

Depression, Shame and Stigma in Therapists:

To share, or not to share – that is the question

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Let me begin by presenting some data on the prevalence of depression in physicians and the problem physicians have in dealing with the reality of this illness which is rather different than the reality of dealing with any other chronic physical illness including cancer.

An article was published in JAMA last year titled “*Prevalence of Depression and Depressive Symptoms Among Resident Physicians.*” It was based on a massive compendium of 50 studies of 18,000 physicians in training and found the prevalence of depression was 29% (close to 1 in 3). We all know that medical training is highly stressful and might be a precipitating factor. However, depression does not disappear among physicians once their training is completed.

Studies have revealed that depression remains more common in the medical profession than in the general population, affecting an estimated 12% of male and 18% of female physicians. This is impressive since so much of the current epidemiologic research connects depression with poverty and unemployment. Yet, the average physician in America earns from \$239,000 a year in the Northeast to \$258,000 in the Great Lakes region.

The high prevalence of depression is not only true in the United States. A 2011 survey of 50,000 practicing physicians in Australia demonstrated a dramatically increased incidence of severe psychological distress and a twofold increased incidence of suicidal ideation in physicians compared with the general population. Sadly, although physicians globally have a lower mortality risk from cancer and heart disease relative to the general population (presumably related to self-care and early diagnosis), they have a significantly higher risk of

dying from suicide: the end stage of an eminently treatable disease process – depression. Indeed, although physicians seem to have generally heeded their own advice about avoiding smoking and other common risk factors for early mortality, they are decidedly reluctant to address depression, a significant cause of morbidity and mortality that disproportionately affects them.

A number of studies have revealed that over 60% of physicians with suicidal ideation indicated they were reluctant to seek help due to concern that it could affect their medical license. To some extent, physicians' reluctance to reach out may be self-imposed. Physicians feel an obligation to appear healthy, perhaps as evidence of their ability to heal others. They may feel this is what their patients expect of them.

The consequence of all of this is that on average the United States loses as many as 400 physicians to suicide each year, the equivalent of at least three entire medical school classes. The physician suicide rate cited in most studies has been between 28 and 40 per 100,000 compared with the overall rate in the general population of 12.3 per 100,000. Overall, then, physicians are more than twice as likely as the general population to kill themselves. Female physicians appear to be especially vulnerable. Suicide rates for women physicians are approximately four times that of women in the general population.

A major problem for doctors in being able to honestly face depression in themselves and seek proper treatment is that physicians who have reported depressive symptoms to their licensing boards, potential employers, hospitals and other credentialing agencies have experienced a range of negative consequences, including repetitive and intrusive examinations, licensure restrictions, discriminatory employment decisions, practice restrictions, hospital privilege limitations, and increased supervision.

Even if disability insurance has previously been procured, its use may subject physicians to repeated humiliating and invasive examinations by detached and dubious “independent medical examiners” for the insurer, whose motivation is to cut company losses.

Many physicians affected by mental illness feel that insurers expect them to adhere to the standard prescription: “Physician, heal thyself!” (i.e. solve your own problems or keep them to yourself). Sharing this reality with others can be hazardous to your health! This may help to explain the reluctance on the part of physicians to step forward and serve as role models either via public statements like those made by Kay Jamison or Marsha Linehan or by a private disclosure to a colleague.

A U.S. study found that half of all psychiatrists with a depressive illness would prefer to self-medicate rather than risk having their illness recognized by another physician. A recent study of Canadian psychiatrists found that one third of respondents admitted to a mental illness. What is equally significant is that only 10% would disclose a mental illness to a colleague because of career implications and sense of stigma.

Furthermore, for the same reasons, three-quarters indicated that if they required hospitalization they would choose to go out of area. And twice as many cited confidentiality as being more important than the quality of care they might receive in their own community. How different this is than when a physician searches for the best surgical care he or she might receive for cancer.

In the simplest terms, one female physician put it this way: “People reach out when you have breast cancer. They hug you and send cards. When you have depression they withdraw and send no cards.”

