Recovering From Depression: How Psychotherapists Come to Know They are Sufficiently Recovered to Practice Competently

By

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A thesis submitted in conformity with the requirements for a degree of Doctor of Philosophy
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Abstract

Several studies have demonstrated that unprocessed depression amongst psychologists and other mental health therapists can negatively interfere with therapeutic work. While there is a large body of knowledge on both depression and recovery (and in particular, recovery as understood within the wounded healer paradigm), little is known about how these mental health professionals come to know that they have sufficiently recovered from a depressive experience such that the experience now generally aids rather than detracts from their therapeutic work with clients. The present study sought to better understand this aspect of therapist awareness by asking the question: how do mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy? Participants were ten mental health therapists currently working in the Greater Toronto Area (GTA). Each participant had at least one significant depressive experiences from which they had deemed themselves sufficiently recovered and were therefore able to speak meaningfully about the experience. In-depth interviews were conducted and transcribed, and the data analyzed using a socially constructed grounded theory methodology. Three key themes—through intrapersonal functioning, through interpersonal relationships, and through client work—emerged, suggesting that the participants understood that becoming aware of their recovery involved a sense of adaptive shifting in both their
personal and professional functioning as well as direct and indirect feedback from a number of important others in their lives. A mid-level theory was generated from these themes. The role of relationships in awareness of recovery had not been previously noted in the literature and as such is a unique contribution to the literature. Broader implications for the field of counselling and clinical psychology are addressed.
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Introduction

Background and Context

The purpose of this research is to gain insight into the recovery process of psychologists and other mental health therapists with a personal history of depression. This research attempts to understand how these mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are able to provide competent therapy. The literature review will attempt to establish both a broad context and theoretical framework for the study. In order to better understand recovery, some context around depression is first warranted. As such, depression is discussed briefly below.

Major Depressive Disorder, commonly referred to simply as depression, is a mental health disorder that has been found to exact a significant toll on an individual’s physical, emotional, spiritual, vocational, academic, cognitive, social and familial quality of life (Hysenbegasi, Hass & Rowland, 2005; Jaycox et al., 2009; Jia, Zack, Thompson, Crosby, & Gottesman, 2015; Mast, 2005; Monden, Stegeman, Conradi, de Jonge, & Wardenaar, 2016; Sockalingam et al., 2011; Stage, Middelboe & Pisinger, 2005). The World Health Organization states that depression affects 350 million individuals of all ages around the world, is the leading cause worldwide for disability and is a major contributor to the global burden of disease (Depression Factsheet No. 369, 2015). Global lifetime prevalence rates of depression in community samples fall between 10-25% for women and 5-12% for men (American Psychiatric Association, 2013). These statistics point to the fact that depression is a far reaching disorder, one that impacts a significant portion of the global population.
A number of studies that have examined rates of depression within the mental health professional community seem to largely suggest that depression in this community is more common than in the general public. Deutsch (1985) found that 57% of therapists surveyed experienced depression in their lifetime. Pope and Tabachnick (1994) found that 61% of psychologists surveyed who had been in therapy reported symptoms they characterized as clinical depression. Mahoney (1997) found that almost 35% of psychotherapists surveyed listed “episodes of depression” as a problematic issue over the course of the previous year. Gilroy, Carroll and Murra (2001) found that 76% of the female psychotherapists surveyed reported some form of depressive illness. Gilroy, Murra and Carroll (2002) found depression, especially dysthymia, to be the most frequently acknowledged diagnosis at 36% of the 242 counselling psychologists surveyed.

As in the general population, depression in the therapist community can lead to similar emotional, cognitive, spiritual and social difficulties (Charlemagne-Odle, Harmon, & Maltby, 2014). Specifically related to clinical work, depression can increase the likelihood of burnout, compassion fatigue and the provision of less competent and effective therapy to clients (Orlinsky, Schofield, Schroder, & Kazantzis, 2011). A number of studies have suggested negative side effects of unaddressed depression and other wounds include decreased empathy, poor concentration, poorly managed countertransference, overidentification, irritability, projection and low confidence (Briere, 1992; Gil, 1988). These studies suggest that addressing this depression can benefit both the therapist as well as their clients.
The topic of processing mental health difficulties within the mental health professional world is often discussed under the umbrella of woundedness and the wounded healer. Jung was the first to write about how the wounded healer might relate to the practice of psychology (Jackson, 2001). For example, Jung (1963), in discussing the wounded healer concept stated that “only the wounded physician heals” (p. 134). The wounded healer archetype suggests that healing power emerges from both the healer’s own woundedness and his or her ability to draw on the woundedness through his or her own recovery process (Nouwen, 1972; Zerubavel & Wright, 2012). The wounded healer paradigm can also be seen in the shamanistic tradition, whereby a shaman’s healing power comes directly (in part) from an illness or injury (Merchant, 2012). Within this tradition, the wound itself becomes a source of validation for the role of healer; the shaman is able to travel between the two worlds of health and sickness. Indeed, whereas western healers are often expected to be well and whole, shamanic healers often display their wounds as marks of the authenticity of their skills (Remen, May, Young & Berland, 1985). Impaired mental health professionals, in contrast to wounded healers, “are broadly defined as psychologists whose work is impaired or adversely affected by physical, emotional, legal or job related problems” (Nathan, Thoreson & Killburg, 1983 as cited in Wood, Klein, Cross, Lammers & Elliott, 1985, p. 843).

While the current research allows for the reality that non-wounded professionals can certainly be competent therapists, the point is also argued that woundedness occurs along a continuum, and so most if not every mental health therapist has experienced (difficult) life circumstances that they can use to empathize and connect with clients. Woundedness as a continuum is reflected partly in Barnett, Baker, Elman and Schoener (2007), who distinguished
between distress and impairment. The authors defined distress as “a subjective emotional state or reaction experienced by an individual in response to ongoing stressors, challenges, conflicts and demands” (p. 603). By contrast, these same authors defined impairment or impaired professional competence as the “deleterious impact of distress, left untreated over time, on the psychologist’s professional competence as well as the negative effects of other personal or professional factors that adversely impact one’s competence” (p. 604). Barnett and Hillard (2001) noted that distress is a precursor to impairment, but that distress does not necessarily lead directly to impairment. Miller, Wagner, Britton, and Gridley (1998) viewed wounded healing as a continuum rather than a dichotomy which would allow for acceptance rather than dissociation of one’s own wounds. Also, according to Zerubavel and Wright (2012), “The wounded healer paradigm suggests that wounded and healer can be represented as a duality rather than a dichotomy” (p. 482). The critical component is not the severity of the wound, but rather the degree to which one can use his or her woundedness to help heal others.

Zerubavel and Wright (2012) also pointed out that limited research has been completed with regard to how the therapists know their recovery process is at a point where they can work with clients effectively. They also note that little research has explored what it means for therapists to process or recover from their woundedness such that it enhances rather than detracts from their ability to work with their clients. Zerubavel and Wright state that it is important to distinguish between an impaired professional and a wounded healer but that the process and the awareness of how one goes from the former to the latter is not well understood. This ambiguity can create difficulties for supervisors and therapists who must take on a gatekeeping role over their supervisees for the protection of the public. This can lead to
shame, stigma and failure to seek help for those mental health therapists struggling with a depressive episode or other wound.

As well as struggling with a depressive episode or other wound, topics such as countertransference, professional competency requirements, gatekeeping responsibilities and recovery trajectories are also closely related to the primary question of how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy. For example, Gelso and Hayes (2007) discuss recovery processes indirectly through their analysis of the risk and management of countertransference for therapists. While they do not explicitly describe the recovery process and how these therapists know they have recovered, Gelso and Hayes draw out a related process for countertransference management. They list five factors: self-insight, conceptualizing ability, empathy, self-integration, and anxiety management, which could be used to help therapists know they have sufficiently recovered from a depressive episode.

Two commonly accepted definitions for recovery from depression are found in the Research Diagnostic Criteria (RDC) (Spitzer, Endicott & Robins, 1978) and in the results of the MacArthur Foundation task force (Frank et al., 1991). Briefly, the RDC defines recovery as a period of at least eight weeks with either no symptoms of depression or only one or two symptoms of mild severity. Frank et al. (1991) has defined remission as “a period of time in which an individual no longer meets criteria for the disorder” (as cited in Boland & Keller, 2009, p. 23), while recovery was “defined as a full remission that lasts for a defined period.
Conceptually, it implies the end of an episode of the illness, not the end of the illness itself” (as cited in Boland & Keller, 2009, p. 24).

As experienced by the individual, however, the definition of recovery is not always as easily understood. For example, Karp (1996) understood recovery in general to involve a return to the social world and away from isolation. The phenomenon of recovery is at times amorphous, partly because of the subjective notion of what it means to be recovered. As Zerubavel and Wright (2012) noted, “recovery is not necessarily linear or, when achieved, permanent” (p. 485). Other difficulties with examining and defining recovery are the unique pressures professionally and personally that therapists face, not the least of which is some therapists’ own beliefs that they should not have mental problems (Spadola, 1995). However, as Welch (1996) noted, it is important to distinguish between the polar ends of impaired professional and wounded healer. Accordingly, this research seeks to understand how a therapist knows he or she has travelled from one end to the other.

**Problem Statement**

If therapists are to provide professional service to their clients, their mental health is critical to the success of their work. In particular, unaddressed depression could lead to maladaptive projections, overidentification, countertransference and burnout. Mental health therapists provide an essential service to their clients, who utilize psychotherapy as a first line treatment for mental health difficulties (National Institute of Mental Health, n.d.). The therapist’s own mental health, including his or her level of recovery and functionality in relation to depression and other wounds is critical to the success of his or her work with clients. Yet an analysis of the depression and recovery literature failed to reveal any studies that specifically
examine the process by which therapists know they have sufficiently recovered from their depression in order to practice competently with their clients. For example, the articles that appeared to align closest to the current study were ones that examined narrative case studies or theoretical frameworks of how an individual becomes a wounded healer (Esping, 2014; Miller et al., 1998; Wolgien & Coady, 1997). While these articles did provide an understanding of the general process of becoming a wounded healer through an adaptation of one’s wounds, they did not directly answer the question of how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy. The lack of research on this topic was viewed as a gap in the literature which the current research attempted to address.

**Statement of Purpose and Research Question**

The purpose of this study was to understand how therapists knew they had sufficiently recovered from their depression in order to work competently with their clients. The central research question was: how do mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy? Stated another way, this research sought to understand how the therapist became aware that he or she had sufficiently recovered from the depressive experience such that the experience now generally aided rather than detracted from the work with clients.

**Research Approach**

This research employed a socially constructed, qualitative grounded theory methodology (Charmaz, 2006; Creswell, 2013; Strauss & Corbin, 1998) to answer the central question of how the therapist knows he or she has recovered sufficiently in order to practice
competently. Grounded theory emphasizes the individual as a unique living whole, and the researcher focuses on the world as it is experienced by that individual (Hallberg, 2006).

As the question of how therapists know they have sufficiently recovered in order to work competently with their clients had not yet been specifically examined in the literature, this study attempted to answer the question by interviewing ten mental health therapists in the greater Toronto area (GTA). The interviews were audio recorded, transcribed and examined for emerging concepts and themes using grounded theory methodology (Charmaz, 2006; Strauss & Corbin, 1998). Several participants were contacted subsequent to the initial conversation in order to clarify unclear points covered in the initial conversation as well as to allow them to more actively engage in the construction of the emerging knowledge.

Rationale and Significance

The rationale for this study began from what was viewed to be a gap in the academic literature related to woundedness and professional practice. Within the practice literature, both the Canadian Psychological Association and the American Psychological Association have set forth guidelines and standards for competence (Canadian Psychological Association, 2014; American Psychological Association, 2014), yet a search through this literature failed to yield any particular process for articulating how therapists can know they have sufficiently recovered from depression (or indeed other “wounding”) to practice competently with their clients other than through supervision or discussions with a therapist. In this scenario it is assumed that the depressed therapist and his or her therapist/supervisor would discuss and track the recovery as it related to the therapist’s ability to provide competent therapy (similar to how a medical doctor might discuss a return to work plan with a patient following that patient’s leave of
absence). The guidelines and standards of practice have not articulated how therapists can know that they are sufficiently recovered; this, then, is one of the reasons for the study. A clearer sense of this process would seem to be in line with transparency and the psychology community’s obligation to the public, as well as being of benefit to the practitioners themselves.

This study differs from previous depression, woundedness and recovery research in that the focus was not on the wound (i.e., depression), the risk of non-recovery, the benefit of recovery or even necessarily how recovery happens, but rather on understanding how it was that therapists knew or became aware that they had recovered sufficiently from a depressive experience such that the experience now generally aided rather than detracted from client work. The focus was on these individuals’ regulatory and reflective functions, to see how these therapists sensed their own recovery, with the assumption that lack of recovery led to poor therapeutic outcomes for their clients. By asking in an open-ended manner about therapists’ process of knowing and sensing and testing their own recovery within the context of their professional practice, this study has helped to uncover processes that have until now been mostly inferred or assumed a priori or thought to be primarily subjective to the individual and therefore not translatable into any general framework.

Knowledge gained from this research could be integrated into best practice guidelines, counselling training curriculum and treatment, and could provide a more nuanced perspective on recovery as it relates to working with clients.
Outline of the Proposed Thesis

The literature review chapter establishes the broad context and theoretical framework for this study. This chapter situates depression and woundedness within a psychosocial context, explores the meaning of competent practice, examines elements of knowing and awareness, and reviews existing research on the process and knowledge of recovery.

The methodology chapter outlines the approach used to explore the experience of mental health therapists with depression and how they come to know they have healed sufficiently in order to practice responsibly. This section also describes the rationale for adopting a qualitative methodology focus for this research. Further, this section discusses criteria used for participant recruitment and selection, as well as the data collection and analysis processes.

The results chapter presents the findings generated from the study in two primary sections. Each section describes themes, subthemes, sub subthemes and categories that emerged from the results. The first section examines the participants’ understanding and experience of depression. The second section examines the participants’ process of recovery awareness, which also included an exploration of competent practice and recovery itself. Each phenomenon explored in the results chapter was framed around the participants’ unique understanding through extensive use of direct quotations derived from the interviews and follow up sessions. The various sections portray the participants’ understanding and experience of depression, their definitions of recovery and competent practice as well as the three primary themes through which they became aware that they were sufficiently recovered from their depressive experience such that they were able to provide competent therapy.
The discussion chapter situates the three major themes derived from the results chapter (through intrapersonal functioning, through interpersonal relationships, and through client work) within the context of other scholarly writings that pertain to depression, recovery, awareness and competent therapy. The chapter also offers a mid-level theory of knowing recovery.

The conclusion chapter highlights the strengths, unique contribution, limitations, and implications for clinical and counselling psychology of the study, as well as recommendations for future research. The chapter closes with a personal reflection on the researcher’s experience of conducting this research.
Literature Review

The purpose of this study was to understand how therapists with an experience of depression come to know they have sufficiently recovered in order to practice competently with their clients.

Although the focus of this research is not depression, the wounded healer, competent practice or even the recovery process per se, it was important to understand these concepts as they relate to the central question of how therapists come to know they have sufficiently recovered in order to practice competently. Therefore, the following section will review the literature relevant to these and other concepts as a way of establishing a broad context and theoretical framework for this study.

To this end, the review begins with an examination of literature relevant to depression and the experience of depression for both the general population and therapists in particular. Next, the concept of recovery is explored, including both definitions and indictors of recovery. The process of awareness and self-knowledge is then examined followed by the concept of competent therapy and what entails a competent therapist. Finally, the wounded healer literature is reviewed. The end of the review summarizes and brings together these researched areas and concludes with a rationale for the study.

Depression

Depression is seemingly ubiquitous. In fact, of all the topics covered broadly under the umbrella of mental health, depression is probably the most commonly researched. A keyword search for “depression” in PsycInfo yielded 100,283 peer-reviewed journal articles written in
just the last 10 years from January 2006 to January 2016. By comparison, keyword searches for “schizophrenia” and “happiness” under the same parameters yielded 32,829 and 3,238 results, respectively. Along with depression itself being heavily researched, depression treatment is likewise well examined, with over 350 randomized controlled trails on the efficacy of depression treatment having been published as of the end of 2015 (Lutz, Schiefele, Wucherpfennig, Rubel, & Stulz, 2016).

Depression is defined by the DSM 5 as involving either depressed mood or loss of interest or pleasure in daily activities, as well as at least four of the following: significant weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive guilt, and recurrent thoughts of death or suicide. These symptoms must have occurred over at least a two-week period of time in which they have been deemed to have caused clinically significant impairment in important areas of functioning (American Psychiatric Association, 2013).

Despite this seemingly simple definition from the DSM 5, depression is rarely viewed in the literature so simply. While much of the research literature takes its definition of depression from the DSM 5, the DSM 5 itself defines depression variously. The subtypes make distinctions between a number of depression related diagnoses, including single episode depression, recurrent depression, Dysthymic Disorder, and Depressive Disorder Not Otherwise Specified. The DSM 5 also lists features of depression in: Bipolar I and II Disorders, Substance-Induced Mood Disorder, schizoaffective disorder depressive type, cyclothymic disorder and adjustment disorder with depressed mood. Even within a diagnosis of depression, single episode, potential
specifiers include: mild, moderate, severe without psychotic features, severe with psychotic features, chronic, with catatonic features, with melancholic features, with atypical features, with postpartum onset, with mixed features, or with anxious distress (American Psychiatric Association, 2013).

