharmacology use. It was found that the components of an effective treatment plan included the establishment of a therapeutic relationship, treatment alliances (including personal and professional associates of the client), and cultural and language services. The three greatest contributions to positive treatment outcomes were listed as maximising client cooperation, identifying and addressing known risk factors for relapse, and maintaining treatment programs for as long as necessary in order to allow for stabilization (i.e. for at least one year, and for as long as three years) (Ellis et al.).

Elsewhere, a number of research findings have been published. The general recommendation for the superiority of CBT methods (Australian Psychological

Society, 2003a; Vos et al., 2004), has been challenged by some researchers. Those who support IPT and its variants point the high levels of relapse when using CBT (King, 1998; Ludgate, 1994; Shea, Elkin, & Sotsky, 1999), others indicate the improvements wrought through IPT (Hilsenroth, Ackerman, Blagys, Baity, & Mooney, 2003), and others suggest there is little difference in results between either methodology when treating depression (Leichsenring, 2001). The training a depressed Psychologist received did not necessarily bias the treatment methodology that was sought; Gilroy, Carroll, and Murra (2002) found that 40% of CBT therapists chose Psychodynamic therapy for their own treatment, with only 12% seeking CBT, a response found incongruous by some (Dattilio, 2003). Therapeutic processes that combine therapy and medication are subject to ongoing research, and have been found to be efficaciousness (Ball, Mitchell, Malhi, Skillecorn, & Smith, 2003; Huber, 2005; Stein et al., 2004). As well as individual therapy, and group programs for depression, alternate approaches included the use of the internet, self-help literature, radio programs, and specifically designed school-based programs (beyondblue, 2005; Ormsby, 2004; Kennedy, Lam, Nutt, & Thase, 2004; Schochet, Wurfl, & Hoge, 2004; The Centre for Mental Health Research, 2005). It has also been reported that there is variable usage of specialist mental health services, such as Psychology and Psychiatry, for depression, and that some Australians preferred to use complementary therapies (Goldney, et al., 2004; Hickie, 2004a; Jorm, Christensen, Griffiths, & Rogers, 2002).

Some researchers have expressed discomfort with aspects of the treatment of depressed women. Whitney and colleagues (2002) reported that depressed females generally presented with a different symptom profile, course of depression, and response to treatment than males; these differences were not necessarily noted in so-

called generic treatment approaches. Elsewhere, Hurst and Genest (1995) were critical that CBT manuals implied gender neutrality, and were inattentive to crucial gender issues. Astbury (1996, 2001) also provided evidence that there was bias and stereotyping in the treatment of women, and that, as a group, they were over prescribed with medication.

A range of positive and negative responses to the use of pharmaceuticals was reported. Their value in cases of serious depression was stressed, as was the importance of symptom abatement, and this contrasted with the fear of addiction expressed by some clients, as well as their reluctance to use medication as a crutch (Ellis et al., 2003; Gammel & Stoppard, 1999; Goldstein & Rosselli, 2003; Jamison, 2000; Preboth, 2000). Patten and Beck (2004) observed a changing pattern of medication usage in Canada, and reported upon the trend to increasingly prescribe antidepressants. The neutrality of the input of pharmaceutical companies was at times open to question; it was observed that the earlier mentioned SEBoD program in Asia was partly funded by an unnamed pharmaceutical company (Sartorius, 2004). In addition, the Mental Health Council of Australia, cited earlier as an independent advisory group, had produced a health report on depression that was apparently intended for public rather than professional use, which was co-produced by the Pfizer company, and had that pharmaceutical company's name in the title (Hickie & Groom, 2004; Mental Health Council of Australia and Pfizer Australia; 2004).

Elsewhere, the benefit of Pharmaceutical materials in the treatment of depression was queried. Healy (2004) strongly questioned the intervention assumptions of a number of national depression initiatives in the United Kingdom that advocated medication, and stated that the marketing of anti-depressants was based upon business rather than scientific precepts (Healy, p. 107).

As noted in this chapter, depression has been addressed in response to the evidence of its destructive effects. Policies and procedures have been constructed upon an understanding of the epistemology and epidemiology of depression, of its risk factors and aetiology, and of its global and individual impact. In the preceding chapters, the depression of Psychologists has been addressed both as an element of these factors, as well as a separate matter that needs to be more fully considered. The literature suggests that the reasons for this include the pressures and expectations inherent to the profession of Psychology, the possible characteristics of individuals who chose to enter the profession, the possibly damaging effects of stigma and/or silence about being depressed, and an apparently delayed and incomplete organisational response to the problem. This information has provided a basis for the current investigation about the professional attitude of Psychologists towards the depression of Psychologists. The way this is to be investigated in the current thesis will be discussed in the next chapter.

CHAPTER FIVE

THEORETICAL RATIONALE

This chapter shall describe the aims of the current research within the context of the review of the available literature explored in chapters 1 to 4. Research questions are described, and a summary of the primary themes found in the literature discussed. This is followed by a rationale for the research methodology selected in this thesis.

5.1 Aims and Context of the Current Research

The current research into the professional attitude of Psychologists towards the depression of Psychologists has sought to provide data that may inform further discussion, and thereby partly redress the gaps within the available literature about the depression of Psychologists. The primary aims are to gain an increased understanding of the experience and opinions of this cohort, as well as to develop theory based upon this information.

A reading of the literature has indicated areas of relevance to the research question. These areas include the development of an understanding of depression through defining it, and considering the implication of these definitions according to their conceptual framework. Another area was related to the prevalence of depression and its spread within population groups. The available data about the prevalence of depression amongst Psychologists and other mental health professionals was noted, and it was questioned whether Psychologists had chosen not to disclose their experience of depression, or had couched it in ambiguous terms. In chapter 2, explanations as to why some individuals became depressed were explored. It was noted that attributions of aetiology were not always able to be separated from value

judgements about the nature of depression, or the nature of the sufferer of depression. In addition, the nature of psychological practice, as well as reported characteristics of Psychologists, were suggested as predisposing or exacerbating factors for depression. The literature also indicated that gender related issues were of interest, and it was observed that some research explored these matters in experiential ways that challenged standard explanations for the experience of depression in women. In chapter 3, the physiological, psychological, social, professional and collegial effects of depression were examined, both in research literature and experiential accounts. Stigma was recognised as an area of concern, and it was also reported that in some cases the experience of depression could be used as an opportunity for personal growth. Finally, in chapter 4, ways in which depression has been addressed were discussed. These areas included policy formation, preventative and treatment programs, and the open discussion of personal experience in public forums. The fact that the depression of Australian Psychologists was yet to be fully addressed in the areas of prevention and treatment was noted.

Four main areas were discerned in a close reading of the available literature that investigated the research question concerning the depression of Psychologists, and these are summarised in Table 7. The areas are a framework of understanding, or the ways in which depression is described and understood within the general population, amongst mental health professionals in general, and amongst Psychologists; personal experience, or the way in which the experience of depression is described by sufferers, and its interaction on Psychologists' roles; disclosure or silence, or public responses towards those who are depressed, and the ways in which sufferers of, and researchers into, depression respond; and external responses, or the ways in which depression has been internationally, nationally, professionally addressed.

Table 7
Summary of Findings in the Available Literature

Primary Areas	Secondary Areas	Sub-categories
Frameworks	Descriptions	Definitions Diagnostic manuals
	Epidemiology	Prevalence DALY
	Models	Aetiology and attribution Medical model Gender
	Comparisons	The general population Other mental health professionals
Personal experience	Experience of depression	Symptomatology Phenomenological experience Personal development
	Personality	Characteristics of Psychologists
	Professional relations	Impact on practice Collegial relationships
	Role	Pressures and expectations Role of dependency within the mental health system Having a mental health problem whilst working in a mental health area
Disclosure or silence	Stigma	
	Disclosure	Openness Secrecy
	Public responses	Public awareness programs The media Literature
	Research	Grounded theory Other methods
External responses	Policy development	International National
	Professional organizations	
	Work place responses	
	Prevention programs	
	Interventions	

It is speculated that these four areas will be of importance to the participants in the current investigation. However, the way in which the opinions and experiences of the participants refer, reject, or supplant these areas is a separate matter. The nature of the theoretical methodology which was selected to investigate the research question, namely grounded theory, does not traditionally impose an external conceptual framework upon the data; instead, theory is driven by the data (Ambert et al., 1995; Glaser, 1992; Glaser & Strauss, 1967). Within the methodological constructs of the current thesis, the information consequently serves but does not govern the results of the research. The information summarised in Table 7 clarifies the current understanding about depression and Psychologists, and can be used as a point of reference with the results of the current research. This, and other matters related to methodology selection, are discussed further in the next section.

A number of research questions were stimulated through research of the available literature. These questions include whether the potential for stigma prevents Psychologists from disclosing their experience of depression, and if the experience of depression has an effect upon the professional role of Psychologists (Fisher, 1994; Gilroy et al., 2001; Gustinella, 1995; Hutchinson & Bhugra, 2000; Schreiber et al., 2000; Siebert, 2001; Stromwall, 2002; Wesley, 1994). Additional areas of interest include whether there are issues related to having a mental health problem whilst working in a mental health area, whether depression is perceived in a pathologised, or medicalised, manner, and to what degree the population under investigation in the current research perceive that gender-related issues influence their experience of depression (Fava, 2002; McMullen, 1999; Stromwall; Whitney et al., 2002). It is also questioned whether the conclusions drawn from the literature pertaining to other groups such as General Practitioners, Nurses, and Psychiatrists have relevance to

Psychologists, (Rout, 1999a; Siebert). Interview questions were based on this information, and are appended for reference (see Appendices F and G).

5.2 Choice of Research Model

This section shall discuss the characteristics of qualitative research, then describe five models of qualitative research and consider their suitability for the current investigation into the professional attitude of Psychologists towards the depression of Psychologists. The chosen methodology, grounded theory, is discussed in greater detail.

Qualitative methodology was thought to be the more suitable approach for the current research. This is because it is a process of inquiry that locates the observer within the world of the participants; in other words, by using distinctive methodological traditions, the researcher attempts to interpret phenomena in terms of the meanings people bring to them, and thereby enable the participant's world to become discernible to others (Creswell, 1998, p.15; Denzin & Lincoln, 2000, p. 3). Data is collected that informs about participants' perceptions, processes, phenomena management, and their relationships with their social world - factors that may be influenced by ever changing historic and social contexts (Berg, 1989; Miles & Huberman, 1994). In short, the role of the qualitative researcher is to "enter the phenomena" under investigation so as to "discover what is significant from the viewpoints and actions of people who experience it" (Charmaz, 2004, p. 981).

Qualitative research has a number of general characteristics. It investigates a phenomenon in depth rather than breadth; seeks to discover the motivations behind behaviour, thoughts, and attributions of meaning; frequently discovers rather than confirms established hypotheses; emphasises meaning; and, is contextual (Ambert,

Adler, Adler, & Detzner, 1995). As a result, qualitative research can provide a “vivid, dense, and full description” that is expressed in the natural language of the phenomenon being explored (Hill, Thompson, and Williams, 1997, p. 517). In addition, new data can be produced, voice can be given to individuals or situations that have been under-represented, theories can be amended or advanced, theoretical biases can be addressed, new questions can be asked, and the unexpected can be confronted (Ambert et al.). From this information, concepts can be discovered, theory refined, causal explanations suggested, and hypotheses developed (Babbie, 1998; Maxwell, 1998; Miles & Huberman, 1994; Strauss & Corbin, 1998).

Consequently, qualitative research is the method of choice when there is a lack of theoretical basis for understanding a particular phenomenon, and if the research question is investigated within the context of the participants’ real-life setting (Miles & Huberman, 1994). As the question investigated in this project is provoked by gaps in the available literature, it is apparent that the research method of choice is qualitative. The question remains as to which qualitative method is most suitable to answer the research question. It is essential that there is congruency between the topic researched, and the research method, as different research methods are more suited to answering different research questions; each epistemological orientation has its own worldview and assumption that governs the questions asked (Ambert et al., 1995).

Various authors have given precedence to different methods of qualitative research. Ambert and colleagues (1995) listed a variety of qualitative procedures, including oral and written words, recorded field notes, life histories and narrative stories, as well as visual observations. Other researchers categorised the major qualitative methodologies as ethnography, case study, grounded theory, and discourse analysis (Angen 2000), or, ethnography, grounded theory, action research, and

feminist research (Burman, 1997; Morawski, 1997). In consideration of their frequency of use as research methodologies, as well as their capacity to be representative of the diversity of qualitative research, Creswell (1998) prioritised five qualitative methods, namely biography, phenomenology, grounded theory, ethnography, and case study. These five research methods will be discussed in turn, and consideration given to their usefulness for the area under investigation. The discussion will conclude with an evaluation of grounded theory, the research method selected for the current study.

A biography is the study of an individual and his or her experiences, as told to the researcher or sourced in archival material; sub-types include individual biographies, autobiographies, life histories, and oral histories (Creswell, 1998; Denzin, 1989). Researchers may take an approach that is objective or interpretative, gives consideration to historic contexts, and/or enlarges understanding through the introduction of fictionalised accounts (Creswell; Denzin). A number of biographies about an individual's experience of depression have been written, including William Styron's *Darkness visible: A memoir of madness* (1991), and Lewis Wolpert's *Malignant sadness: The anatomy of depression* (2001). Both texts have contributed insights about the experience of depression, and expounded a particular thesis about the experience: Styron's work portrayed a sense of the lived experience of depression, whereas Wolpert's more instructional approach explored many aspects of depression, including its historic context, aetiology, and treatment. Elsewhere, Barker-Benfield (1985) used a biography of the 18th century writer, Mary Wollstonecroft, to explore the author's depression within the context of a personal and historic environment that was reportedly hostile to females. A biography is not considered to be suitable for the current project as information from a number of individuals from which theory could

be drawn is sought, rather than an individual's story about his or her experience of depression.

A phenomenological study describes the meaning of the lived experiences for several individuals about a concept or phenomenon (Amedeo, 1997; Ashworth, 1996; Moustakas, 1994). The researcher undertakes "the phenomenological quest for entry into the life-world of the research participant" (Ashworth, p. 1), so as to discern "the central underlying meaning of the experience, and emphasises the intentionality of consciousness – where experiences contain both the outward experience and inward consciousness based on memory, image, and meaning" (Creswell, 1998, p. 52). This was observed in the research of Hedelin and Strandmark (2001), who sought a deeper understanding of the meaning of depression to elderly women. The so-called essence of depression was explored from the point of view of the participants, and thereby the researchers gained an understanding about the "whole life space" of the participants (Hedelin & Strandmark, p. 401). Elsewhere, Raingruber (2002) used narratives that were interpreted phenomenologically to investigate issues about the relationship of stigma with depression and/or suicidal ideation. A phenomenological study is not the research method of choice for the current study, as, rather than focusing only on understanding the intrinsic nature of participants' attitudes, or experiences, to do with the depression of themselves or other Psychologists, the aim is to formulate theory that is based upon a developed understanding of this information.

An ethnography is "a description and interpretation of a cultural or social group or system" (Creswell, 1998, p. 58). In this model, data is gathered through a prolonged period of fieldwork, which may extend for as long as one year. The group's patterns of behaviour, customs, and ways of life are observed by the researcher, who produces an holistic cultural portrait that includes the researcher's interpretations

(Creswell; Hammersley & Atkinson, 1995). Bhui, Bhugra, Goldberg, Sauer, and Tylee (2004) attributed inconsistent findings about the prevalence of depression in South Asians living in Britain to a failure to include ethnographic considerations within research structure. Consequently, cultural adaptations were made to the instruments that were used, and bilingual interviews were conducted. The findings indicated higher levels of depression within the target group in some areas, a result that had not been anticipated, and which would not have become apparent without recourse to ethnographic considerations during interviews, as recommended by other researchers into depression (Tsai & Chentsova-Dutton, 2002). In the current study, Psychologists are not perceived as a cultural group or system to be observed, although this may be an area of interest in another study. The core interest in this study is to discern theory that develops out of data obtained from interviews in response to the research question about depression.

A case study is “an exploration of a ‘bounded system’ or a case (or multiple of cases) over time, through detailed, in-depth data collection involving multiple sources of information rich in context” (Creswell, 1998, p. 61). A case study is bounded in time and space, as well as the case being studied (which could be a program, event, activity, or individuals) (Creswell; Stake, 1995). Soloff (2003) presented the case study of a woman who had chronic depression and suicide ideation over an eleven-year period. The in-depth discussion enabled the writer to discuss suitable treatment methods, the choice of which was moderated by the woman’s irregular clinical attendance. Van de Vliet and colleagues (2004) investigated whether exercise, which in this case was included as part of a CBT program, was beneficial to a depressed male. Their research was based on retrospective interviews of the single case. A case study is not considered to be suitable for the current project because the research is

limited to investigating a specific research question to do with depression, so that theory about this question could be developed.

Grounded theory was developed by Glaser and Strauss in the 1960's from the "Chicago School" of the 1920's and 30's, and its interest in anthropological ethnography (Ambert et al., 1995; Denzin & Lincoln, 2000; Glaser & Strauss, 1967). In the years subsequent to their collaboration, Glaser's and Strauss' opinions about the process of grounded theory diverged on some points, perhaps in reflection of their differing backgrounds: Glaser's academic heritage had been in quantitative social research, whereas Strauss' had been in qualitative investigation (Glaser, 1992, 1999; Jeon, 2004; Strauss & Corbin, 1990, 1998).

Grounded theory, the so-called gold standard of qualitative data collection (Silverman, 2000, p. 291), purposes:

To generate or discover a theory, [or] an abstract analytical schema of a phenomenon, that relates to a particular situation. This situation is one in which individual's interact, take actions, or engage in a process in response to a phenomenon (Creswell, 1998, p. 56).

The key focus of grounded theory is illustrated by the slogan of the website of the Grounded Theory Institute: "trust in emergence" (The Grounded Theory Institute, n.d.). During the process of data collection and data analysis, the grounded theory researcher aspires to be objective, whilst at the same time being open to developing, or emerging, theory (Ambert et al., 1995; Glaser, 1992; Glaser & Strauss, 1967).

Theory emerges from attending to participants during the process of an interview, and the constant comparison of current data with previously collected information, in order to elicit patterns, themes, and common categories (Babbie, 1998; Bickman & Rog, 1998; Blaike, 2000; Glaser & Strauss, 1967; Mason, 1996; Miles & Huberman,

1994; Strauss & Corbin, 1990). The constant comparison of data operates like an internal check that increases the rigor of a particular investigation:

This modifying of theory is crucial because it constantly keeps up with what is going on as changes occur and it increases its formal abstraction. It constantly corrects for poor data (eg. response sets of interviews), and it brings the theory into closer grounding. (Glaser, 1999, p. 841).

The emphasis in grounded theory is not only upon collecting data, but also on organising the rich and complex ideas that emerge from the analysis of the data, so that hypotheses are produced that are not dependent upon research speculation, but upon data deduced from the phenomena under investigation (Glaser, 1992; Miller & Fredericks, 1999; Strauss, 1993; Wilson & Hutchinson, 1996).

Since its inception, the process of grounded theory has been utilised, adapted, and incorporated, by a variety of epistemologies and researchers with assorted theoretical aims, including those who operate in the areas of objectivist, feminist, Marxist, and phenomenologist research (Agigian, 1999; Ambert et al., 1995). Some writers have lauded this diversity as evidence of the flexibility inherent to grounded theory, namely, its capacity to be inclusive, adapt to changing social contexts, challenge basic preconceptions, and to discern the unexpected, all of which are valued attributes within the human sciences (Arcury & Quandt, 1999; Charmaz, 2000; Wolcott, 2002).

Belgrave, Zablotsky and Guadagno (2002, p. 1427) add, “health researchers are dealing with many new issues, situations, and concepts ... until we know what the real issues are, our work in such areas calls for inductive, qualitative approaches”. Other researchers have been critical of the methodological authenticity of some of this research (Charmaz; Miller & Fredericks, 1999; Wilson & Hutchinson, 1996), and

warned of the consequences of using so-called grounded theory to service the agenda of the researcher. “Corruptions of the method in recent years place its credibility at risk, and the findings generated are earning a reputation as trivial or obvious” (Wilson & Hutchinson). The less prescriptive nature of grounded theory may have made it more open to ill-advised usage, which neglects reference to the systematic approach inherent to the method (Morse, 1999b). Grounded theory “is a total methodological package. It provides a series of systematic, exact methods that start with collecting data and take the researcher to a theoretical piece that is publishable” (Glaser, 1999, p. 836).

Grounded theory has been selected as the model for research in this project because of its capacity to answer the primary research question about the depression of Psychologists, because of the opportunity it offers to describe the experiential nature of the depression of Psychologists, and for this to inform theory development. The method, thereby, facilitates challenges to “socially structured fictions”, or assumptions, that have been formulated without theoretical basis about depression and Psychologists (Glaser, 1999, p. 842). A close reading of the literature indicates that the needs of this particular cohort have not been fully addressed in the available research, and as they are not able to be operationalised, informed hypotheses cannot be formulated. Grounded theory has provided the systemic framework for the various research stages in the current project: data collected from objectively conducted semi-structured interviews; progressive comparison of the findings from each interview to guide ongoing categorisation and further data collection; the analysis of the information by dis-assembly and re-assembly into generalisable categories; an analysis of similarities, differences, and interconnections; and finally, the formation of testable hypotheses (Glaser & Strauss, 1967; Miles & Huberman, 1994).

The next chapter describes the process by which the theoretical construct of grounded theory was applied to the current investigation.

CHAPTER SIX

RESEARCH METHODOLOGY

In order to explore the professional attitudes of Psychologists towards the depression of Psychologists, a series of semi-structured interviews were conducted during two phases of investigation. In the first phase, Psychologists who had experienced depression were asked what they considered to be the important issues related to this experience, and in the second phase, Psychologists who had not themselves experienced depression, were asked what they considered to be the important issues about the depression of those who were also Psychologists. The data collected from these interviews was analysed according to the standard protocol of grounded theory, a model of qualitative investigation (Glaser, 1992, 1999; Glaser & Strauss, 1967; Strauss, 1993; Strauss & Corbin, 1990, 1998). This methodology was selected because of the nature of the research question, gaps observed in the available research literature, and finally, because of the opportunity to describe the experiential nature of the depression of Psychologists, and for this to inform theory development. The research methodology involved three main areas, namely, preparation, data collection, and data analysis. Each area will be discussed in turn, and include reference to comments from the available literature. In addition, this chapter will discuss issues related to writing up the research findings, and to research validity.

6.1 Research Preparation

6.1.1 Literature Review

The initial stage of the current project involved reading the available literature so as to site the investigation within a framework that considered historic and

contemporary perspectives, as well as future concerns. This enabled gaps in information and understanding to be highlighted, and assisted in framing the research question, clarifying the aims of the project, and formulating interview questions.

There has been debate about the degree to which the researcher should read the available literature before undertaking a research project, about the way in which this knowledge should be used, and at what stage it should be undertaken (Ahern, 1999; Bringer, Johnston, & Brackenridge, 2004; Morse, 2002; Wolcott, 1994). Glaser (1992) stated that preconceived theories should be set aside when conducting grounded theory research, and cautioned researchers about their preliminary knowledge that may inadvertently influence data collection and analysis. Similarly, Ahern (p. 410) recommended that a substantive literature review should follow, rather than precede, data analysis, at which time, themes and other areas of interest would be revealed. In contrast, Strauss encouraged discipline-based knowledge, with the proviso that it was applied appropriately (Bringer et al., 2004; Strauss & Corbin, 1998), and Morse (p. 295) argued that the knowledge of previous research could inform and expedite current work. This project followed the recommendations of the latter researchers, and sought to balance the ensuing knowledge with objectivity during the processes of data collection and analysis.