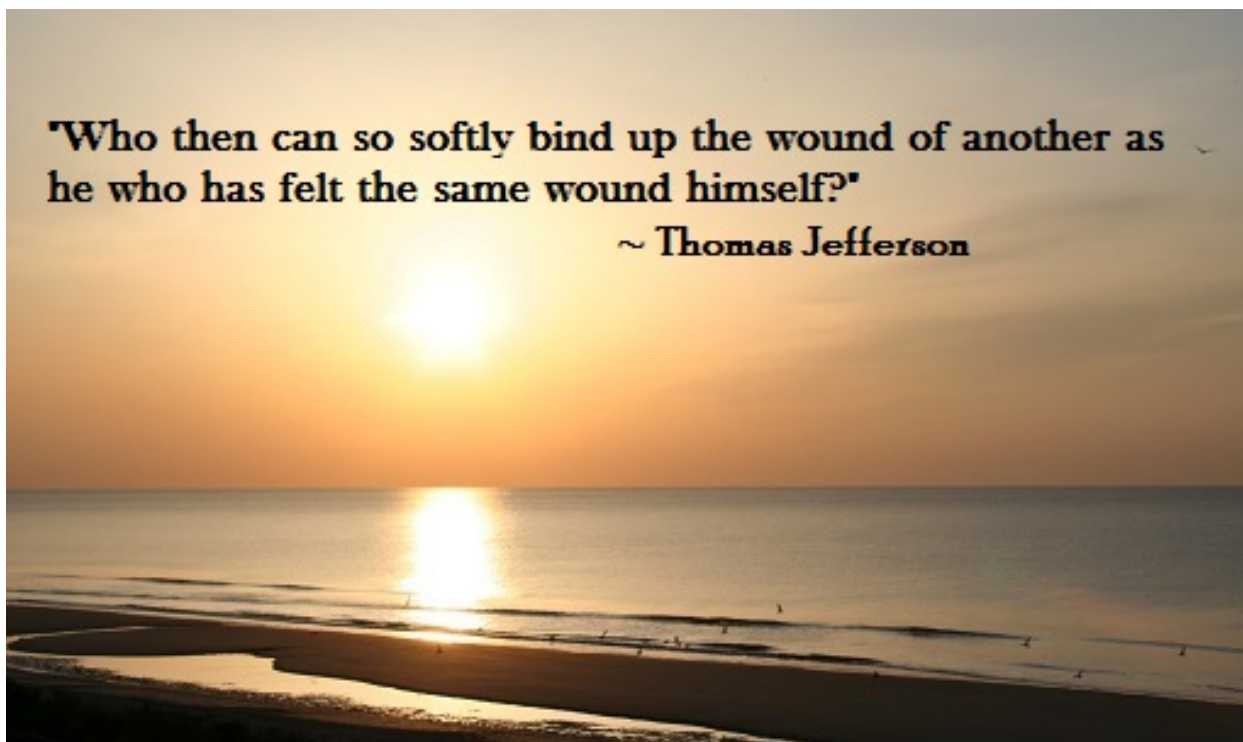
What I found striking as I started researching this topic both on my own and with the assistance of a medical librarian was that there were so few articles on this very important subject. There was limited research, limited prevalence data, even less advice to doctors with this problem and virtually nothing to be found about the value of self-revelation, of sharing, of “coming out.” Simply stated, there are huge negative consequences associated with “coming out.”

So the trend among depressed psychiatrists is certainly denial and concealment and, even if, by some chance, a depressed physician or therapist were aware of the existence of a support group for people suffering with depression, there would be a huge reluctance to attend such a group where, God forbid, they might run into one of their patients!! Presumably this might be analogous to a physician’s reluctance to attend an AA meeting in his or her community.

Though, I should comment that there is perhaps less stigma in 2016 in going for rehab and/or attending an AA meeting than in attending a support group for major depression or bipolar disorder. In this context, it may surprise some of you to learn that there actually is an organization that can easily be found online called the idaa.org, International Doctors in Alcoholics Anonymous. The organization has existed since 1949. We have nothing like this for doctors or therapists suffering with depression.

What about the prevalence of depression among psychiatrists as compared with other physicians? I searched extensively to see whether psychiatrists as a group were more depressed than other docs and all I came up with was the following: A study from Johns Hopkins of 1,300 of their graduates found that psychiatrists had the highest rate of suicide of any of the medical specialties. In another study, Blachly and his colleagues gathered data on 249 physicians listed in JAMA obituary columns and made extrapolations to determine which specialties had the highest risk of suicide. They interpreted their data to show that psychiatrists had the highest suicide rate and pediatricians had the lowest. Further support for the notion that psychiatrists might be at higher risk is found in the work of Rich and Pitts who found that psychiatrists committed suicide at twice the expected rate.