It follows then, that research on depression would be equally varied. In reviewing the literature, the broad nature in which depression has been researched became apparent. Indeed, a sample of these articles demonstrated that it is not researched as a unitary construct, but at various times as: subsyndromal depression (e.g., Kasckow et al., 2014), lifetime subthreshold depression (e.g., Bertha & Balázs, 2013), major depression (e.g., Baier, Fritsch, Ignatyev, Priebe, & Mundt, 2016), treatment resistant depression (e.g., Bennabi et al., 2015), severe depression, (e.g., Zimmerman et al., 2014), adolescent depression (e.g., Bares, Delva, & Andrade, 2015), teenage depression (e.g., Dignam, 2014), postnatal depression (e.g., Ramchandani, Richter, Stein, & Norris, 2009), adult onset depression (e.g., Taha & Goodwin, 2014), geriatric depression (e.g., Li, Theng, & Foo, 2015) and late life depression (e.g., Hall & Reynolds-III, 2014).

The experience of depression

As the focus of this research is on how one becomes aware of recovery from depression and not on depression per se, a focused examination on the phenomenon of depression was not warranted. What was believed to be more salient to the proposed research was an understanding of the experience of depression, and so the following section begins with an examination of the literature to that end.
In his book *Speaking of Sadness* (1996), David Karp attempted to understand the experience of depression through in-depth interviews with 50 participants who had previously sought psychiatric treatment for a diagnosed clinical depression. He noted that minimal depression research has been written from the perspective of the depression and the depressed and instead on a more clinical, third-party understanding of the phenomenon.

Karp (1996) noted that much of the work in depression surrounded identity, “discovering who you are in the depression” (p. 10). For many people, this was a process, or an illness journey that began with discovering a name for the awful feeling of depression, to negotiating through the stigma and self-hatred and feelings of weakness often associated with it. This journey was a socialization process that often involved the person viewing himself or herself as a sick person who required help. Karp compared his own experience with depression to a kind of “mental arthritis” (p. 17), something he had to just live with and submit to the idea that it might never fully remit.

Karp noted that part of the process of illness identity involved an action component. For some, this was a turn to medication and the medical establishment, which required the person to first consider and process such issues as “the connection between drug use and illness self-definitions, the meanings of drug side effects, attitudes towards physicians, evaluations of professional expertise, and ambiguity about the causes of one’s problem” (1996, p. 16). For others, the action component was a turn to any number of personal or social solutions – from religion to gardening to travelling to group therapy to self-help of many stripes. Indeed, some
people viewed their depression as a gift that could help teach them about the world and themselves.

Karp (1996) noted that many of his participants viewed depression as, at its core, a “disease of isolation” (p. 20). What people wanted was to have connection with others, but they found their depression fundamentally isolating. Their depression took away their energy, motivation, and ability to connect with people and spiraled them downward. Depression was also described as a contagious illness in that it was felt to infect friends and family. Many subjects spoke about fears of their depression negatively impacting their children and their partners and how amazed they were when their families remained as close as they had over the course of their depression.

Moving away from Karp’s work, other research on the experience of depression has examined populations as diverse as emotionally abused children (Shapero et al., 2014), college students (Lester, 2014), young black men (Perkins, Kelly, & Lasiter, 2014), postpartum women (Vliegen, Casalin, & Luyten, 2014) and religiously oriented senior citizens (Krause, 2012). As an example from this list, Perkins et al. (2014) examined the depressive experience of young black men with histories of incarceration. The authors found a number of themes they believed to be less prevalent in previous qualitative descriptors of depression in other populations. For example, many of their young black male participants described feelings of anger, frustration and negativity – being tired of the cycle of incarceration but turning that frustration and fatigue into anger in order to cope. The participants discussed how anger seemed more acceptable than feelings of helplessness or sadness. For many of them, depression equalled weakness,
which was considered feminine. The participants felt their depression was invisible as, “a lot of people don’t look at young Black men as being depressed” (p. 170). They felt as if their depression was different due to the negative impact of racism, discrimination and white privilege, and that black men had to be stronger just to make it through life. Coping techniques were commonly discussed.

Notably, while some of the perceptions of depression differed in the Perkins et al. (2014) research (e.g., depression as feminine), many of the experiences were similar (e.g., feeling sad, empty, suicidal, feeling as if no one cared, having difficulty engaging in activities). Indeed, these affective, cognitive and behavioural experiences appear to be similar across populations even if the descriptive language is different. This would lend evidence to the idea that the emotional experience at the core is similar, even if the expression and sequelae differ across populations.

In a similar vein, Cohen, Greenberg and IsHak, (2013) argued that the impact of depression extended beyond simply the presence of depressive symptoms. They discussed the “burden of illness,” defining this to include “suffering due to symptom severity (intensity, frequency, and duration), impairment in functioning (occupational, social, and leisure activities), and reduction in quality of life (QOL; satisfaction with health, occupational, social, and leisure activities)” (p. 343). They further argued that remission in depressed patients, as defined by a reduction in symptom severity, does not denote normal quality of life or functioning. Rather, they noted that the inclusion of the full burden of illness in depression
both prior to and following treatment provided a more accurate picture of the individuals’ experiences and difficulties.

While the therapist’s experience of depression will of course be similar in many regards to the themes discussed in Karp’s (1996) work, this section will provide a review of current clinical knowledge on the specific experiences of therapists who themselves are depressed. Implicit with this focus is an exploration of the experience of depression as well as the impacts of that depression on the therapists’ professional and personal life in relation to stigma, feeling they should be more in “control,” concerns about their credibility/employability, issues related to continued practice and notions of the wounded healer. Therapists face unique pressures professionally and personally, not the least of which is some therapists’ own belief that they should not have mental problems (Spadola, 1995). Therefore, research into this area is very important for clinical practice but also for the therapists’ private, non-clinical selves.

The section is divided into two subsections: the therapist as depressed and the therapist as wounded healer. Research with both a quantitative and qualitative focus will be examined. Gaps in current knowledge that the research aimed to address will also be discussed.

The therapist as depressed

The following section provides some contextual data for how therapists and other mental health professionals experience depression. To this end, rates of depression and related sequelae are reviewed, as are the risks and benefits, treatment options and five qualitative vignettes of mental health professionals’ personal experiences with depression.
A review of a number of studies suggests that therapists and other mental health professionals experience depression at a higher rate than the general public. For example, when looking over the course of a one-year period, Mahoney (1997) found almost 35% of 155 psychotherapists listed “episodes of depression” as a problematic issue. When looking over the course of their career, Gilroy et al. (2002) found 62% of counselling psychologists had self-identified as depressed. When looking over the course of their lives, Deutsch (1985) found 57% of 264 therapists experienced depression, while Pope and Tabachnick (1994) found 61% of 476 psychologists reported a lifetime incidence of clinical depression. At the highest estimate, Gilroy et al. (2001) cited research by Swearingen (1990) estimating the percentage of depression among psychiatrists as being between 60-90%.

Though not a focus of the proposed research, a few studies have examined depression specifically in relation to female mental health professionals. The results seem to correlate with the findings of mental health therapists in general. Clayton, Marten, Davis and Wochnik (1980) found that 39% of woman physicians and 30% of women Ph.D.s had met criteria for major depression during their lifetime with an additional 12% meeting criteria for either questionable or very brief depression among physicians (11% for the female Ph.D.s). The authors noted no significant under- or over-representation of either psychiatrists or psychologists with depression among the sample. At a higher percentage, Gilroy et al. (2001) found 76% of 220 woman psychotherapists reported some form of depressive illness. Approximately 49% of these indicated they were aware of being given a DSM-IV diagnosis.
The research suggests that therapists and other mental health professionals have higher rates of depression than the general public, or at least, report higher rates. Indeed, Clayton, Marten, Davis and Wochnik (1980) have opined that the rates of depression are higher than the general population due potentially in part to the fact that “they or the interviewers were overly sensitive to changes in mood” (p. 43). Others note that the mental health profession is a somewhat self-selective process for vocation, one chosen due to the practitioner’s own emotional or personal difficulties (Farber, Manevich, Metzger, & Saypol, 2005; Miller et al., 1998).

As noted in the introduction, depression can have a profoundly negative impact on a person’s life. Research has already suggested that depression can have detrimental effects on therapists who practice while in the midst of a depressive episode (Guy, Poelstra & Stark, 1989; Sherman & Thelen, 1998). Since the rates of depression appear to be higher in the mental health community than the general population, the review will now examine the specific ways that depression may impact the life of the mental health professional.

In a survey examining whether depression affects clinical practice, Gilroy et al. (2001) found both positive and negative consequences of depression on clinical practice. Positive consequences included:

(a) increased empathy, (b) ability to make more accurate assessment and diagnosis, (c) less fear of client’s anger, (d) increased sensitivity to client’s depression, (e) increased compassion, (f) greater insight into client’s experiences, (g) increased knowledge base, and (h) increased patience and understanding. (p. 22)
Negative consequences included “(a) low/lack of energy, (b) lack of confidence, (c) concentration difficulty, (d) decreased enthusiasm, (e) decrease in ability to be emotionally present, (f) fatigue, and (g) memory problems” (p. 23).

Gilroy et al. (2002) examined the depressive experience for both genders of counselling psychologists. Similar to their 2001 research, the participants stated that their depression and other emotional issues gave them more empathy for their clients. On the maladaptive side, participants reported an increased sense of isolation from colleagues as well as lowered energy level and ability to concentrate.

Of course, depression is not the only element that is problematic to therapists. As for related issues, Deutsch (1985) found 82% of respondents had experienced relationship difficulties over the course of their lives. Pope and Tabachnick (1994) found between 35-42% of respondents experienced episodes of irritability, emotional exhaustion, concern over the size of their caseload, poor sleep, doubts about their effectiveness as a therapist, interpersonal issues, fatigue, anxiety, and isolation. In a survey of distressed psychologists, Thoreson, Miller and Krauskopf (1989) found that 10% experienced distress in the areas of marital/relationship difficulties, physical illness, alcohol use, loneliness as well as depression. Norcross, Strausser-Kirtland and Missar (1988) reported that, while undergoing therapy, 13% of psychotherapists listed depression as a presenting problem during their treatment.

The effects of depression and related difficulties can be as severe as suicide. Pope and Tabachnick (1994) found that 29% of psychologists who had been in therapy reported suicidal ideation and 4% reported at least one suicide attempt. Gilroy et al. (2002) found that 42% of
the respondents who indicated an experience of depression also reported some form of suicidal ideation. In a study of suicide among male and female psychologists, Mausner and Steppacher (1973) found that over a 10-year period, women suicided at a rate of nearly three times the expected number. Men suicided at a rate slightly lower than expected – the reason for this was not entirely known to the researchers. Regarding the high level of female suicidality, it was theorized that marginality, role conflict and ambivalence about achievement of success may have contributed to the increased number of women who suicided.

**Qualitative experiences of depression.** As reviewed in the previous section, much of the quantitative research on therapists’ depression follows a survey approach, in that the researchers are often not simply looking at how therapists experience depression (or how often, or how severely, etc.) but rather at issues related to the depression such as the therapists’ fitness to practice, the potential impact on their clients, and treatment options within the context of professional outcomes. The research described in the following section utilized in-depth, qualitative methods to better understand the nuances of the depressive experience for the mental health professional.

A number of excellent memoirs on the personal journey of mental illness have been written by mental health professionals: for example, Endler’s account of his depressive history in *Holiday of Darkness* (1982), Jamison’s account of her bipolar disorder in *An Unquiet Mind* (1995), and Manning’s account of working with her depression in *Undercurrents* (1994).

The following discussion is a synthesis of five vignettes (two clinical psychologists, a psychotherapist, a child and family psychiatrist and a medical doctor) that trace the individual’s
experience of depression. One vignette is borrowed from Anonymous (2007), one from Anonymous (1981) and three from Rippiere and Williams’ (1985) book *Wounded Healers*. Relating to the proposed study, the central focus of this synthesis is the descriptions of how depression impacted the health professionals’ work and their clients, how and through what means the health professionals attempted and experienced recovery to the extent it was achieved, and, most critically, how they came to understand that they had indeed recovered.

The impact of depression on work and clients was typically viewed as negative. Common themes were: not wanting to see clients because they either felt the client’s problems were too petty or that the health worker would be unable to help, feeling hypocritical as a therapist, having difficulties with even simple tasks like test material gathering, having difficulty switching between being a client and a therapist within the same day, having difficulty feeling competent and voicing one’s opinion during clinical rounds at work, having difficulties with supervisor/colleagues as they either did not want to divulge, or if they did divulge, not receiving appropriate emotional support, questioning their choice of profession and wondering what else they might try instead. Most persisted in their work despite these difficulties. One vignette, for example, described the feeling that the work was important and a reason to get out of bed in the morning.

Attempts at recovery were made through a number of avenues: music, food, sleep, activities with friends, reading volumes of literature, and purposefully “blanking out” in order to obliterate thoughts of dread. Paradoxically, one person coped with depression by remaining depressed, in that while depressed she found herself abler to work without distractions. Most
sought help from a mental health professional. One writer described a very negative experience with a psychotherapist which she was later able to use as an example of how not to do therapy with her own clients. For others, medication was suggested, as well as traditional therapy. All expressed experiencing support from colleagues, family or friends. One described developing numerous coping strategies, such as adopting the aphorism to live one day at a time and getting in touch with emotional cycles. The same vignette attributed survival from these depressive episodes partly “due to luck, to meeting the right people at the right time, but to a great extent... a deliberate, cold-blooded effort to survive” (Ripplere & Williams, 1985, p. 34).

Central to the current study, the experience of recovery and the ways these professionals knew they had recovered were touched on indirectly through their descriptions of feeling differently when not in a depressive state or by discussing the benefits of the depressive experience. Typically, the recovery was evidenced by shifts in mood, being able to differentiate mood states, thinking more clearly and finding pleasure in activities. Specifically related to clinical work, the authors felt they had achieved recovery to some extent when they felt in more direct contact with clients, were less self-conscious and more responsive, felt relaxed and confident in session, were able to act without impedance, made conscious effort to stay focused with each client and felt less irritated and pessimistic. Some who received personal and professional support noted getting feedback from others that indeed the depressed individual seemed to be improving.

Overall, a number of metrics appeared to be in use by these mental health professionals as they engaged with the attempt to know they had sufficiently recovered, including a reflexive
awareness of their own emotional, cognitive and behavioural states and feedback from personal and professional support networks. Just what was meant by “recovery” is explored in the next section.

Recovery

In the context of the current research, recovery is understood in relation to depression. While some researchers define recovery as the absence of depressive symptoms (e.g., Frank et al., 1991; Spitzer, Endicott, & Robins, 1978), others note that that recovery is more closely related to how the individual relates to his or her depressive experience rather than the presence or absence of symptoms (Andresen, Oades, & Caputi, 2003), while still others relate the phenomenon more closely to posttraumatic growth (Tedeschi & Calhoun, 2004). These perspectives will be explored in this section, along with indicators of recovery.

Defining recovery

For an individual to meet criteria for a depressive disorder, the DSM 5 requires that five out of the nine listed depressive symptoms be present in an individual’s life for at least two weeks and that these symptoms result in significant functional impairment as determined by a psychologist or other qualified mental health professional (American Psychiatric Association, 2013). Both the Research Diagnostic Criteria (RDC) (Spitzer, Endicott, & Robins, 1978) and the MacArthur Foundation task force (Frank et al., 1991) define recovery as an abatement of these depressive symptoms such that the individual no longer meets criteria for the disorder: the RDC defines recovery as a period of at least eight weeks with either no symptoms of depression or only one or two symptoms at a mild severity level (Spitzer, Endicott & Robins, 1978), and Frank
et al. (1991) defines recovery as full remission from depressive symptoms that lasts for a defined period.

Beyond these basic definitions of recovery, Boland and Keller (2009) distinguished between the end of an episode of the illness and the end of the illness itself. This distinction was echoed by writers like Zerubavel and Wright (2012), who noted that “recovery is not necessarily linear or, when achieved, permanent” (p. 485). Boland and Keller (2009) further described some difficulties with Frank et al.’s definition of recovery, noting that it is “based on a number of assumptions that cannot be proven, because we lack valid biological markers for major depression” (p. 24). Instead, they suggest that the construct relies on a range of statistical likelihoods, within which one must decide where to place symptomatic and duration cutoffs; they ask whether such cutoffs should be conservative or liberal, and what type of error is acceptable.

Beyond depressive symptom abatement, a more holistic conceptualization of recovery can be found in Andresen et al. (2003). They defined “psychological recovery” as “the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination” (p. 588). This understanding came out of the mental health consumer movement, which focuses on more severe mental difficulties such as schizophrenia and personality disorders. This movement “questions the medical model of mental illness and insists that people who have been labelled as mentally ill speak on their own behalf and not be represented by others who claim to speak for them” (Chamberlain, 1990, p. 323). Andresen et al.’s (2003) definition focused on the recovery from the psychological trauma
of the illness rather than a cure or the absence of symptoms. As such it contrasts with the DSM 5 idea of recovery. Four key components of the process of recovery, based on personal accounts, were defined: finding and maintaining hope, the reestablishment of a positive identity, finding meaning in life and taking responsibility for one’s life.