6.1.2 Ethical Considerations

Davies and Dodd (2002) refined the concept of ethics in research, and suggested that areas such as attentiveness, empathy, carefulness, sensitivity, respect, honesty, reflection, conscientiousness, engagement, awareness, openness, and context, were basic ethical principles that should underpin qualitative research practice. As well as these considerations, there were also indications that the current investigation had the

potential to be of a highly sensitive nature. For instance, a review of the available literature indicated that Psychologists who had been depressed may have experienced stigmatisation, and consequently be cautious about disclosing their experience, and as well, the reflective nature of some of the questions might mean that participants would be deliberating on issues of a personal and possibly distressing nature (Gilroy et al., 2001; Hutchinson & Bhugra, 2000; Rogers et al., 2001; Siebert, 2001; Sonneck & Wagner, 1996). As a result of these considerations, issues of privacy and confidentiality, as well as other ethical matters, were deliberated upon from the initial stages of the preparation of the project (Boman & Jevne, 2000; Christians, 2000; Australian Psychological Society, 1999, 2003b).

Ethics approval for the first phase of the current thesis was obtained from the Department of Psychological Research Ethics Committee, Victoria University, and for the second phase from the Human Research Ethics Committee, Victoria University (see Appendices H and I).

6.1.3 Participants

In phase one of the current project, participants were operationalised as Psychologists, who, during the progress of their career, had experienced a depressive illness that had been diagnosed by a professional such as a General Practitioner from whom they had sought treatment. Participants in phase two of the project were operationalised as Psychologists who had themselves not experienced a depressive illness. Participant choice conformed with the general recommendations found in the literature. In other words, participants were not selected according to whether their opinions conformed to a particular theoretical model, but whether they fitted the

criteria spelt out in the research question (Babbie, 1998; Berg, 1989; Gehart, Ratliff, & Lyle, 2001; Mason, 1996; Miles & Huberman, 1994; Wilson & Hutchinson, 1996).

6.1.4 Recruitment

Participants were invited, without coercion, to participate in the current project. Participants in phase one of the study were recruited by word of mouth, leaflet distribution, and through advertisement in the professional magazine of the Australian Psychological Society (see Appendix A: Recruitment Advertisement). Particular attention was given to the wording of the leaflet and advertisement, with emphasis given to the privacy and confidentiality of potential participants. Participants in phase two of the study were recruited by word of mouth; further advertisement was not required because of interest that had been expressed in the project during its first phase.

6.1.5 Sample Size

Glaser and Strauss (1967) did not specify the optimum number of participants for a grounded theory study; it was reported that guidelines, rather than rigid rules, were more representative of the spirit of grounded theory (Wilson & Hutchinson, 1991). When selecting the number of participants in a grounded theory study, Morse (2000, pp. 4-5) recommended considering factors such as the scope of the study (whether it was broad or focused), the nature of the topic (whether it was obvious and clear, or difficult to obtain information), the quality of the data (related to the communicative skills of the participants), the study design (or the number of interviews per participant), and the use of “shadowed data” (such as whether participants expanded the study by reference to the experiences of others, and thereby

indicated the possibility of verification through theoretical, or discriminant, sampling). In addition, the literature recommended that sampling continued until theoretical saturation was reached, when no more new information was able to be obtained from the interviews (Blaike, 2000; Glaser & Strauss). When compared with certain other methodologies, the generally small number of participants in a grounded theory study facilitates the process, and enables closer attention to be given to understanding the particular contribution of each participant (Kvale, 1994; Maxwell, 1998; Miles & Huberman, 1994).

In the current project a total of 14 participants were interviewed: 8 individuals in phase one, and 6 in phase two. Four main factors determined the number of participants who were interviewed. The data collection of each phase was concluded when a state of theoretical saturation was achieved. To use the earlier mentioned descriptors of Morse (2000), in the current thesis, theoretical saturation was facilitated by the focused scope of the study, the clear nature of the topic, and the relatively good quality of the data.

6.1.6 Informed Consent

Written permission was obtained from interested parties after each had read a plain language statement about the project (see Appendices B and C: Invitation to Participate), and any further questions were verbally addressed. This included reiterating information about the purpose and nature of the project, the stages of the procedure (including the use of an audiotape recorder), the ways in which privacy would be assured, as well as any potential risks and their management. Care was taken to ensure that there was no deception of any potential participant through the failure to omit disclosing any information (Follette, Davis, & Kemmelmeier, 2003;

Kemmelmeier, Davis, & Follette, 2003). In addition, participants were reminded that they were free to withdraw from the project at any stage without recrimination. If potential participants agreed to participate in the project, consent forms were signed, and a duplicate provided for their records.

Christians (2000) argued that so-called codes of ethics were the product of a faulty assumption that it was possible to conduct value-free research, and consequently, questioned whether it was possible to meaningfully apply informed consent, avoid deceptive processes, ensure privacy and confidentiality, and ensure data accuracy. The current project acknowledges that there is probably little research, either qualitative or quantitative, that is value-free, but nevertheless, chose to follow standard and acceptable ethical practice. The researcher sought to provide information that was not merely modelled on “good intentions and intuition”, but upon research and adherence to recommended guidelines (Follette et al., 2003, p. 219; Australian Psychological Society, 1999, 2003b).

6.1.7 Privacy and Confidentiality

In an investigation of this nature, where it was suspected that the public disclosure of having experienced a mental disturbance might contribute to professional and personal stigma, it was thought essential that the normal and appropriate processes associated with ensuring the privacy of each participant were scrupulously adhered to. This was pertinent during stage one of the project, when it became apparent that issues associated with privacy were particularly salient, and it was suspected that the writer’s status as a student researcher, with an unknown professional placement in the future, emphasised uncertainty about privacy issues in the minds of some potential participants.

A number of precautions were undertaken to ensure the privacy of the participants. The names of the participants were known only to the researcher, and were stored securely in a location separate to the research data, which was also stored securely. Data was stored with due consideration for security, and was only made available for reading by the researcher's supervisor. The tape of the interview was transcribed by the researcher without outside assistance, so as to preserve each participant's anonymity, and was destroyed following transcription, unless the participant wished to reserve it for his or her records. Any identifying material such as names, dates, or places was excluded during the process of transcription, after discussion with each participant. The transcription was shown to the participant so that it could be edited according to his or her preference, and after these alterations were made, the original transcript was destroyed. The final transcription supplied the data for analysis, and became the source of citations which were attributed using a pseudonym. For organisational purposes, the transcription was identified by a code known only to the researcher. Further, the collection of possibly identifying demographic material was minimal, and any discussion of the project was circumspect.

Boman and Jevne (2000) questioned whether privacy was possible in certain research projects, regardless of the precautions taken, as a particular cohort may be so distinctive that that he or she could be identified because of the phenomena that was described by him or her. These cautions were considered in the current project. Baez (2002) was less coy than other writers about maintaining participant privacy, and provided an eloquent argument in favour of disclosure in order that qualitative research could achieve social change. He stated that, "confidentiality protects secrecy, which hinders transformative political action" and accused researchers who did not

ascribe to this view, of assisting in the maintenance of unequal and covert power systems (Baez, p. 35). This thesis does not concede to these opinions, and it is wondered whether the researcher rather than the participant is served by the politicisation of research practice.

6.1.8 Precautions

During the interview process, some participants in phase one of the research recalled events that were of a measure of distress to themselves. The possibility that this may occur had been anticipated, and had been accounted for, both in the preparation of the project and the preparation of potential participants, and contact details of a source of counselling support were provided (see Appendices B and C: Invitation to Participate). It was acknowledged that the group of participants selected for this research project were an aware cohort, who were familiar with the potential for risks within their professional relationships, and practiced in methods of maintaining psychological health, and indeed, self-protective measures were discussed. The participants were not uninformed about risk management, and this level of understanding was taken into account when gaining informed consent.

In addition, safety issues and vicarious traumatisation of the researcher was also recognised as a possibility (Hesse, 2002; Paterson, Gregory, & Thorne, 1999). This was attended to through good preparation, supervisor and peer group discussions (with appropriate attention to issues of participant privacy and confidentiality), as well as the useful practice of reflexive bracketing, which is discussed later.

6.1.9 Reflexive Bracketing

Reflexive bracketing “underscores how the aim to document absences always

involves analysing the unmarked presences” (Burman, 1997, p. 795), and assumes that data collection and data analysis, cannot be separated from place, time, and/or culture (Ahern, 1999). It is a potentially arduous exercise, where the researcher, through the process of reflexivity, makes persistent efforts to identify personal interests and motivations, clarify personal value systems, identify possible areas of potential role conflict, and recognise feelings that could indicate a lack of neutrality, then attempts to “bracket” them so that the participant’s particular world-view is better understood (Ahern; Ashworth, 1996; Charmaz, 2004). In other words, the overlay of the researcher’s opinions are identified, so as to enable the participant to be seen more clearly.

As previously mentioned, a secondary purpose of reflexive bracketing is for it to serve as a means of self-monitoring, as in effect, one’s self is located in the research process (Sword, 1999, p. 277), but its primary purpose is to facilitate the researcher’s awareness of areas of potential bias (Sinding & Aronson, 2003; Sword). The presumption of either researcher bias or objectivity is an area of dispute in some circles of qualitative research. Generally speaking, reflexive bracketing does not appear to be standard to the original design of grounded theory, where there is an expectation of a suspension of preconceptions, or impartial interviewer openness to the development of theory during data collection and analysis (Glaser & Strauss, 1967; Wilson & Hutchinson, 1996). Nevertheless, in this thesis, it is acknowledged that no matter how objective the researcher may strive to be, perception is still filtered through the lens of each interviewer’s life-view, and is influenced by social constructs (Blaike, 2000; Hall & Callery, 2001; Sword). Theoretically, reflexive bracketing encourages transparency, and facilitates research validity, as the researcher becomes more aware of perceptions that could influence data production and bias

interpretation, and can thereby put them aside (Ashworth, 1996; Creswell, 1998; Hall & Callery).

Reflexive bracketing was practiced throughout the current project. The material produced by the researcher was not intended for publication, but was found to be a useful tool that assisted in understanding the stance and place of the researcher throughout the process of the project. One useful product was a clarification of the researcher's increasing sense of protectiveness towards the participants who were interviewed in phase one of the project, namely, Psychologists who had experienced depression. Consequently, it was thought that the process of discriminant sampling might assist in providing research balance, and Psychologists who had themselves not experienced depression were interviewed, with the expectation of obtaining data that would challenge and/or confirm perceptions and emerging hypotheses.

6.2 Data Collection

The processes of data collection described in this sub-category were undertaken for both phases of the project. It is noted that in grounded theory the stages of data collection and analysis are undertaken at the same time (Glaser, 1992, 1999; Glaser & Strauss, 1967; Strauss, 1993; Strauss & Corbin, 1990, 1998). Nevertheless, to facilitate clarity, the two areas are discussed separately.

6.2.1 *Environment*

Each interview was conducted at a different location, in compliance with the needs of the individual participant. Matters that were taken into account included participant privacy (so that he or she was not overheard), convenience (all individuals who participated in this study had busy schedules, and were generous in the provision

of their time), sensitivity towards any possible sense of vulnerability by the participants, and the suitability of the surroundings to the process of interviewing (namely, that they were professional, comfortable, and had no intrusive background noise during the process of recording).

6.2.2 Engagement

The researcher-participant relationship has been described as a bond that facilitates the “interactive” process through which the researcher develops an understanding of the data each participant presents (Crooks, 2001). In the current project, attempts were made to engage with each participant prior to the commencement of his or her interview. The researcher kept in mind the professional status of the participants, and the sensitivity of the material being discussed.

One of the arguments of the current study was that it would be advantageous to the participants, and to the profession of Psychology in general, if the depression of Psychologists was openly and appropriately discussed in considered research. However, this belief did not presume that the investigation was given priority over the dignity of the participants. It was also kept in mind that the relationship between researcher and participant can be open to exploitation, and/or the negative use of power, such as when the researcher seeks to “elicit unguarded confidences” (Burman, 1997, p. 791; Hall & Callery, 2001). In addition, the so-called opportunity for the participant to have his or her voice “heard” was challenged by Atkinson (1997, p. 327) as a “romantic” attribution, that could even be thought of as demeaning or “patronizing” (Burman, p. 790).

6.2.3 *The Interview*

The interview has been likened to an entree into another realm of understanding, “a privileged access to [a] linguistically constituted social world” (Kvale, 1994, p. 147). There are different views about interviews, and whether one that sources data from a particular time “grab”, is adequate either in scope or duration (Atkinson, 1997; Sandelowski, 2002). Nevertheless, Glaser (1992) stated that in an interview of around the length of time that was used in this project, participants would reveal their primary concerns, and satisfactory data would be accessed. In contradiction, Charmaz (2004) argued that individuals do and say different things in different settings, and advocated data collection from a variety of settings in order to increase its potential as a source of rich information.

In the current project, standard grounded theory practice was followed during the process of the interview (Glaser & Strauss, 1967). Information from each participant was obtained during an interview period that was about 40 to 60 minutes in length. Questions were semi-structured and open-ended, and unscheduled probing was used to further inform about developing theory, as well as clarifying the researcher’s understanding of the participant’s perceptions (Berg, 1989; Miles & Huberman, 1994; Rapley, 2001). In order to avoid overlooking or misinterpreting valuable constructs because of an unwitting pursuit of a personal agenda, the researcher practiced attentive listening and sought to be flexible in outlook (Berg; Jack, 1999; Miles & Huberman).

In the first phase of the project the participants were asked what they, as Psychologists, considered to be the important issues about their experience of depression. In phase two of the project, participants were asked what they, as Psychologists, considered to be the important issues about the depression of those

who were also Psychologists. In both phases, the primary question was followed by questions that had been drawn from a close reading of the available literature, as well as from themes that had been introduced by participants during previous interviews, in keeping with standard grounded theory practice (Glaser, 1992; Glaser & Strauss, 1967; Miles & Huberman, 1994) (see Appendices F and G).

6.2.4 Note Taking

During the interview brief notes were taken by the researcher. This was in order to clarify the main points being discussed, identify emerging themes, guide further questioning, and to assist the researcher in reflecting the process back to the research question. No identifying details such as the name of the participant was recorded on these sheets.

6.2.5 Demographic Information

Both Strauss (1993) and Berg (1989) warned that traditional demographic data should not be assumed to have any analytic relevance to research that used the grounded theory model, unless it was indicated as such by emerging theory; later hypothesis testing would confirm whether these details would have any bearing on the results. As a result of reading the available literature, it was surmised that the gender and professional experience of the participants would provide sufficient demographic information for the current project, and these details were requested of the participants, along with a categorical descriptions of the area/s in which they worked. Detailed demographic information was not considered to be relevant, and also minimised the collection of information that might possibly identify the participants at a future time.

6.2.6 Audio Recording

With the participant's agreement, the interview was audio taped so that an accurate transcription of the interview could be made. In order to ensure privacy and confidentiality, the tape was labelled with a code that did not identify the participant and which would be only known by the researcher. The participant was instructed as to how to turn the recorder off if he or she wished to make comments that he or she did not to have transcribed. Following transcription, the tape was destroyed; only one of the participants in this project chose to accept the researcher's offer of keeping the tape of their interview as a personal record.

6.2.7 Disengagement

As the research question was of a sensitive nature, it was thought that some participants might feel a sense of exposure subsequent to the interview. Consequently, sufficient time was allowed for an unhurried period of disengagement from the process of interviewing if it was required.

6.3 Data Analysis

All processes described in this sub-category, except for the last process listed, were undertaken for both phases of the project. The last process, discriminant sampling, was conducted in response to the emergent data, and precipitated phase two of the project.

6.3.1 Transcription

Each audiotape was transcribed by the researcher without the assistance of any other individual, so as to minimise any possible violation of privacy and

confidentiality. The transcript was edited by the participant who had been interviewed, and all identifying material such as names, dates, or places, was excluded in consultation with the participant. He or she was also offered the opportunity to amend the transcript if they wished to exclude areas, which they had changed their mind about, elaborate upon facts which they thought had not been given sufficient exposure, and/or correct perceived and actual transcription errors. Each transcript was modified accordingly, thereby replacing the original transcript, which was subsequently destroyed.

6.3.2 Contextual Understanding

Each amended transcript was reviewed line by line by the researcher. Data was repeatedly read so that themes and concepts were understood within their context, and in the way each participant intended them to be understood, rather than being quantified as words in isolation (Berg, 1989; Strauss, 1993). Computer software specifically designed for qualitative research was not used in this project, even though a number of researchers support its use, both as a tool for analysis, and as an efficient method of organising and retrieving large amounts of data (Bringer et al., 2004; Creswell, 1998; Seymour, 2001). Reliance on software can become a substitute for a, sometimes tedious, close reading of the data that, through its repetitiveness, facilitates a deeper understanding of the information provided by each participant (Creswell). In addition, the underlying meaning of the data, and therefore, the intent of the participant, may be distorted or neglected because of the “too literal ... immersion in the materials” (Strauss, p. 29), which is often, but not solely, a characteristic of reliance upon computer software for interpretation (Babbie, 1998; Blaike, 2000; Maxwell, 1998). Finally, although counting the times a word appears in a transcript

produces quantifiable material, this should not be interpreted as valid grounded theory methodology. By using this method, core variables are based on frequency rather than emergent theory, and this is contrary to standard grounded theory practice (Wilson & Hutchinson, 1996).

6.3.3 Member Checking, or Respondent Validation

When the data was understood within its context, a one-page summary was made of the essential themes and categories presented in each interview. During a second interview with the participant, or by post or e-mail, if he or she preferred, the researcher's summary was confirmed or amended by the participant. This process has been criticised as participants may change their mind about the data that was initially produced, or they may lack the ability to perceive themes within their comments (Sandelowski, 2002). However, in this project, the researcher thought that it was of value that theory development, and that the potential for researcher bias, was open to participant scrutiny.

6.3.4 Open Coding

Using the transcript, and guided by the summary approved by the participant, the data was further read by the researcher. After being understood within its context, it was broken down into basic elements, themes, or concepts (Blaike, 2000; Strauss, 1993). This process is illustrated in Table 8, and more fully discussed later in this section.

Table 8

Example of Data Analysis

Interview Transcription	Open Coding	Preliminary Stage of Axial Coding	
		Proposed Primary Areas	Potential Areas
<p>I'm <i>glad</i> I've had the personal experience because I think it's enriched my ability to help people. Now I'm not just talking the cognitive behavioural technique, I'm knowing and understanding what the certain ones do work well, and that you can get some control over what's happening for you. But not in all cases. Sometimes the medication is needed to help. I probably was more anti-medication prior to this experience.</p> <p>The DSM-IV says it all, but it's just words. The actual experience seems to be so much more, and so much more outside of the normal experience. DSM-IV, some of the descriptives: "tearfulness", well what does that mean? But what we're really talking about is absolutely ridiculously unreasonable tearfulness. And they don't use those sort of descriptives in DSM-IV. And so I just think you could take DSM-IV and make everyone fit into it if you really wanted to. Whereas it's not, ah, it's not emphasising the extraordinary nature of a true depression. It's not just feeling sad. It's not just being miserable. It's outside the realm of normal cognitive functioning. Okay. And it's an unwilling cognitive functioning. Something that you don't have a direct, um, absolute direct ability to control. So it is in a sense uncontrollable, and the person experiencing it finds it extremely hard to control.</p>	<p>Gratitude ("glad"). Has increased therapeutic skills.</p> <p>Knows/ understands what works.</p> <p>Symptom control possible.</p> <p>Sometimes medication needed.</p> <p>DSM limited. Depression beyond ("outside") normal experience.</p> <p>Example: "tearfulness".</p> <p>DSM lacks specificity (explained later).</p> <p>Depression is <i>extraordinary</i>.</p> <p>Depression is "outside" normal cognitive functioning.</p> <p>Cognitive functioning is not (always) able to be controlled.</p>	<ul style="list-style-type: none"> • informing professional practice • informing professional practice • informing treatment approaches • understanding depression • understanding depression • depression experienced • depression experienced • understanding depression • understanding depression • understanding depression 	<p>GLAD</p> <p>CONTROL</p> <p>CONTROL</p> <p>CONTROL</p>

6.3.5 Axial Coding

The basic elements, themes, or concepts were systematically reassembled into new categories, so that patterns of inter-relations and exceptions were revealed. Elements were systematically related to other categories, validated, and further refined until units could be classified, observable patterns emerge, and core categories discerned (Blaike, 2000; Strauss, 1993). This process is illustrated in Table 8, and is more fully discussed in the following sub-section.

6.3.6 Further Comments About Data Analysis

The processes of transcription, contextual understanding and summary, open coding, and axial coding were conducted after each interview, and informed the researcher about developing theory that could be further explored with subsequent participants. As the process was repeated after each interview, the preliminary stage of axial coding was a constant state of flux, or modification, with new data either supporting or de-emphasising proposed categories (Glaser, 1999). Hence current data was constantly compared with previously collected information, in order to elicit patterns, themes, and common categories, as theory emerged (Babbie, 1998; Bickman & Rog, 1998; Blaike, 2000; Glaser & Strauss, 1967; Mason, 1996; Miles & Huberman, 1994; Strauss & Corbin, 1990).

During data analysis in the current thesis, precedence was given to the issues prioritised by each participant, frequency of comments (rather than frequency of specific words), the strength of opinion expressed by each participant, and comments that were not contaminated or spoiled by association with the ideas of another, such as the interviewer. Attention was also given to non-verbal cues that were later explored with further questioning. It was not considered the task of the current thesis to analyse

the transcripts beyond providing an answer to the research question, within the bounds of a grounded theory enquiry. In other words, it was neither the role of the researcher, nor agreed to by the participants, that a therapeutic analysis of the content of the interviews be undertaken.

The process of coding enabled raw data to be transformed into concepts upon which theory could be grounded, and matrices were constructed from that data that described knowledge, clarified evidence, and indicated the relationships between data (Averill, 2002; Boyatzis, 1998; Miles and Huberman, 1994; Weston et al., 2001).

Table 8 provides a simplified example of the way in which data was analysed in the current project. In this table, column one contains an extract of a transcription obtained in the early stages of phase one of the current thesis. Unlike the original process where areas of interest were coded with a complex system using numbers and coloured markers, in this example, only two modes are shown. Phrases considered to be of significance are shaded, and words considered to be of importance are in bold.

Column two indicates the next stage of analysis, open coding, where data was broken down into basic themes or concepts (Blaike, 2000; Strauss, 1993). This was undertaken in consideration of the tenet of the interview as a whole, and confirmed through member checking, or respondent validation.

Column three indicates the process of axial coding, and is described as “preliminary” in Table 8, so as to emphasise the flexibility of the early stages of the data collection process. In this stage, basic elements obtained from column two were reassembled into new categories, and through constant comparison, were systematically related to other categories obtained from previous interviews; the repetition of themes validated emergent categories (Blaike, 2000; Strauss, 1993).

Column three is divided into two sub-columns. The first sub-column lists “proposed” primary themes, which would be later confirmed and validated, or otherwise, by the data obtained from subsequent interviews. Further information may change the status of these themes to secondary themes, or concepts that support a larger category. In this extract, the four so-called primary themes that had emerged at this stage were “informing professional practice” (or, the ways in which the experience of depression enriched skills and understanding); secondly, “informing treatment approaches” (for example, by providing understanding about medication); thirdly, “understanding depression” (through such means as definitions and theoretical frameworks); and finally, “depression experienced” (through phenomenological and symptomatic descriptions).

In the second half of the third column, capitalised words indicate areas found to be independent of previous opinions at the stage of the current interview; in Table 8 they are described as “potential” areas so as to emphasise this role. They may inform future categories, become core elements of reframed categories, remain as separate and significant areas, or be considered to have little significance when compared to other information. The two areas in this example, which at this stage of the process did not fit in with any other groups, were to do with control (or, the way in which depression challenges this, and the way in which CBT assists in restoring it), and gratitude (or, being glad for having experienced depression because of the ways in which it had informed professional practice).