Now I would like to shift the focus from prevalence, shame and concealment to the value of people who have suffered with depression acknowledging their illness and then utilizing this experience as an opportunity to meet with peers, share their pain and both receive and offer help.



This quote attributed to Thomas Jefferson, the father of the Declaration of Independence, serves as the symbol of the Greenwich Depression and Bipolar Support Alliance (DBSA) support group.

DBSA was started thirty years ago in Chicago to provide support for people with depression and bipolar disorder through establishing support groups in many communities in the United States. There are now 1,000 support groups in our fifty states. Our chapter in Greenwich was started fifteen years ago. It was the first chapter in State of Connecticut, and there are now five additional chapters in the state.

Of course, as a prerequisite to participating in peer support – whether as a layman, a lawyer, a physician, a psychiatrist, a psychologist, a social worker or a minister, all of whom have been members of our Greenwich DBSA support group at one time or another – the individual must find the courage to self-identify as currently having or having had depression or bipolar illness in themselves or in a loved one.

Permit me to further personalize this subject of depression by inviting you to ask yourself the following questions: Have you have ever been depressed or had a family member with depression?

1. If you answered YES:
 - a. Have you ever told a member of your family about it?
 - b. Have you ever told a friend about it?
 - c. Have you ever told a professional colleague?
 - d. Have you ever shared it with someone in your hospital or in your department of psychiatry?
 - e. Have you ever shared it with a patient?
2. How would you feel if a patient knew that you or a family member were or had been depressed?
3. Have you ever felt ashamed of having depression?

4. Do you believe that having had depression or a family member having had depression has had a negative impact on your ability to work with depressed patients?
5. Or has it in any way been beneficial – enabling you to be more understanding, more compassionate or perhaps more authentic in working with a depressed patient?
6. If you felt it would benefit a patient, would you ever share your having had depression and/or any of the details associated with your experience?
7. What factors would you consider in deciding whether or not to discuss your having had depression with a patient?
8. Have any of you ever referred a depressed patient to a peer support group like the Depression and Bipolar Support Alliance?
9. Would you consider attending a meeting to explore its usefulness for your patients?
10. Would you consider attending a DBSA meeting for your own personal support? Or would you refer a member of your family to a DBSA support group meeting?
11. Finally, what are your thoughts about a more “universal” disclosure by a distinguished health professional, as was done by:
 - A. Marsha Linehan and Kay Redfield Jamison, or
 - B. Dr. Leon Rosenberg, former Dean of the Yale School of Medicine who in an article published in October of 2002 in *Cerebrum*, a publication of the Dana Forum of Brain Science indicated that he had suffered from a mood disorder for more than 30 years, but had declined treatment for fear that his career could be adversely affected. Having overcome that fear and gotten help for his manic depression, Dr. Rosenberg believed he had a story to tell that might prod his profession into recognizing that its members were just as likely to suffer a mental illness as anyone else. He titled his essay, “Brainsick.”

I would like to conclude by saying that in the intervening 14 years, although many well-known actors, athletes, artists, musicians, entertainers, prominent public figures, politicians, and even astronaut Buzz Aldrin have come forth and have acknowledged being depressed,

very few physicians and/or psychiatrists or psychologists have followed their example and have written or spoken about their personal experience of being depressed.

There has been one recent exception. On May 15th of this year, an article appeared in the Hartford Courant titled: “Damaging Secrets: Breaching Wall Of Silence About Mental Health,” written by Charles Atkins, a member of the Yale Voluntary Faculty. Dr. Atkins had the courage to acknowledge his own depression and concluded his article by saying: “So as I think about how we'll ever make inroads past the negativity and discrimination concerning mental health, a good place to start is among the professionals, such as me. That artificial wall of us and them must come down...” and he ends with saying “...how nice it would be if we could ever get to the point where acknowledging things that are a common part of the human condition could be freely discussed without fear and the threat of negative consequences.”

Perhaps it is time for other psychiatrists to discover the power that results from being both authentic and vulnerable. I suspect that if they find the courage to “come out” as Dr. Atkins has done, they might even have the experience that Martin Buber famously identified: “When people relate to each other authentically and humanly, God is the electricity that surges between them.”

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