A related concept to recovery is the idea of posttraumatic growth or “the experience of positive change that occurs as a result of the struggle with highly challenging life crises” (Tedeschi & Calhoun, 2004, p. 1). These authors noted that growth can manifest as an increased appreciation for life, more meaningful relationships, increased sense of personal strength, changed priorities and a richer existential and spiritual life. While not specifically relating to the onset of a depressive experience, Aldwin and Stokols (1988) noted that environmental stressors that were severe, that had a rapid onset, and that affected multiple domains in the individual’s life were more likely to result in change processes rather than homeostatic processes. Aldwin, Sutton and Lachman (1996) noted that whether these “change processes” were adaptive or maladaptive (in others words, relatable to recovery or not) were determined in part by the individual’s personality and coping resources. Aldwin et al. (1996) defined positive change or recovery as the development of coping resources and negative change as their depletion. Coping resources included emotional, tangible and philosophical factors such as mastery, self-esteem, increases in coping repertoires and positive changes in philosophy and life. Aldwin et al. (1996) noted that these various strategies also helped predict depressive levels of the participants. Recovery therefore was linked to, in part, the presence or absence of these coping resources.
Overall, in terms of defining recovery, Whitley, Palmer and Gunn (2015) stated that the concept of mental health recovery has emerged in recent years due in part to the perceived overemphasis of biological as opposed to psychosocial factors in severe mental illness. They noted that

Many definitions of recovery exist, but shared across these definitions is an emphasis on recovery as an individual process (or journey) involving much more than symptom remission. Instead, recovery involves development in life domains considered subjectively important to the person, commonly related to progress in normative activities such as education, employment, housing and social relationships (p. 951).

This synopsis of recovery captures well the various facets of recovery, not simply symptom remission but also the different developmental domains and the importance of the individual’s subjective experience of key elements of recovery. The literature review next explores various indicators that have traditionally been associated with recovery as described above.

**Indicators of recovery**

As an aid to knowing and being aware of recovery, a number of scales and inventories have been created to assess mental illness recovery. Giffort, Schmook, Woody, Vollendorf and Gervain (1995) designed the 24-item *Recovery Assessment Scale*, which covers five sub-scales: personal confidence and hope, willingness to ask for help, goal and success orientation, reliance on others, and no domination of symptoms. Relating recovery to empowerment, Rogers, Chamberlin, Ellison and Crean (1997) created the *Making Decisions Empowerment Scale*, whose items were modeled after the *Rotter Internal-External Locus of Control Instrument*, the *Self-
Efficacy Scale, and the Rosenberg Self-Esteem Scale (p. 1043). Lloyd, King and Moore noted that the Making Decisions Empowerment Scale identified “the relevance of self-efficacy/self-esteem, power/powerlessness, community activism, righteous anger and optimism/control over the future as the key components of recovery” (2010, p. 221). In a related fashion, Gordon, Ellis, Siegert and Walkey (2013) designed a 65-item self-assessed Consumer Recovery Outcome Measure that assessed eleven factors: “relationships, day-to-day life, culture, physical health, quality of life, mental health, recovery, hope and empowerment, spirituality, resources and satisfaction with services” (p. 199).

While some researchers focused on creating measures and inventories, others looked more broadly at factors indicating or supporting this mental illness recovery. While speaking generally about traumatic experiences rather than depressive experiences specifically, Aldwin (1994) noted that factors such as social support, intelligence, a “sunny” disposition, effective coping and determination coupled with flexibility in attitudes potentially resulted in the development of resources that promote posttraumatic growth and recovery, whereas social isolation or negative social interactions, a difficult temperament, poor coping strategies, and lack of social and cultural resources may result in a negative adaptive spiral and the depletion of coping resources.

As indicators of recovery, Solomon et al. (1997) argued that neither sociodemographic variables nor clinical variables consistently predicted duration of major depression. They stated that the “most that can be said is that sociodemographic variables do not predict the likelihood of recovery, including age at study intake, sex, marital status and socioeconomic status” (p.
Dowrick et al. (2011), however, provided a competing perspective to the findings of Solomon et al. (1997). Dowrick et al. examined factors predicting sustained recovery from mild to moderate depression, based on the Hamilton Depression Scale and the Bradford Somatic Inventory. A predictive model was developed based on the research findings: factors associated with sustained recovery were found to include being female, being married or cohabiting, having fewer somatic symptoms and receiving preferred treatment. A significant difference between these two studies is that Solomon et al. examined major depression, while Dowrick et al. focused on mild to moderate depression.

Solomon et al. (2008) examined psychosocial functioning as a predictor of recovery from episodes of unipolar major depression, as there were, at the time, “no markers or diagnostic tests to help clinicians determine when a patient will recover from an episode of major depression” (p. 286). They concluded that assessment of psychosocial impairment might help identify patients less likely to recovery from an episode of major depression. This impairment was assessed through the four domains of work, interpersonal relationships, recreation and satisfaction on a five point scale of no impairment to severe impairment for each domain.

Lloyd, King and Moore (2010) examined whether subjective dimensions of recovery such as empowerment correlated with objective measures of recovery such as income from employment and level of community participation. They found that empowerment was strongly correlated to recovery assessment and community integration. They argued that subjective measures such as feelings of empowerment were a valid measure of global recovery for people
with severe mental illness. Neither age nor gender had any relationship to the recovery measures.

A number of indicators of recovery have been developed, both assessment measures as well as central features of the phenomenon. Central among these are a sense of empowerment and ability not noted during the non-recovered state. The review next turns to an exploration of what is meant by awareness and knowledge in terms of recovery and the felt ability to provide competent practice.

**The Process of Knowing**

For the purpose of the current research, the terms knowing and awareness were used somewhat interchangeably (Halligan, 2006; James, 1895; Lewis, 1991). The current study theorized that individuals use knowledge gained from their own senses, functioning, and the perspectives of other people in their lives to provide a sense of knowing and awareness of their recovery state and whether they are competent to perform therapy.

A common starting point in the discussion of knowing and knowledge is the field of epistemology. Epistemology is the study of the scope and nature of knowledge (Fish, 2010). It deals with the study of knowledge, truth, belief and justification and answers how we know what we know (Ibid, 2010). It also makes a distinction between justified true belief and opinion.

Justified true belief is a definition of knowledge that states that a proposition is true if: the proposition is true, one believes it to be true and is justified in believing that this is so (Bengson & Moffett, 2011). In the case of the current research, an individual therapist can know his or she is recovered in terms of being able to provide competent therapy only when
this is true, when they believe it to be true and when they are justified in believing this. Given the focus of the study, the truth of their recovery state is presumed to be accurate beforehand, and so therefore the research is primarily interested in how therapists come to believe or know they are recovered and how this belief is justified. While there is some debate as to whether justified true belief is accurate knowledge (Gettier, 1963), for the purpose of the current research, justified true belief is considered functionally accurate knowledge for recovery and competent practice awareness.

Within the philosophical tradition of epistemology, distinction is typically made between three different types of knowledge: knowledge that, knowledge how and acquaintance-knowledge (Bengson & Moffett, 2011). A good example of the first two types of knowledge is the mathematics statement 2+2=4. In this example, there is knowledge that the answer is 4 as well as knowledge of how to add those two numbers together. The third type of knowledge, acquaintance-knowledge, is knowledge about a person, place thing or activity (Ibid, 2011). Whereas epistemology is typically interested in this first type of knowledge, the current research is primarily interested in the second type of knowledge: in other words, the knowledge of how they knew they were recovered. Three forms of justification are often used to this end: empiricism or evidence from the senses, deductive reasoning, and authoritative testimony (Gertler, 2011). The theory of justification holds that a justified belief is one that we are within our rights to hold.

This way of knowing connects well with attribution theory, the process by which individuals explain the causes of behaviours and events either typically employing an external or internal attribution (Hewstone, 1983). In the case of the current research, individuals come
to know they are sufficiently recovered when they are able to attribute changes in their life to their recovery as opposed to a coincidence or other external factors.

A number of theoretical orientations, such as interpersonal theory (Sullivan, 1953), object relations (Klein, 1960), and attachment theory (Bowlby, 1988), generally hold that knowing and self-knowledge is generated primarily through relationship, both interpersonally and intrapersonally. In fact, beginning in childhood the fundamental role that parental relationships play in developing and guiding the self from birth onwards is well understood within the field of developmental psychology and more specifically through attachment theory. John Bowlby (1969), Mary Ainsworth (Ainsworth, Blehar, Waters, & Hall, 1978), Mary Main (Main, Kaplan, & Caddidy, 1985), Peter Fonagy (Fonagy, Steele, & Steele, 1991) and others have examined attachment within the parent/infant dyad and the crucial importance of this early attachment on the stance of the self in relation to knowing oneself and indeed generating a representational model of self and others. These researchers have all noted that both the development of the self and the ability of the self to be self-reflective are strongly influenced by the quality of the person’s interpersonal relationships with significant others (Wallin, 2007).

Regarding therapeutic practice, orientations as seemingly diverse as interpersonal theory (Sullivan, 1953) and intersubjective psychoanalysis (Stolorow, Brandchaft, & Atwood, 1987) utilize relationship, specifically the therapist/client relationship, to help the client know himself or herself better so that the client can improve or heal from a problematic, fixed position. While the two are unique orientations, both hold general assumptions that this therapeutic relationship can provide a corrective emotional experience as well as a wealth of
knowledge to both the client and therapist about the client’s core schemas, biases, coping styles and other elements of self-knowledge. In terms of the process of knowing for the individual, relationships appear critical both as the arena in which knowing occurs as well as a catalyst by which knowing occurs.

Exactly how knowledge can lead to awareness was explored by Stange (2010), who drew out the data-information-knowledge-understanding-wisdom pathway. While this applies more to knowledge in the health field (e.g., how to treat diabetes or what a new medication does for people) rather than knowledge of a personal state of mood/ability, it is still relevant for the current research. Stange (2010) noted that:

Data can be processed into information that answers who, what, where, and when questions. With application and sense-making, information becomes knowledge that answers how questions. Continued synthesis of knowledge and learning can generate understanding that sheds light on why. Further discernment, judgment, and openness that put understanding into a larger context foster the possibility of wisdom. Development along the higher levels of this continuum is facilitated when different ways of knowing are considered together. (p. 5)

Related to the current research, this quote suggests that the individual takes in information gathered from his or her own senses, level of functioning and feedback from others, synthesizes these “different ways of knowing” through “application and sense-making” as well as “discernment, judgement, and openness” in order to “generate understanding” of his or her state of recovery and ability to provide competent practice.
Therapist self-awareness is widely regarded by clinicians as an essential element of competent practice (Ridley, Mollen, & Kelly, 2011). Continuing along the lines of how awareness of recovery and competent therapy is generated, Pompeo and Levitt (2014) examined self-reflection and self-awareness in relation to counselor mastery. These authors discuss a three-phase “path of counselor self-awareness” (p. 82), which relates strongly to the current research’s focus on how knowing recovery relates to competent practice. Phase one involves counselor self-reflection and stagnation. In this phase, an individual is presented with a problem or dilemma. They refer to this as a potential opportunity, noting that not all triggering events necessarily lead to change. This is well suited to the current research in that not every therapist who has an experience of depression will become a wounded healer; rather, some may remain impaired professionals. Thus, one is on a path of self-reflection and the other on a path of stagnation. One element that appears to distinguish the former from the latter (and therefore that relates to knowing recovery or not) is this self-awareness and self-reflection process. Phase two is the self-awareness process. Pompeo and Levitt note that this path involves ethical decision making and professional and personal experience. Phase three involves achieving self-awareness, which leads to counselor mastery (competent practice). The authors note that “mastery does not imply that there is nothing left to learn or develop. Rather the master counselor is constantly seeking out new opportunities for personal and professional development” (p. 86).

Citing a specific example from the literature, Goldberg, Hadas-Lidor, and Karniel-Miller (2015) explored the developmental process of 12 social work students with psychiatric difficulties who went from being patients to therapatients (therapists who were also patients).
Of the four stages from initial exploration of the health care world to the integration of the patient and therapist role to become a therapatient, the stage most relevant to this study was “identifying their ability to be professionals” (p. 887). This stage involved the interaction of three factors: the theoretical materials discussed in class, the field work, and the student therapist’s own personal experience. Related to the current research, it is theorized that the process of awareness and knowing involves taking in information from the senses, examining one’s functioning, comparing it to previous functioning, and getting perspective from important other people. This process gradually generates a justified true belief as the information adds up to create a more convincing argument of the state of recovery and ability. Of course, this ability to provide competent therapy requires a definition of competent therapy. This is covered next.

**Competent Therapy**

The current research is interested not simply in how an individual knows he or she is recovered, but more specifically how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy. Implicit in this focus is the notion that recovery involves, to a large degree, the therapist’s ability to provide competent therapy relative to the therapy he or she might have been providing while in the midst of their depressive experience. This section therefore discusses what is meant by competent therapy and explores the key features of a competent therapist.

Sharpless and Barber (2009) discuss the idea of “intervention competence of psychologists” (p. 47) by adapting Dreyfus and Dreyfus’s (1986) five stage theory of
competence development to a clinical framework. Sharpless and Barber (2009) note that questions remain about what competence means, how best to measure it, and how it develops. The authors define intervention competence as “that particular type of competence demonstrated when remedying psychological difficulties” (p. 48). They note that adherence and competence are often improperly comingled in the literature. Adherence is “typically considered to be the extent to which a therapist utilizes prescribed interventions without taking recourse to proscribed techniques” (p. 48). Adherence is knowledge of how to intervene and what to intervene on (e.g., depressive symptoms), whereas competence is knowledge of when and where (and possibly why or why not) to intervene. The authors argue that the psychology community houses competing paradigms about competence and that what is considered competent practice within CBT might be considered incompetent and even unethical within psychoanalysis. Sharpless and Barber argued that competence is a “dimensional construct” (p. 50) and that the development of competence “is an ongoing process within an individual that is, ideally, in a state of constant flux and renewal” (Nagy, 2005, as cited in Sharpless & Barber, 2009, p. 51). Regarding Dreyfus and Dreyfus’ five stage model, Sharpless and Barber note that “as in all developmental models, stages are never as distinct in reality as they are in theory” (p. 51), and that the danger is that stages may become conceptually reified. The five stages are novice, advanced beginner, competence, proficiency, and expertise. In general, the progression through the stages is “movement away from a detached and rule governed psychologist consciously deliberating on “facts” about a patient and towards an embodied, experienced psychologist engaged in the moment with the full particularity of the individual before them” (p. 51). In other words, the therapist moves away from adherence and towards competence.
Sharpless and Barber (2009) argued that given this five-stage process, “the field may be better served by evaluations which focus less exclusively on skills and knowledge assessment (e.g., standardized tests), and more on the development of sound, nuanced, and well-reasoned judgements in applying these skills” (p. 51).

In a related attempt to address the question of what exactly entails competent therapy, Ridley, Mollen, & Kelly (2011) developed a model of counselling competence consisting of four superordinate competencies, twelve subordinate competencies and five metacognitions. The superordinate competencies included: determining therapeutic outcomes, facilitating therapeutic outcomes, evaluating therapeutic outcomes and sustaining therapeutic outcomes. The subordinate competencies included: self-appraisal/self-evaluating, structuring the therapy, building a therapeutic alliance, applying a conceptual map of therapeutic change, using therapeutic techniques, self-correcting, surmounting obstacles, leveraging opportunities, managing special situations, working with other systems of care, consulting other sources, and terminating therapy. Integral to the model is the integrated deep structure, which consists of the five metacognitions: purposefulness, motivation, selection, sequencing and timing.

In terms of practice, relationship and working alliance are seen to indicate competent therapy and are regarded as critical in most if not all therapy modalities (Ridley, Mollen & Kelly, 2011; Sommers-Flanagan, 2015). For this reason, Summers and Barber (2003) argue for the use of therapeutic alliance as a measure of competence, stating that therapeutic alliance has a “robust effect on treatment outcome” (p. 160) and therefore might in fact be a “holy grail” (p. 160) of psychotherapy competence.
Given that one of the current research objectives is the understanding of competence as it relates to the well-being of the client, this section closes with a brief review of four of the more salient articles covered under the Canadian Code of Ethics for Psychologists (3rd edition, 2000) related to competence. These are discussed under Principle II: Responsible Caring:

**Article II.6** - Offer or carry out (without supervision) only those activities for which they have established their competence to carry them out to the benefit of others.

**Article II.10** - Evaluate how their own experiences, attitudes, culture, beliefs, values, social context, individual differences, specific training, and stresses influence their interactions with others, and integrate this awareness into all efforts to benefit and not harm others.

**Article II.11** - Seek appropriate help and/or discontinue scientific or professional activity for an appropriate period of time, if a physical or psychological condition reduces their ability to benefit and not harm others.

**Article II.12** - Engage in self-care activities that help to avoid conditions (e.g., burnout, addictions) that could result in impaired judgment and interfere with their ability to benefit and not harm others.

As demonstrated in the above articles, competence is not defined as such, but rather the method of exploring and maintaining one’s competence is laid out as well as the express command to stay within the bounds of that competence, however it may be defined by the individual and his or her supervisor. Reading from the overall literature, competent therapy is understood as a dimensional construct which involves both therapeutic knowledge as well as
the ability to apply this knowledge. It is a relational, ongoing process of self-awareness and improvement which should lead towards expertise rather than simply dry adherence to a set of therapeutic principles. The concept of competence relates strongly to the focus of the next section, that of the wounded healer.