The data also produced from an analysis of the extract of the transcript in Table 8 also informed future interviews. In addition to the questions included in Appendices F and G, participants subsequent to this analysis were asked questions to do with the way in which their experience of depression informed their practice, issues associated

with treatment, and attitudes towards having experienced depression. So as not to bias the responses of the participants questions were general, and potentially biasing terms such as “control” and “gratitude” were avoided.

The information obtained from subsequent interviews indicated a number of categories that, through the process of axial coding, were classified as either primary or secondary areas. Table 8 indicates part of this process in regards to the data obtained in the early stages of the current thesis, and Table 9 lists the results of the final stage of axial coding in phase one. The terms used to describe the categories, as well as the findings as a whole, are discussed further in chapters 7, 8, and 9.

Table 9

Stages in Axial Coding: Development of Primary Areas in Phase One

Secondary Areas	Primary Areas
Depression experienced Intervention experienced Processing the experience	The inner self
The nature of Psychologists Positively informing practice Informing treatment approaches Challenges to practice	Professional self
Disclosure Stigma	Relational responses
Lack of understanding depression Frameworks for understanding depression Causative factors	Depression frameworks

Table 10

Stages in Axial Coding: Development of Primary Areas in Phase Two

Secondary Areas	Primary Areas
Motives for becoming a Psychologist Characteristics of Psychologists	The Psychologist
Positively inform practice The negative effects of depression upon practice Capacity to practice Management of depression	The Psychologist as a practitioner
Commonality of the experience of depression Disclosure Stigma Empathic understanding Depression as a professional health issue	The Psychologist as a member of a body of colleagues
Aetiology Describing depression Treatment perspectives	Understanding depression

6.3.7 Matrices, Visual Diagrams, and External Frameworks

The construction of matrices or visual diagrams has not been listed as a separate process in this thesis as it is understood that they are useful tools that are merely supplementary to, and illustrative of, theory generation. This thesis understands that an insistence that these elements are integral to grounded theory design is contrary to the spirit of the model (Glaser, 1992; Glaser & Strauss, 1967; Wilson & Hutchinson, 1991).

In addition, externally sourced frameworks have not been used in this thesis for theoretical reasons that can be explained by reference to the literature. Following their divergence as co-researchers, Glaser and Strauss upheld differing opinions about the organisational structure of the process of coding (Glaser & Strauss, 1967; Strauss &

Corbin, 1990). In essence, Glaser (1992) was critical that one stage of Strauss and Corbin's analysis of data was organised according to a framework, or paradigm, namely: (A) causal conditions → (B) phenomenon → (C) context → (D) intervening conditions → (E) action/interaction strategies → (F) consequences (Kendall, 1999; Strauss, 1993; Strauss & Corbin, p. 99). Glaser felt that the use of a framework distracted attention away from the data and neglected the underlying principle of emergence of theory, and stated that the result was a "forced, preconceived product" that was independent of grounded theory (Glaser, p. 3; Kendall; Strauss & Corbin; Wilson & Hutchinson, 1996). Both opinions have amassed supporters with well argued opinions (Kendall; Miller & Fredericks, 1999; Weston et al., 2001; Wilson & Hutchinson, 1996).

In summary, Jeon (2004, p. 254) stated that because Strauss and Corbin's work was "prescriptive and procedure focused", it was an impediment to the development of "creativity and flexibility that [was] essential in discovering theory". For this reason, the current project avoided using an externally sourced framework, and followed Glaser's (1992) emphasis upon data as the source of theory. This does not mean that the differing opinion does not have value, or would not provide useful outcomes in another study.

6.3.8 Theoretical Saturation

A state of theoretical saturation is defined as being reached when the data is no longer able to provide further insights; any additional collection and analysis becomes superfluous to the needs of the research (Blaike, 2000; Strauss, 1993; Strauss & Corbin, 1990). The fact that the state of theoretical saturation can be rather "elastic" means that some researchers are less than content at its imprecision (Charmaz, 2000,

p. 520). Nevertheless, it is important to avoid premature closure because of researcher boredom or lack of alertness, as concepts may otherwise not develop beyond a superficial appraisal of the data (Ahern, 1999; Wilson & Hutchinson, 1996). As mentioned earlier, in this project, theoretical saturation in phase one was reached following eight interviews, and in phase two after six interviews, when no new information appeared to be provided by the data.

6.3.9 Hypotheses and Theory Development

When no further insights were able to be made, hypotheses were advanced by grouping and interconnecting information, and then by contrast with data that did not conform to generalised trends (Blaike, 2000; Glaser & Strauss, 1967). Even though hypotheses suggested themselves to the researcher from the onset of data collection, and note of these was taken, it was not until the final stage of analysis that substantive assumptions were able to be postulated. In a grounded theory study, hypothesis and theory development can assume the form of a narrative statement, a visual picture, or a series of hypotheses or propositions (Creswell, 1998; Morrow & Smith, 1995; Strauss & Corbin, 1990). In the current study, this information is presented in the form of an extended narrative statement in chapter 7 (for phase one), and chapter 8 (for phase two). Chapter 9 describes the findings of the research as a whole in the form of a shorter narrative statement, and this is followed by a series of hypotheses.

6.3.10 Discriminant Sampling

Discriminant sampling is the judicious selection of sites, persons, and/or documents that can confirm or challenge categories and conclusions that have been drawn from an analysis of the data, and as a result, supply information to enrich

under-developed areas (Creswell, 1998; Strauss & Corbin, 1990). In the current study, analysis of the interviews of Psychologists who had experienced depression indicated areas that would be further informed by interviews with a selected cohort, namely Psychologists who had not themselves experienced depression (Morse, 1999a, 2000). For example, in phase one of the project, the potential for Psychologists who had been depressed to receive professional stigmatisation, was an area of interest, and in order to enrich an understanding of this factor, and challenge assumptions, a variety of opinions from Psychologists who had not themselves experienced depression were explored and analysed. This set of interviews comprised phase two of the project, and each of the processes employed in phase one in the areas of preparation, data collection, and data analysis, were also applied during the second phase.

6.4 Writing the Thesis

When writing the finished thesis, consideration was given to each participant's ownership of his or her words in the interview transcript. In law, the copyright of each transcript rests with the individual who has been interviewed, and as such, fair dealing is allowed in the use of direct quotations, and care is to be taken that these are not excessively protracted. In keeping with the earlier mentioned considerations of privacy, pseudonyms were used when citing the transcripts. Names used were selected alphabetically, and then applied randomly. Hence, for the purposes of citations, the first randomly selected participant was given a name that began with the letter A, the second randomly selected participant was given a name that began with the letter B, and so on.

When reporting the results of the data, numerical frequency was given less precedence than the reportage of frequency trends. As a result, on most occasions,

“numerative” attributions were stated qualitatively though the use of such terms as “most participants” or “few participants”.

Consideration was also given as to so-called voice that should be heard within the finished thesis (Sword, 1999). A balance was sought between providing objectively deduced data that provided useful information about the research question, and a forum for the various perceptions of the participants. This contrasted with the research of Ribbens and Edwards (1998), whose primary concern was to provide a voice for a cohort that the writers understood as under-represented. As a result, they stressed the importance of retaining a sense of these opinions within their final analysis, so as to “facilitate the vocalisation of the more subdued personal voices” (Ribbens & Edwards, p. 17).

6.5 Validation of the Research

In this section a review of themes considered by some to be more suitable to assessing the rigor of grounded theory will be discussed, along with arguments about the use of triangulation. In conclusion, the measures employed in the current project in order to facilitate the trustworthiness and confirmability of the results, are listed.

6.5.1 *The Rigor of Grounded Theory*

A number of researchers have challenged the theoretical suppositions associated with measures used to ensure the trustworthiness of qualitative research, and have made suggestions for alternative measures that are not loaded with so-called quantitative assumptions (Davies & Dodd, 2002; Gehart et al., 2001; Wittemore, Chase, & Mandle, 2001). The following recommendations of Glaser, and of Strauss and Corbin were of particular interest, and have been considered in the current

project. Glaser (1992) suggested that it was more suitable to look at fit (or the relationship of the core category to the research area, and its capacity to account for data variance); work (or the ability of the core category to operate in relation with other categories, and be useful); relevance (of the core category to the data, and an explanation of actual problems); modifiability (or flexibility); and parsimony (or scope of accountability) (Charmaz, 2003; Hall & Callery, 2001; Jeon, 2004). In addition, Strauss and Corbin (1990) indicated six areas to consider when evaluating grounded theory research. These are plausibility (or, the usefulness and understanding wrought by process and theory); reproducibility; generalisability; concept generation and systematic conceptual relationships (evaluated according to systematic linkages, and meaning); density (the properties of condition, context, and consequences); as well as variation and specificity within categories (Hall & Callery).

6.5.2 *Triangulation*

Some researchers have advocated the process of triangulation to underscore the validity of qualitative research. This process involves the use of additional research methods to confirm the results of the original research, and assumes that different investigators, methodologies, and data sources will reach a convergence of agreement about an underlying objective reality within a research topic (Angen, 2000, p. 384). The term often refers to the use of quantitative methodologies subsequent to, or combined with, qualitative research (Wilson & Hutchinson, 1996), but this is not always the case, and may for example, indicate the use of two methods of qualitative research (Wilson & Hutchinson, 1991).

It is possible that some arguments in support of triangulation are based upon an assumption of the objective superiority of quantitative research (Kvale, 1994), and

thereby attempts to validate quantitative research through association. Qualitative and quantitative research are constructed upon different research assumptions that are at once complementary and contradictory (Hiles, 1999); measures of evaluation that are suited to one area, may indiscriminately invalidate the findings of the other area, at the expense of increased research discovery. Triangulation inaccurately presupposes that all methods of research have equal power within a particular circumstance, and infers research validity if there is agreement amongst results following the process of triangulation (Bloor, 1997). Conversely, it could be argued that validity could be assumed if the results were in disagreement.

It is the opinion of this thesis that both qualitative and quantitative research are of value, and that further quantitative investigation into the findings of the current study would provide useful additional, but not substitutive, information (Davies & Dodd, 2002; Polkinghorne, 1991).

6.5.3 The Current Research

In order to ensure the trustworthiness and confirmability of the current project, a number of practices were applied during the stages of preparation, data collection, and data analysis. Some of these practices were part of the structure of the methodology chosen, whilst others were related to constructs that reflected the general nature of qualitative research. To avoid repetition, practices shall not be described in detail.

Whilst the current project was under preparation, trustworthiness and confirmability was sought by providing an informed context for the research through a review of the available literature, matching research method with research question, adhering to standard grounded theory practice and not muddling methodologies, selecting participants according to set criteria, and establishing an ethical framework

that considered such issues as privacy and confidentiality (Davies and Dodd; 2002; Wilson & Hutchinson, 1996).

During the stage of the collection of data in the current project, trustworthiness and confirmability was sought by seeking a stance of objectivity, addressing areas of potential bias through reflexive bracketing, challenging and enriching conclusions through discriminant sampling, supplementary validation of themes through reference to the literature, and through attention to minimising data collection irregularities by the preliminary checking of equipment, having back-ups and spares of everything to be used, and ensuring that the place of interview was quiet and that the process would not be interrupted (Blaike, 2000; Creswell, 1998; Easton, McCormish, & Greenberg, 2000; Gehart et al., 2001; Strauss & Corbin, 1990; Sword, 1999).

During the stage of the analysis of data in the current project, trustworthiness and confirmability was sought by minimising transcription errors by having the same person (the researcher) as the interviewer and transcriber, checking the transcription for visible errors and mis-hearings, respondent validation, maintaining an attitude of scepticism, upholding the process of constant comparison that initiated in the first stages of data collection, attempting to support each assertion with at least three examples from the data, inclusion of participant quotes in the final thesis, and reporting inconsistencies which did not fit into the final hypotheses (Angen, 2000; Babbie, 1998; Easton et. al., 2000; Gehart et al., 2001; Glaser, 1999; Miles & Huberman, 1994; Strauss & Corbin, 1990).

Using this methodological practice, the current investigation into depression and Psychologists was undertaken. The results, and a discussion of these, follows in the next three chapters.

CHAPTER SEVEN

RESULTS AND DISCUSSION: PHASE 1

The current thesis investigates the professional attitude of Psychologists towards the depression of Psychologists. In the first phase, participants who had themselves experienced depression were asked what they, as Psychologists, considered to be the important issues about their experience of depression. In phase two of the project, participants who had not themselves experienced depression were asked what they, as Psychologists, considered to be the important issues about the depression of those who were also Psychologists. As this is a grounded theory study, the results as well as the discussion of the research, are presented together, rather than separately, in contrast with the protocol for other forms of research (Glaser, 1992, 1999; Glaser & Strauss, 1967; Strauss, 1993; Strauss & Corbin, 1990, 1998). Consequently, the results obtained from an analysis of the data obtained from both phases of interviews in the current study, are sequentially described and discussed in chapters 7, 8, and 9. Chapter 7 will discuss the results of phase one of the current project, chapter 8, will discuss the results of phase two, and chapter 9 will conclude with a discussion of the findings of the project as a whole.

It is reiterated that within a grounded theory study, theory is driven by data which is ideally uncontaminated by influences external to the participants during both stages of collection and analysis (Ahern, 1999; Glaser, 1992; Glaser & Strauss, 1967); information that is neither influenced by the interviewer nor a review of the literature is sought from participants. As a result, the primary questions in both phases of the current study are designed to be broadly framed. During analysis of the data, the researcher strives to put aside preconceptions, and organises the data according to the

constructs that are suggested, or driven, by emergent theory (Ambert et al., 1995; Glaser; Glaser & Strauss). As the participants in the current thesis selected the agenda, and prioritised issues according to what was designated as being of personal importance, some areas were thought to be of little value and were only briefly, if at all, mentioned. This is unlike other forms of research where it is usual to obtain responses to every sub-category under investigation. Accordingly, in a grounded theory study, both the framework and agenda of a particular research area are selected by the participant, and both the emphasis and neglect of certain issues point to the individual participant's priorities. Hence, if most participants discuss an issue, this is indicative of its general importance to the cohort; if an issue is neglected, the silence is also indicative of the priorities of the cohort (Ambert et al.; Glaser; Glaser & Strauss). For this reason, chapters 7 to 9 contain information considered to be of importance to the participants in the current thesis, that was neither composed of information that was formulated upon an agenda of the researcher, nor organised upon a pre-existing paradigm in order to extract meaning from that data.

The current chapter will discuss the research findings of phase one of the current thesis by first noting the demographic details of the participants. This is followed by general, then specific descriptions of the four primary themes that are discerned as important to the participants who were interviewed.

7.1 Participant Demographics and Recruitment Issues

As discussed in the previous chapter, in a grounded theory study, detailed demographic information is considered to be of less importance than the fact that the participants fulfilled the criteria requirements, namely, that they were Psychologists who had experienced a period of depression that had been diagnosed as such by a

treating mental health practitioner such as a GP. The information obtained from the 8 Psychologists who participated in phase one of the current study indicated that they were mainly female (there were 2 male participants), and that both their mean and median years of professional practice was 10 years (ranging from 3 to 18 years). At the time of interview they practiced in a wide number of areas, with the more experienced Psychologists being generally more active, and operating in 2 to 4 spheres. The descriptors that were used by the participants to indicate their areas of practice were: Private Practice, Psychiatric Disability Services, General Clinical, Counselling, Student Counselling, Community, Educational Psychology, Academia, Supervision, and Research.

Issues associated with participant recruitment have been discussed earlier. It is of interest to note that there were difficulties associated with recruitment in phase one of the project, both in gaining and retaining potential participants. A number of reasons were speculated to contribute to this, including concerns about openly discussing painful experiences, particularly with a stranger; issues to do with disclosure, and uncertainty about the maintenance of privacy; and concerns about the potential for stigma. All of these factors were possibly reinforced by the interviewer's status as a student, which brought with it uncertainty about trustworthiness, uncertainty as to the merit of the research, and prospective privacy concerns due to lack of certainty about the participant's future professional location within the small pond of practicing Psychologists in metropolitan Melbourne. Given these, and other, possible concerns, it is a credit to the courage and conviction of those who participated in the study, to agree to be interviewed.

7.2 Primary Themes

In the first phase of the current thesis, eight Psychologists who had themselves experienced depression, were asked what they, as Psychologists, considered to be the important issues about their experience of depression. The data provided by the participants, and organised according to the grounded theory processes of constant comparison and axial coding (see Table 9) (Blaike, 2000; Strauss, 1993), suggests four primary themes that are conceptualised according to the experience of the depressed Psychologist, and are summarised in Table 11. The first of these themes is to do with the inner self, the second is to do with the professional self, the third is to do with relational responses, and the final primary theme is concerned with depression frameworks. It is understood that these areas are not mutually exclusive, and that there is a measure of interconnection or flow between the concepts that are presented, some of which are referred to in more than one area.

Table 11

Phase One: Primary and Secondary Areas

Primary Areas	Secondary Areas
The inner self	Depression experienced Intervention experienced Processing the experience
Professional self	The nature of Psychologists Positively informing practice Informing treatment approaches Challenges to practice
Relational responses	Disclosure Stigma
Depression frameworks	Lack of understanding depression Frameworks for understanding depression Causative factors

7.3 The Inner Self

All of the participants in phase one of the current thesis chose to discuss the ways in which their experience of depression was understood according to their inner self. The data obtained from this discussion is organised into three secondary themes, namely the personal experience of depression, the personal experience of intervention, and the ways in which the experience of depression was processed.

7.3.1 Depression Experienced

Almost all of the participants chose to explain what their personal experience of depression was like, and its influence upon their physical, cognitive, and emotional selves.

It was described as an emotionally and physically exhausting period; a supreme effort was required to attend to the apparently small tasks of the day, with one participant describing only being able to operate for periods of about half an hour at a time when the condition was at its worst. Nevertheless, many described attempting to “soldier on”, to continue, “as if nothing had happened ... as if you weren’t depressed”, and to “struggle” to appear productive within a critical workplace. Another said that it was as if, “your brain, your cognition, and your body, are betraying you”, and elsewhere, this was described as a sense of a loss of personal control. Carol described the unwelcome cognitive thought patterns that were also discussed by other participants. “You tend to ... negate everything positive and just concentrate on negatives. ... You say to yourself, ‘I’m incompetent’, ... [and] tend to undermine your successes.”

The depth and frequency of tearfulness was mentioned by a few participants. One said, “the weepiness ... just comes from no-where, and it just goes on, and on,

and on. ... Crying that comes from, you know, some well in the centre that you can't connect to." Elsewhere, participants described their experience as an "absolute nightmare", emotionally "chaotic", a "maelstrom", a "dark hole", and "like death". Two participants looked back upon the period, and identified it as a "shitty place", another felt that it was a "bitch at times", descriptions that appeared to understate the terribleness of the experience.

The state of depression was also identified as a condition that could worsen daily:

It just goes on and on. ... There's nothing happy the next day, and then the next day, and the next day, and you're just spiralling down, and down, and down. ... You can't get out of bed, and you don't want to do anything, and you don't look after yourself.

This description was reiterated by another participant who said, "I found that it was possible to descend, and descend, and keep descending, and descending further. You would think that you were at your worst, and then you would get worse."

These feelings were associated with a pervasive sense of isolation, and "extraordinary" loneliness. "I closed myself off from human relationship [and went into] a place of isolation and *un*-life ... a flattening place, an indiscriminate deadly flattening". A large number of participants specified having experienced a sense of deep and painful isolation within their professional, social, and relational lives. Examples were provided of hurtful and unsupportive responses from family members, as well as people who had formerly been thought of as friends, and as one participant discerned, it felt as if, "there was no-one there any more".

A number described themselves as being particularly vulnerable during their period of depression, and felt that they needed care and sanctuary, or the reassurance

of well-meaning oversight, that sadly, was not always forthcoming; “what I would have liked them to know was that I was in pain. ... I wanted care, I mean, I *needed* care, and I didn’t get it.” Another participant expanded upon this concept, and suggested that despite being ill with depression, something akin to vigilance still had to be maintained, “I never really felt able to be ‘cared’ for, because I guess I felt that ... I wasn’t free to assume that role. ... I certainly got ‘care’, but ... I could never be somebody ‘sick with depression’. ... I was never actually allowed to be sick.”

A number of participants discussed feeling suicidal during their period of depression. Some spoke of an ongoing and persistent desire to kill themselves, likened by one to a “constant desire to ... be dead” on the one hand, yet on the other hand was, a “struggle to actually want to be alive”. Another understood suicide as a way to excise unbearable pain, “I was suicidal, ... no longer being able to *bear* the pain anymore. It was beyond human endurance.” One participant described having frequent and uninvited suicidal thoughts:

The best one I came up with was taking myself somewhere out in the bush, and making a nest of leaves like a bird, and just curling up in it, and just lying there until I ... faded away. And there was something warm and luxurious about that notion. ... They were just stupid thoughts that were popping into my head uninvited. ... There was no conscious thought involved in them. They were just in there.

7.3.2 *Intervention Experienced*

Participants spoke of the assistance they had received through psychotherapy, their appreciation of medical practitioners who carefully selected appropriate medication, and of the helpfulness of medication. The ways in which these and other

interventions informed professional practice will be elaborated upon later in this chapter. Some participants mentioned the assistance they gained from having a spiritual focus. Helen described this as a source of strength, and another stated, “I sort of got that idea that there was someone outside of me, who was also orchestrating that I’d get through”. Other participants described their resourceful implementation of preventative and protective practices. Carol recommended participating in study programs, attending conferences, writing papers, organising groups, becoming “politically” active, or even changing jobs within the same area. She said that the result of being proactive in these ways was as if you had “new blood in you. Like someone injected B12 into you!”, and rhetorically added, that if circumstances around her began to “crumble”, “what do you do? You go to conferences, or you go down! ... You have a choice.”

The process of intervention did not always provide the refuge and place of healing that might be otherwise anticipated. A few participants described therapeutic experiences that could be summarised as neglectful and assaulting. Terms such as feeling “disregarded”, “unheard”, “humiliated”, “harmed”, “unsafe”, “devastated”, and being “decimated” by the process, were used to describe interventions that, in the main, were conducted by professionals of otherwise good repute. Deidre elaborated upon this theme. “Some of my treatment by health professionals was just dreadful. Just *absolutely* horrible. And I guess that maybe that sensitised me quite a lot to ... how harmful some approaches, [and] attitudes can be.”

Elsewhere, an incident of gross professional insensitivity was described, whilst the participant was in a state of heightened vulnerability during a period of hospital treatment for depression:

I actually overheard a Nurse once say, “oh do you know what she is?” ...

And the other person, [a Resident Doctor,] ... said, “what?” ... And the [Nurse] ... said, “oh she’s a Psychologist”. And then there was this great laughter in the room. And that’s something that’s really stuck with me.

And I thought, ... “if I felt well enough I’d do something about this. But I just don’t feel well enough.”

On reflecting about this incident, the participant discussed the sense of shame she felt because she was perceived as, “the ward joke”.

One participant described a series of interventions conducted by respected professionals whose conduct towards their client/patient appeared to be less than benignly incompetent, and displayed elements of power and authoritarianism:

There was a phoniness ... about what I was experiencing. ... I was quite sick at this stage [but was aware of] ... how much damage people can do if they don’t do it well. ... I suppose what I saw in him was an arrogance that he ... knew how to treat me, and he was going to treat me this way. And me just being devastated by the experience. ... I was trying to work out how much was related ... [to] whether he felt threatened in a way by seeing somebody in the field. ... But then, the other side of my head was thinking, “I don’t want to have to worry about that, ... I don’t want to be harmed either”. And I felt harmed.

The participant described subsequently attending another mental health professional who “was very derogatory ... about how I’d come to end up where I was, ... and made real value judgements, ... about ... whether I deserved to be depressed or not”, before eventually finding a helpful clinician. A central theme of these experiences could be summed up as a lack of personal and professional care that was

exhibited as professional arrogance; “they thought they knew better ... than me, ... being the patient at that point”. It is not unexpected that this participant described the process of treatment as more distressing than the experience of depression.

7.3.3 *Processing the Experience*

The participants described a number of ways in which they processed their experience of depression. Many described feeling shame, guilt, and self-stigmatisation. One participant wondered, “should I be ashamed of all this? I’m not sure. I don’t know. Intellectually, no, of course I shouldn’t be ashamed, but emotionally, yes.” Another participant’s sense of shame and guilt was related to a sense of needing “care”, and was further reinforced by workplace difficulties, “you think, because I can’t do this anymore, therefore I’ve failed”. Elizabeth described her difficulties as being less about shame, and more about self-punishing thoughts. She described thinking:

“I’ve got to work through this. I’ve got to work through this, I’m a Psychologist I can do this. ... Stop being silly, get your act together.” All those nice punishing things that we say to ourselves that aren’t cognitively healthy, and I did exactly that.

Frank discussed a similar process, “I still get trapped by it. It’s *that* pervasive. And all the knowledge in the world doesn’t help. ... [I tell myself things] like, ‘you’re a Psychologist – you should know better’.”

Brian described an ongoing fear of the recurrence of depression; “it could happen to anyone. It could happen to me again ... if something else crappy happened again.” Helen recalled what that fear had been like, “for some time, I had a great fear of depression – as if it was an entity that could descend at any time”. Deidre

wondered how the negative experiences of herself and others could be usefully applied. She said, “It’s created lots of questions for me. Questions about the way that depression is managed, and treated, and perceived both within, and without, and outside of, professional contexts. ... How you do anything about that? ... How you change that?”

Regardless of these experiences and considerations, some participants described being able to look at their experience of depression within a broader developmental context, “at the time it was horrible, but now looking back you sort of think, well, ... you’ve survived”. Andrea commented, “awful things happen to people, but people have the will and, usually, have a drive to try and heal and make things better”. Brian expressed similar sentiments:

I survived ... You know, we survive all these shitty things in our lives. I think, “yes, you are resilient. Yes you can bounce back. Yes you do have these inner resources.” ... So, in that sense it is quite empowering. And ... yes, shitty things in life happen, but you can make it in the end. Somehow you can make it through.

In addition, some participants expressed appreciation for having had the experience of depression. Elizabeth stated that she was, “*glad* I’ve had the personal experience because I think it’s enriched my ability to help [depressed] people” gain a measure of control. Frank thought that his experience of depression, and subsequent acknowledgement of his vulnerabilities, had enabled him to become a better Psychologist. As such, depression was perceived as “a gift”. He had found the consequent opportunity for self-reflection within extended periods of psychotherapy was extremely useful. Carol felt that Psychologists were only effective healers when they attended to their own needs for healing, “if we as the professionals are not going

to ... pay attention to our depression, then we cannot do justice to our clients”.

Geraldine expanded upon this view; she found that her experience of depression provided an opportunity for “enormous” personal growth. By following the process of depression through its specific course, it enabled a:

More engaged relationship to life than had you not really dug into that depth. ... I see it as potentially salutary for people who have the willingness and the ... strength and tenacity, to go through a depression, rather than ... subvert it or mask it.

Like Geraldine, Helen also described the experience of depression as having the potential to direct towards a process of maturation. She said, “I think the underlying thing is maturity. I have increased maturity that has come through ... difficulty. I am a person with more depth now.”

It was generally described as beneficial to view depression within a broader context, and to acknowledge that, like one’s fellow Psychologists, clients, and the population in general, all shared a general human vulnerability to depression and similar difficulties. Frank explained, “we’re all damaged goods in some way. We all have some forms of psychopathology.” It was an encouragement to know that this was not only a shared problem, but also a manageable problem. As Brian said, “you know it can affect anyone. ... That people *do* get depressed, and that ... [for] some people ... it never goes away, but they still live quite functioning lives.”

The participants in phase one of the project sought to gain an understanding of the effects of depression upon themselves by exploring the depressive experience, exploring their intervention experience, and by processing these experiences. In addition to being a personal experience, being a survivor of depression is also

understood to relate to an understanding of one's self within his or her professional role, an area which is discussed in the next section.

7.4 Professional Self

All of the participants in phase one of the current study chose to discuss the ways in which their experience of depression informed themselves as practicing Psychologists. The data obtained from this discussion is organised in three secondary themes according to speculation about the nature of Psychologists, the ways in which having been depressed positively informs practice and treatment options, and finally, the challenges that being depressed brings to the practice of Psychology.

7.4.1 The Nature of Psychologists

Divergent views were held about whether the profession of Psychology attracted individuals who were more likely to become depressed. A few participants felt that this was likely, but one felt that the prevalence of depression amongst Psychologists was no more frequent than in other fields, and pointed out that the diverse opportunities within the field of Psychology attracted individuals with various characteristics. Elsewhere it was stated that Psychologists tended to "invest emotionally" in their work, and that this could lead to depression in given circumstances.

It may be that the motivation for becoming a Psychologist is indicative of certain biases of personality that could be associated with depressive affect. Frank identified reasons why people opted to become Psychologists; he felt that people went into the profession so as to understand themselves or significant others, and thereby

heal the pain of themselves or others. He had also observed that some Psychologists were motivated to enter the profession through a desire to manipulate others.

7.4.2 Positively Informing Practice

Almost all participants used the terms “empathy” and “understanding” to describe the ways in which their experience of depression had positively informed their practice. The main areas discussed were related to an appreciation of the experience of their clients, as well as an increased understanding of the management of depression.

In general, the participants stated that they found that their experience of depression had facilitated their ability to be more empathic, patient, tolerant, and compassionate towards their clients. Geraldine stated that she now had, “a lot more, compassion and empathy for people who are going through it. A lot more patience.” Deidre felt that she had gained insight into the condition of her clients, and added, “you learn that empathy. You learn that compassion. You learn to value [the] struggle that people have.”

Most participants explained that that this appreciation was based upon having had a first-hand experience of depression. Carol said that, “having suffered [has] made you more ... understanding. More sensitive to their needs. ... You know what it’s like. You know.” This sentiment was reiterated by Geraldine:

Having experienced something, I think you have a better understanding of it. ... An academic understanding of any experience is one thing, but to have actually been through it is ... a very significantly different understanding of it.

Deidre also stated:

I understand how hard it is to manage the experience of depression in a way that I don't think that I'd have understood from outside of that context. ... I know what it feels like to ... struggle. ... [I realise] how vulnerable people are at that time.

An understanding of vulnerability was central to Helen's understanding of the depressive experiences of both herself and her clients, "I have increased empathy, increased understanding. ... I understand our *shared* human vulnerability." Frank described having a "*keener* appreciation than I would have had without it, in terms of an appreciation of human frailty. ... You have a lot more really intimate painful knowledge that you can use". He found that it equipped him to:

Reinterpret the client's stories in a way that helps them realise, "oh, he really heard that". Because you're reinterpreting them through a personal lens of a similar experience. ... Being able to filter through that personal lens, and give it back to them – I find that they just go, "oh yes! I've been heard".

Andrea felt that the processing of personal experience could be used as a framework through which the experience of the client could be validated, thereby challenging unhealthy biases of power. She said:

You validate your experience so you can validate others. ... Moving away in fact from the counsellor-client model ... [and] trying to establish egalitarian relationships with your clients instead of maintaining the power imbalance. Almost deconstructing the power relationships that exist between client/ patient/ doctor/ counsellor.

Consequently, it was argued that the Psychologist who had experienced depression was able to offer therapy from an "informed position"; in other words, the possession

of an increased repertoire of experience could facilitate an ability to authenticate the position of the client.

7.4.3 Informing Treatment Approaches

The participants felt that they were able to offer treatment advice from a position that was “informed” and based upon an “understanding” of the experience. There was a diversity of opinions about treatment options that included the use of CBT and its variants, the use of medication, and being non-intrusive.

CBT was found to be extremely useful by some participants, but questioned by others. Brian found it particularly effective when challenging the automatic thought patterns that typified his experience of depression, and Elizabeth reported the sense of control that could be restored to clients through CBT methods. She stated that, “it’s certainly been cognitive behavioural tools [that] help them to get through it quicker, [and] to be able to take better control once they’re off medication”. Elsewhere, some participants described the process of self-observation of depressive symptomatology, and their application of self-preserving measures that included CBT approaches. One said, “I knew what it was and I managed to work with it cognitively and just push it aside, get on with life, do the things I had to do”. Another described using a number of approaches, and explained, “you learn how to deflect and defend and ... preserve yourself. ... You learn about your reactions. You learn what can make you really depressed, ... and you learn to deal with it.”

The use of CBT was challenged by Carol and Geraldine. Carol questioned the method’s usefulness because of the emotional and intellectual inertia frequently associated with depression:

You know yourself that ... CBT exercises work bugger-all! ... You know because you just can't be bothered! ... You're so exhausted you can't be bothered. And you'd rather sort of veg in front of the TV, which makes you even more depressed!

Geraldine's opposition was more theoretically based. She understood that CBT could be helpful, and might be specifically requested by some clients, but her opinion was that it was a "band-aid" treatment that avoided confrontation with deeper issues that may have contributed to the experience of depression. She stated, "generally speaking, I see CBT as fairly superficial, and helping people to get back to a functional state, rather than becoming more self aware, and ... deeper human beings as a result of ... going through the depths of [depression]."

Some participants spoke positively about their experience with medication, and it was generally recognised as a life saving measure, and as one participant stated, "I don't know what would have happened if I didn't have medication". Frank described how appropriately chosen medication helped him to emerge him from the "dark hole" of the initial symptoms, and enabled him to be able to make use of psychotherapy. He said, "the nice thing with anti-depressants is they sure help pull things out relatively fast ... [and] get the biochemistry back up to a place where I can actually think".

Other participants were critical of some issues associated with the prescription of medication. Deidre felt that the significance of the side effects was often minimised:

I saw practitioners being very ... offhand about ... the side effects of a lot of the medication. [They didn't acknowledge] that those sorts of side effects are really important to people. You know, people don't want to put

on weight, they don't want to be zombied out, they don't want to feel sick all day.

Geraldine was critical of the culture of acceptance of medication as a solution for depression:

Somewhere along the track ... the reason they needed the medication in the first place is going to have to be addressed. So, I think a lot of people are being robbed of the opportunity to ... just sit with the depression, by being medicated.

For these reasons, she and others recommended self-exploration through the use of psychotherapy and other processes.

As a result of knowing what it was like to be depressed, some participants described how they had adapted their treatment approaches. Andrea described her preferred manner of working:

I understand the importance of sitting with them and being with them for like ten to thirteen sessions, or seeing them drop in year after year. And even though there appears to be no change in what we could call clinically affect, know that at least I'm giving them somewhere to sit and be themselves for an hour, without having to have a mask on, so to speak, in terms of how they're operating.

7.4.4 Challenges to Practice

Although the participants agreed that having had the experience of depression provided a basis upon which their practice was better informed, many participants also discussed the difficulties associated with practicing whilst depressed. One participant described being less efficient than formerly, "you're not using your skills

to the best ability”, and elsewhere this was attributed to the depleting effects of depression, “you are *so* exhausted, ... [but] you still do your duty. ... You do what you have to.” Another participant described being aware, “that my own state is going to interfere with what’s happening” within the consulting room, and another described less sensitivity to client need:

I’m less sensitive ... to their needs. ... I would ask my colleagues or my clients if they’d noticed anything, ... and they’d say, “oh, you look a bit more tired than usual”, but they mostly would not pick [it] up. But I think, ... you’re so exhausted emotionally yourself that it’s ... hard to be a hundred percent there for a client.

As a result of being depressed, participants described making adaptations to their practice. After consideration, they reduced their workload, and some chose not to see clients with certain types of problems. On one occasion, the matter was discussed with the senior clinician at the workplace, but the participant described being disappointed with the ultimate outcome. A measure of assistance was offered, but no adaptation to workplace conditions was offered, in order to tide over the period of difficulty:

They were sympathetic, but ... they were like, “well keep on doing your work. Don’t let the standard fall. It’s okay to be depressed but don’t let your work standard fall!” ... From what I see of other work places, you know, basically you’re forced to resign. ... They were helpful in [some ways], ... but in terms of flexible work place arrangements were not helpful at all, ... and in the end I ended up resigning.

As well as receiving treatment for their depression, the participants discussed the value of receiving ongoing supervision and oversight. One held ongoing discussions with her treating Psychiatrist about whether she should continue to practice:

I talked a lot about [this] with the Psychiatrist who I was ... seeing, [and] ... she always felt I should. I'm ... grateful for that Psychiatrist who encouraged me ... to continue. ... She was good to encourage me, and support my capacity ... to manage but do no harm.

The participants in phase one of the project sought to gain an understanding of the effects of depression upon their professional selves by exploring the nature of the Psychologist, the ways in which having been depressed positively informs practice and treatment options, and finally, the challenges that being depressed brings to the practice of Psychology and the ways in which these challenges can be managed. In addition to the experience of depression being framed as a personal and professional experience, being depressed is also understood to relate to the participants' understanding of themselves within the framework of collegial and other relationships, an area which is discussed in the next section.

7.5 Relational Responses

All of the participants in phase one of the current study chose to discuss their experience of depression within their relational roles as Psychologists. The data obtained from this discussion is organised into two secondary themes, namely disclosure and stigma. The decision about whether or not to disclose having had depression is discussed as a factor separate to stigma because of the emphasis given to both areas by the participants in the current thesis.

7.5.1 Disclosure

All of the participants in phase one of the current study chose to discuss issues about whether or not, and to whom, they should disclose having had depression, as well as the consequences of disclosure, the influence of public figures who disclose having had depression, the disclosure behaviour of Psychologists, and whether or not to disclose to clients.

The attitudes towards disclosure amongst the participants varied between moderately expressed openness, cautious discretion, and decisive silence. It appeared that for some of the participants the decision to participate in the current study, and their subsequent discussion and disclosure of the experience of depression, was a difficult decision. This may explain why a number of potential participants who had initially contacted the researcher, chose not to proceed to the interview stage. A number of participants found that the decision about whether or not to disclose having had depression was not a straightforward issue; even though a decision may have been made about the approach to take, uncertainties still remained. One participant admitted to having, “always struggled with issues of how much you disclose, how much you don’t disclose. ... But I don’t know, I don’t know how you balance that well.”

Some participants elected to keep silent about their experience. One mentioned feeling, “under pressure to, to keep the secret”, and another maintained silence following the recommendation of a trusted supervisor. Helen explained that she had chosen not to disclose having been depressed out of a sense of privacy, and a perception that others may not understand. Another participant spoke of adeptly masking the symptoms, and of playing a role, “a pretend ‘you’ ”, whilst continuing with the daily tasks of life. Other participants were more specific, and expressed

caution about letting colleagues know of anything that may be misconstrued as professional inadequacy. One spoke of acquaintances who:

Grind themselves into the ground and become quite depressed, ... but they are terrified. They know enough how to mask it, but they are terrified to tell their supervisors at work because the supervisors at work also are the people who employ them. ... Are you going to tell your boss, ... “I think I feel incompetent”? I don’t think so!

Nevertheless, following a period of consideration, most participants decided to disclose having had depression to selected individuals. As one participant stated, “I’ve never disclosed to a colleague that I’m working with. ... I’ve only disclosed to supervisors that are off-site.” Another explained, “disclosure is ... not *done*, or if it’s *done*, ... [it’s done] carefully.” Some participants spoke of their decision to be open about their experience of having been depressed. A few initially felt uncomfortable about doing this, but conceded that the public acknowledgement of having been depressed was important. As Elizabeth said:

I’ve come to terms with the more we’re open about this the better it is for all people out there to acknowledge that depression does happen. It can happen in [the] awful situations that life sends you, and so when it does happen to you, deal with it. You know, treat it. Get the help that you need, don’t just hide away from it.

An analogy was made between caring for one’s physical health, and the similar attention that should also be given to mental health. “It’s just a health issue like any other. ... That’s how I work. I think you should look after your mental health as well as you look after your physical life.”

Reference was made to the value of public figures discussing their experience of depression, and it appeared that greater credence was given to figures who were considered to be more acceptable personal role models. One participant expressed caution about the use of celebrity figures whose usual state appeared to be less than stable, but was impressed by the example of more contemporary figures who were closer to her age group. Brian noted the value of seeing examples of people who, despite their depression, were able to live “functioning” and capable lives. He provided an example of the earlier mentioned Australian Rules footballer who publicly discussed being depressed (Ker & Nader, 2004):

Now I think those things are just great role models. I remember when that came on I [thought] ... “good on you”. That’s such a good model – you know. You can still be physically active, and coach a football team. You can still use your brain and be clinically depressed.

All of the participants referred to colleagues or acquaintances who were also Psychologists, and who had also experienced depression at some period in their lives. As one said, “some of my colleagues that I’ve kept in touch with certainly know that I’m now on medication, and some of them have been too. I think it’s a fairly open discussion amongst ourselves that, yes, we’ve suffered from depression too.” One participant initially disclosed her experience of depression during a professional meeting. She said, “I think it is important that we break down that stigma amongst each other, because lots of Psychologists ... are going to be suffering from depression.”

Another participant expressed frustration at the apparent unwillingness of some Psychologists to be more open about discussing their experience, despite making

somewhat academic statements to the contrary. “The reality is that ... *many* colleagues that I know have struggled with depression, at various levels”, however:

It is all rhetoric. You know, ... people don't want to talk about it. But, yes, they've been there, they've experienced it, but they're not going to say anything about it. ... I think that there is no transparency, and honesty, and real discussion. ... [They model] shame, and secrecy ... but the rhetoric is a lot different. ... I feel quite cross about that.

Frank's comments were in agreement. He attempted to model that there was no shame in having had depression, and that conversely, the experience was developmentally and professionally expansive. He explained, it “gives me a different picture of the world ... to look at and be fascinated by, and study, and possibly use”. He understood that personal vulnerability, accessed through experiences that included depression, both informed and was a universal condition:

The best Psychologists I know are the one's who've stepped out of the closet doors. ... I mean, open the closet door – everybody's got a closet door, or five. ... Use your own damage, and your own psychopathology, to help you become a better Psychologist.

Helen expanded upon this view to include the importance of mutual collegial support. She said, “it's important that we, in the profession, support one another, and admit to our humanness”.

Most participants discussed having briefly revealed aspects of their previous experience of depression to selected clients, for purposes that were understood to be helpful to the clients. A number used their experience as a source of encouragement to persevere, to instil a measure of hope when their clients appeared to be struggling, to reduce fear and the sense of isolation, to help their clients know that they were heard

and understood, and to normalise the experience. As one participant explained, “I never had anybody for whom ... that was [not] okay. ... [Disclosure] normalised it for people, ... and de-stigmatised it for them.”

Frank held firm opinions about the value of judicious disclosure to client wellbeing. He had found self-exposure to be, “an *extremely powerful* therapeutic technique if used properly”. He felt that the choice of some clinicians to not disclose, was the consequence of a misinterpretation of Psychological theory, and had the potential to be abusive of the client. He said that it was a, “protective, unnecessary, and damaging practice *not* to self-disclose”, and provided an example of when the client’s expectation for a measure of clinician reciprocity had been blocked, with hurtful consequences.

Carol felt that disclosure was not a useful practice with certain types of clients. She had observed that if some thought their treating therapist had a mental disability, “they may be attracted in the beginning, but then they will turn away from you. Because they will stop ... seeing you as ... their support.” She added, “because that’s not what they’re looking for. What they want is somebody ... [who] is problem free. They’ve got enough [problems] of their own.”

7.5.2 *Stigma*

All of the participants in phase one of the current study chose to discuss the factor of stigma. They emphasised that stigma was an experienced reality, and related it to both personal and professional expectations. The stigma experience of clients was also discussed.

Participants who had courageously chosen to be open about their experience of depression, reported a diversity of responses. Many reported being stigmatised, one

reported little change in attitudes, and some mentioned positive responses. Elizabeth felt that disclosure had not resulted in stigma, but had actually improved her standing in the eyes of her professional colleagues, as evidenced by the increasing numbers of referrals she now received.

In general, almost all participants provided examples of stigmatic responses directed towards themselves from family members, colleagues and superiors at work, reputed friends, and even those who were responsible for their professional care and treatment. Amongst other things, responses were reported as being insensitive, cruel, and angry. On reflecting about her treatment, one participant said, “things like that ... gave me insights into how dangerous the territory is for [depressed] people”. A few participants felt that stigma was related to the chronicity of depression. One said, “we like it when people get better, but if it’s something that’s chronic, something that they might have to live with forever, I feel we’re less understanding of that and there is more stigma.”

Most participants felt that the stigma that they received from their colleagues was related to perceptions that being ill had “let the side down”. One participant reported that the perception that a depressed worker may not be productive, muted the potential for sympathetic professional relationships, regardless of the worker’s previously valued role. It was stated, “I feel that [my boss] was protecting the organization rather than protecting me. So she was more worried about ... would I keep on doing the same amount of work of the same quality.”

The negative attitude of colleagues towards their depressed peers was explained by one participant, “we’re psychological professionals, our job is to fix these things, so you shouldn’t have it. You know. You should have fixed it.” Another participant said, “we still think at some level that there is something ‘wrong’ or ‘shameful’ [about

depression], especially if it happens to a Psychologist”, and it was also reported that, “people start thinking, ‘well if you can’t do it you shouldn’t be here’ ”. Another participant commented:

Even amongst professionals there is a stigma attached, ... simply because sometimes they think well, you might not be reliable, ... because, “we can’t give you a depressed person because ... it might trigger you”. Some people might think, “well we can’t protect you all the time, we can’t give you what they call light cases”.

Frank expressed distress at the presence of peer stigma within the profession of Psychology:

That Psychologists would actually attach a stigma to a Psychologist who’d actually been depressed, ... that I find disturbing coming from a Psychologist. ... Quite distressing. ... It’s punitive, ... we all have human frailties. ... I find it shocking, distressing, that members of my own profession hold those views.

He queried the motivation behind such behaviour, and questioned whether finger-pointing was indicative of the accuser’s pathology. They, “are *in* closets ... [and] not acknowledging what stuff is going on with them, and that’s effecting their practice”.

External stigma was apparently matched by the unhelpful self-attributions of a number of participants, discussed in an earlier section. Participants described having negative and destructive thought patterns, as well as feelings of shame and guilt.

Some participants expressed more concern about the effects of stigma upon their clients than upon themselves. Elizabeth described the experience of her clients:

They feel awfully embarrassed and awkward and they think they’re going crazy. ... They think they’re losing control of their own thought processes.

... They're worried about going on medication because of the stigma associated with that, and the fact that they've got to go to a chemist and buy it, all that sort of thing. All the people around them will know. So there is a lot of stigma out there about depression, and I'm just saddened that it's the case.

Her openness about having been depressed, and willingness to receive treatment was found to be a positive model for her clients.

The participants in phase one of the project attempted to gain an understanding the effects of depression upon their relational selves by exploring the areas of disclosure and stigma. In addition to the experience of depression being framed as a personal experience, a professional experience, and a relational experience, the participants sought to understand depression through frameworks. This area will be discussed in the next section.

7.6 Depression Frameworks

All of the participants in phase one of the current study chose to discuss the ways in which they gave meaning to depression. Three secondary themes are discussed, namely, the need for understanding depression, gaining an understanding of depression by looking at the ways in which it is explained, and understanding depression by perceiving it to be the consequence of causative factors.

7.6.1 Lack of Understanding Depression

Many participants felt there was greater need for an understanding of, and research into, depression, as it was perceived that what was known about the condition was inadequate. Because they had experienced being depressed, the

participants felt that they were in a better position to understand it, and consequently, to be aware of the lack of understanding about the condition. Helen emphatically said, “people *do not* understand what depression is. Do not *really* understand it.” Geraldine expanded this comment to include Psychologists in general, “I don’t think Psychologists understand what depression is! People who have had depression understand what depression is!”