**Wounded Healer**

The topics covered in this literature review (depression, recovery, awareness and competent therapy) can perhaps best be synthesized within the wounded healer paradigm (Jung, 1963). This paradigm assumes, as noted by Foreman, that the wounded healer is an individual who is transcending or has transcended the trauma and injury of personal wounding by integrating his or her issues (2005). In other words, being a wounded healer assumes that both a wound (i.e., depression) and recovery have occurred, that the individual is aware of this and is furthermore providing competent therapy. This phenomenon is discussed in more detail below.

The idea of the wounded healer dates back to at least the time of the ancient Greeks, first being seen in the myth of Chiron the Centaur and the cult of Asclepius (Jackson, 2001). Both figures suffered physical and emotional wounds that were incurable and both were able to teach and heal, in part because of the perspective afforded by these very wounds (Foreman, 2005). In its modern context, the archetype suggests that healing power emerges from the healer’s own woundedness (Aponte & Winter, 1987; Nouwen, 1972).

The wounded healer archetype can be seen in the shamanistic tradition, whereby a shaman’s healing power comes directly (in part) from an illness or injury (Merchant, 2012).
Within this tradition, the wound itself becomes a source of validation for the role of healer; the shaman is able to travel between the two worlds of health and sickness. Similar to the focus of Alcoholics Anonymous, which holds that the best person to help an alcoholic is a recovering alcoholic (Landherr, 2013), the shamanic tradition and the wounded healer paradigm point to the importance of experiential knowledge in recovery. Indeed, whereas western healers are often expected to be well and whole, shamanic healers often display their wounds as marks of the authenticity of their skills (Remen et al., 1985). The paradigm of the wounded healer suggests that it is the activation of the wounded-healer duality for both the therapist and patient that constructively informs the healing process (Kirmayer, 2003).

The wound of the wounded healer can be either physical or psychological in nature. The experience of being wounded can differ as to the basis of the nature and severity and chronicity of the wound as well as its prognosis and whether or not (or how much) stigma is attached (Zerubavel & Wright, 2012). Zerubavel and Wright noted that research has rarely discussed specific characteristics of the wound that may lead to different response outcomes from stigma to support (2012). Related to this point, Day, Edgren and Eshleman (2007) noted that the more visible and dangerous the wound, the less treatable it is, and the greater impact it has on relationships, the higher the social stigma associated with it may be. This is important when considering the current research, as stigma is associated with help seeking behaviour. If a participant feels his or her wound may be stigmatized rather than supported, he or she may be less likely to seek help, which can impact their recovery process (Hinshaw & Stier, 2008). This experience of stigma can lead to efforts to conceal the wound, lowered self-esteem, self-
consciousness, social isolation and negative mood (Pachankis, 2007). Pachankis noted that this experience of stigma can at times be internalized and lead to self-stigma.

Certain wounds (like being an incest survivor or harming another person) are still seen as taboo or disgraceful and enter the realm of the “unspeakables” or “unmentionables” (Zerubavel, 2006, p. 76). These types of wounds are especially at risk of being avoided, and the chance for recovery is diminished. Zerubavel and Wright (2012) refer to this as “social conspiracies of silence” (p. 485) and note that this factor along with stigma helps explain the general lack of discussion about the wounded healer.

Depression was chosen as a focal point for this research in part because depression can be both a wound and the result of a wound. Depression is a common result of woundedness, and the language is broad enough to capture many different perspectives and therapist wound narratives. Also, the aforementioned commonness of the phenomenon in society made it a suitable candidate of focus.

Recovering from (and using) woundedness

As suggested by Zerubavel and Wright (2012), very little research has examined how therapists come to know they have sufficiently recovered in order to practice competently. Miller et al. (1998) examined a related concept with their framework for how mental health professionals become “wounded healers” especially as therapists-in-training. They cited Witmer and Young’s (1996) contention that students with serious problems were often drawn to the counselling profession.
Miller et al. (1998) viewed wounded healing as a continuum, which would allow for acceptance rather than dissociation of one’s own wounds, rather than a dichotomy. Their framework involved the importance of understanding “soft spots,” (p. 125) or places of vulnerability for the therapist who is entering a new system (such as a training facility) containing the types of power differentials that could lead to numerous losses and discrepancies between expectations and reality. They noted the troublesome and toxic environments of some training experiences that can lead to stress and burnout and critical incidents. When a critical incident occurs, if the response from authority is one of criticism rather than compassion and open dialogue, more emotional damage can result. Miller et al. (1998) noted that if wounds are to be healed, respectful dialogue between counsellors and counsellors-in-training must occur. The Miller et al. (1998) article, like many others (Anonymous, 2007; Deutsch, 1985; Gilroy et al., 2002; Pope & Tabachnick, 1994; Zerubavel & Wright, 2012), says little about how one knows one has recovered beyond noting the absence of the depressive state and cognitive difficulties.

Once the framework of the wounded healer has been established, how does the wounded healer use his or her woundedness to help their clients? Guggenbuhl-Craig (1971) discussed the power differential between the healer who wants to heal and the client who wants to be healed. Both of these are projections to an extent, and progress will not be made if the healer cannot balance these projections. Guggenbuhl-Craig stated that maintaining the presence of the healer’s woundedness would help to balance out these projections. Furthermore, a successful healer must keep in mind his or her inner patient and the client must
eventually understand his or her own inner healer. This is made possible as the healer is able to work from (and recover from) his or her vulnerable places of wounding.

Groesbeck (1975) described the wounded healer dynamic in therapy as a third force that is present between client and therapist. Similar to Guggenbhul-Craig (1971), Groesbeck argues for the healing power of transference in that the client is able to heal his or her own wounds as his or her own inner healer is being gathered into and accessed within the field of the wounded healer archetype.

There are both positive and negative effects from a professional perspective related to the wounded healer and his or her work in a clinical setting. On the positive side, research has pointed to increased empathy, warmth and genuineness (Gelso & Hayes, 2007; Peebles, 1980), improved sensitivity to the client’s needs as well as increased patience, self-awareness and focus on the interpersonal dynamic with the client (Norcross, Strausser-Kirtland, & Missar, 1988). Countertransference has been shown to have a positive influence on therapy at times (Fauth, 2006). And self-disclosure, if used appropriately, can instill hope and a sense of possibility for the client (Kirmayer, 2003).

Pope and Tabachnick (1994) noted the three most common benefits of recovery were self-awareness, self-confidence and improved skill as a therapist. The most harmful act performed by the therapists’ own therapist was sexual acts or attempted sexual acts with their client.

Similarly, Gilroy et al. (2001) reported that many therapists described both adaptive and maladaptive consequences of their own depression when working with clients. From the
maladaptive perspective, many respondents described memory problems, fatigue, low energy and motivation as well as being unable to maintain focus with the clients. Some doubted their ability to help their clients and felt hypocritical discussing empowerment strategies when they themselves felt so stuck. On the adaptive end, a number of respondents described increased empathy for the client, patience with their difficulties, trust in the process of therapy as well as greater appreciation for how difficult therapy can be. In relation to their colleagues, many reported fearing negative reactions if they divulged their depression, and that they might begin to question their professional competence. These therapists found that when they did divulge, their colleagues often did not listen or seem concerned, or seemed even intolerant of their symptoms. No specific improvements in collegial relationships were listed.

An example of a recovered therapist was provided by Adame (2014). The author demonstrated the relationship between recovery from mental illness and competent practice by focusing on how survivor-therapists’ unique experiential knowledge contributed positively to their work with clients. The article profiled one counselor, “Matthew,” who had been formerly hospitalized for a psychiatric break. He was told in hospital that his brain was “irreparably damaged” (p. 458). He used these experiences in his work as a counselor. Part of Matthew’s rationale to begin working was that “there was still a part of him that needed healing and helping others in similar situations was one way of addressing this part of him” (p. 461). Through recovery, Matthew learned to be more aware of countertransference. Adame noted that “there needs to be a place for madness in society” (p. 469).
In a similar vein, Sahpazi and Balamoutsou (2015) interviewed four therapists who had recovered from a relational breakup which they conceptualized as a “wound.” The therapists noted that their recovery from this experience “led them to ‘growth,’ and this experience has been transformative and valuable. This contributed to more understanding, and being a more empathic, congruent and helpful therapist” (p. 258). The therapists in this study were able to use their difficult experience in the service of their work with clients, incorporating wounding and recovery into their practice. As will be discussed in the next section, this recovery and incorporation of the wounds in an adaptive way into the practice does not always successfully occur.

**Risks of not being recovered**

While there are obviously risks for the therapist of not being recovered from his or her wounds, there are risks for the client as well. Miller and Baldwin (2000) cautioned against a lack of integration of wounds by the healer which could lead to a projection of woundedness onto the patient:

> If the wounded pole is not experienced or integrated by the healer, the wound is likely to be solely identified in or projected onto the patient. Projection of the healer wounds onto the patient is largely unconscious and is likely to occur in a number of circumstances, especially if both the helper and patient have something in common and consciously or unconsciously identify with each other. In such a case, treatment may be compromised through loss of professional objectivity (p. 248).
As a means to overcome this, Miller and Baldwin (2000) suggested that wholeness be the goal both for therapist and client. To this end, the authors viewed vulnerability not as a flaw but rather as a strength and a quality to be cultivated. They stressed the importance of “conscious inner attention” (p. 250) in order to more fully understand this vulnerability. With regard to the wounded healer, they stated that “recognition of the wounded-healer archetype signifies how we cannot altogether separate healer from the wounded one” (p. 250).

The conscious inner attention described by Miller and Baldwin (2000) can be understood to reflect Ogden’s (1994) description of the effort made by the analyst to “recognize, understand and verbally symbolize” (p. 3) for both analyst and the analysand the nature of the moment-to-moment interplay of not only the analyst’s and analysand’s subjective experiences, but also the “intersubjectively-generated experience of the analytic pair” (p. 3), by which he meant the analytic third. The ability demonstrated in this type of in-depth clinical activity would be difficult if not impossible to do were the analyst not in a suitable state of grounding and recovery.

Therapists who deny their own conflicts and vulnerabilities are at risk of projecting onto patients the persona of the wounded one with themselves as the one who is healed. This splitting can lead to a lack of acknowledgement of the client’s own healing powers, which fosters dependency as well as an inability to access and be aware of the therapist’s own wounds (Zerubavel & Wright, 2012).

Several scholars have made distinctions between the wounded healer and the impaired professional (Jackson, 2001; Mahoney & Morris, 2012; Swearingen, 1990; Wood, Klein, Cross,
Lammers & Elliott, 1985). At times referred to as troubled colleagues or distressed psychologists, “impaired practitioners are broadly defined as psychologists whose work is impaired or adversely affected by physical, emotional, legal or job related problems” (Nathan, Thoreson & Killburg, 1983 as cited in Wood, Klein, Cross, Lammers & Elliott, 1985, p. 843). According to Maslach (1982), impaired practitioners commonly experience burnout, which includes symptoms of emotional exhaustion, depersonalization and a feeling of reduced personal accomplishment. Miller and Baldwin (2000) noted that if both the therapist’s vulnerabilities and the patients’ pain are suitably attended to by the therapist, burnout can be avoided.

Some common negative effects of therapists’ woundedness in relation to their clinical work include a decreased ability to be emotionally present, poorly managed countertransference, overidentification with the client, projection and having a personal agenda in relation to the therapy process (Briere, 1992, as cited in Zerubavel & Wright, 2012). Wounded healers also run a higher risk of experiencing compassion fatigue when working with victims of crime and trauma (Pearlman, 1995; Salston & Figley, 2003). Despite these difficulties, many therapists never themselves seek treatment (Gilroy, Carroll, & Murra, 2002; Zerubavel & Wright, 2012).

Beyond these risks, as well as reasons not to attend therapy for a therapist is the difficulty and at times double standard mentality of a therapist as patient. This tension can be understood most readily by examining the notion of self-disclosure. Hill and Knox (2002) defined therapist self-disclosure as “therapist statements that reveal something personal about
therapists” (p. 256). The process of disclosure (i.e., when to disclose, to whom, and in what manner) can be challenging for anyone. Schulze (2007) noted that psychologists are embedded in a larger social context and as a result are susceptible to being influenced by the beliefs of that society. This can be indirectly seen in the double standard wherein therapists are often more understanding and empathic towards a client’s issues than they are towards a colleague’s (Zerubavel & Wright, 2012). Therapists who tell another therapist that they are depressed can face issues related to stigma, social taboos, perceptions of professional competence, personal blame, self-consciousness and gatekeeping responsibilities of the therapist to whom the disclosure is made.

The disclosure process is further complicated by the uncertainty of the recovery of the therapist. Zerubavel and Wright (2012) described four possible recovery trajectories, from best possible scenario to worst: posttraumatic growth, recovery, relapse, and chronic dysfunction. If the treating therapist suspects the client therapist is in the latter rather than the former camp, this might activate their gatekeeping responsibility, altering the tone of the dyad and making the client therapist perhaps less likely to share. Zerubavel and Wright (2012) noted that recovery is not linear and relates to a number of factors. Related to posttraumatic growth in the therapist, some therapists are able to use their recovery to help their clients recover, working as a catalyst for healing (Sedgwick, 1994).

The concept of recovery trajectories is useful for the purpose of this research in that, while not indicating how the therapists come to know they have sufficiently recovered, they
can help indicate whether and to what extent these therapists have or have not recovered sufficiently in order to practice competently.

Zerubavel and Wright (2012) note that “recovery is not necessarily linear or, when achieved, permanent, contributing to the complexity of assessing a wounded healer’s recovery status” (p. 485). Further, they note that “while psychologists can assess the wounded healer’s history of functioning, there is, inevitably, uncertainty about the wounded healer’s future trajectories” (p. 485). This research was interested in the middle space of that timeline, neither the past nor the future, but the present ability of competent practice and how the therapist knows they are in that space of sufficient recovery. Of the four recovery trajectories, the authors noted that relapse and chronic dysfunction are typically seen as indicators of returning or continued depression, whereas posttraumatic growth and recovery are typically seen as indicators of a movement beyond depression and into emotional wellness, even beyond that of the pre-depressed state.

Knowing one has recovered would seem to suggest a stability of sorts in relation to one’s depressive episode or experience. It would therefore seem important to make a distinction between stability and instability of recovery. To that end, Howard (2006) explored the temporal ambiguity of recovery identities, making distinctions between whether recovery is permanent/stable, temporary/fragile or not achieved at all. This uncertainty around the recovery leads to doubt and tension and can result in gatekeeping behaviour from fellow therapists. This is especially true if the wound is considered chronic and enduring (e.g.,
dysthymia) or if the wounds could easily become activated, such as a relapse into addiction (Zerubavel & Wright, 2012).

It is one thing for a therapist to understand his or her wound and to understand working with clients, but how does one know when one has recovered sufficiently to work competently? Certainly there are reasons to “not know” one’s own recovery (e.g., risks to examining oneself too closely). According to Emerson and Markos (1996), one risk of obtaining treatment for mental health professionals is they will find a flaw that will inhibit their own counselling practice. This desire to avoid finding a flaw could make these therapists less likely to begin therapy than the average lay person.

Another difficulty for the recovered therapist is simply stepping away from the “recovery identity”. Howard (2006) examined the question of how one exits from recovery identities such as that of an alcoholic or an anorexic. In this sense, the label itself was established in order to ultimately be transcended; it is a means to an end. For the wounded healer, a tension therefore exists between the need to accept and not dissociate the wounded self, but also to see oneself as a healer and not simply someone who is wounded. Howard used the terms expecting trajectory and accepting trajectory to describe this tension.

As noted earlier, Zerubavel and Wright (2012) have pointed out that limited research has been completed with regards to how the therapists’ own recovery process impacts their work with clients as well as how they know their recovery process is at a point where they can work with clients effectively. They also noted that little research has explored what it means for therapists to process or recover from their woundedness so that this enhances rather than
detracts from their ability to work with their clients. They noted that a common reference in the literature is simply a parenthetical comment about the recovery process of wounded healers. They referenced Gil (1988), who said that wounded healers are “familiar with the difficulties that survivors face, having experienced these difficulties and (one hopes) having worked through them” (p. 275). Zerubavel and Wright (2012) note there have been “surprisingly few detailed reports about what it means for a therapist to process, resolve, or recover from a wound in such a way that it might enhance, rather than interfere with, providing effective psychotherapy” (p. 483).

Of course, in some mental health fields, having a wound is seen as being beneficial. For example, in alcohol or substance abuse treatment or in the field of eating disorders, there is potential benefit for the client whose therapist has struggled with the same issue (Costin & Johnson, 2002; Jackson, 2001). However, in relation to depression work, the idea that a therapist has to have had their own experience with depression is less closely associated (Jackson, 2001).