7.6.2 Frameworks for Understanding Depression

The participants discussed the merits of a number of ways in which their depression could be framed, including diagnostic manuals, expanding diagnostic understandings, using a framework of mental health rather than illness, developmental and socio-political models, and finally, medical and pharmaceutical models.

Many participants discussed the usefulness, and also the inadequacy, of diagnostic manuals to provide a framework for understanding depression. The DSM was generally acknowledged as having value as a diagnostic device that drew “a line in the sand”. However, it was also censured for being “culturally limited”, “perfunctory”, “generic”, “superficial”, and “reductionist”. Elizabeth was critical of its lack of descriptive richness:

The DSM-IV says it all but it’s just words. The actual experience seems to be so much more, and so much more outside of the normal experience. [It lists] ... “tearfulness”, well what does that mean? But what we’re really talking about is *absolutely ridiculously unreasonable* tearfulness.

She added, “it’s not emphasising the extraordinary nature of a true depression. It’s not just feeling sad. It’s not just being miserable. It’s outside the realm of normal cognitive functioning.”

Geraldine was critical of the inadequacy of diagnostic manuals to describe a more complex understanding of depression:

I think that depression needs to be understood as a much wider spectrum. ... Like, ... two weeks, you're in! - you're in that big pool of depressed people. ... Within that big pool there is just such diversity. ... Some people might just go through it for a month, or two months, and come through it. Some people have been there for 20 years, ... and yet it's all "depression", and therefore slapped on the same sort of perfunctory understanding.

Others agreed that depression was a complex condition, and some felt that the large number of factors often associated with its presentation was indicative of this. A manualised approach to understanding depression was thought to have resulted in neglect in identifying essential variants of the condition.

Other participants described depression as being part of continuum that ranged from sadness to pathology, and which at some point was no longer a "normal" state and was beyond regular cognitive functioning. It was also proposed that the range contained grey areas that were less easy to categorise. As Carol stated:

To me it's anything from sad mood to ... a pathological description by the DSM. ... And sometimes a lot of people mingle in the middle! ... Where the normal depression, or the normal sadness stops, and the pathological ... begins, who knows?

It was suggested by some participants that an understanding of depression might be better obtained by focussing on the concept of mental health or wellness, rather than mental illness. Brian utilised this approach in his professional practice, and explained that "the reason I do that is because all of us experience the absence and

presence of mental health to varying degrees”. He added, it only became a problem when there was, “enough wellness missing”. This view is contrary to a pathologised, or medicalised, understanding of depression, and brings with it questions about investigating the context of the sufferer, and whether intervention should be focused upon symptomatology, or so-called deeper issues.

Some participants discussed frameworks for understanding depression that were other than the disease, or medical models. Helen said that she liked, “the developmental frameworks, because I think, ‘yes, working *with* depression *is* a path to maturity’ ”. Andrea indicated the importance of having a socio-political context of understanding, and Frank ceded that all models for understanding depression had their place. He added that to focus only on a medicalised understanding of the condition was custodial, “if that’s as far as it goes then it becomes custodial. Rather than one step of the process”.

The medicalised framework for understanding depression was directly criticised by some participants, and others found this evidenced by the influence of pharmaceutical companies upon treatment options. Advertisement was identified as a prominent means for disseminating this viewpoint, and offence was taken that a professional body for Psychologists was used, at one stage, to distribute this material. It was stated, “our professional network does not exist for a drug company to be pushing its product or any related spin-off of its product. ... It’s also pushing a certain understanding of depression as well.” Areas such as Clinical Psychology were thought to be particularly vulnerable to this way of thinking. Elsewhere, it was stated that, “we are in incredible danger of the medical viewpoint just, just swamping”, through the “insidious” promotion of a view-point which states, “don’t blame yourself for your depression, ... it’s just an imbalance in your biochemistry, and we can do something

about that". This attitude was understood to be converse to undertaking personal responsibility for addressing the internal circumstances that had contributed to the occurrence of depression.

7.6.3 Causative Factors

Almost every participant in the current study attributed their experience of depression to certain factors, or, to use Brian's words, distinct catalysts. A number said that they had "every reason" to be depressed, and indicated its commonality. As Frank explained, "there's good reasons to be depressed. ... I mean, depression's the common cold of mental health." Factors which were ascribed as contributory to the participant's depression included a combination of single and multiple factors such as the experience of violence and trauma, exhaustion, marital breakdown, and prolonged legal concerns. Other participants felt they were influenced by an existing genetic predisposition to depression, as well as other biological factors.

Other elements were described as more specific to the practice of Psychology. An inexhaustive list included repeated exposure to with clients with particularly difficult mental health problems, the apparently minimal progress of psychological work, heavy caseloads, frustration and a sense of futility associated with the mental health system, unsupportive workplaces, poor working conditions, and the cumulative effects of general stress and exhaustion. Carol expanded upon this:

The little successes you have are very small steps and sometimes in the overall [view of things] it's very hard to see whether you're doing something. Whether you're changing someone's life, or whether you're helping somebody to survive. ... [However,] you know you do make a

difference - that person would be dead three times over you know if it wasn't for you.

It was also explained, “the counter-transference of depressive people, or borderlines is huge. ... [Spending] one hour with a florid psychotic person ... [leaves you] totally *drained*.”

The correlation between attribution of cause and the experience of depression may suggest a number of factors. It may be that by ascribing a cause to depression, blame is exonerated. One participant felt that by crediting a so-called medical cause to the depression of themselves or their clients, the experience was in effect normalised, “it’s normalising by saying, well, I have an illness, ... and ... the normalisation comes from removing the blame from yourself. So, if it’s an illness then it’s ... not your fault.” However, as noted earlier, there may have been good reason for being depressed. In this light, Andrea questioned the motivations behind, and limitations of, a so-called medical understanding of depression that might neglect the context of the depressed individual. She said, sometimes, “you have every reason to feel depressed and that shouldn’t be medicalised. It’s actually the circumstances. I think that however you understand depression can be ... related to your socio-political understanding of what is occurring.”

The participants in the current study did not give the prominence to issues related to gender, that might be otherwise expected from a reading of the literature. Only one participant discussed the particular difficulties of women, and another noted the capacity of women to have greater circles of support, and to more ably express their emotions. The participants discussed the different ways in which the genders expressed their depressive experiences, from an observational, rather than causative, perspective. For example, it was observed by one participant that males and females

used different methods to mask, or medicate, their depression. In the experience of this participant, males tended to abuse substances, whereas, females tended to overeat, or stop eating. Other participants felt that the depression of males tended to be more agitated. Contrary to the findings in the literature, another participant found that males were more likely to ruminate, and focus upon negative thoughts about other people.

The participants in phase one of the project framed the experience of depression as a personal experience, a professional experience, and a relational experience, and sought to frame depression in order to understand this experience. The next chapter will discuss the ways in which the participants in phase two of the project explored the depression of their peers.

CHAPTER EIGHT

RESULTS AND DISCUSSION: PHASE 2

In phase two of the project, participants were asked what they, as Psychologists, considered to be the important issues about the depression of those who were also Psychologists. This chapter describes the areas that were seen as important by this cohort, which together with the results discussed in the previous chapter, forms the basis for the final analysis described in chapter 9. The current chapter will describe the demographics of the participants in phase two, and then discuss the four major research findings generally and specifically.

8.1 Participant Demographics and Recruitment Issues

The participants in phase two of the current thesis were operationalised as Psychologists who had themselves not experienced a depressive illness. The information obtained from the 6 Psychologists who participated in phase two of the current study indicated that, similar to phase one, they were mainly female (there was 1 male participant). Their mean years of professional practice was 2 to 3 times greater than that of phase one, at 27 years (in comparison to 10 years), and ranged from 21 to 30 years, with a median of 23 years. At the time of interview they practiced in a wide number of areas, with all operating in at least 2 to 3 spheres, but having experience and interest in a broader number of areas.

The descriptors that were used by the participants to describe their current areas of practice included: Clinical Psychology, Psychotherapy, Counselling Psychology, Child and Developmental Psychology, Community Psychology, Forensic Psychology, Professional Supervision, Clinical Teaching, and Academia. They also described that

they worked with children, adolescents, adults, families, and parents, as well as the areas of women's mental health, mental health and human rights, and the impact of gender-based violence on mental health. Although it was not a requirement for participation in the current research, the participants in phase two of the project were identified as generally having a broad and rich expanse of experience upon which to draw their opinions.

8.2 Primary Themes

In the second phase of the project, six Psychologists who themselves had not experienced depression, were asked what they, as Psychologists, considered to be the important issues about the depression of those who were also Psychologists.

The data provided by the participants, and organised according to the grounded theory processes of constant comparison and axial coding (see Table 11) (Blaike, 2000; Strauss, 1993), suggests four primary themes that are conceptualised according to the person of the depressed Psychologist. These areas are the characteristics of Psychologists in general, the depressed Psychologist as a practitioner, the depressed Psychologist as a member of a body of colleagues, and ways in which to understand depression. It is understood that these areas are not mutually exclusive, and that there is a measure of interconnection and flow between the concepts that are presented, some of which are referred to in more than one area.

Table 12

Phase Two: Primary and Secondary Areas

Primary Areas	Secondary Areas
The Psychologist	Motives for becoming a Psychologist Characteristics of Psychologists
The Psychologist as a practitioner	Positively inform practice The negative effects of depression upon practice Capacity to practice Management of depression
The Psychologist as a member of a body of colleagues	Commonality of the experience of depression Disclosure Stigma Empathic understanding Depression as a professional health issue
Understanding depression	Aetiology Describing depression Treatment perspectives

These four primary themes differ to the results found in phase one which conceptualised the findings according to the experience of the depressed Psychologist, and categorised these areas according to the inner self, professional identity, relational responses, and depression frameworks. Although there are certain similarities between phase one and two, this is not because a similar, or any, framework was used to encapsulate the information, but because the data provided by the participants suggested these categories (Ambert et al., 1995; Glaser, 1992; Glaser & Strauss, 1967).

8.3 The Psychologist

Many participants in phase two of the current project sought to express their understanding of the person of the depressed Psychologist by considering the reasons

individuals chose to become Psychologists, and the characteristics of Psychologists in general. These two secondary themes shall be discussed in turn.

The two main reasons for selecting Psychology as a profession were thought to be a desire for self-understanding, as well as an interest in others. Margot said, “lots of us are probably drawn to Psychology partly in terms of a wish to understand ourselves better”. Kate added that most are, “likely to have come into the field of Psychology through an interest in the experience of other people. ... [They have a] core of interest in the experience of others, and their own experience.” Personal neediness that had neglected to be explored and worked through, was thought to be an insufficient and inappropriate reason to enter the profession, both from the client’s and the future practitioner’s point of view.

Psychologists were identified as having a propensity to be introspective and depressive, “as a group”, and to have a “relatively depression prone ... personality style”. Kate felt that, “a *personal* orientation to introversion, tends to go hand in hand with a tendency towards depressive experience in general.” An orientation towards being introversive, or reflective, was thought to be related to the capacity to use the depressive experience as a source of personal growth. It was wondered whether, “the fact of being introspective in this way, and confronting yourself [facilitated] issues of self-growth ... *through* depressive experience”. As a result, having been depressed could be thought of an experience that facilitates the individual’s potential in ways that might not be possible otherwise. Such a tendency may also explain the culture within Psychology of professional and self exploration by the means of supervision and personal psychotherapy, with the latter being practiced in some areas of Psychology, for reasons of personal growth and health, rather than overt pathology.

Margot also indicated the peculiar interests of the Psychologist; “being a good Psychologist requires one to be ... interested in distress, ... and in some ways being interested in being a helper”. In some circumstances of practitioner distress, these interests could be thought of as somewhat ironic, but nevertheless, can explain why the Psychologist may chose to expose themselves to various measures of client trauma. The Psychologist is interested in these aspects of the human experience, and amongst other things, is consequently liable to vicarious traumatisation, including depressive experience.

The participants in phase two of the project sought to gain an understanding of the person of the depressed Psychologist by exploring the reasons individuals chose to become Psychologists, the characteristics of Psychologists in general, and by describing their empathic understanding of the depressed Psychologist. It was speculated whether these factors predisposed individuals to future depressive experiences. In addition to this main factor, the participants also discussed the role of the depressed Psychologist, an area which is discussed in the next section.

8.4 The Psychologist as a Practitioner

All of the participants in phase two of the project described their understanding of the person of the depressed Psychologist by discussing a number of ways in which the experience of depression by a colleague may influence his or her practice. The secondary areas discussed are the ways in which depression positively informs practice, the negative effects of depression upon practice, the capacity to practice in general, and the management of depression.

8.4.1 *Positively Inform Practice*

The participants in phase two of the project discussed their observations of the ways in which the depression of their colleagues had, as a consequence, positively informed their practice, and in some cases, had been incorporated as a growth-producing opportunity.

It was conceded that the Psychologist who had the practical and experiential knowledge of depression was in a better position to understand the experience and “emotional pain” of their depressed clients. Lisa felt that the “Psychologist who had experienced depression, and who understood the aetiology of that within what had happened within their own lives, ... would be very *well* placed to respond more meaningfully to other people in that situation”. In addition, it was suggested that the therapeutic process involved in the experience, as well as the process of having worked through depression, would inform their practice. Margot commented that a Psychologist’s understanding of “their own depression, ... can be ... of benefit in understanding others. So, coming to Psychology out of one’s own work on one’s self could be a positive thing.” Irene pointed out that it could be advantageous to one’s profession practice to be aware of personal vulnerability; this process suggested that there was a relationship between both personal and professional processes, and the so-called impaired clinician had much to “offer” the client, by having made himself or herself vulnerable.

The overall merit of having been depressed, in order to achieve so-called professional “advantages”, was questioned by some participants who had observed the painful experience of depression in others. It was wondered whether it was worth the cost. Irene said, “it may well make you a better Psychologist, but do you want to go through all of that?” The response of some would be “yes”, as the process, and

processing, of depression, was understood to be both personally and professionally advantageous; the experience of depression is not, “a cost, but a benefit, and one which is essential to the process of personal growth and development”. Kate felt that participation in this process was essential to the development of basic professional competence. She said, it’s, “the opposite of a problem. ... [I see] depressive experience as being ... a *great boon*. ... A position from which the world can be viewed in a realistic and compassionate way.” The way in which personal and professional development informed each other was emphasised: “personal development and professional development reverberate with each other. There’s a synergy between the two which is *extremely* powerful in whatever direction you’re looking.”

8.4.2 *The Negative Effects of Depression Upon Practice*

Most of the participants in phase two of the project described their observation that being depressed has negative effects on the practice of depressed colleagues. It was described as having a negative effect on “competence with everything”, and depressed Psychologists were also observed as having reduced energy levels. It was thought that depressionogenic affect had the potential to be projected onto the client, and negatively influence optimism for change. John noted that depressed Psychologists had a reduced capacity to be acutely aware of, or sensitive to, the status of the client. He said, they are, “not as *sharp* about where the person who is consulting them is at”, and were less likely to sensitively respond to the material that was provided within the period of consultation. Lisa added, depression, “*reduces* the insightfulness of the Psychologist into other people’s emotional difficulties”, and Margot said there were issues associated with whether the Psychologist could be

“*fully* present and in touch”. She also questioned, “how well you can acknowledge your clients pain when you’re busy trying to in some ways set your own pain aside”. It was observed that some of these issues were consequences of the way in which depressed Psychologists typically coped, “by developing ... tunnel vision, and just focusing on the few things that are important”, a characteristic that was described as a “*narrowing* of experience” by John.

8.4.3 *Capacity to Practice*

Most of the participants in phase two of the project discussed issues surrounding the actual and perceived capacity of the depressed Psychologist to practice. It was emphasised that the focus should not be upon the fact that the Psychologist had depression, but instead, upon the capacity of the Psychologist to practice, irrespective of the reason for any change in that capacity. This was reiterated by Irene, who said, “the *clear* issue ... is not the depression itself but how it is affecting the practice”. Naomi added, “I think it would be difficult to have some kind of policy about it. ... Why would you [target] depression, and not divorce, or having children?”

It was pointed out that all Psychologists have periodic variations in their levels capacity, regardless of their health status. Margot described measures of capacity as including various levels of sufficiency, a descriptor that was not to be confused with *in-sufficiency*. She said:

With professional competence there’s a range, isn’t there? Whether you’re depressed or not there’s the days that you do your best work, and there’s the days that you do work that’s ... “sufficient”. And I guess when you’re depressed you may be more around the sufficient end, but you’re not necessarily incompetent.

Nevertheless, it was recognised that professional competence may become an ethical matter, and, “ethical issues may arise around whether or not one feels one really is delivering a satisfactory service”.

A period of difficulty, such as depression, was not thought to negate the clinician’s capacity to be of assistance to clients. Irene said, “just because ... you’re struggling with something at the moment, doesn’t mean ... you have nothing to offer”. John added:

I don’t think treatment for depression should preclude people from acting as Psychologists. ... Even though it will be quite debilitating, ... they still are able to function in other ways and are able do their work. So it’s one of the ... paradoxes, if you like, of depression. ... Even if not quite so efficient, it might not be destructive at all.

A realistic case-by case assessment of individual capacity was recommended; “it’s a question that individual Psychologists need to think about for themselves, ... think realistically about what it is possible to”. Margot had observed that a highly experienced colleague had been better able to manage a period of depression, than a person new to the profession might be able to. She reported that her colleague, “had a lot of experience and intellectual understanding to draw on, and she felt that she was able to keep working in a way that was satisfactory”. Naomi had never thought that any of her depressed colleagues should not be working. She said, “I don’t think that [depression] means they should stop practicing. ... I think it’s possible for people to practice quite well. I have no problems. ...I haven’t known anyone who I thought shouldn’t be working.” Lisa pointed out that attributions of causality could influence perceptions of capacity. She questioned whether depression influenced competence, “I think that it *can*, I don’t think that it necessarily *does*. And whether it *does* or *doesn’t*

affect the competence relates to ... the causal theories that people use to understand their own and other peoples depression.”

8.4.4 Management of Depression

The management of depression was understood to be both protective and restorative for the depressed Psychologist. Protective measures that were suggested included the reduction of workloads, and reducing exposure to potential stressors. One participant recommended that practitioners who were subject to repeated episodes of depression should establish a contingency plan, and another recommended an ongoing process of self-monitoring. Ongoing psychotherapy, supervision, and other forms of support were identified as helpful preventative and treatment measures, and were described by Kate as important ongoing elements of the career of Psychology, that, by its nature, requires support. Margot noted that for “some realms of psychology, going to therapy is not seen as a stigmatising thing – it’s seen as a good, appropriate, professional development thing”.

During a period of depression, it was recommended that the depressed Psychologist refer clients, be selective about having clients with certain issues, cut back, and consider taking a break for a period. One participant suggested, “nurse yourself through by just missing the occasional day here and there”, and added, “it would be very difficult, for example, to have issues around, say, client self-harm, or client suicide attempts.” It was only suggested that the Psychologist should stop work all together, if their depression was severe. Lisa pointed out, however, that if this was the case, the clinician would be unlikely to be practicing anyway. She said, “I don’t think that someone who was ‘severely depressed’ would be able to practice”.

Finally, it was suggested that it may be helpful for the Psychologist who was having difficulties that may be attributable to the nature of his or her work, that their reasons for undertaking it should be re-evaluated. It may be helpful to explore “whether or not to continue with the particular line [of work, and] ... whether Psychology is really for them”.

All of the participants in phase two of the project have described their understanding of the depressed Psychologist as a person and as practitioner. The latter has been considered by discussing the depressed Psychologist within the role of a practitioner, by considering the positive and negative ways in which depression informs practice, depression’s influence on the capacity to practise, and the ways in which depression can be managed whilst practising. The next section will discuss the ways in which the depressed Psychologist is perceived as a member of a body of colleagues.

8.5 The Psychologist as a Member of a Body of Colleagues

All of the participants in phase two of the current project sought to express their understanding of the person of the depressed Psychologist by considering his or her participation within an informal body of colleagues. A Psychologist not only functions as an individual and as part of a therapeutic team within the consulting room, but also operates in close and/or loose relationships with other Psychologists. Naomi stressed the importance of support within this cohort, and Margot indicated that, “for many people, what happens at work is not only working with clients, it’s also about working with colleagues”. This section discusses the shared commonality of depression within Psychology, as well as issues related to disclosure and stigma,

empathic understanding of the depressed Psychologist, and suggestions that colleague depression is a workplace health issue.

8.5.1 Commonality of the Experience of Depression

The participants indicated that depression was a common occurrence amongst their colleagues within the profession of Psychology, as well as in the population in general, and a few described their experience of non-clinical depressive symptomatology in the past. Like others, Kate commented that the depressive experience of Psychologists was experienced in common with those who were not Psychologists. She said, that as an issue, it was, “not that different from the issues of people in the general population. ... It’s part of the *human* experience, a very central part.” John felt that the extended structure of training, in addition to the nature of Psychological work meant that, “Psychologists are very prone to mid-life problems, ... [and] that most Psychologists get depressed at some time or another”.

8.5.2 Disclosure

The decision as to whether or not to disclose having had previous or current depression to other Psychologists, was thought to possibly influence the way in which the discloser is perceived, in addition to the way in which the professional body perceives itself. The areas considered in this section include uncertainty about the responses of others, pre-judgements about professional skill, empathy, and whether or not to disclose having been depressed to clients.

Some participants discussed the way in which the decision about whether to disclose was moderated by uncertainty about the responses that would be received. Irene explained, “you can’t guarantee what other people’s reactions are going to be.

... Where there's no obvious external cause, ... people can't quite make sense of it themselves." Naomi suggested that a better course of action may be to disclose, "on a 'needs to know' basis", and elsewhere it was suggested that the desire for privacy may restrain disclosure. Others felt that it was an imperative that Psychologists openly discussed having been depressed with their colleagues. John felt that, "practitioners should be outed, because if we don't talk about it, then it becomes stigmatised". This suggests that the decision about whether or not to disclose could be thought of as a political decision, with the consequences of that decision not only effecting the individual, but the profession as a whole; it may be that if the matter is not openly discussed and admitted to, then the entire cohort could be harmed in some way.

The perception of others towards their depressed colleague may be coloured by accurate or inaccurate judgements about his or her professional acumen. This may also encourage depressed Psychologists not to disclose, so that they "tend to want to keep it to themselves, because they don't know how that will affect how they're seen professionally". On the other hand, if a Psychologist's performance has declined, and there is irregular workplace attendance, disclosure may help colleagues understand what was happening; "if people *don't* know, ... you can be just seen as manipulating the system, or bludging". Some felt that responses to the depression of a colleague might also be moderated by whether the sufferer had an established professional reputation, and it was suggested that a depressed Psychologists may attempt to embellish this reputation to protect themselves from criticism. Colleagues may also more harshly judge newly qualified Psychologists, who had yet to establish their standing. Margot summarised these responses:

It can be a very sensitive issue, how you stand in the workplace, and if you're seen to be struggling. ... And whether it helps to explain that you're

struggling because you're depressed, or whether that makes the situation worse; ... whether it would diminish you in the eyes of others, or whether it would provide support. I'm sure some of both happens, but which is going to happen might be quite hard to judge. ... I don't think their reputation has diminished, if they already were at a stage where they had a strong reputation established.

The perception of others could also be tempered by empathy towards their depressed colleagues, as previously described. Conversely, some symptoms of the depressive experience may be expressed in ways that overwhelm, or invoke fear in their colleagues. Irene succinctly described this when she observed that, "people get scared ... when people have 'big feelings', ... and 'leaky bits' ".

Generally, the participants felt that there should be considered restraint around the issue of whether to reveal having been depressed to one's clients. It was suggested that a recovered Psychologist may erroneously perceive that he or she can generalise their own experience to the depression of others. One participant said:

There's a danger saying, "I got over it, and so you can too. I know my solution's going to be right for other people." ... Is it helpful to [clients] ... to be blurting out "what worked for me"? ... I just think you have to be really careful about whose interests you're doing it in. ... Is it part of your own healing, or is it ... for [the client's] ... benefit?

It was also suggested that disclosure may clarify issues associated with a perception of clinician inattentiveness:

There may be times when you need to make it clear to a client that something is not with them, but is to do with you. ... Clients are sensitive to feeling that people are ... a bit inattentive, and it may be important to

say, at certain points, and to certain clients, that there are issues in your own life that currently are making it more difficult for you to be fully present.

8.5.3 *Stigma*

All of the participants in phase two of the current project discussed the issue of stigma responses directed towards their depressed colleagues. The behaviour was understood to be somewhat irrational, and “not based on a realistic judgement”, and it was also described as “a violation of the person’s human rights”. The areas considered in this section include expectations associated with the role of Psychologist by others, colleagues, as well as depressed individuals, the influence of descriptors, and the consequences of stigma.

It was suggested that there was an expectation that those with an expertise in the mental health field should not have mental health problems, and Psychologists who struggled indicated a lack of professional expertise that was illustrated by their inability to manage their own lives. One participant reported, “people are saying, ‘if she’s a Psychologist, how did she get into this position?’ It’s like, ‘physician heal thyself’.” Another said, “I think that there’s always stigma when the help *giver* is seen to be in need of help. I think that’s almost universal.”

Punitive responses were observed from the profession of Psychology in general, and were particularly noted amongst those with little insight into the difficulties of clinical work. It was commented:

Some ... research Psychologists, with not much clinical insight, ... do indulge themselves in stigmatisation of this sort. They don’t appreciate that everybody faces these sorts of problems, especially clinicians. ... There

are research-orientated Psychologists (measurers of one thing or another) who usually do not have much insight into the demands of the work, and regard depression in their Clinical colleagues, or their Practicing colleagues, as a sign of some sort of weakness.

Lisa noted the generally self-protective responses of groups towards peer impairment. She said, “I don’t think that any group of professionals copes well with mental health issues in their peers. They see it as a sort of threat to the body politic.”

It was also observed that depressed Psychologists could stigmatise themselves. It was questioned whether such an attitude indicated an underlying similar attitude to clients. It may be that some see the client as distinctly different from themselves, and a supposed violation of the division between care-needers and care-givers is also an assault on personal identity. It was suggested that:

It’s about, “do we think that we’re people who would never have to have treatment”. Which is kind of stigmatising about clients. But then, if we’re in the position where we think we might need to have treatment, do we then say, “well we’re joining those people who need to have treatment as distinct from being one of the people who doesn’t”?

The way in which stigma is framed through the use of descriptors was challenged by a number of the participants. Some wondered whether describing depression as a mental illness was actually a stigmatising term, in contradiction with that which was publicly promoted. One participant commented, “some mental health promotion campaigns ... seem to function on the view that calling something an illness is in a sense *de*-stigmatising, ... but I think calling something a *mental* illness is probably more stigmatising”. It was also suggested that it served the purpose of pharmaceutical companies to define depression as a problem to which they had the

solution, and that apparently consoling public attitudes towards depression, were part of a marketing agenda. Irene reported:

The term stigma ... is peddled by the drug companies. ... It's very hard to separate the interests of the drug companies from a generally supportive response to depression. ... Nearly all of the mental health campaigns, [including] anti-stigma, ... [have] been funded by drug companies. ... I remember [a colleague] quoting one of the drug companies saying, ... "we've saturated the market on depression now, and we need to move on to anxiety".

The consequences of stigma were identified as disadvantageous to the sufferer. John pointed out that stigma responses interfered with the readiness and capacity of Psychologists to access treatment services, and this was observation was also noted by Margot:

Whether the Psychologist feels able to seek treatment, or whether they are concerned about those issues about stigma and reputation and all of that, [may] make them hesitant to seek treatment. ... It does concern me that people may not seek help for all of these reasons, and end up in a much worse state.

She indicated the relatively high rate of suicide in some areas of the profession, and suggested that some cases may be related to incidences of depression.

Nevertheless, stigma was not an issue that all participants had observed. This may be because of the framework for understanding depression in these cases was not to discern it as a problem, but instead, identify it as an opportunity for growth. Kate said about the stigma of depressed Psychologists that:

To be perfectly honest, I have never come across an instance of that in my career. I just haven't come across an instance of a Psychologist being branded or criticised for expressing depressive ideas, or even for having a depressive episode and having to take time off work.

Elsewhere, it was emphasised that collegial responses were not always negative, and could be highly supportive. It was stated, "there can be issues of loyalty, and of really wanting to support people. ... It's not all about stigma; it's also about loyalty and support, and trying to help people get through."

8.5.4 Empathic Understanding

The participants in phase two expressed empathy with the experience of the depressed Psychologist. Some indicated that familial and collegial experiences had informed their understanding of the difficulties of the condition. Irene was particularly aware of the fear of the recurrence of depression expressed by those who had previously experienced it. Margot discussed the ways in which a sense of self-competency was assaulted by having been depressed, and how important it was for the sufferer to attempt to "maintain" a sense of competence. Others discussed the ways in which the depressed Psychologist may consequently attempt to compensate, or reportedly over-compensate, for a perceived lack of competence. Naomi's description of one of the causes of depression brought with it a picture of what the experience is like for some sufferers. She said, "I think of depression as being like a death. More of you has died than you can cope with."

8.5.5 Depression as a Professional Health Issue

In keeping with the attitude that responses towards depression could be

collegially supportive, it was suggested that depression was not necessarily an issue to be borne alone, but one that was a professional health issue that expected a collegial, and/or organisational, response.

Workplace issues were indicated as pertinent to the mental health of Psychologists, and it was suggested that they may well have contributed to, or exacerbated, some incidences of depression. It was felt that Psychologists were often positioned in roles where there was little actual power, or potential to impact change, and consequently there was a sense that one was “just a band-aid”. Overwork and exhaustion were also mentioned, as well as the neglect of adequate levels of emotional support and opportunities for debriefing. It was also understood that it should be the responsibility of the workplace to adaptively support employees with temporary or periodic concerns such as depression; Psychologists should be treated as “valued members of the professional team”, and be offered an alternative role whilst “you were pulling yourself together”.

The nature of the practice of Psychology, as well as the nature of the clientele, was identified as a source of exposure to difficult and unpleasant issues that may need to be repeatedly explored during the therapeutic process. As Naomi explained, “there can be some pretty horrific things that Psychologists have to [work with], ... because it puts you in touch with the ‘greater evils’ of the world”. She added, this work, “can add to existential experiences of depression”.

It was felt by some participants that, in general, professional bodies had neglected to address the need for the care of their members. One participant said:

I just think the whole care of the profession is appalling. ... I think the whole issue of working with people’s troubles should be more helped. ...

I'd like to see the APS doing more to look at the kind of "industrial hazards" of working with people in therapeutic ways.

The neglect of training bodies to address the potential for, and the reality of, facing difficult personal issues whilst practicing as a Psychologist, was also criticised. One participant commented, "most training courses don't even address the person's own personal issues. ... I'd be surprised if there's any addressing of the way in which one's own mental health might impact on work." Solutions to this concern did not include the enforcement of personal counselling as a requirement for college membership, as it was thought that there were any number of potential solutions:

It's about acknowledging, naming, [and] looking at how they might help support themselves, because there's a variety of ways that Psychologists just might do that. Just as there's a variety of ways the public might do.

Not everybody goes off to therapy to get over something.

The participants in the second phase of this study have discussed their understanding of the person of the depressed Psychologist, and the depressed Psychologist as both a practitioner and a member of a body of colleagues. The latter has considered the commonality of the experience of depression, issues to do with disclosure and stigma, and whether mental health is a professional health issues. The next section will discuss the ways in which depression is understood.

8.6 Understanding Depression

All of the participants in phase two of the current project sought to express their understanding of the person of the depressed Psychologist by constructing an understanding of depression. Three secondary themes will be discussed, namely, aetiology, describing depression, and treatment perspectives.

8.6.1 *Aetiology*

An understanding of the aetiology of depression frames attitudes towards depression, intervention solutions, and importantly, perceptions towards the depressed Psychologist. Most of the participants in phase two expressed the opinion that there was often good reason for being depressed, and this was located in a number of sources. Areas discussed in this section include alternate models for understanding depression (including developmental, CBT, and biological explanations), and an appreciation that depression may be caused by multiple factors. Difficulties associated with the practice of depression because of session content and workplace factors, have been discussed in an earlier section; the participants identified these as potent professional health issues that could also contribute towards the Psychologist's experience of depression.

The literature has proposed many models to understand and describe depression, such as personal, therapeutic, community, and medical measures. Some of these were discussed by the participants in phase two of the current thesis. One had observed that the depression of Psychologists was frequently related to a re-enactment of experience as a small child, and was likely to occur during the years of their mid-career. Kate understood depression, or depressive experience, from a developmental point of view, and perceived it as an opportunity for exploration and ensuing personal development. She identified it as part of a "sophisticated level of psychological development", and added:

I see depressive experience ... as a natural and positive stage in a person's development that needs to be, that can be, worked through. When it is worked through it fortifies, and informs a person. ... It places the person in

a much better position to be able to explore and go after novelty and mastery.

Some models for understanding depression were perceived to be of limited usefulness. One participant felt that CBT approaches were not sufficient to develop an understanding of what was happening with the client, and another said that the methodology lacked breadth and depth, as evidenced by its limited scope when appraising client experience. Elsewhere, it was felt that this not only led to an inaccurate understanding of the client, but was “also disrespectful to the person that feels depressed”. Others expressed criticism of general approaches that had an information, and history, gathering approach that was “narrowing” and “truncated” rather than appreciative of the complexity of individual lives, and of understanding it from the perspective of the client. The authenticity and motivation behind the construct of some models for understanding depression, as well as the promotion of these views, was also questioned. Irene suggested that there was “ownership” of some models, that was primarily driven by a competitive desire for research funds.

A number of participants expressed disquiet about the prominence given to biological explanations for depression. John questioned the accuracy of this assumption, and ultimately did not feel that the this was “compelling”. Elsewhere it was pointed out that this attribution did not provide a sufficient explanation for the global increase of the number of sufferers.

In addition, many participants described their concern about the implications suggested by biological explanations. It was acknowledged that by describing depression as a “brain disease” that only needs to be diagnosed and treated with medication, “blame” is reduced, people are encouraged to seek treatment, and theoretically, stigma is also reduced. It was conceded that this concept “has great

value for people who need to recognise how badly they're functioning, [by] actually drawing them towards a conception of themselves as in need of treatment". However, disadvantages were also described. Some felt that a biological explanation was, in effect, more stigmatic. Naomi pointed out that it was a potentially damaging attribution as "you're really saying that you're affected genetically – and I'm not sure that's a very good message for your family". It was also pointed out that the publicity given to biological explanations relies on "flattening", or qualitatively reducing, the descriptors that indicate the experience of depression, with the result that treatment solutions are simplistically biased towards medication. As a result, sufferers of depression may be drawn, "to a form of treatment which may be no more than a 'holding' treatment rather than 'curing' ". In addition, people are led away from seeking deeper solutions to their experience of depression, and away from alternative explanations.

Naomi suggested that a Psychologist who has experienced depression may enter the profession with a vulnerability to the condition that may be exacerbated by the nature of the work. She also indicated the influence of professional issues, as well as life-span, and other matters that are shared in common with the general population:

You can come into the profession with your own problems, and also, anyone can develop problems across their life, regardless of what they started out with. ... [Other contributing factors include] abuse, loss, lack of connection, [and] social and cultural factors.

Standard theories to explain the aetiology of depression may neglect to acknowledge these, and other influences. As Lisa said, "intimate partner violence, and childhood sexual abuse are very potent risk factors for depression, but you know, if you look at a lot of theories of depression, they haven't necessarily accommodated those things".

A number of participants described the aetiology of depression as a complex issue that brought with it an exploration of issues that transcends a cursory framing of the problem within the individual. Depression was described as ultimately being a public health, human rights, and women's health issue, that should be looked at from the aspect of prevention as well as treatment. In addition, access to appropriate and timely medication was framed as a political/ human rights/ marketing issue. Lisa indicated that, "there is a very long history of depression being seen as a biologically based vulnerability, and not to attempt to contextualise that vulnerability, or to see it in relation to *other* vulnerabilities." She was critical of:

Theories that were too heavily focused on the individual and the intrapsychic, without having regard for both current context, and the life difficulties in that current context or past history - broadly conceived. Personally, I don't feel that that is a very good basis for responding meaningfully to the range of causes of depression in clients.

Other issues that were also considered to contribute to the occurrence of depression, that were discussed by the participants, included discrimination at work, inadequate rates of pay, and other "socially structured inequalities".

8.6.2 Describing Depression

The participants in phase two of the current project also indicated that an understanding of depression may be refined and/ or adjusted through the use of different descriptive terms or definitions. This includes having a broader understanding of depression, considering the descriptive terms that are used, and appreciating the limits of diagnostic manuals.

It was suggested that depression could be better understood by having a broader context of understanding. It was described as operating on a “continuum along a scale” that included normal sadness and pathology, and at one point a diagnosis of depression could be made. The use of broader descriptive and diagnostic means to describe depressive experience was recommended. Irene said:

There’s an infinite way that people come in and tell you about their lives.
... If you confine yourself only to ... professional language, and not to the language of people’s lives, then there’s a gap between, and they have to then squeeze themselves into your definitions before they can get help.

Elsewhere, thin, rather than dense descriptions of experience were described as ways that could “narrow down” understanding and treatment options to fit in with pre-formed biases and neglect the rich complexity of life-experience. If, when formulating diagnoses, “we say we do ‘this, this, and this’ then it sort of rules out a whole lot of ways that people describe their lives”.

Other participants thought it was preferable to avoid the word “illness”, and describe depression as a mental health “problem”. As well as implying a biological problem (and hence, a pharmacological solution that is prescribed within a medicalised setting), the term illness may lead to an abrogation of personal responsibility, and an expectation for special treatment; an attitude which can in a sense handicap both the sufferer as well as those with whom they associate. Discomfort with having a mental illness perspective towards depression was expressed by Naomi:

I have problems with the whole concept of “mental illness”. The idea that it’s a mental illness is problematic, because it can happen to anyone.
The idea that somebody’s depressed, and they should stop working and get

better is an easy one to say - as if it were a cancer, or something. I don't think that it is like that.

Suggestions were made for ways in which depression could be better described. Some participants thought it important to emphasise the experiential aspects of depression, rather than depression as an entity in itself. Lisa suggested that the term “demoralisation” was a “more accurate summary term for what people are experiencing” when they are described as being depressed. In comparison to the more historic term of “melancholia” (Freud, 1917/1985; Styron, 1991), it was thought that that latter had a “feeling of a miasma, [as if it was] sort of descending on someone”. Demoralisation was thought to more accurately indicate the complex community and social factors that contribute to the experience of depression, and associated conditions, as it was a word that inferred “look[ing] *out* as well as in”. Depression was understood to be a comorbid state; part of a broader area of experience, and possibly symptomatic of other issues. Lisa added, “I think what we should be doing as health professionals is getting a better understanding of the way in which the *whole* of that emotional experience fits together, rather than just sort of zoning in on depression”.

Diagnostic manuals such as the DSM were understood to be “adequate enough” for their purpose. However, they were also understood to reflect and reinforce some of the limitations in the understanding depression that have been discussed earlier. It was suggested that the DSM should not be used as the only descriptor, that it neglects the “huge amount of comorbidity” with depression, and that “not all depressive experience progresses to the disorder known as clinical depression”. As such, a focus upon the signs and symptoms of depression brings limited understanding of, and to, the condition. Irene summed up these comments, “the DSM's a finite list, ... but there's an infinite way that people come in and tell you about their lives. ... [It is

important] to unpack it in the person's terms, rather than [only] looking at what the DSM says."

8.6.3 Treatment Perspectives

The participants in the phase two of the current study discussed perspectives to do with the treatment of depression. These solutions are closely related to causal attributions, and include a discussion of the reasons why Psychologists may be difficult to treat, and a consideration of treatment measures, including medication.

It was pointed out that Psychologists can be a difficult cohort to treat. It was suggested that there may be a reluctance to seek treatment because of professional knowledge, and defence structures constructed upon this information. It was commented, "I think one of the dilemmas for somebody who's a Psychologist ... is partly around being almost too much of an expert, and developing protective defence structure around this belief." There may also be a reluctance to admit to need. One participant said that it would be difficult for depressed Psychologists, after, "being expected to be an expert in managing your life, then to find yourself in the position where you're struggling". Margot suggested that this difficulty may also be related to a sense of personal self that is related to professional identity. She said:

Psychologists can be reticent to acknowledge that they may need treatment for reasons that are to do with one's sense of one's self, and who one is, and how one should be strong. ... Psychologists are a bit inclined to think, "we can withstand hearing about distress", and, "we can withstand experiencing distress". ... You think of yourself as somebody who in some way ... is stable enough, and strong enough to deal with other people's distress, and other people's trauma. ... And if ... [you think], "I'm not

managing my own life, and my own feelings”, [and] ... “I need to go and get professional help”, is to ... acknowledge to yourself that you’re not as strong, or not as invulnerable, and not as stable, as you’ve kind of been working on the assumption that you are.

However, admitting this need, and making oneself vulnerable may be part of the healing process. As one participant said, “it can be *freeing* to be able to ... own it as something seriously wrong, and [to say] ‘I need help’ ”. It was also thought that learning what it was like to be in the role of the client, was also potentially helpful. It was said:

If you don’t think you could seek help then you shouldn’t be giving it. Because otherwise you’re placing yourself in some other level that’s away from where your clients are. ... If you wouldn’t accept something for yourself, then you shouldn’t be doing it for others. That’s quite a challenging thought for some people who don’t like to see themselves in that role.

Some participants thought that flexible treatment responses could be useful. A formal diagnosis may be less necessary than the recognition of client need, and there could be a number of ways in which the depressed Psychologist could be helped, as, “there are lots of ways out of depression”. Most participants discussed the value of supervision and psychotherapy. One participant said, “you need to have good supervision with somebody that you can trust, and good therapeutic help from somebody who knows how to help other professionals with these issues”. Another participant was confident about the value of access to psychotherapy, and the opportunity to work through difficulties, “plainly, depression is something that requires talking about”.

The participants discussed that value of using medication, and it was recognised to have some initial value, and, “helps them to... get their head clear enough to actually be able to tackle their lives”. Another participant added, that it can, “give a person just that little bit of a boost ... so that they then can become more insightful”. The negative responses of others towards medication, such as from friends and family members, may place an unreasonable burden upon the depressed individual who clearly requires medication. Irene expressed sympathy, and said, “I wouldn’t want to add to somebody’s personal burden by having a negative view of what they’re taking – that’s really dangerous”.

Nevertheless, using medication beyond the initial stages of a depressive illness, or even within these limits, was thought to be associated with difficulties. It was suggested that the issues foundational to the experience of depression may become obscured by the medication, and symptomatic relief may convey the illusion of being cured, yet actually be dependent upon medication to remain that way. As a result, the medication, “becomes part of the problem rather than part of the solution”. John explained, that in such a situation:

Psychological causes ... and situational expressions of the depression are obscured by the drugs. And ... willingness to pursue psychological origins to the problems is reduced. ... [It] helps them to be convinced that they have a life-long deficit that, ... needs boosting from time to time. Drugs can be very persuasive in this way.

Naomi also said:

The idea that medication’s going to cure you, I don’t think is true. It might lift your mood, and help yourself out of it for a while, but ... it’s a crutch

to help you. A good crutch, I admit, ... [but it is] just helping you stay in the same situation, ... and [you are] medicating yourself to stay there.

The participants in the second phase of this study discussed their understanding of the person of the depressed Psychologist, the depressed Psychologist as both a practitioner and a member of a body of colleagues, and by constructing an understanding of depression. The latter has looked at the ways attributions of cause, descriptions, and treatment perspectives informed an understanding of depression, and of the depressed Psychologist. The participants suggested that an understanding of the person of the Psychologist is not a straight forward matter, but is complex. The issues, both to do with the condition described as depression, as well as the experience of the depressed Psychologist, and his or her environmental interactions, are multifaceted. Depression itself is an “idiosyncratic”, and “highly complex psychological disorder”, and approaches to understanding its experience and perception are not able to be responded to in formulaic ways, as, “there aren’t simple answers, either in life or in treatment. ... Sometimes the solutions that are put out make it sound simple and medical, and it’s not.”

This chapter has explored the responses of Psychologists who have not experienced depression about the depression of those who are also Psychologists. In chapter 9, these findings will be discussed in relation to the findings of the previous chapter.

CHAPTER NINE

CONCLUDING FINDINGS

This chapter will present the final results of the current grounded theory investigation into the professional attitude of Psychologists towards the depression of Psychologists in the form of both narrative and hypotheses. In order to provide a framework upon which these findings can be presented, the information obtained from the analysis of the data in phases one and two of the current research, as well as that which was obtained from a close reading of the available literature, will be discussed. Following a discussion of the research findings, the limitations and implications of the current research will be considered, as well as areas of interest for future research.

9.1 The Context of the Findings

The findings of the current thesis are based upon a review of the available research literature, as well as the conclusions drawn from investigations specific to the current research. This section will summarise this foundation described in the previous chapters by noting the research question, the aims of the research, the rationale for the chosen research methodology, and a summary of the available literature in general, as well as the literature that is specifically devoted to Psychologists and depression. Finally, the findings of phases one and two will be summarised and compared, as well as their implications for hypothesis generation.

9.1.1 Research Question and Aims

The current thesis investigated the professional attitude of Psychologists towards

the depression of Psychologists by conducting a grounded theory study into the ways in which the depression of members of that cohort is experienced and perceived within the same cohort. The aims of the current investigation were to gain an increased understanding of the experience and opinions of this group, and to develop theory based upon this information. Additional aims were to provide data that may inform further discussion, and thereby, to partly redress the gaps within the available literature about the depression of Psychologists. These aims are partly addressed by a discussion and analysis of the two phases of the current research, as described in chapters 7 and 8 and summarised later in this section, and a critical discussion of the available literature that is presented in chapters 1 to 4 and also summarised later in this section. The current chapter, which discusses the research findings as a whole, completes the requirements of the aims of the current research.

9.1.2 Choice of Methodology

Chapter 5 describes the distinctiveness of grounded theory within the context of a stable of five prominent qualitative methods, and provides evidence for the suitability of its use within the current study. In summary, the available literature indicated that the depression of Psychologists had not been fully addressed, and as such, informed hypotheses about the research question could not be formulated. Grounded theory was the methodology of choice because of its capacity to answer the primary research question about the depression of Psychologists, as well as the opportunity it offered to describe the experiential nature of the depression of Psychologists, and for this to inform theory development and formulation. Chapter 6 describes how this method was applied, as well as describing how reliability and validity was ensured within the current grounded theory thesis.

9.1.3 The Findings of the Available Literature

The first four chapters of the current thesis describe the findings of a close reading of the available literature that focused specifically on the depression of Psychologists, as well as upon depression in general. Four main areas were found, and these are listed in Table 7 of chapter 5. In summary, these areas are frameworks for understanding depression, the personal experience of having been depressed, decisions related to disclosure or silence about having had depression, and the responses of others towards depressed individuals. In addition to the primary research question, this reading stimulated a number of questions, and participants in both phases of the current research were asked if they wished to comment on these areas. These questions are detailed in Appendices F and G. The areas that were addressed in the first phase of the current project included issues to do with the experience of depression, defining depression, stigma, disclosure, having a mental health problem whilst working in a mental health area, medicalised perceptions of depression, and gender-related issues. Additional areas that were addressed in the second phase of the current project included issues to do with professional competence, and the aetiology and treatment of depression. It was also wondered whether the conclusions drawn from the literature pertaining to the depression of members of other groups such as General Practitioners, Nurses, and Psychiatrists had relevance to depressed Psychologists.