Zerubavel and Wright (2012) note that psychologists do not respond to all wounded healers in the same fashion and proposed that these differences are based on perceptual differences about both the characteristics of the wound itself as well as how fully recovered the healer was (i.e., the “scar” that remains of the wound). They speculated that approaching the wounded healer with wariness or doubt implied that the wound had not truly healed and that the therapist was still vulnerable.
Conclusion

This literature review covered a number of topics relevant to the current research, including definitions and qualitative experiences of depression, the impact of depression on clinical practice, definitions and indicators of recovery, the process of knowing, definitions of competent therapy, what entails a competent therapist, and a discussion of the wounded healer paradigm. A number of points became clear through this review, such as the genuine difficulties that depression can place in an individual’s life yet the power that recovery and healing can create for both the individual wounded healer and for his or her clients. Competence was understood as an ongoing process involving several dimensions leading away from strict adherence of a therapy modality and “towards an embodied, experienced psychologist engaged in the moment with the full particularity of the individual before them” (Sharpless & Barber, 2009, p. 51). Awareness of recovery appears to be gained through a sense of a justified true belief that takes into account empirical evidence, deductive reasoning and authoritative testimony. A wounded healer is an individual who has transcended his or her wounding and is now able to use this wound as a strength in the service of his or her client. Keeping the duality of wounded and healer in mind for both the client and therapist appears critical to this end.

Given the importance that recovery from depression and other wounds can have on an individual’s own personal functioning and well-being (Andresen et al., 2003; Tedeschi & Calhoun, 2004), and more specifically on a therapist’s professional functioning (Aponte & Winter, 1987; Jackson, 2001; Nouwen, 1972), as well as the mental health of his or her clients (Briere, 1992; Zerubavel & Wright, 2012), it was difficult to understand why the mechanics of
how an individual therapist comes to know that he or she has sufficiently recovered and able to provide competent therapy have not been specifically researched in the literature to date. This was perceived to be a gap in the literature addressed by this study. The literature review helped inform the general structure of the process of inquiry and the specific research methodology chosen while also providing an interpretive context with which to help understand the interview data. The specifics of the research methodology are covered in the following chapter.
Methodology

The purpose of the current research was to gain insight into how therapists come to know they have sufficiently recovered from their depression in order to work competently with their clients. The primary aim of this study was to understand how they conceptualize this process. While Appendix C lists all of the research questions, the central question is: How do mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy?

This section will describe the qualitative grounded theory research methodology used to address the primary research question, the rationale for choosing this approach, limits of the methodology, ethical considerations for research in this area, an overview of the design, participant recruitment and data analysis, issues around rigour and trustworthiness and the researcher’s assumptions.

Rationale for Qualitative Approach

In order to answer the central question of how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy, this research utilized a qualitative approach. More specifically, this research followed a socially constructed, grounded theory methodology.

A brief definition of terms: social constructivism assumes that meaning is constructed by humans as they engage with the world they are interpreting, that this engagement is based on both their historical and social perspective and that the basic generation of meaning always arises out of interaction with the broader community (Crotty, 1998). The qualitative approach
adapts the assumptions of social constructivism in order to make knowledge claims based on participants’ perspectives by employing a number of data gathering techniques (Creswell, 2009). In this instance, grounded theory was the chosen technique due to its focus on deriving theory from the data and analyzing it through the research process (Strauss & Corbin, 1998). Strauss and Corbin (2009) noted that with this method, “data collection, analysis and eventual theory stand in close relationship to one another” (p. 12).

Within this framework, the research employed open-ended questions (see Appendix C) and attempted to let the data generate and drive the attempt to better understand the process whereby mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy. Implicit in this framework was the importance for the researcher to remain reflexively aware of his positionality and how his own experiences and background helped shape the data interpretation (Denzin & Lincoln, 2005).

In qualitative research, participants are considered to be the experts in their own experiences as well as collaborators in the research process (McLeod, 2011). Given this focus on the world as it is experienced by the individual, grounded theory fits well with this current research project on one’s subjective views towards depression and its benefits.

The decision to use a qualitative framework was suitable for this research for two primary reasons. First, qualitative research allows for in-depth description and insight into people’s experience. This is accomplished through a careful analysis of how social occurrences are made meaningful and how people interpret these experiences for themselves. McLeod
(2011) noted that qualitative research is a “process of careful, rigorous inquiry into aspects of the social world” (p. 2) with the goal of understanding how this social world is constructed. Stiles (1993) noted that qualitative research invited readers to enter into the world of the research participants. This perspective lined up well with this study’s goal of understanding the experience of therapists as they came to know they had recovered sufficiently from their wounds in order to practice competently with their clients.

The second reason for choosing this approach is that qualitative methodologies are well suited for examining minimally studied research areas or populations (Sciarra, 1999). As has been stated before, a review of the literature has suggested that the process of knowing that a therapist has sufficiently recovered from woundedness in order to practice competently has not been documented. Therefore a quantitative approach (i.e., using hypothesis testing to analyze relationships) appeared ill suited (Creswell, 2009). As Heppner, Kivlighan, and Wampold (1992) stated, “before one can test the adequacy of a theory in explaining a phenomenon, one needs a reliable and detailed description of the phenomenon” (p. 195). As the process of how a therapist comes to know they have sufficiently recovered from a wound in order to practice competently has not been adequately described in the literature, a qualitative inquiry appears appropriate.

Rationale for grounded theory methodology

Within the framework of a qualitative approach, this research is best suited for a grounded theory tradition of inquiry. Grounded theory was first developed by Barney Glaser and Anselm Strauss (1965) while researching terminal hospital patients. The constant
comparative method, a central feature of grounded theory, was first written about in their book *Awareness of Dying* (1965).

At its most basic level, grounded theory is a process whereby questions are asked, and initial data is gathered, analyzed and coded so that further data can be collected to fill in what might have been missing initially. Eventually concepts and integrated theories about the collected data are generated through this process. This end product can then be used itself to guide future grounded theory research. A mid-level theory is often generated, what Creswell (2013) referred to as a substantive-level theory “written by the researchers close to a specific problem or population of people” (p. 58). Strauss and Corbin (1998) note that grounding concepts in data is the primary feature of grounded theory. They also stressed the creative element of the researcher in how he or she gathers data from participants.

Grounded theorists shape their data collection from their analytic interpretations, and therefore, sharpen their observations. Furthermore, they monitor and expand ideas by collecting further data through a process known as theoretical sampling. Grounded theorists do not necessarily rely directly on existing literature to shape their ideas, as both the processes and products of research are generated from data and their own analyses. In the case of the current study, the literature review suggested a number of possible findings while also informing the research, yet both the processes and products of the research were generated and grounded directly from the data gathered and by this researcher’s own analysis. Third, grounded theory does not subscribe to conventional quantitative methods of verification. Grounded theorists do, however, engage in systematic comparisons between observations and
check their merging ideas with further specific observations. The data was analyzed from the earlier interviews and follow up with any new merging ideas with the newer interviews.

One of the key notions in grounded theory (Charmaz, 1994) is the idea of saturation (O’Reilly & Parker, 2013). As Morse (1994) argued, the aim of this type of research is to reveal shared patterns of experience within a group of people who share some characteristics. The sample size is adequate when sufficient data is collected and saturation occurs and variation is both accounted for and understood (Strauss & Corbin, 2008). In qualitative research, the investigator samples until repetition from multiple sources is obtained. It is felt that after interviewing this number, saturation is met (Charmez, 2006).

Considering that this study aims to understand the process of how a therapist comes to know they have sufficiently recovered from their depression in order to work competently with clients, grounded theory, with its emphasis on deriving a general abstract theory of a process in the views of study participants was warranted (Creswell, 2009). The multiple stages of data collection and refinement of the interrelationship between information categories was used as this researcher attempted to understand the process of knowing in regards to working competently with clients. Grounded theory is also primarily used for studies with multiple sources of descriptive data (Creswell, 2009). As each participant in this study was considered a separate data source, the methodology was suitable.

Grounded theory has been fairly well established within the qualitative research world and has been used to explore a diverse set of research questions (Charmaz, 2006). For example, grounded theory has recently been used to explore the social psychological process of men
who suffer from depression (Ramirez & Badger; 2014). Within the field of counselling and clinical research, grounded theory has been used to examine factors that promote counsellor competency when working with sexual minority intimate partner violence victims (Hancock, McAuliffe & Levingston, 2014) and to examine the process of how counsellors develop confidence in addressing the spiritual or religious orientation of the clients during therapy (Tillman, Dinsmore, Hof & Chasek, 2013). Specifically related to recovery (albeit of the client), a study by Dilks, Tasker and Wren (2013) used grounded theory to analyze therapy and recovery processes in clients suffering from psychosis.

**Limits of grounded theory methodology**

Every research methodology has strengths and drawbacks. This is true of quantitative and qualitative research alike (Charmaz, 2006). Thomas and James (2006) critiqued grounded theory on the basis that what it produces is purported to be theory of a process rather than the components of that process. They argued that the formulaic nature of the methodology prevented true knowledge from arising and instead that the formula perpetuated knowledge and processes already present in the literature. Others have noted that grounded theory relies too heavily on empirical data and in a somewhat rigid way opposes the use of preceding theories (Stern, 1994). Strauss (1987, as cited in Berg, 2007) considered many of the criticisms leveled at grounded theory to be better understood as misconceptions in that the critics did not appear to understand the nature of grounded theory. Strauss stated that common critiques of grounded theory, i.e., that it “is an entirely inductive process, that it does not verify findings, and that it somehow molds the data to the theory rather than the reverse” (Berg, 2007, p. 311) were in fact not true of the theory.
Despite the strength of grounded theory in relation to the research area, other methodologies were also considered in the initial proposal stages of this research, including narrative inquiry (Clandinin, 2007) and interpretive phenomenological analysis (Smith, Jarman, & Osborn, 1999). These types of approaches do allow for a qualitative investigation of the phenomenon and would have been suitable candidates for methods of inquiry. However, grounded theory was decided upon for the rationale stated above.

**Ethical Issues**

Ethical issues, such as the need to protect the participant, are of primary concern with any research project (Berg, 2007). When discussing topics as sensitive as depression, clinical work and unrealistic expectations of the mental health professional, this protection is especially important. As this study involved individuals who have experienced depression and could in theory be susceptible to an additional episode, this next section outlined safeguards put in place prior to data collection. Additionally, ethical approval was sought and approved from the University of Toronto Research Ethics Board as part of the research process.

**Risks and safeguards**

Talking about one’s own woundedness and recovery can be emotionally challenging and/or rewarding. As was emphasized to the participants in this study, the research did not require them to talk explicitly about their depression and woundedness. The focus instead was on the process whereby they came to know they had sufficiently recovered in order to work competently with clients. By inviting the participants to share however much or however little they wished about their own experiences with depression, the researcher attempted to help
them regulate their own comfort level with the material during the interviews (see Appendix B). Strauss and Corbin (1998) noted the importance of maintaining a balance between objectivity and sensitivity during the interview process. Again, as the focus was not on the depressive experience, if the participant was becoming upset during the interview, the researcher would check in with them and the interview could be redirected, paused or stopped depending on the need of the participant. Of note, the participants in each interview appeared sufficiently comfortable with the material discussed and no redirections, pauses or stopping of interviews were required.

Given the at times double standard between how the general population and mental health professionals are allowed to be wounded (Zerubavel & Wright, 2012), participants could have had concerns about issues of anonymity and confidentiality along with the purpose and intent of the requested data. To address these issues, a few points were important. Primarily, the notion of informed consent was stressed (Appendix B). The researcher provided both verbal and written information about the study and allowed for opportunities throughout the process for participants to seek clarification as needed. The researcher helped protect anonymity by assigning pseudonyms to the participants and obscured any identifying information to maintain that anonymity. The right to withdraw their data at any point during or after the interviews was also stressed.

A resource sheet was offered to the participants during the interview, though none of the participants ended up taking one (Appendix G). The researcher provided the participants
with personal contact information (Appendix B) in case they needed to contact the researcher after the research was completed.

**Study Design**

The research question underlying the proposed study was addressed by conducting in-depth qualitative interviews with participants who had personal experiences with depression and recovery and who work with clients in a therapeutic context. Interview data was analyzed for themes in accordance with the principles of grounded theory methodology (Strauss & Corbin, 1998).

**Participant characteristics**

Participants were ten therapists who had experienced symptoms synonymous with depression at least once in their adult lives and were able to speak about their recovery and how they knew they were sufficiently recovered in order to provide competent therapy to their clients. The rationale for selecting ten therapists was due to the nature of the proposed method of data collection and analysis (Charmaz, 2006). All of the participants were between their early 30s and late 60s. At the time of the interviews, two were in their 30s, two were in their 40s, two were in their 50s and the remaining four were in their 60s. Each of the participants had at least six years of experience working therapeutically with a community population with the high end of 40 years of experience. The mean years of experience was 17.5. Three of the participants identified as male and seven as female. Three of the participants were psychologists, three were physicians practicing psychotherapy, three were psychotherapists and one was a social worker/Gestalt therapist.
In line with the inclusionary criteria, each participant had a minimum of three years of experience as a mental health practitioner. Participants had at least one personal experience of depression from which they believed they had sufficiently recovered. The participants were asked to pre-screen themselves for any active symptoms of depression that could have complicated the research or posed a risk to themselves (e.g., suicidality). Each participant was currently working with clients in a therapeutic environment, some of whom presented with depression. For the purpose of the study, the participants were each able to speak functional English. A gender sample representing the weighted tendency towards female practitioners in the mental health profession (Willyard, 2011) was achieved. While a range of ages, educational backgrounds, years of working and preferred modalities was achieved, the primary ethnicity was white Canadians. Sexual orientation was not queried. There were no further exclusionary or inclusionary criteria. Basic demographic information about the participants was collected (Appendix D).

**Participant recruitment**

In line with qualitative research sampling guidelines (Berg, 2007), participants for this study were recruited using a site-based, snowball approach (Creswell, 2009). Participants were recruited by contacting a number of therapy clinics, agencies and other institutions within the greater Toronto area (GTA) as well as through the researcher’s extended professional network. As part of this process, both recruitment flyers (Appendix F) and direct contact through email (Appendix A) were utilized as a means of making contact with the prospective participants.
Given their public profile in the community, it was felt that direct contact to these prospective participant therapists was appropriate, and certainly as effective as placing flyers or other means of participant sourcing. An information letter was provided to potential participants as part of the process of recruitment (Appendix B).

**The consent process**

For the participants of this study, the introductory email included a brief description of the purpose of the study (Appendix A), the significance of the research to the profession, inclusion criteria for participation, the voluntary nature of the study, the ability of participants to withdraw from the study at any time before data analysis, the confidentiality of the data, the potential risks and benefits of participation, and the researcher’s contact information.

For those interested in participating, informed consent was sought. The participant consent form (Appendix B) explained in more detail the purpose, voluntary nature, termination options, confidentiality, anonymity, time commitment, and potential risks and benefits of the study. As well, the participants were advised as to how their information could potentially be used (e.g., conference presentations, symposiums, future publications). The six participants interviewed in person signed two copies of the consent form, one of which they kept and the other that remained with the researcher. For the four remaining participants interviewed via telephone (where meeting in person was not feasible), the researcher emailed them a copy of the consent form. These participants attached an electronic signature to this document and emailed it back to the researcher.

**The interview**
Prior to sitting down formally with the participants, it was important to negotiate access, or how the participants were invited to take part in the research. Measor and Sikes (1992) have outlined the research bargain and the need to discuss what would be gained for both the researcher and the informant-participant. As well, it was helpful for the participants to think about what would be discussed in the interview, as a way to prime and deepen the conversation. In this light, the researcher contacted the participant prior to the interview to discuss (via phone or email):

(a) Time commitment (60 to 90 minutes, plus potential follow-up via phone, email or additional in-person discussion).

(b) General focus and style of the upcoming interview.

(c) Expectations that both parties are bringing to the interview.

The average length of time for these interviews ranged from 60-90 minutes for both the in-person and telephone interviews. The in-person interviews took place (based on the participant’s preference) at either the participant’s home or office location. Before beginning the interviews, the researcher reviewed the purpose of the research, informed consent, withdrawal, confidentiality, anonymity and the potential benefits and risks in participating. Each participant stated that he or she understood the process and agreed to continue.

The researcher began the interview by building rapport rather than immediately asking about the topic of discussion. Consistent with grounded theory methodology, the specific direction of the discussion was tailored or modified as the interviews progressed and relevant concepts emerged and evolved (Strauss & Corbin, 2008). Over the course of the ten participant
interviews, the interview structure was fine-tuned as a result of participant feedback and emerging themes. For example, the initial two interviews did not ask directly about the participants’ experience of depression. However, after it became clear that details about this experience provided context for the conversation about knowing recovery and were therefore important to understanding the research focus, the researcher asked about this experience more specifically. It should be noted, though, that the participants continued to dictate the manner and depth in which this topic was discussed. Towards the end of each interview, the researcher asked the participants to complete the participant information sheet (Appendix D). For the four telephone interviews, the questions were read to the participants and the researcher marked down their answers on a copy of the information sheet.

At the end of each interview, the researcher asked the participant whether he or she could be contacted in the ongoing months should clarification on any points be required. Each participant agreed to this. In three instances, the researcher did email participants for clarification in line with the principles of selective sampling and constant comparisons (Creswell, 2013). Contact was made via email with three earlier interviewees after a potential subtheme emerged in two of the later interviews (re: the use of humour as an indicator of recovery). These three participants provided their perspectives on this topic, which aided in the analysis.

At the end of each interview the researcher also reminded the participants that they would be contacted prior to the end of the analysis stage for their continued consent. Towards the end of the analysis stage, an email reminder was sent out to each participant asking
whether he or she wished to continue their consent to have his or her information used for this research. Each participant continued to provide consent. One participant elected to first see the transcript excerpts from the interview being used in the dissertation. Once the researcher provided these excerpts, the participant granted continued consent.