It was speculated that the areas of interest found in the literature would be pertinent to the experience of the participants in the current investigation, and in general, this was found to be so. However, it was also found that in comparison to the research findings of phases one and two, greater prominence was given within the available literature to issues to do with women and depression than by most of the

participants in the current study. There may be a number of explanations for this difference. It may be that most of the participants did not, themselves, find this to be a remarkable issue within the context of more overwhelming issues related to their experience of depression. In addition, it may be that the above average level of education of the participants, and their commitment to their chosen profession, may have made the socio-economic association between depression and being female of less importance than other matters.

In addition to literature that was devoted to the depression of Psychologists, it was also surmised that the depression of Psychologists may be disguised by the use of other terms, and that depression may be concurrent or comorbid with other conditions. The summary of these findings is found in Tables 3 and 4 in chapter 1, and confirms the meagre quantity of investigation devoted to depression and Psychologists, and suggests that one of the reasons for this lack of acknowledgement may be due to the possibility of stigma. Additional research into the available literature specifically concerned with Psychologists also indicated areas that may have an influence upon, and be subsequent to, the occurrence of depression. These findings are listed in Tables 3 and 4 in chapter 1, and informed subsequent research in the current thesis, and as a result, influenced the findings noted in the previous paragraphs and which are summarised in Table 5 in chapter 5.

9.1.4 Summary of the Findings of Phases one and two

Chapters 7 and 8 of the current thesis present an analysis and discussion of the research findings of phases one and two. It is reiterated that these findings are the result of a grounded theory investigation, and as such provide information that the

participants in the project prioritised as important, rather than that which a reading of the literature may give precedence.

Chapter 7 describes and discusses the research findings from phase one of the current thesis. The participants, eight Psychologists who had themselves experienced depression, were asked what they, as Psychologists, considered to be the important issues about their experience of depression. In summary, an analysis of the data indicated four primary areas that are conceptualised according to the experience of the depressed Psychologist. These areas are to do with the inner self, professional identity, relational responses, and ways to frame depression.

Chapter 8 describes and discusses the research findings from phase two of the project. The participants, six Psychologists who themselves had not experienced depression, were asked what they, as Psychologists, considered to be the important issues about the depression of those who were also Psychologists. In summary, an analysis of the data indicated four primary areas that are conceptualised according to the person of the depressed Psychologist. These areas are the characteristics of Psychologists, the depressed Psychologist as a practitioner, the depressed Psychologist as a member of a body of colleagues, and finally, the ways in which depression can be understood.

9.1.5 Comparison Between the Findings of Phases one and two

A number of details were repeated by the participants within each phase, as well as between the two phases. These indicate the importance given to these facts by the participants, and suggest areas of priority when the two groups are compared.

However, it is noted that such a comparison is not standard grounded theory practice, and it is consequently presented as a matter of interest only. These areas of emphasis

do not suggest that that the same, or similar areas, were not also important to the participants in the other phase, but that the concepts were more strongly stressed by one group of participants. The overall value of these observations is whether they contribute to developing theory, and as a result, whether the final findings are enriched by this information.

In comparison with the participants in phase two, the participants in phase one showed a deeper understanding of the “painful” experience of depression, presumably as a consequence of the individual experience, disclosure, stigma, and negative collegial responses. A second area of difference was that the participants in phase one showed a unique capacity to draw meaning from their experience of depression, both in the way that they were informed as practicing Psychologists, and in the area of personal development. A third area of difference was that the participants in phase one were more likely to draw attention to their experience of difficult workplace conditions. In addition, it was observed that many of the participants in this phase criticised the use of the medical model in order to obtain meaning and/or describe interventions for depression.

In comparison with the participants in phase one, the participants in phase two showed a greater critical awareness of a depressed Psychologist’s overall reduced capacity to practice efficiently; this awareness did not appear to be associated with censure. A second difference was that the participants in phase two clearly enunciated their tolerance towards, and in many cases their support of, their depressed colleagues, and this was often subsequent to the way in which an understanding of depression was framed. It may be that this supportive response is related to the nature of the participants, and may or may not be typical of the cohort of Psychologists as a whole. Although theoretical saturation had been achieved in the current research, and no

further interviews were undertaken, additional research which specifically sought a less sympathetic cohort may provide further information about this matter. Thirdly, the participants in phase two showed an acute awareness of disclosure and stigma. In addition, it was observed that many of the participants in this phase were critical about the excessive promotion of the use of medication as a solution to the so-called problem of depression. Criticism was also expressed that depression was often not perceived as a component of a complex contextual picture, and that depression was not being addressed as a workplace issue.

9.2 Overview of the Concluding Findings

As a result of an investigation into the professional attitude of Psychologists towards the depression of Psychologists, the current thesis found four primary areas, organised and constructed according to the grounded theory processes of constant comparison and axial coding (see Table 9) (Blaike, 2000; Strauss, 1993). These areas are summarised in Table 13, and discussed in later sections of this chapter.

Table 13

Concluding Findings : Primary and Secondary Areas

Primary Areas	Secondary Areas
Struggle	Silence Pain Harm
Sense	Descriptive terminology Aetiology Models for understanding depression Self-exploration
Sensitivity	Identity as a Psychologist Personal identity
Engagement	Individual and collegial responses Professional body and workplace responses

The primary areas describe the struggle or difficulties that the depressed Psychologist experiences, the attempts of the depressed Psychologist and his or her colleagues to make sense, or bring meaning to the experience of depression, thirdly, sensitivity, or the product of the experience of depression upon the personal and professional spheres of practice of an individual, and finally, engagement, which is concerned with responses towards the depression of Psychologists. It is understood that these areas are not mutually exclusive, and that there is a measure of interconnection and flow between the concepts that are presented, some of which are referred to in more than one area.

The contextual framework for understanding the final results is related to the primary questions that were asked of the participants in phases one and two. Consequently, the results are related firstly, to the participants' perception of themselves as Psychologists, and secondly, to the participants' perception of themselves in relationship with their Psychologist colleagues.

As described in chapter 6, and summarised in Table 8, the data which informed these four primary areas, was produced by the grounded theory practices of open and axial coding. Tables 9 and 10, also in chapter 6, summarise how secondary areas informed primary areas during the process of axial coding for each of the two phases. The following table, Table 14, summarises the ways in which the primary areas of phases one and two informed the construction of the secondary, then primary, areas in the final analysis of the data. It is noted that some of the initial phases provided information for more than one secondary area in the concluding findings.

Table 14

*Final Stage in Axial Coding:**Concluding Findings: Development of Primary and Secondary Areas From Phases One and Two*

Phase One and Two Primary Areas		Concluding Findings	
Phase One	Phase Two	Secondary Areas	Primary Areas
Depression experienced Disclosure	Disclosure	Silence	Struggle
Depression experienced Stigma	Stigma Depression as a professional health issue	Pain	
Depression experienced Stigma Intervention experienced	Stigma Depression as a professional health issue	Harm	
Lack of understanding of depression Frameworks for understanding depression	Describing depression	Descriptive terminology	Sense
Causative factors The nature of Psychologists	Aetiology Characteristics of Psychologists Depression as a professional health issue	Aetiology	
Frameworks for understanding depression	Describing depression Treatment perspectives	Models for understanding depression	
Processing the experience	Empathic understanding Motives for becoming a Psychologist	Self-exploration	
Positively informing practice Informing treatment approaches Challenges to practice	Positively inform practice The negative effects of depression upon practice Capacity to practice Management of depression	Identity as a Psychologist	Sensitivity
Processing the experience	Positively inform practice	Personal identity	
Disclosure Stigma	Commonality of the experience of depression Disclosure Stigma Empathic understanding	Individual and collegial responses	Engagement
Causative factors	Depression as a professional health issue	Professional body and workplace responses	

The four primary areas of the concluding findings that are earlier summarised in Table 13, shall be discussed in turn. The discussion of this material is in a briefer format than that of phases one and two in chapters 7 and 8. This is to avoid undue repetition of material, and because, unlike phases one and two, the concluding results described and discussed in this chapter are not only in narrative form, but also presented as hypotheses. In addition to noting the material provided by the participants in the current thesis, reference shall also be made to the findings in the literature.

9.3 Struggle

Struggle, or the difficulties experienced by the depressed Psychologist, is identified as a major category in the final findings of the current investigation into the professional attitude of Psychologists towards the depression of Psychologists. The participants in both phases of the research described their intimate acquaintance with, and observation of, the enormity of the struggle associated with being depressed. This section will describe the difficulties experienced by the depressed Psychologist by discussing the secondary areas of silence, pain, and harm.

9.3.1 *Silence*

The participants discussed the silence they subjectively experienced as a symptom of depression, as well as a self, and socially impressed, response to the depressive experience. A number of participants described their sense of isolation and extreme loneliness; others indicated a sense of experiential flattening, “a place of isolation and *un-life* ... a flattening place, an indiscriminate deadly flattening”, where “there was no-one there any more”.

The silence associated with depression was also related to the dilemma of whether or not to disclose having had the condition. Although lucid arguments were provided for both positions, and it was suggested that remaining silent about being depressed further encouraged stigma, there appeared to be an overarching culture of secrecy, and a sense of uncertainty as to how much and to whom to disclose. Rogers and colleagues (2001) alluded to a conspiracy of silence about having depression; participants spoke of masking their depression, playing the role of “a pretend ‘you’ ” whilst “soldering on”, being cautious to avoid anything that implied so-called professional inadequacy, and feeling the need for privacy and self-protection. Similar responses were also reported elsewhere in the literature (Gilroy et al., 2001; Sonneck & Wagner, 1996).

A motivating force for being silent about being depressed was described by the participants as the fear of stigma, a paradoxical position, considering depression’s frequency within the profession of Psychology, and the population in general (as observed by the participants, and also reported in the literature) (Collins & Parry-Jones, 2000; Cushway & Tyler, 1996; Farber, 1990; Gilroy et al., 2001; Miller, 1998; Reamer, 1992). According to their 2002 study of the experiences of depression and intervention by Counselling Psychologists, Gilroy and colleagues reported that more than two thirds of their respondents identified themselves as currently being depressed.

It may be that the depressed, or so-called impaired Psychologist, provides evidence of a shared collegial potential, and, as suggested by Schreiber and Hartrick (2002), he or she may be subject to sanctioning because of being so-called deviant from the norm. Participants felt that the depressed Psychologist may be perceived as letting “the side down”, and possibly ceding to a common vulnerability. Some, but not all, participants described their observations of stigma towards colleagues, expressed their

abhorrence that this occurred, and provided examples of having been stigmatised. As stated earlier, there was a perception that, “there is something 'wrong' or 'shameful' [about being depressed], especially if it happens to a Psychologist”. A collegial response that emotionally and cognitively debarred the offending Psychologist was also described by some; “people start thinking, ‘well if you can’t do it you shouldn’t be here’ ”.

9.3.2 *Pain*

The participants described depression as a painful and sometimes indescribably dreadful experience, and a number discussed their identification with the pain of loved ones who had been depressed. Some participants spoke of the darkness they associated with depression, as well as emotional chaos, similarity to death, and the depths of despair typified by weeping that came from, “some well in the centre that you can’t connect to”. Other researchers reiterated these experiences of the participants. For example, Rowe (1978) cited an unnamed Psychiatrist who wrote of experiencing exquisite vulnerability, and of also having an intimate knowledge of blackness, grief, and despair.

One participant suggested that the term “demoralisation”, and all that it implied, was a better descriptive term for depression, an opinion that was also explored in a qualitative study by Hurst (1999). In this research it was found that women who had experienced depression felt demoralised, and had a sense of being betrayed.

Pain was also experienced by the participants within their relationships with others. They provided examples of hurtful and unsupportive responses from family members, colleagues, and people who had formerly been thought of as friends. At

times this pain progressed into potentially harmful situations, and these factors are described further in the next sub-section.

9.3.3 Harm

The depressed Psychologist was observed to be in danger of harm from a number of sources, including from him or her self. Although suicide is a complex state, depression has been identified in the research as a significant contributing factor to its occurrence (Australian Institute of Health and Welfare, 2004; Jamison, 2000; Rihmer, 2001; Ukens, 1995). During one phase of their depression, some participants reported having frequent and uninvited suicidal thoughts, and an ongoing desire to kill themselves. Another contemplated suicide as it was thought to be the only means to excise unbearable pain that was “beyond human endurance”.

Other sources of harm were described as colleagues, the workplace, certain interventions, and being exposed to “the ‘greater evils’ of the world” through psychological work. One participant’s experience of harmful interventions led to the general comment that, “things like that ... gave me insights into how dangerous the territory is for [depressed] people”.

9.4 Sense

Sense, or the attempts by the depressed Psychologist and his or her colleagues to make sense, or bring meaning to the complex experience of depression, is identified as a primary area in the final findings of the current investigation into the professional attitude of Psychologists towards the depression of Psychologists. This section will describe the ways in which meaning is brought to the experience of depression by

discussing the secondary areas of terminology, aetiology, models for understanding depression, and self-exploration.

9.4.1 Descriptive Terminology

Many of the participants in the current study discussed the descriptive terminology used to clarify an understanding of depression, and it was stated that depression was not fully understood by people who had not experienced it. Nevertheless, it was observed that participants who had not themselves experienced depression, were not uninformed about the experience, and had an understanding that may have benefited from being less overwhelmed by the symptomatology. In general, the participants felt that depression encompassed a much broader sphere, with greater variety and subtlety, than that described in the commonly used diagnostic manuals such as the DSM-IV-TR, and the ICD-10 (APA, 2000; WHO, 1993). It was also suggested that depression might be one part of a complex emotional picture that reflected the influence of social and other factors. A number of participants challenged the terminology used to describe depression and/or its context, for reasons that included the facilitation of a less mechanistic and more experiential understanding of the condition.

There was also attentiveness to the use of terminology in the literature. Some used defining terms as a way in which to make the definition of depression more specific (Goldney, et al., 2004; Silverstein, 2002; Vetter et al., 2000), whilst others used qualitative research methods to explore a wider understanding of depression. For example, Jack (1992, 1999) used the phrase “silencing the self” to describe depression in women, and “thinking too much” was used to describe the experience by women in Ghana (Patel et al., 1995).

9.4.2 Aetiology

The participants sought to make sense of the experience of depression by seeking an explanation for its occurrence. Some participants suggested that Psychologists might have personal characteristics that may make them more prone to depressive experience, a possibility that was also discussed by Malan (1994) and McWilliams (2004). A number of participants related their experience of depression to causative factors external to themselves, or to biological determinants. Others felt that depression was a developmental process that was a normal feature of human life. This diversity of opinion was reflected the content of the literature (Elliot & Guy, 1993; Kartsavdakis et al., 2004; Kendler et al., 1995; Malan, 1994; McWilliams, 1994; O’Conner, 2001; Pope & Feldman-Summers, 1992; Sibille et al., 2004; Steiner, 1992).

The nature of Psychological work was specified as a contributory factor by some participants, both because, “the little successes you have are very small steps”, and as “there can be some pretty horrific things” that are worked with in the course of a therapeutic session. Cushway and Tyler (1996, p. 147) supported these assertions, reporting that the conduct of therapy was an, “inherently stressful and emotionally demanding activity”. Both the participants and the literature also reported upon the contribution that stressful and unsupportive workplace conditions could make towards the experience of depression (Collins & Parry-Jones, 2000; Firth-Cozens, 2003).

9.4.3 Models for Understanding Depression

The participants sought to make sense of the experience of depression by the use of explanatory models, or frameworks, which facilitated an understanding of causality, and consequently, the development of appropriate interventions. Standard

explanations did not remain unchallenged by participants or within the literature (Goldney et al., 2004; Vetter et al., 2000). Some participants criticised theories that neglected the range of causes of depression by not attempting to obtain a broader understanding of the sufferer's current or past context, and which instead, focused on the individual and the intrapsychic.

The participants discussed positive and negative aspects of the medical (and therefore, biological and pharmacological) model for understanding depression. This approach was identified by the participants as potentially life saving, enabled cognitive functioning to be restored so that other forms of therapy could be pursued, and removed a sense of depression being "your fault".

Other participants stated that the medical model formed only part of a full understanding of depression, and that it was associated with the assumption that depression was a "problem" that was "solved" by medication. A limited and simplistic "flattening" of the experience of depression was reportedly promoted by pharmaceutical companies, and was also identified with campaigns that publicly addressed depression. This approach was identified as obscuring "deeper" causes of depression, as well as encouraging an avoidance of personal and collective responsibility to address contributory and causative factors. Ongoing medication was perceived to be a "holding" rather than "curing" process, that tended to make sufferers feel there was a need to supplement their so-called "life-long deficit".

The literature also reported a number of opinions about the value of a medicalised approach. Goldstein and Rosselli (2003), and Schreiber and Hartrick (2002) reported that the medical model, or the attribution of a cause to depression, reduced stigma. Elsewhere it was reported that a medicalised approach actually increased stigma by verifying personal failure, as well as the sufferer's deviation from

the norm, and that medication neglected to attend to the foundational reasons for a person's depression, and risked anaesthetising any awareness of these factors (Hood et al., 1999; Healy, 2004; Rowe, 2002, 2003; Schreiber & Hartrick, 2002; WHO, 2002).

It may be that differences in attitudes and attributions are not only indicative of general theoretical divergences, but also indicate essential historic and philosophic difference between the practice of both Psychology and Psychiatry (Bannister, in Rowe, 1978; Littlewood, 1996). The attributes of the former profession can lead to an appreciation of the individual as an 'agent' who has the capacity to intervene and be self-transformed, and the attributions of the latter profession can lead an individual to perceive that they are powerless in the face of biological and biomedical forces (personal communication, D. Rowe, February 10, 2006), a perception that is not necessarily based upon scientific fact (Healy, 2004; Plomin, 2005).

9.4.4 Self-Exploration

The participants identified self-exploration, or a personal scrutiny of the meaning of the experience, as a way in which to make sense of the experience of depression. Some models for understanding depression, such as the developmental perspective, were thought to be more suited to introspection and to understand depression as an essential element in an individual's developmental progress. Other identified the propensity of the Psychologist to be introspective, as a factor that facilitates the process.

Many identified personal therapy as a means of personal therapeutic assistance, and recommended it as an opportunity for reflection and personal growth, as a preventative measure, as a means of self-monitoring, as a reminder of personal

vulnerability, and as a means through which the experience of the client may be better appreciated. The participants identified other means by which self-exploration was facilitated, including peer support, supervision, and professional development.

The available literature has tended to emphasise peer support, supervision, and professional development as some of many helpful ways to avoid or minimise depression, rather than specific means to gain increased levels of personal understanding (APS, 2003a; Miller, 1998; Pope & Tabachnick, 1994). Nevertheless, authors including Rowe (1991, 1999, 2002, 2003) and McWilliams (1994), and Steiner (1992) have indicated the value of the exploration of the depressive state, and the growth and wisdom that can be thereby attained.

9.5 Sensitivity

Sensitivity, as a product of the experience of depression, is identified as a primary area in the final findings of the current investigation into the professional attitude of Psychologists towards the depression of Psychologists. This section will consider the secondary areas of the development, or otherwise, of sensitivity within the depressed Psychologist's professional and personal spheres of operation.

9.5.1 *Identity as a Psychologist*

The participants described the ways in which depression had increased their levels of sensitivity towards their clients in general, and particularly towards those who were experiencing depression. They described having increased levels of empathy, compassion, and understanding, wrought from a "*keener* appreciation" of shared pain. However, participants also described experiencing, or witnessing, reduced levels of sensitivity during a period of depression. This was identified as a

possible diminution of skills, being less present for the client, and having one's personal state interfere with therapeutic practice. It was also pointed out that variations in normal practice, and the impact of any number of negative life events, may also produce similar results, and that they were not an exclusive consequence to being depressed.

In two research papers, Gilroy and colleagues (2001, 2002) reported upon the effects of having been depressed upon the professional role of the Psychologist. Positive effects included the ways in which the Psychologist had become more sensitively attuned to their clients.

9.5.2 Personal Identity

The participants not only described how the difficult experience of having been depressed increased their experiential knowledge, but paradoxically described their gratitude for the so-called gift of depression, and their appreciation for their resultant development as individuals with greater depth and an increased capacity for a "more engaged relationship to life". The literature also identified this process as a source of potential wisdom and awakening (Rowe, 1978, 1991; Steiner, 1992; Street et al., 1999; Thompson, 2004). Some participants, due to the frameworks within which they understood depressive experience, did not necessary isolate the personal from the professional self. What was learnt from the experience of depression in a personal way, was also understood to inform professionally. It was stated, "*use your own damage, and your own psychopathology, to help you become a better Psychologist*"; increased sensitivity and progress in one area was understood to "reverberate" with progress in the other.

9.6 Engagement

The final findings of the current research into the professional attitude of Psychologists towards the depression of Psychologists also identified engagement as a primary area. The term is used to describe responses towards the depression of Psychologists, and will be discussed in this section by considering the secondary areas of individual and collegial responses, followed by the responses of professional bodies and the workplace.

9.6.1 Individual and Collegial Responses

The participants in the current thesis described the helpful ways in which the experience of depression could be addressed or averted, such as being engaged in activities that involve active participation in professional and recreational activities. Recommended activities included exchanging ideas with their peers at conferences, receiving peer support and supervision, changing jobs, and taking holidays. It was also suggested that participants should expose themselves to opportunities to review personal constructs through such activities as ongoing therapy, and the development of philosophic and spiritual concepts for understanding the experience. The participants in both phases also discussed the value of mutual collegial support.

Similar views were expressed in the literature (Gilroy et al., 2002; Sherman & Thelen, 1998). Both participants and researchers who perceived depression within a social or community model, understood that it brought with it an expectation for an active and political response (WHO, 2002), as well as approaches that encouraged increased social and community inclusion and engagement (Rosen, 2003). In addition, Gilroy and colleagues (2002) stressed the importance of collegial support.

6.6.2 Professional Body and Workplace Responses

Responses to the depression of Psychologists by professional bodies has been previously described within an historic context that has indicated that efforts have been somewhat tardy, particularly in comparison with the efforts of other professionals who work in the mental health area (Barnett & Hillard, 2001; Stanton & Caan, 2003). There may be a number of reasons for this, including the possibility that Psychologists are perceived to be a less powerful cohort than Psychiatrists who are part of the medical fraternity, that intra-discipline variation within Psychology is a philosophically dis-unifying factor, and that Psychologists are less politically active than other groups because of personality or gender factors.

The participants noted the value of adequate supportive responses from their professional bodies. They were critical of workplace responses that were not supportive or adaptive, and of workplace environments that were stressful and frustrating. It was suggested that some of these concerns were related to the supposition that neither Psychologists nor the profession of Psychology were fully valued, and that there was a general lack of recognition of the intrinsic difficulties within the nature of the work, where clients may never be completely “cured”, and may describe appalling and highly distressing experiences, without adequate opportunities for the treating Psychologist to receive debriefing.

As a result of these observations, some participants concluded that health care responses to the profession of Psychology were “appalling”, and recommended that professional bodies should take an “industrial hazards” perspective towards the difficulties of the work.

The literature recommended the development of a professional ethos which prioritised self-care through prevention training and professional support programs;

that trainee Psychologists were taught that depression was a professional likelihood, and as such was not discordant with the profession; that there was further research to increase understanding and facilitate realistic attitudes about vulnerability and needs; and that self-care should be a requirement of training and licensure, a conclusion that was disputed as a limited perception of support and restoration by some of the participants of the current study (Gilroy et al., 2002; Pope & Tabachnick, 1994; Sherman & Thelen; 1998). In addition, Gilroy and colleagues felt that their recommendations for collegial support and self-care or protection, were helpful ways to counter stigma.

9.7 Summary and Hypotheses

In summary, the current thesis found four themes as a result of a grounded theory investigation into the professional attitude of Psychologists towards the depression of Psychologists, within a framework that contextualised these findings according to the participants' perception of themselves as Psychologists, as well as the participants' perception of themselves in relationship with their Psychologist colleagues. The themes are summarised as struggle, sense, sensitivity, and engagement, and are summarised in Table 13, and more fully described in previous sections. The first primary area is understood to describe the struggle or difficulties that the depressed Psychologist experiences, and includes the secondary areas of silence, pain, and harm. The second area describes the attempts of the depressed Psychologist and his or her colleagues to make sense, or bring meaning to the experience of depression, and includes the secondary areas of terminology, aetiology, models for understanding depression, and self-exploration. The third area describes the development, or otherwise, of sensitivity within the depressed Psychologist's

professional and personal spheres of operation. The fourth primary area is engagement, which includes the secondary areas of individual, collegial, professional body, and workplace responses towards the depression of Psychologists.

Formulated upon the narrative statement that is constructed upon these four themes, and is described in the preceding sections of this chapter, two major hypotheses are suggested. It is noted that in a study of this nature any number of hypotheses could be formulated. For example, a number of areas of interest for further research have been suggested in the next section, and some of these have been drawn from possible hypotheses such as speculation about the potentially large numbers of Psychologists who currently, or in the past, have personally experienced depression. However, it was decided that this and other matters would be categorised as areas of future interest, and that two hypotheses would better serve the aims of the current thesis. These two hypotheses are selected on the basis of the major areas indicated in the final analysis of the data, and as such, reflect the findings of the research rather the areas of unique or particular interest. The first hypothesis is drawn from the first three primary areas, and the second is drawn from the fourth primary area.

In the light of the descriptions and observations made of the depression of Psychologists, and of the ways in which the participants sought to make sense of the experience and to utilise this understanding in professional and personal ways, it is hypothesised that *an understanding of the experience of depression is a difficult struggle of which the depressed Psychologist seeks to make sense to effect personal and professional progress*. This hypothesis implies that Psychologists question their experience, whatever their theoretical or philosophical construct, and that this inquiry stimulates understanding and awareness. It also implies that depression is an often misunderstood condition that is yet to be fully described or appreciated.

In the light of the strength of the influence and importance of professional relationships, as expressed by the participants, and their understanding of the commonality of the experience of depression as a complex and multifactorial condition, it is also hypothesised that *the depression of Psychologist colleagues demands a collegial response*. This hypothesis implies that a supportive approach towards depression is normalising and destigmatising, and questions whether public campaigns and disclosure are always the healthiest response to depressive illnesses, and whether, in some way, stigma is consequently reinforced. The term “demands” was chosen in order to emphasise the imperative of the response for the benefit of the effected individuals and for the overall unity of the profession. It is also implied that the depression of their colleagues may be incomprehensible for some Psychologists, who may respond in rigid and discriminating ways to a condition which, as described earlier, is not uncommon, is part of the human condition, and which has effects on individuals that may not be dissimilar to the impact of any number of life experiences

9.8 Limitations, and Recommendations

This section will discuss the limitations of the current thesis, as well as recommendations and suggestions for areas of future research drawn from the hypotheses and the data in general.

9.8.1 Limitations

The limitations of the current research are related to the ways in which the research question was framed, and consequently the ways in which these decisions influenced methodology choice and participant selection. In effect, the limitations were purposefully constructed following a reading of the available literature, and the

resultant awareness of gaps in the research. It is understood that a variation of even one of these basic elements, such as using a different research method, or focusing on factors other than depression or professional practice, may produce findings of additional interest and potential discovery, and a number of these alternatives are discussed later in this section. The purposeful selection of a cohort that was more critical of their depressed colleagues may have provided data that could have challenged or supported the comments by the participants of the current thesis. As noted previously, this would be a matter of interest to explore in future research. Every effort was made in the current thesis to follow acceptable grounded theory practice in a verifiable, reliable and valid manner.

9.8.2 Recommendations

The implications of the research have been partly discussed earlier, in relation to the hypotheses that an understanding of the experience of depression is a difficult struggle of which the depressed Psychologist seeks to make sense to effect personal and professional progress, and that the depression of Psychologist colleagues demands a collegial response. Consequently it is recommended that efforts are made within the profession as a whole, as well as within professional organizations, workplaces, and training programs that are specific to Psychologists, that a supportive and preventative approach towards the depression of Psychologists be followed, which, rather than regulatory, is adaptive and flexible in philosophy, approach and solutions, and does not enforce a particular viewpoint. Examples of support include the establishment of a resource network for depressed Psychologists that takes into account areas such as crisis management; referral to suitable and experienced Psychologists, Psychiatrists, and other professionals; group support; ongoing support; prevention programs;

opportunity for public forum and discussion; and research into areas specific to Psychologists and depression. It is also recommended that these resources be overseen, reviewed, and publicised. A possible lack of use may not indicate an absence of need of these resources, but instead, a lack of confidence in what is offered for a number of reasons including effectiveness and confidentiality. Hence, it is also recommended that these services would be highly respectful of privacy and confidentiality, and it may be that an independent body may be a suitable organization to provide this assistance for depressed Psychologists. It is understood that as the decision as to whether or not to disclose having had depression is a personal one that is congruent with the philosophical construct of each individual, and consequently no recommendation can be made that encourages universal disclosure.

In addition, it is also recommended that there are increased levels of workplace advocacy. Particularly in the areas of raising awareness of the psychological risks of the profession because of the potential exposure to personal and environmental toxicity through clients, as well as increasing the levels of respect for the profession and its unique characteristics, and for its practitioners as highly skilled professionals.

It is recognised that the content of some of these recommendations has not been unconsidered by some individuals and groups, and that some recommendations may have been addressed. It is also understood that depression may be one of a number of conditions which could be assisted by the aforementioned recommendations. The historic progress of groups other than Psychology, particularly in regard to medical practitioners and depression, has been noted previously, nevertheless, it is suggested that Psychology would be well served by an approach that does not only, after forethought, follow the example of other groups, but that also forges change after studying the needs of its cohort.

9.8.3 *Future Research*

Suggestions are also made about a number of alternate ways in which the research topic of depression and Psychologists could be explored. These would enrich an understanding of the area because each research methodology offers specialised approaches and insights, and produces results that have unique perspectives.

Quantitative investigation into the findings of the current research may provide additional information about the areas under investigation. Data about the prevalence of depression amongst Psychologists would be of particular interest, as would inquiry into the proposed hypotheses. Founded upon the first hypothesis, this inquiry might be in the areas of aetiology, attribution, personal and philosophical constructs, and perceptual changes wrought through the experience of depression. Similar investigation into the findings of the second proposed hypothesis might include the areas of collegial attitudes, stigma, disclosure, and symptomatology within a context that makes reference to current and historical factors.

Other suggestions include research into the individual stories of depressed Psychologists, both as case studies and as phenomenological examinations; considering the cohort of Psychology as an ethnological group with a particular ethos; looking at the expressive responses of depressed Psychologists, for example as narrative, poetry, or the visual arts; or exploring the personal insights of individuals into his or her particular experience of depression, for example, by exploring the value of politicised or philosophical responses, or the ways in which depressive illness has been framed as a positive and beneficial experience. In addition, it might be of interest to compare the approaches, experiences, and attitudes of new and experienced Psychologists, and of Psychologists who practice in different areas within Psychology, such as research or community work.

It may also be revealing to compare the experience of depression of Psychologists who have varying opinions about the medicalisation of the condition, and whether this is limited to the way depression is described and may include attributions and interventions. Further, it would be of interest to compare these experiential attitudes within the fields of Psychology and Psychiatry.

Within the specific area of research undertaken in the current thesis, a rich amount of information has been explicated from the data that suggests other areas that would be of interest in future investigations. These areas have stimulated additional questions that are based upon the suppositions and conclusions of the current thesis, and include the areas of depression, stigma, and disclosure, each of which shall be discussed in turn.

A number of areas of interest are related to the condition of depression. During the conduct of the research it became apparent that many of the participants felt that an understanding of depression was not well served by current forms of classification. Some closely attended to the terms used to frame this understanding, and others chose to emphasise that depression could be thought of a symptom or component of a broader picture. These thoughts suggest further inquiry that investigates the nature of depression, such as whether depression is more than a group of observed symptoms, and whether it is better described as a condition or a symptom? Can depression only be really understood by its sufferers or survivors, and consequently only be satisfactorily described through the eyes of their experience, or would such a response be overly biased by subjectivity? Is the current understanding of depression overly simplistic, or is this approach more appropriately perceived as a facilitative instrument that enables understanding? Depression has been focused upon as an issue of concern in much of the literature, is this because of its reported prevalence, or because it has

been identified as being a health burden, with ultimate fiscal effects? Or, is depression's importance related to it being a component, and indicator, of larger issues? In addition, it would be of interest to further investigate certain symptoms of depression in regard to their experience by, and prevalence amongst, Psychologists, notably suicidal ideation, as well as suicide itself, because of its serious nature and aetiological complexity.

Another area of further interest is to do with stigma, and the concern expressed by some participants about stigmatic responses from Psychologist colleagues, although it is noted that not all participants reported witnessing stigmatic collegial behaviour. Are Psychologists, more than other groups, likely to stigmatise their depressed colleagues, and are other mental health issues responded to in similar ways? How does the cohort of Psychologists respond to mental health issues within their group in general, and does this reflect the sometimes self-punitive thoughts of some of the participants? Are issues to do with fear and the need for control features of this response? Issues to do with disclosure and stigma were discussed by the participants. It has been suggested that secrecy feeds stigma, and it is wondered whether this is the case amongst Psychologists, and if so, is stigma actually reduced by being open about experiencing depression, or in such a situation do stigmatic responses become more covert? Do the solutions to stigma of education and disclosure, as practiced within a number of community programs, really address stigma, or does their essential publicity actually contribute to an environment that instead validates stigma? Are supportive approaches that draw less public attention and perhaps generate less financial support, more helpful? It is generally accepted that the fear of stigma may prevent help-seeking behaviour, is this also the case for Psychologists? In the current research, there was no sense that the participants stigmatised their clients because of

their mental health status, but instead, suggested that the participants held unrealistic expectations that they themselves could manage difficulty, or that their professional status precluded succumbing to difficulties by becoming depressed. Is this also a tacit opinion or expectation of the profession in general, and is a depressive response from a colleague indicative of a potential undermining of the professional body?

9.9 Conclusion

The current thesis investigated the professional attitude of Psychologists towards the depression of Psychologists by conducting two phases of interviews that were designed and analysed according to the protocol of grounded theory. Four primary areas were found. These were, firstly, the struggle or difficulties experienced by the depressed Psychologist, secondly, the attempts of the depressed Psychologist and his or her colleagues to make sense, or bring meaning to the experience, thirdly, the product of the experience of depression upon the personal and professional spheres of practice of an individual, and finally, responses towards the depression of Psychologists. The summary term of engagement was used to describe this final area, as it was hypothesised that this descriptor indicated the usefulness of a helpful, and subsequently restorative, response to the experience of depression both from those who have, and those who have not, personally experienced the condition. Further, this term suggested a key area of the final hypotheses and recommendations, namely that of responsive collegial behaviour.

In the current thesis, by definition as well as the descriptions of the participants, depression is understood to be typified by the antithesis of engagement; there is symptomatic “shut-down”, where the sufferer can be conceptualised as both prisoner and jailer (Rowe, 1991), and which is particularly, but not exclusively, experienced

emotionally and socially. It is consequently understood that the facilitation of personal engagement, as well as social or relational responses that “engage” with the depressed individual and address depression in general, are helpful. In keeping with these and other concepts, it is hypothesised that an understanding of the experience of depression is a difficult struggle of which the depressed Psychologist seeks to make sense to effect personal and professional progress, and secondly, that the depression of Psychologist colleagues demands a collegial response. As a result of these findings, recommendations were made in the areas of collegial and organization support of depressed Psychologists, as well as workplace advocacy.

The questions asked of the participants in both phases of the current thesis framed the responses in the first phase according to the participants’ perception of themselves as Psychologists, and in the second phase, according to the participants’ perception of themselves in relationship with their Psychologist colleagues. The participants indicated that their professional role was not experienced in isolation, but was an inclusive relationship that included his or her Psychologist colleagues, and, as stated earlier, “what happens at work is not only working with clients, it’s also about working with colleagues”. The workplace may be a source of rejection and stigma, but it may also be a source of loyalty and support, where Psychologists attempt to assist their depressed colleagues “get through” their difficulties. The experience of depression can be complicated by an atmosphere of secrecy about the reality and frequency of depression within the profession, a factor that is in contradiction with its commonality as a shared human condition. Nevertheless, although depression is acknowledged as, “part of the *human* experience, a very central part”, the decision as to whether or not disclose having depression is a personal one that is constructed upon individual experience, and congruent with chosen philosophical constructs.

The richness of the individual stories of each participant has contributed to the findings of the current thesis, which, in turn, has made inferences about the impact of depression upon the professional and personal life of Psychologists in general. Despite being, in many cases, a dreadful period of suffering, the deliberations of the participants have indicated that the very human experience of depression also has the potential to facilitate personal insight, and augment professional practice.

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APPENDIX A

Recruitment Advertisement

**EXPRESSIONS OF INTEREST
TO MENTAL HEALTH
PROFESSIONALS****ARE YOU ACQUAINTED WITH THE
'BLACK DOG' OF DEPRESSION?**

My name is Dianne Lawrence, a Clinical Masters student who is supervised by Dr. Bernadette Hood at the Department of Psychology, Victoria University, St. Albans campus.

I am undertaking research on the experience of depression by mental health professionals such as Psychologists and Social Workers. Through the process of confidential semi-structured interviews, and using the qualitative research model of grounded theory, I shall provide an opportunity for participants to describe their particular experience of depression and its impact on, or relevance to, their role as a mental health professional. This will mean that a greater understanding of the important issues may be gained about a neglected and under-acknowledged area.

I recognize that this material is extremely sensitive, and scrupulous care will be taken with all aspects of privacy.

If you are interested in finding out more about this project you are invited to contact me at

dlaw25@froggy.com.au

or my supervisor on 9365 2381.

APPENDIX B

Invitation to Participate (phase one)

Invitation to Participate in a Research Study

Dear ----

My name is Dianne Lawrence; I am a Doctor of Clinical Psychology Student, supervised by Dr. Bernadette Hood, Department of Psychology, Victoria University, St. Albans Campus. I am undertaking research into the experience of depression by Psychologists, a cohort which has been previously under-investigated.

The process would involve a semi-structured interview where you would be asked what you think are the important issues related to your experience of depression. It is not expected to exceed 60 minutes in length, and would be audio taped with your permission. I would transcribe the interview, excluding any details that may identify you or any other people or places, and make a summary of the succinct points. At another shorter meeting, or by mail if you preferred, the transcript and the summary would be checked by you so as to make sure that I had fully understood you, as well as giving you an opportunity to amend the text to your preference. Because the information provided in the final transcript would be the source of the data analysis, and may be read for academic purposes (by my supervisor or by request following the publication of the final project), it is important that you are satisfied with what has been written and that no identifying details are included. Any material which you found unsatisfactory would be replaced, and the audio tape would be either destroyed or given to you.

As you would be aware, there is always the potential for risk in any project, and in this investigation scrupulous care will be taken to ensure your welfare, and to maintain your privacy. Should the discussion of your experience of depression be found to be unduly distressing, or for any other reason at all, you are free to withdraw from the process at any stage. Dr. Bernadette Hood's contact details will be made available to you should any professional support be required.

Because it is speculated that one of the reasons there has been a lack of research about the depression of mental health professionals is because of possible of social or professional stigma, for this and other reasons it is of importance that I respect your confidentiality. Consequently, interviews would be arranged without discussing their purpose to anyone other than yourself, the names of the participants would only be known to myself, data and transcripts would be referred to by a code known to myself and no other, and all information would be stored under lock and key. No demographic material is considered necessary for this project other than gender and a general statement about professional experience. Citations from the transcript would not be over-long (so as to respect your copyright of the words that you have spoken), and would either be attributed with a pseudonym or kept anonymous.

It is felt that this investigation into depression would be of benefit not only because there are gaps in the understanding of depression experienced by mental health professionals such as Psychologists and Social Workers, but it would also provide an opportunity for you and the other participants to anonymously describe your unique world-view. This may result in an increased appreciation of this experience, a positive collegial response, increased professional dialogue, and decreased professional and social stigma. Because theoretical constructs would be drawn from an analysis of the data obtained from the interview transcripts, this project would have real-life relevance and would assist in the focus and usefulness of ongoing research.

Should you have any concerns regarding the manner in which this research project is conducted, please do not hesitate to inform the researchers directly, or the Victoria University Human Research Ethics Committee (tel. 9688 4710).

Results will be available at the end of the project from the Department of Psychology. If you have any queries you can contact myself or Dr. Bernadette Hood on (03) 9365 2334.

Thanking you in anticipation

Yours sincerely,

Dianne Lawrence.

APPENDIX C

Invitation to Participate (phase two)

Invitation to Participate in a Research Study About Depression

Dear ---

My name is Dianne Lawrence, I am a student in the D. Psychology program, supervised by Dr. Bernadette Hood, School of Psychology, Victoria University, St. Albans Campus. I am undertaking research into the professional attitudes of Psychologists towards the depression of Psychologists. This is to supplement the information I have received from interviews with Psychologists about their personal experience of depression.

The process would involve a semi-structured interview where you would be asked what you, as a Psychologist, think are the important issues about the depression of those who are also Psychologists. It is not expected to exceed 60 minutes in length, and would be audio taped with your permission. I would transcribe the interview, excluding any details that may identify you or any other people or places, and make a summary of the succinct points. At another shorter meeting, or by mail if you preferred, the transcript and the summary would be checked by you so as to make sure that I had fully understood you, as well as giving you an opportunity to amend the text to your preference. Because the information provided in the final transcript would be the source of the data analysis, and may be read for academic purposes (by my supervisor or by request following the publication of the final project), it is important that you are satisfied with what has been written and that no identifying details are included. Any material which you found unsatisfactory would be replaced, and the audiotape would be either destroyed or given to you.

Although it is not anticipated that material of a personal nature would be discussed, as you would be aware, there is always the potential for risk in any project, and in this investigation scrupulous care will be taken to maintain your privacy and respect your confidentiality with regards to participants or any other third party. Consequently, interviews would be arranged without discussing their purpose to anyone other than yourself, the names of the participants would only be known to myself, data and transcripts would be referred to by a code known to myself and no other, and all information would be stored under lock and key. No demographic material is considered necessary for this project other than gender and a general statement about professional experience. Citations from the transcript would not be over-long (so as to respect your copyright of the words that you have spoken), and would either be attributed with a pseudonym or kept anonymous.

It is felt that this investigation into depression would be of benefit not only because there are gaps in the understanding of the depression of Psychologists, and the professional implication of this experience, but would also provide an opportunity for you to anonymously describe your unique world-view. This may result in an increased understanding of depression and its implications, and increase professional dialogue in the area of depression.

Should you have any concerns regarding the manner in which this research project is conducted, please do not hesitate to inform the researchers directly, or the Victoria University Human Research Ethics Committee (tel. 9688 4710).

Results will be available at the end of the project from the Department of Psychology. If you have any queries you can contact myself or Dr. Bernadette Hood on (03) 9365 2334.

Thanking you in anticipation
Yours sincerely,

Dianne Lawrence.

APPENDIX D

Consent Form (phase one)

INFORMATION TO PARTICIPANTS:

We would like to invite you to be a part of a study about the experience of depression.

CERTIFICATION BY PARTICIPANT

I,

of

certify that I am at least 17 years old* and that I am voluntarily giving my consent to participate in the study entitled: The Experience of Depression by Psychologists,

being conducted at Victoria University of Technology by: Dr Bernadette Hood and Dianne Lawrence.

I certify that the objectives of the study, together with any risks to me associated with the procedures listed below to be carried out in the study, have been fully explained to me by: Dianne Lawrence,

and that I freely consent to participation involving the use of these procedures,

Procedures:

- an audio taped interview,
- agreement with/or amendment of the transcription,
- agreement with/or amendment of the transcription summary.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential.

Signed:

Date:.....

<p>Any queries about your participation in this project may be directed to the researcher (Name: Dr Bernadette Hood ph. 9365 2334). If you have any queries or complaints about the way you have been treated you may contact the Secretary University Human Research Ethics Committee Victoria University of Technology PO Box 14428 MCMC Melbourne 8001 (telephone no: 03 9688 4710).</p>

APPENDIX E

Consent Form (phase two)

CERTIFICATION BY PARTICIPANT

I,

of

certify that I am at least 17 years old* and that I am voluntarily giving my consent to participate in the study entitled: Professional Attitudes of Psychologists Towards the Depression of Psychologists,

being conducted at Victoria University of Technology by Dr Bernadette Hood and Dianne Lawrence,

I certify that the objectives of the study, together with any risks to me associated with the procedures listed below to be carried out in the study, have been fully explained to me by Dianne Lawrence,

and that I freely consent to participation involving the use of these procedures:

Procedures:

- an audio taped interview,
- agreement with/or amendment of the transcription,
- agreement with/or amendment of the transcription summary.

I certify that I have had the opportunity to have any questions answered and that I understand that I can withdraw from this study at any time and that this withdrawal will not jeopardise me in any way.

I have been informed that the information I provide will be kept confidential with regard participants or any other third parties.

Signed:

Date:.....

<p>Any queries about your participation in this project may be directed to the researcher (Dr Bernadette Hood, phone 9365 2334). If you have any queries or complaints about the way you have been treated you may contact the Secretary University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC Melbourne 8001 (telephone no: 03 9688 4710).</p>
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APPENDIX F

Questions (phase one)

POSSIBLE INTERVIEW QUESTIONS and AREAS TO BE DISCUSSED

PROJECT: The Experience of Depression by Psychologists

Primary Question:

- ❖ What do you, as a Psychologist, consider to be the important issues about your experience of depression?

The Experience of Depression:

- What is of value for others to understand about your experience of depression?
- What was misunderstood by others [for example, friends, family, colleagues, and professionals] in their interaction with you when you were depressed?
- What would you have liked them to know?

Defining Depression:

- Do people really understand what depression is?
- Do the DSM and ICD define it adequately?
- Is depression best understood from a medical or psychological viewpoint?
- Are there preferable frameworks for understanding it?

Stigma and Disclosure:

- Is stigma relevant to your experience?
- Has the possibility of stigma influenced your readiness to disclose your experience of depression?
- Have you found that disclosure has brought negative or positive consequences?
- Has disclosure influenced your professional standing?
- Are the methods of public discussion and testimony that are being used in depression education programs useful?

Professional Role and the Experience of Being a Client or Patient:

- Did you experience difficulties in the change of role from carer to one who needed care?
- Did that influence the way in which your case was managed?
- Has the experience of depression influenced your practice as a Mental Health Professional?

Social and Political Issues:

Some researchers stressed the importance of socio-political issues:

- In your experience, does the experience of depression have relevance to issues such as gender, role, perceived power, or the medicalisation of treatment?
- Are there other issues that are important to you?

APPENDIX G

Questions (phase two)

INTERVIEW QUESTIONS and POSSIBLE AREAS TO DISCUSS

PROJECT:

Professional Attitudes of Psychologists Towards the Depression of Psychologists

Primary Question:

- ❖ What do you, as a Psychologist, consider to be the important issues about the depression of those who are also Psychologists?

Supplementary Questions:

Professional Competence

- Do you think depression affects the professional competence of a Psychologist?
- Should a depressed Psychologist continue to practice?

Stigma

- Are depressed Psychologists stigmatised?
- Is this warranted?

Attribution and Treatment

- Do you have an understanding as to the primary cause of depression?
- Can depression be satisfactorily treated, and how?

Definitions

- Are the current diagnostic descriptions of depression adequate?
- Should the diagnostic labelling of depression as a mental illness be challenged?

APPENDIX H

The Department of Psychological Research Ethics Committee, Victoria University
Ethics Approval

APPENDIX I

Human Research Ethics Committee, Victoria University Ethics Approval