Data recording

Due to the length of the interviews as well as the need to capture as much of the context and nuances as possible for later analysis, the interviews were audio recorded. While this had the potential to create a level of negative “artificiality” in the interview sessions, the benefits seemed to outweigh the costs. In the end, several participants noted that they essentially forgot about the presence of the recording device; based on these comments as well as the quality of the interview material gathered, it was reasoned that audio recording the sessions had minimal if any negative impact on the overall quality of the interviews. Brief note taking was also used, with special attention paid to changes in tone of voice, silences, body language and gestures, that might have been missed in the audio record of the sessions.

Data analysis

Proper research lays out the elements of philosophical ideas, strategies and methods (Charmaz, 2006). One of the general difficulties with qualitative data analysis is the power and direction that the researcher can take, in leading the data in whichever ways he or she prefers (Strauss & Corbin, 2008). Grounded theory research is certainly not immune to this difficulty. However, as others have argued, no social research is free of a contaminating bias (Whitehead,
While much of the qualitative research literature has focused on the techniques of data gathering, data analysis is of obvious and equal importance.

As the initial interviews were completed and transcribed, the data was analyzed using open coding grounded theory methodology. This process itself involved a number of structured yet flexible features. The process that this research followed involved a number of stages. According to Charmaz (2006), grounded theory begins with a research problem and possible questions. Data is then collected and coding begins. Importantly, the data was analyzed as it was collected (Charmaz, 2006).

A key component of grounded theory is coding. Coding involves the categorization and sorting of data into codes or labels that serve to separate, compile, and organize descriptive data obtained from transcripts and/or field notes (Straus & Corbin, 2008). Open coding “allows researchers to identify and even extract themes, topics, or issues in a systematic manner” (Berg, 2007, p. 205). Codes range from simple, concrete, and topical categories to more general, abstract conceptual categories for an emerging theory (Charmaz, 2006). Depending on the emerging category in question, these codes ranged from single descriptive words relating to labels of depression to entire paragraphs relating to elements of knowing recovery.

Memo writing is a part of the data analysis process and occurred on several levels. The memos were notes written about the process and the data, thoughts and comparisons that helped illuminate notions that may have been hidden otherwise (Charmaz, 2006). One purpose of the memo writing in this research was to raise the codes into tentative categories. It was a pivotal step between data collection and writing drafts of the final report and was important in
that it encouraged an analysis of the data and codes early on in the process before the data was set in place too firmly. The memos served later on as a check for the concepts. The memo writing was also a reflexive step, a way to take another look at the data while helping to increase the level of abstraction of the ideas. This researcher used memo writing extensively throughout the process, both immediately following each interview as well as between interviews when attempting to discover the categories and themes present in the interview transcripts.

Forced coding, otherwise known as reduction, was another important step in the analysis process (Creswell, 2009). At this point, a large number of possible categories for the data had been generated relating both to depression and the various indicators of knowing recovery. Again, through the process of constant comparison, categories were compared with one another to see how they clustered or connected. Memos were used at this stage as well. Attempts to identify some higher order of category were made, thereby collapsing and reducing the initial categories to form more general categories. Such categories tended to be conceptual in nature as they upgraded the sorting of data to an analytic level from one used to simply summarize rich data (Charmaz, 1994). Stern (1994) suggests that when these broader categories are obtained, the researcher may use knowledge of the existing literature to expand and clarify them and to familiarize himself or herself to ways of examining the emerging analysis. In the case of this research, the notion of depression and recovery was already well understood from a variety of perspectives, so a literature base already existed which was incorporated into the analysis.
Generated from this reduction in categories, a conceptual framework was tested by collecting additional data, which helped in some cases to prove and in other cases to disprove the framework hypotheses. This final step is called selective sampling, which involves collecting additional data in order to advance the theory (Strauss & Corbin, 1998). After this stage, the memos were reviewed and integrated into the concepts that were developed in the previous stages. Categories which could be refined, elaborated, and exhausted by the new data were preserved for the purpose of advancing the theory. Categories which could not be supported by the newly collected data were dropped. A good example of this process was evident wherein an earlier stage of the analysis considered four subthemes rather than the final three that remained at the end of the data analysis. The fourth subtheme tentatively generated was “non-relational feedback” and included elements such as the use (or nonuse) of medication, the process of time and the use of assessment measures as a collected subtheme for knowing recovery. Through the use of constant comparison, selective sampling, forced coding, memo writing, consulting with colleagues and relevant literature, this fourth potential subtheme was deemed to not be sufficiently supported as a separate entity, and instead elements of this tentative subtheme were clustered into other subthemes or else dropped entirely.

In this study, theoretical saturation was achieved once the researcher felt that the process of knowing recovery was understood sufficiently in its depth and complexity. This researcher hoped to better understand the process by which these mental health therapists come to know they have sufficiently recovered from their depression in order to work competently with their clients. This will be discussed in the results and discussion chapters.
Data storage/privacy

For each participant, the data included audio tapes from each session, notes from each session, the demographic information form, consent form, transcripts from each session, logs of any phone calls or emails made, photocopies of any relevant documentation brought in by the participant, as well as the participant’s information as it was analyzed into different forms to be written about in the research dissertation. Whenever not in use by the researcher, these items (as well as any other items/documents from the participants) were kept in a locked filing cabinet at OISE (room 9-164). As was made known to each participant, three years following the completion of the dissertation, all data relating to the identity of the participants will be destroyed. When writing about the participants within the dissertation itself, the participants are referred to by their pseudonyms.

Issues of Rigour and Trustworthiness

Knowing that a particular project is trustworthy is of course a critical feature of any research (Charmaz, 2006). Without trustworthiness, there can be no confidence in the process or the findings, making the application of these findings difficult to carry out. In order to address this concern, Guba (1981) and Lincoln and Guba (1985) designed a four component system for testing the trustworthiness and rigour of the method of inquiry as well as the arising results. Trustworthiness can be seen as a parallel to the criteria of validity and reliability central to quantitative research (Bloomberg & Volpe, 2008). Briefly, these four overlapping components are: credibility, transferability, dependability and confirmability. Credibility refers to the degree in which the findings authentically represented the participants, transferability indicates to what extent the findings can apply to other participants or settings, dependability
defines the extent to which the research process and procedures are transparent or traceable, and confirmability states the extent to which the findings are genuinely derived from the participants and the research inquiry rather than from the bias and preconceptions of the researcher (Lincoln & Guba, 1985; Petty, Thomson, & Stew, 2012). In the current research, each of these components of trustworthiness was attempted as discussed below.

**Credibility**

Lincoln and Guba (1985) have identified three activities that enhance credibility: prolonged engagement, persistent observation and triangulation. They argued that “it is not possible to understand any phenomenon without reference to the context in which it is embedded” (p. 302) and recommended investing time to learn the culture and testing for potential misinformation generated by distortions either from the researcher or the participants.

Prolonged engagement and learning the culture was one of the more straightforward components of the research because this researcher has been fortunate to interview and study fellow therapists. Through his own training and experience, this researcher understood some of the unique pressures and characteristics that make up a mental health therapy career. Furthermore, this researcher identified as having been wounded and being a wounded healer and so understands, at least in relation to his own unique experience, the process of recovery and the use of wounds as a strength in session with clients. This subjective experience was augmented through reading relevant literature, speaking to the dissertation committee and
other colleagues about the topic (separate from the interviews) as well as spending a significant amount of time with both the audio interview files as well as the written transcripts.

The second goal of prolonged engagement was to test for misinformation potentially brought about by distortions of the participants or the interview (Lincoln & Guba, 1985). Charmaz (2006) points out that constructive grounded theory research focuses on the intended meaning of words because meaning is how we make sense of intention and action. Throughout the process of interviews, this researcher continually referenced points made in earlier interviews with later interviews, seeking clarification and a nuanced understanding of the topic at hand. During interviews, this researcher often repeated back what was heard and attempted to remain present and open to the surface level of what the participants had to say as well as the deeper potential meaning behind their words. The researcher also contacted three participants after the interview through email seeking clarification on particular points of their interviews that were unclear after having read through the transcripts and listening to the interviews. The reading, re-reading, listening and clarifying stages as well as the immersion in the literature and culture of therapy aided in persistent observation, which also facilitated what Wertz (2005) referred to as the immersive experience of indwelling.

Triangulation involves “the combination of multiple methodological practices, empirical materials, perspectives and observers in a single study” (Flick, 2002, as cited in Denzin & Lincoln, 2005, p. 5). For this study, this researcher sought triangulation through the in-depth interviews and follow up responses from participants, becoming immersed in the data and the relevant literature, taking into account his own experiences as a wounded healer and speaking
with colleagues to get feedback on the topic and the progress of the research. Triangulation through debriefing (Lincoln & Guba, 1985) was also achieved through frequent discussions with this researcher’s dissertation supervisor as well as members of his committee. Their questions and comments helped expose and alter assumptions and weak points and potential blind spots that might not have been noted otherwise.

**Transferability**

Transferability refers to how much or how well the findings from the research can be extended to other participants, settings or studies (Lincoln & Guba, 1985). Charmaz (2006) noted that transferability is enhanced through the use of thick data and by situating a grounded theory in a specific context. This process was also discussed by Hjelmeland and Knizek (2010), who distinguished between statistical generalization and analytical generalization. They noted that the former is not suitable for qualitative work, but that the latter is in that it involves other researchers deciding on the transferability of one’s research. This research attempted to achieve thick data by generating detail from the interviews such that other researchers in the field would be able to conclude whether the results were transferable (Cohen & Crabtree, 2006). As noted earlier, the context from which this socially constructed grounded theory was developed has been laid out such that transferability is hopefully achieved.

**Dependability**

Noting whether the findings are consistent with the data collected or that there is a traceable path from one to the other is what is meant by dependability. Dependability can be enhanced by thoroughly documenting all activity from proposal writing, data storage and
analysis to theory generation and beyond. Lincoln and Guba (1985) referred to this as an audit trail, and this research attempted to make this trail as clear as possible throughout the research process. This involved keeping detailed notes of the progress and alterations made during the course of writing, especially in the emergence of themes and generation of the discussion and mid-level theory. Also, as noted earlier, this researcher sought feedback from a number of participants on points that were unclear during the initial interviews.

Another means of enhancing dependability was through researcher reflexivity. The reflexive researcher is one who is able to examine his or her assumptions and interpretations in order to help alter those assumptions and interpretations (Charmaz, 2006). The activity relates to the circular relationship between cause and effect. Charmaz noted that researchers can run the risk of elevating their own assumptions to an objective status if they not able to engage in reflexivity. This researcher attempted to adhere to the principle of dependability and attempting to be aware of his assumptions through frequent memo writing, speaking with his dissertation committee and other colleagues and reading broadly on the relevant topics of depression, competent therapy, recovery and the wounded healer paradigm.

Confirmability

Confirmability has been theorized to correspond “to the notion of objectivity in quantitative research” (Bloomberg & Volpe, 2008, p. 87) in that the outcome of the study is more than simply the net result of the researcher’s biases and preconceptions. This researcher attempted to maintain confirmability through previously mentioned methods of journal writing, reflexivity, discussions with the dissertation committee members, immersion in the
data, clarification from participants and relevant readings in the literature. The researcher’s own assumptions are laid out as clearly as possible to that end. This is discussed next.

**Researcher Assumptions**

Based on the researcher’s own experience with wounding as well as being a mental health therapist, three primary assumptions were held regarding the focus and population in this research proposal. First, the researcher views depression and other related forms of wounding as a difficult and at times traumatic experience while also being a normal developmental feature and a near universal experience within the human race. This assumption is based on the researcher’s own clinical experience, the research literature, and on what could be seen as a general knowledge of the human condition.

Second, the researcher believes, as suggested by other studies (Briere, 1992; Gilroy et al., 2002) that woundedness and recovery can make a therapist more empathic and indeed a better therapist in a number of metrics. This is not to say there is not a process of improvement as well as difficulty during this process; however, the end result can be a therapist who is more in touch with the process of therapy and who is therefore better able to enter into the world of his or her client.

Third, the researcher believes there is personal and professional risk to identifying oneself as a wounded healer. This is less so for more experienced therapists who have a proven track record (Zerubavel & Wright, 2012). However, it can be a risk to anyone’s career. Given that (from the first assumption) most people will experience some form of woundedness,
it would appear somewhat unrealistic and counterproductive to hold these therapists to an unrealistic standard. It is in part for this reason that this research was initially proposed.

**Researcher Background**

At the time of this writing, the researcher is a doctoral student in counselling psychology as well as a part-time therapist in a clinic in downtown Toronto. As a therapist, the researcher has noted the impact that his own mental and emotional state and background has had on his work with clients. The researcher’s own experiences with wounding have led to personal as well as professional growth as a psychologist in training and as such, the researcher is interested in understanding his own processes as well as those of others in the field. The researcher therefore brings both theoretical and phenomenological knowledge of both wounding and recovery processes into the research.

The researcher is aware that his personal experience provides both insight and potential bias in judgement regarding both research design and findings. As noted previously, to help mitigate this potential effect, the researcher has attempted to make these assumptions explicit. The researcher kept a research journal for self-reflection, and was in frequent dialogue with his academic advisors and therapist supervisor. Feedback was sought from a number of participants on key points from the interviews and feedback in a general form from the earlier interviews helped shape the subsequent interviews.

In this chapter, the qualitative grounded theory research methodology was described that was used to investigate the process whereby therapists come to know they have sufficiently healed in order to work competently with their clients. This chapter also discussed
the rationale for selecting the research methodology, the study design, details about participant recruitment, data collection and analysis methods and the personal assumptions of the researcher. The following chapter lays out the results from the participant interviews.
Results

The aim of this study was to gain insight into how therapists come to know they are sufficiently recovered from a depressive experience in order to practice competently. To examine this issue, the researcher conducted in-depth qualitative interviews with ten mental health professionals, each of whom, at the time of the interviews, had at least six years of experience working therapeutically within a community population. Graham, Mocha, Tallulah, Heather, Lucy, Jennifer, Peter, June, Kohnka, and Samuel (all pseudonyms chosen by the participants) had each experienced symptoms consistent with depression at least once in their adult lives and were able to speak about their recovery and how this influenced their work with clients.

The interviews were transcribed and the transcripts examined for themes, sub-themes and sub-sub-themes using grounded theory methodology. By outlining the themes that emerged from the interviews, this results chapter will present the ways in which these therapists knew they were sufficiently recovered in order to provide competent therapy and how their recovery process influenced their work with clients.

This chapter begins with a description of participants’ experiences with and understanding of depression as well as related factors that exacerbated or at least complicated their depressive experience, and proceeds to a review of the variety of ways in which these participants came to know they were sufficiently recovered from their depressive experiences such that they were able to provide competent therapy. This chapter presents participants’
responses as closely to their own language as possible with the goal of organizing the coded interview data thematically into two sections. These sections are briefly outlined below.

The first section of the results chapter reflects what participants said about their own depressive experience, ways in which they understood depression as well as events, factors and related mental health difficulties that exacerbated or at least complicated their depressive experience. It is important to note that as the focus of this study was not to examine depression itself, but rather the ways in which participants had come to know they were sufficiently recovered from their depressive experience as well as ways in which their recovery process impacted their work with clients, the research did not require them to recount their own personal experiences with depression. However, during the interviews, each of the participants spoke not only about their understanding of depression, but also their own experience with it. While some spoke about their own experience only briefly, a number spoke about it in depth. Besides describing their own depressive experience, many also offered labels for depression, thoughts on possible origins of depression, and alternate views on depression as well as contextual factors from their own lives. This section was valuable in providing context for the participants’ experiences with knowing their recovery and client work by understanding both as, in part, an outgrowth of those depressive experiences.

The second section describes the various ways in which participants came to know that they were sufficiently recovered from their depressive experience in order to be able to work competently with their clients as well as briefly discusses what was meant by the terms competent therapy and recovery. Participants shared a number of ways in which this knowing
arose. Many spoke about changes in intrapersonal functioning that suggested they were recovered from their depressive experience. This functioning included shifts in their emotional state, how they related to their own self, how they related to depression, their own sense of self-agency as well as behavioural changes. Another theme involved knowing recovery through changes in relational interactions. Participants spoke about adaptive changes and shifts in a number of relationships, including those of their clients, colleagues, supervisors, therapists, health professionals, family and friends. A third theme involved sensing recovery through noting changes in how they functioned professionally in session. A number of participants spoke about changes in their ability and use of therapeutic skills with their clients as a way of knowing they were recovering. This included the use of empathy and focus, the therapeutic use of humour and self-disclosure, increased self-awareness in the context of therapy, and therapeutic autonomy.

Overall, the participants revealed that their depressive experiences and their understanding of these experiences and related factors contained both common and unique characteristics. These interviews also revealed that the participants used several methods of knowing they were sufficiently recovered.

Understanding Depression

Participants were invited to explore their understanding of depression. Though not specifically asked about, all spoke about their own personal experiences with depression, some only briefly while others more at length. Many began by defining depression before turning to their own experiential knowledge of the subject, the impacts of the depressive experience on their lives and the impacts of related factors on their depressive experience. By offering a
summary of participants’ understanding of depression, this section will provide the context for and entry point to the subsequent sections, which focus on how they knew they were sufficiently recovered from their depressive experience in order to work competently with their clients.

Although the participants’ accounts reflected a broad diversity of experience, and included descriptions that varied in terms of circumstances and setting, they also contained elements of a thematic nature that, to varying degree, were shared among all the participants. Two sub-themes emerged as significant in the accounts of the participants in relation to depression. These sub-themes were termed *depression defined* and *depression experienced*.

**Depression defined**

Reflecting on their understanding of depression, most participants began by discussing and defining depression through a variety of means. These discussions included the following issues: describing depression, for example as “intense sadness” by Jennifer; labelling depression, for example as “major depressive disorder” by Samuel; thoughts on the origins of depression, including June’s point about “a genetic component”; and the perspective, shared by Lucy, of viewing depression as a natural human process, or in other words “painful” but not “harmful.” This chapter will elaborate on each of these issues and will present relevant excerpts from the participants’ interviews to illustrate their reflections on these issues.

**Descriptions of depression.** Each of the participants was able to provide descriptions of depression, their reflections highlighting the challenging nature of depression. In describing depression, participants talked about its wide-ranging effect on affect, energy, mood, thoughts,
relationships and outlook. For example, Heather described depression in terms of the “hopelessness” that can accompany a depressive experience. She also described the significant interference it creates in how people are “able to interact with the world”:

[I view] depression as a huge amount of hopelessness, you know that things are really bad and that they’re never going to get any better... It’s a condition that has a significant impact on people’s mood, thoughts and behaviour, and how they see the world and how they’re able to interact with the world while they’re being affected by that depression.

In describing the all-encompassing “mood, thoughts and behaviour” aspect of depression, Heather shared a similar sentiment as Samuel, who noted the “multi-factorial” nature of depression.

Samuel also referred to the elusive nature of depression in that it is “so many different things.” By this, he was referring to depression’s relationship to biology, genetics, social learning and modelling:

[Depression is] multi-factorial and it’s multi-lensed. There are many lenses to look at depression because depression is so many different things. It’s hard to pin it down because it’s a biochemical thing ... and then it has to do with loss and it has to do with social integration.

Whereas Samuel focused on factors such as “biochemical” and “social integration” to describe facets of depression, Jennifer noted that a depressive experience “may or may not be
connected to a particular trigger,” by which she meant that the factors Samuel mentioned may provide a foundational understanding of depression but are not always sufficient to explain how or why a depressive experience manifests itself in particular instances.

Jennifer described depression as “intense sadness that persists over a period of time but may or may not be connected to a particular trigger.” Jennifer also reflected upon the common experience of a mild to moderate level of depression that “most people would probably experience at some point in their lives whether it’s from a divorce or a death or getting fired or whatever.”

The “intense sadness” described by Jennifer is similar to June’s description that “part of what I call depression [is] the sense of no vitality, no energy.”

Tallulah brought in a description of depression provided by her therapeutic training. She noted the “fixed figure” of depression and how it takes away a person’s ability for “creativity, spontaneity and humour”:

In gestalt psychotherapy we refer to the neurosis [depression] as a fixed figure or a creative adjustment. When you are fully invested in your reactive neurotic response - creativity, spontaneity and humour don’t have room to evolve because you are too close to your fixed response ... Depression can be seen as fear that has gone unsupported.

In each of these accounts, Heather, Samuel, Jennifer, June and Tallulah provided descriptions of depression that highlighted its “multi-factorial” nature, the feeling of
“hopelessness,” “intense sadness” and lack of “energy” that accompanies it, as well as a number of real world experiences that can result in a depressive experience “whether it’s from a divorce or a death or getting fired,” as shared by Jennifer, but that do not necessarily need to be connected to a “particular trigger.” Through these descriptions, depression could be described as a fixed disconnection from the world as well as an altered view of the person and his or her abilities, thoughts and desires.

**Labels of depression.** In addition to describing depression, a number of participants provided a label for their own unique depressive experience. These labels were typically succinct but even in their brevity provided an authentic voice as to how the participants understood and viewed their own depressive experience. The specific label(s) that the participants provided varied from participant to participant, with the differences relating to a number of factors including age of onset, frequency and the severity of the depressive experience as well as exacerbating factors. For example, Graham shared that on the “PHQ-9 depression measure” he “certainly would have been scoring in the moderate range at different times” in the early years of his work as a therapist, even though “a lot of people wouldn’t have seen me as depressed.” He noted feeling “depressed” for a number of years in his early adulthood though not in late adulthood. In a similar fashion, Tallulah noted being “depressed” for most of her adolescence and early adulthood. She reflected coming into her own therapy training “in crisis” due to her depressive experience. Graham and Tallulah shared their perspectives, respectively, in the following two excerpts:
I would say for the first 12 or 14 years of my practice I would have had depression but I handled it by just being hyperactive. If I was to answer the PHQ-9 questionnaire – I certainly would’ve been scoring in the moderate range at different times. So until I started doing my own psychotherapy, which happened about 14 years in, I wouldn’t have even acknowledged being depressed. It was more retrospectively.

I was depressed from like aged 17 to probably 25. So I came to therapy training in crisis, in a sense I subconsciously wanted to work with clients in order to fix myself. I go through sad periods, I wouldn’t call it depression, but sad periods now.

Samuel labelled his own experience as “depression,” “major depressive disorder,” as well as “dysthymia.” He shared that he had experienced depression “a few times” over the course of his life though most notably during his time as an undergraduate in university. Samuel shared,

In my early twenties I had significant mental illness. Depression, social anxiety, generalized anxiety, depressive disorder, dysthymia. Not major depressive disorder at that time. I didn’t have much help yet, and then got worse, and had a major depressive disorder. And then in my early twenties I attempted suicide.

Similar to Samuel, June provided more than one label for her depressive experience. She shared that she had “depression,” “post-partum depression” as well as potentially a “bipolar” episode. She reflected that she has suffered from depression “on and off” for most of her adult life. She shared that she still struggles with “depression” at times. June reflected,
Because of my chaotic and disorganized childhood, I don’t think my depression would have ever been recognized until I had postpartum depression after my first child. If I was to go back in my own depression, it’s hard for me to pinpoint in youth. I think it would be more anxiety at that point. But I think what tipped me over was the birth of my first child. Then in my late 20s, I had an episode of almost like bipolar.

Although each of these participants used slightly different labels when referring to their personal depressive experience, there was a fair degree of agreement with the primary term of “depression” as well as with labelling depressive experiences exacerbated by external events such as childbirth. Many of the participants used more than one label in describing their depressive experiences, with some labels altering over time while others being used interchangeably to describe the same experience.

**Origins of depression.** Another category that emerged from participant reflections was the broader influences of factors such as genetics and childhood experience and larger social influences on the origin and expression of depression. For example, June pointed towards “a genetic component.” She reflected that,

For some families, there might be a predisposition to bipolar or mood disorders or alcoholism. However, one can never be clear on what aspect of [depression] might be learned behaviours to cope when you are growing up in an environment where there is depression and you’re seeing coping skills modelled that are not adaptive. These might shape your future relationship with depression but that tipping point is based on something that gets fired, at some point, because of the genetic component.
June pointed out a number of precursors to depression including genetic influences, family dynamics, poor coping styles and maladaptive modelling. She noted that while one could “never be clear” on the relative influence of learned behaviours or genetic predisposition, both played a role in the expression and experience of depression and that the “genetic component” activates “at some point,” leading to the “tipping point” of a depressive experience.

June also reflected on the role of early parent/child attachment styles in the origin and later expression of depression in children and adults. She noted that when the mother is struggling with her own depression and when mother and baby are not properly attuned, the baby “gives up” and can develop an “early priming” towards experiencing depression:

If you observe infants you know it starts that early in terms of misattunement. If there is misattunement very early on then you’re already being set up for [depression]... If you have a depressed mother you will find that the baby is trying to make eye contact but cannot because the mother is depressed. Eventually the baby may give up, so there is early priming. The baby is living with some type of depression already.

June noted that the misattunement starts “early” and that the baby “is living with some type of depression already.” She noted that this depression can carry on into the infant’s adult life.

Lucy shared her thoughts on the broader social influences on depression, noting that although depressive symptoms may not necessarily start out as harmful, “it gets harmful because of the judgements of others that there’s something wrong.” She shared that,
The whole system is constructed right now in a way that doesn’t accept depression as part of a human experience. So that we’re a pack animal, we need to be accepted. As soon as you don’t, well now you’ve got some really big problems. Not only are you not feeling great, the whole world says there’s something wrong with you.

Lucy reflected that what begins as a normal human experience is judged as “wrong” by others, with the person being told there is “something wrong” with them. Because of the need to be “accepted,” this person takes on that belief, and their relationship with their depressive experience shifts into something viewed as “harmful” by the individual.

Similar to Lucy, Kohnka also pointed to the socialized “political” influence on depression. She noted that our material and economic success has actually made depression more likely because we are no longer simply fighting for survival. We now have time to sit and reflect and to feel jealous and to “push” for more that we see others enjoying:

Well it’s also political, right? Since the society, especially here in North America more than in other areas, but since we are economically well enough we don’t have to fight for every piece of bread. So we have time. That’s when the feelings start to come up, and then they start to push.

Whether discussing genetic predispositions, parent/child attachment styles, coping patterns or even economic impacts, these excerpts share the idea that depression has a myriad of influences. While it can “never be clear” on exactly which influence most directly impacted their experience of depression, these participants seemed to believe that each played its own
role and that each should be examined to best understand depression and the depressive experience.

**Depression as a natural human experience.** While most participants defined depression in terms of descriptions, labels and origins demonstrating the difficult, isolating and impoverishing nature of the phenomenon, a number of participants defined depression as more of a “natural,” potentially adaptive “human experience”. Specifically, Tallulah, Lucy and Jennifer offered ideas that defined depression as a choice that is painful but not harmful and which in fact allows for personal reflection, rest and growth. For example, Tallulah reflected on the perspective shared by her therapeutic modality:

> In Gestalt we talk about depression but we have a very different perspective about depression than other models... Depression is seen as anger turned inwards, so in a way we really do see depression as a choice... On some level and depression really works for us.

This notion shared by Tallulah that depression is a “choice” that “really works” for people on a certain level was shared by Lucy, who reflected that “this is subtle perhaps, but, I don’t see [depression] as necessarily harmful. It’s painful, yes, but it’s also an opportunity. I see it as an opportunity for growth, because it calls you into yourself to do some examinations.”

In describing depression as “painful” though not necessarily “harmful” as well as “opportunity for growth,” Lucy echoed Tallulah’s sentiments and viewed depression not as a problematic disorder, but rather as an experience that can provide growth if the person takes the time to “do some examinations.” She then clarified her perspective by saying,
Depression is the name we give a collection of presenting symptoms. So that’s the medicalization part of it. My sense is this is artificial and not necessarily meaningful. We give it a name and then we think we can box it tightly. So I think there’s a continuum of human experiences from contented to not-so-contented with your life.

In Lucy’s position, the “medicalization” element of depression is connected in part to the diagnosis of depression. The fact that “we give it a name” and then think we can “box it tightly” is problematic for Lucy because these practices are “artificial” and do not allow for the “continuum of human experiences,” instead presuming that if we name depression, we understand depression.

After explaining this position, Lucy then stated her definition, “I see depression as a natural human experience. I see it as a system or a mechanism in a human being that alerts us to what we need in the world, because it’s painful and pain is a great teacher for human beings.” She further noted that “it’s one of the ways you learn the most quickly, and it’s very difficult to ignore what we need when we’re in pain... So, a very non-pathologizing, non-medical approach would be my [definition].”

Lucy’s definition of depression as a “natural human experience” allows for a more adaptive view that understands the phenomenon as a “mechanism” that “alerts us to what we need in the world.” The experience can be “painful” and “difficult to ignore”; however, in Lucy’s view, this is beneficial because pain “is a great teacher” and also provides a motivation to change. Her view is “non-pathologizing” in that she does not view depression as a disorder or a
disease as much as she views it as a “teacher” and a “mechanism” that allows for change and growth.

In a similar vein, Jennifer shared her perspective on the importance of seeing depression as an “intuitive” sign that a person needs to “rest and not do anything” at times. She shared,

If something negative happens that there is an event that triggered the intense sadness or a period of sadness it gives your body and your mind an opportunity to rest ... people always think “Oh you have to get out and you have to keep busy...” And I think that’s bullshit. I think if your body’s telling you to rest and not do anything and just lie in bed for three days maybe that’s exactly what you need. If we were to really connect with ourselves on an intuitive or instinctual level or you look at what the animals do when they’re ill: nothing.

The experience of a triggering event will impact people in different ways. Jennifer suggests that if the event triggers a period of sadness, it is important to listen to your body and to take the chance to “rest.” She disagreed with the idea that the solution for depression is to just “keep busy” and reflected that we can learn from other animals that seem to know on an “intuitive or instinctual level” that what they need when ill is to do “nothing” for a time.

In defining depression as a “mechanism” that can allow for “reflection,” “rest” and “growth,” Tallulah, Lucy and Jennifer provided a perspective that viewed depression as a “natural” reaction that can occur when “something negative” happens which can lead to a “continuum of human experiences”. This perspective suggests a “non-medical” and “non-
"pathologizing" view of depression and implies that simply because we have a “name” for depression does not mean we necessarily understand everything about it.

Reflecting on various means of defining depression as a starting point for understanding the phenomenon and its relation to knowing one’s recovery and client work, the participants provided rich and varied perspectives on the definition of depression. Four categories emerged from the participants’ comments: descriptions of depression; labels of depression; origins of depression; and depression as a natural human process. These four categories provided an important element towards a multi-layered definition of depression that is used as a foundational point for this research. The final section in particular, which defined depression as a natural human experience, offered a strong counter-perspective to the majority opinion that understands depression to be largely problematic and maladaptive and as such helped to provide a more nuanced definition of the phenomenon.

**Depression experienced**

The interview process provided participants with an opportunity to move beyond simply defining depression to exploring how the participants experienced depression in their own lives. This exploration was intended to reveal the essential, experiential features of depression as understood by the participants, which will provide a better overall understanding of depression and furthermore its relationship to recovery and client work. This exploration revealed two key issues: the participants’ personal experience with depression—the “painful experience” as noted by Mocha—as well as a discussion about childhood, adolescent and adult experiences that contextualized and at times exacerbated their depressive experience, for
example through “divorce” and “family stressors” as described by Peter. These issues are discussed in detail in the following section.

**Direct experience.** Each of the participants was able to share a variety of ways in which their depressive experiences directly manifested in their lives. Three areas in particular were identified as significant in relation to this category: the impact of depression on the participants’ cognitive abilities; the “loss of perspective” as shared by Lucy; the impact of depression on the participants’ emotional state, as Heather described feeling “stuck and overwhelmed”; and the behavioural changes such as Peter’s description of his body behaving in “all sorts of strange ways.”

**Cognitive state.** Reflecting on changes to their cognitive abilities and states in relation to their depressive experiences, Lucy, Kohnka and Heather spoke about the loss of perspective, the sense that awareness is being narrowed to a very small part of one’s life, a sense of confusion, an inability to “figure things out,” thinking no one wants to speak with you, an increased level of self-absorption or being in their own head, confusion and feeling like a “zombie.” Also discussed was the potential for mindfulness and a perspective shift.

Lucy shared that, while in the midst of her depressive experiences, she “did not have a perspective that there was a whole life.” She described that the depressive experience narrowed her perspective to specific elements of her existence.

In the deepest part of it, perhaps I did not have a perspective that there was a whole life. It brought me into a singular part of my life. The experience brought with it a loss of perspective. However, it also brought me directly into my life in the present. I became
more mindful of my own experience, how the way I was living my life and the way I perceived the way I was living my life was negatively impacting my life.

Lucy reflected that while the depressive experience created a “loss of perspective” it also had the opposite effect of making her “more mindful” of her experience. It brought her into her life “in the present.” This mindfulness helped her be more aware of how she was living her life and the way she “perceived” that she was living her life. This perception on a cognitive level was impacted both by her depressive experience as well as the mindful state that she was able to inhabit in part as a result of this depressive experience.

In Lucy’s description of how her depressive experience initially created a “loss of perspective” that brought her into “a singular part of my life,” she reflected the sentiment shared by Kohnka, who shared that while depressed, “I would not think that anybody wanted to talk to me. I experienced a sense of confusion, a lot of thinking, trying to figure things out that you cannot really.”

Kohnka noted that she was often confused and unable to figure things out because of both her impaired mental faculties as well as the nature of depression as being something that “you can’t really” figure out. She also spoke about her thinking that no one wanted to speak with her, the belief that she was not valued or noticed by others.

Heather noted that during her depressive state, she was “self-absorbed” and felt like a “zombie” who was not able to engage with life “right now”. She reflected that,

I was very self-absorbed. I was so focused on my own pain and situation that I couldn’t really listen to other people. I couldn’t concentrate on things. It just felt as if I was sort
of a zombie. I think that mental piece was really just like “This isn’t going to be something that I can do right now.”

With each of these participants, a depressive experience had a significant impact on their cognitive abilities. They experienced a narrowed focus on life, a loss of perspective, confusion, difficulties with concentration and figuring things out, increased self-absorption, a belief that no one wanted to speak with them, and the sense of being “sort of a zombie.”

Emotional state. Several participants described the experience of depression in terms of their altered emotional state. In particular, Peter, Mocha, Heather and Samuel shared experiences of emotional pain and wanting to avoid pain, attempts to suppress this pain that resulted in a suppression of their own life energy, feelings of self-consciousness, failure, self-hatred, sadness, and loneliness, as well as feeling both emotionally triggered by events and stuck with a lost sense of optimism.

These emotions were not always viewed as problematic. For example, Mocha noted that her experiences were “painful” but that she also viewed them as “learning opportunities” rather than experiences to be suppressed. She shared that “it was painful at times for sure. My depression experiences were just kind of lows and learning opportunities, that's the way I was framing it, and continue to actually.”

Unlike Mocha, Peter responded to his emotional pain through attempts to avoid them. He reflected upon his felt sense of “not wanting to go into” his painful emotions and also made attempts at “suppression” of these feelings,
[I had] a sense of not wanting to go into the emotional aspect and, I guess suppression of my emotions and feelings... Not wanting to experience [my emotions] which really ends up being a kind of a suppression of my life energy. Living my life on the surface...

That was okay. It wasn’t great, it wasn’t bad.

In his efforts to avoid his own depressive emotions, Peter ended up suppressing his own “life energy.” He explained that as a result, he lived life “on the surface” and so it was an “okay” life which “wasn’t great” but also “wasn’t bad.” While Peter was able to suppress and avoid his emotions to some degree, Heather experienced an intensely acute trauma in the sudden death of her infant daughter, which prevented her from being able to avoid or suppress her emotions.

Following the death, she shared that,

My emotions were so intense, I would be crying regularly and at the drop of a hat. I would think of something, I would see something, I would hear something and it would sort of trigger memories and trigger depression. I felt stuck and overwhelmed which was such a change because I was always a very optimistic person.

According to Heather, her depressive experience took her regular “optimistic” mood and replaced it with a sense of being “stuck and overwhelmed.” She described crying regularly due to her “intense” emotions and the ease with which she would be triggered by events and people around her.

In a similar manner, Samuel described how hopeless and futile he felt during the time he was contemplating suicide. During this time, he shared that,
Every moment was sort of painful. My worst day in the last year, couple of years, was better than every day at that time. I experienced a massive amount of self-consciousness, self-dread, self-hatred, futility, hopelessness, a need to get away from the pain. I felt I was like a complete failure.

Samuel explained that while he was depressed, his emotional experience was largely one of self-consciousness, self-hatred, hopelessness and pain from which he wanted to escape.

Each of the participants expressed fairly significant changes in their emotional state, whether that was feeling generally painful, self-conscious, hopeless, stuck or overwhelmed. These feelings were suppressed and avoided, life was just “okay” or joyless, and the participants’ usual sense of optimism and energy was absent during these depressive experiences.

**Behavioural state.** The final category that arose from the participant interviews was the impact of depressive experiences on participants’ actions and bodily functioning. Several participants discussed behavioural elements of their depressive experience. In particular, Graham, Peter, and June described efforts to avoid depression through a variety of behaviours, a bodily awareness of depression, “strange” body reactions in relation to depression, poor sleep behaviours, reactivity with family, and self-isolating behaviours.

Graham noted that depression impacted his behaviours largely in terms of his efforts to avoid an awareness of this depression. He described a number of denial strategies he used to improperly care for himself while avoiding his depression, including “drink” and “smoke” and “sex and all those things”. Graham shared:
In looking back I just got aware of just having this internal dead hand on me. A sense of darkness and I would try and deny and drink to be happy and smoke and sex and all those things to distract myself from it. Once I became aware of the depression it became harder [to distract myself] as I started being more tuned in to how I was feeling when I started being aware of what was going on in my body.

He noted that as he became aware of a felt sense of “this internal dead hand on me” he was less able to distract himself with these behaviours. He noted that “once I became aware of the depression it became harder [to distract myself].” Graham also discussed the role that his awareness of “what was going on in my body” had in his relationship to depression. By this he was referring to the negative impact of these maladaptive behaviours on his health as well as the bodily sensation of depression.

Continuing with the idea of bodily sensations, Peter noted that during his depressive experiences,

My body would just express itself in all sorts of strange ways. One day I started to vomit every 15 minutes for 24 hours. I was so weak, I couldn’t stand up and had to go the hospital to get rehydrated. That happened twice. On another occasion, my body started to go into this shaking business and it just shook and shook and shook into this crescendo of shaking. In retrospect there was just a lot of emotional energy which had got pushed down.
Peter noted that his body behaved in “all sorts of strange ways” including vomiting and shaking that he at first was unable to explain. These behaviours were unfamiliar to him but he finally realized that they were the result of “emotional energy” which he had “pushed down” until this energy was no longer able to be contained and manifested itself in this physical manner.

In a similar way, June also reflected upon containment attempts that eventually led to a “tipping point” during her postpartum depression. June shared that,

For a time I can handle it, then I hit a tipping point where I am not being able to sleep and then being very irritable and unable to cope with very much; self-isolating. Feeling like I need a lot more sleep and harder to function. Crying more easily than usual, a real sense of having to conserve my energy. More reactive with my children. More reactive with my husband and not as patient.

While June’s particular physical manifestations were different from Peter’s, her “tipping point” led to crying, more reactivity with her family, loss of patience and irritability. She attempted “self-isolating” tactics such as sleeping as ways to cope with these feelings however, she was unsuccessful.

Common amongst the participants’ reflections in this section were unsuccessful efforts to avoid or contain the depressive experience. These efforts led to either “strange” physical manifestations, or else irritability and reactivity and self-isolating behaviours. The participants described in various ways being unable or unaware that they should care for themselves
properly. Attempts were made in various other ways such as drinking, smoking, sex and other distractions.

**Contextual factors.** Over the course of the discussion on depression, each of the participants recounted to some extent experiences, factors and events that exacerbated or at least complicated their depressive experience; whether that was “shit” that happened during Tallulah’s childhood, another mental health issue like Samuel’s “social anxiety” as an adolescent, or Peter’s “break up” as an adult. While not direct experiences of depression, these factors were certainly related to the depressive experience. This category divided further into two sub-sections: childhood and adolescent experiences and adult experiences. Both sub-sections are discussed below.

*Childhood and adolescent experiences.* The experience of having lived through a difficult childhood and adolescence was common amongst a number of the participants. Some only mentioned this fact in passing, whereas others reflected upon this in more detail. Tallulah, Samuel and Kohnka shared difficulties with family dynamics, related mental health difficulties, various traumas and unsuccessful attempts to receive self-care. Tallulah shared her experiences of a disorganized childhood and adolescence. While not stating explicitly what she experienced, Tallulah noted that,

All my shit happened in my childhood and my teens. I had difficulties with my mother as well and she was not supportive of me. Unfortunately, at the time I did not have the skills to cope with what I’d been through, so instead I smoked pot and just sort of checked out of my teens.
She described both her difficulties as well as a method of dealing with these difficulties. Tallulah reflected that she had undergone “all this shit” from her childhood and teen years. She lacked the support of her mother who also appeared to be an additional source of stress. Tallulah noted her lack of skills in being able to handle this “shit” and instead turned to “pot” and “checked out” of her difficult teen years as best as she could.

Similar to Tallulah, Samuel described difficulties in his childhood and a non-supportive home environment. He reflected that,

There was social anxiety and generalized anxiety stemming from my early years. My childhood was pretty rough. I think I had dysthymia since I was a kid, maybe even depression. Our family dynamics [growing up] was you don’t complain about anything. You could say positive things but you couldn’t say negative things.

Samuel shared that his “family dynamics” involved not complaining and a level of forced positivity wherein authentic communication was not possible. He also described suffering from “generalized anxiety,” “dysthymia” and “maybe even depression” as a child. Likewise, Kohnka also reflected that she struggled with “some anxiety” and that she was “very depressed” during her childhood and adolescence. She shared that,

I was medically traumatized. I spent 18 months in hospital as a kid having major invasive procedures done to my sinuses but I had no concept at the time that I was traumatized, as if “it’s normal” so instead I just shut down. My parents were Jewish and there was also a lot of trauma from the war, so family trauma. I would also say there was some anxiety in my childhood. As I got older I wanted somebody to take care of me, so what
would I do? I would project on people and I would take care of them, right, and that was a primary relationship with my parents even though I was very depressed.

She described a number of issues including being “medically traumatized,” “family trauma” from her Jewish parents’ experience in World War II, “anxiety” depression and an imbalanced relationship with her parents whereby she “would take care of” her parents and others in the hope that they would take care of her.

These participants each expressed difficulties in their childhood and adolescence that complicated and perhaps exacerbated their depressive experience. They reflected upon the lack of coping skills to handle stressors, turning to activities like pot smoking, as well as unsupportive parents and home lives, inauthentic and falsely positive “family dynamics,” related mental health difficulties like “generalized anxiety,” “medical trauma” and shared “family trauma” and repeated attempts to acquire self-care through the caring of family and others.

*Adult experiences.* Several factors were discussed by the participants in relation to contextual factors stemming from their adult life that exacerbated or at least complicated their depressive experience. Mocha, Graham, and Peter reflected upon relational difficulties, lack of confidence, divorce, the loss of a child, facing personal bankruptcy and difficult decisions about how to alter their lives. For example, Mocha shared that as an adult she was active in “relationships” and “situations” that she did not handle very well. She shared,

I tended to create situations in my life that would eventually make me pretty distressed and pretty depressed. Not handling relationships or situations very well and not
knowing how to get what I wanted. I was fairly withdrawn and not really showing much
of myself, and not very confident.

Mocha tended to react to her experiences by becoming “fairly withdrawn and not really
showing much of myself.” She also struggled with feeling “confident” and was not
knowledgeable about how to “get what I wanted”.

As an adult, Graham also struggled with relationships, namely his first marriage. He
reflected,

I was sort of an ADHD type of person. I was moderately depressed but I never received
treatment. A lot of it was situational – I also lost a child. And there was a very
dysfunctional marriage that was pretty constantly painful. But I did not receive therapy
for these until several years later. I eventually divorced and remarried.

Graham shared he struggled with “ADHD” related symptoms, the “loss of a child” and a
“dysfunctional marriage.” He noted that each of these experiences seemed to have a
cumulative effect on his ability to function and contributed to his depressive experience. Peter
also shared difficulty “handling” his relationship with his wife.

Similar to Graham, Peter also divorced,

I had what I called a “break up” as opposed to a “break down.” At the time, people
probably had thought I had gone insane, but I think I was “going sane.” I had been
facing personal bankruptcy - financially and spiritually and emotionally. Over time, I
made a conscious choice to sell my practice and I could at the time and out of that
money, I was able to live for six months and still sort of pay my alimony and all the
things that were necessary in terms of getting divorced.
He reflected upon experiencing what he called a “break up.” By this he was contrasting to the idea of a “break down” and noted that during the time he was getting a “divorce,” facing “personal bankruptcy” and selling his “[medical] practice,” he experienced an awareness, a “knowing” about his own situation that he had previously lacked. He noted that “at the time, people probably had thought I had gone insane, but I think I was ‘going sane,’” by which he meant that while his external life was stressful with the divorce and change of careers, he was beginning to feel connected to his life in a way he had not experienced before.

With each of the participants, depression was often situated alongside other difficult situations in adulthood including divorce, family stressors, personal bankruptcy, the loss of a child, other relational challenges and career changes.

In sum, participants encountered a number of depressive experiences as well as related mental health difficulties, events and factors that exacerbated or at least complicated these depressive experiences. Many participants spoke about the difficult nature of both the depressive experience and these related factors. A few spoke about more adaptive and less problematic elements to both their depressive experience and related issues. Overall, when discussing the experience of depression, participant interviews revealed two categories: direct experiences and contextual factors. Within these two sub-themes, five categories emerged: three categories in relation to changes in cognitive, emotional and behavioural states and two categories in relation to childhood and adolescent experiences as well as adult experiences, respectively. This section, along with the previous section on defining depression, helps provide an understanding of depression from the perspective of the research participants. This
understanding will be important, as the next section will focus on a variety of ways in which the participants came to know that they were sufficiently recovered from their depressive experience in order to work competently with their clients.

**Summary: Understanding depression**

Reflecting on aspects of knowledge and personal history of depression as well as related factors and events, participants provided rich descriptions of depression and helped to set the stage for discussions about knowing recovery and client work. While not specifically asked about, all of the participants spoke to some extent about their personal experience with depression as well as related factors that seemed to exacerbate or at least complicate their depressive experience. Many shared the difficult nature of their experiences, although some spoke about the self-reflectivity and personal growth that the experience provided.

Within the first sub-theme, participants provided descriptions of depression that focused on its multi-layered nature, the feeling of “hopelessness” and lack of “energy” that accompanies it and the “intense sadness” involved. Depression was viewed as something that prevented creativity, spontaneity and humour. Depression was described as a fixed disconnection from the world as well as an altered view of the person and his or her abilities, thoughts and desires. When speaking about depression, participants used labels like “depression” and “dysthymia” in describing their own depressive experience as well as labelling depressive experiences in relation to external events such as “post-partum” difficulties. Often, more than one label was used to describe the experience, and the labels used tended to change over time. Participants also reflected upon notions of larger antecedents to a depressive
experience such as genetic impacts, learned behaviours, coping patterns, parenting styles, misattunement, as well as larger economic and political impacts. While one could “never be clear” on exactly which influence most directly impacted the experience of depression, it was believed that each played a role. The judgement of others and the need to be accepted could also exacerbate the depressive experience. The final category viewed depression as a “natural,” potentially adaptive “human experience”. Participants offered ideas that defined depression as a choice that is painful but not harmful and in fact allows for personal reflection, rest and growth. In this instance, depression was viewed through a “non-medical” and “non-pathologizing” perspective. Overall, the four categories that arose from the discussions provided important elements toward a multi-layered definition of depression that is used as a foundational point for this research. In particular, the view of depression as “painful” but not a “harmful” human experience provided a counter-perspective to the majority opinion that understands depression to be largely problematic and maladaptive. This helped situate the understanding of depression in a more nuanced light.

The second sub-theme was a recounting of the participants’ experiences with depression and related contextual factors. In discussing their experiences with depression, participants reflected upon the loss of perspective, increase of self-absorption and idea that no one wanted to speak with them, as well as the sense of being “sort of a zombie”. They described confusion, difficulty concentrating, and the inability to “figure things out.” Participants also described experiencing significant changes in their emotional state, whether that was feeling generally “painful,” overwhelmed, “hopeless and stuck,” lacking optimism. In this state, life was viewed simply as “okay” and the depressive feelings were dealt with through
attempts to avoid or suppress. Participants reflected upon increased difficulty with “reactivity,” “irritability,” “vomiting,” “body tremors” and self-isolating behaviours. Drinking, smoking, sex and other distractions were also part of the depressive experience as participants attempted to contain or avoid the depressive experience. A number of participants also shared their difficulties not only with depression, but related issues that arose variously throughout childhood, adolescence or their adult years. The experiences varied, from related mental health issues like “generalized anxiety,” “medical trauma,” shared “family trauma,” to unsupportive families and unhealthy family dynamics, poor coping strategies like “pot smoking” and other attempts to acquire self-care as well as divorce, bankruptcy, career changes and the loss of a child. What these factors shared was the effect they had on exacerbating or at least complicating the participants’ depressive experience. This sub-theme, along with the previous sub-theme on defining depression, helps provide an understanding of depression from the perspective of the research participants.

This first section revealed the participants’ understanding of depression. The subsequent sections of the results chapter build upon this understanding of depression in order to more accurately explore how these therapist participants came to know that they were sufficiently recovered from these depressive experiences in order to work competently with their clients through an exploration of their definitions of competent therapy and recovery as well as how they came to be aware that they were sufficiently recovered in order to provide competent therapy.
Before examining how it was therapists came to know they were recovered, this section turns to a brief exploration of what participants meant by the terms *competent practice* and *recovery* and how specifically recovery relates to healing. The section then focuses on the means through which participants came to know they had recovered from their depressive experience in order to provide competent practice.

**Competent Therapy Defined**

Over the course of discussions about how participants knew they were sufficiently recovered in order to be able to provide competent practice, several participants shared their ideas about competent therapy, what it meant to be a competent therapist, and the ways one could distinguish competence from incompetence in client work. For example, Tallulah first and foremost described a competent therapist as one who formed a solid relationship with the client by maintaining a solid relationship with her own self. She stated,

Therapy is so relational and a lot of the success of therapy depends on the health of the relationship. So if I’m in a bad place then I’m not really nurturing that healthy relationship that is, from my perspective, the ground from which we work. So if that’s not there I don’t really believe people can do good work. You have to have a good relationship with yourself before you can have one with others.

Tallulah stressed that “a lot of the success of therapy depends on the health of the relationship.” She suggested that an incompetent therapist was someone who was “in a bad place” and therefore “not really nurturing that healthy relationship.” She stated that “I don’t really believe people can do good work” if they are not able to nurture a healthy relationship...
because from her perspective, the relational core was the “ground from which we work.” In a similar manner, Lucy stressed the importance of connecting with the clients and their strengths rather than viewing them as a “symptoms list” for competent therapy. She distinguished between competence and incompetence by saying,

Incompetence is running the symptoms list and then coming up with what is wrong with the person and trying to fix that... a flowchart or a checklist or whatever you’ve got. And that’s a really big problem in our profession, because it takes the individual you're sitting with out of the picture and places somebody else’s agenda on them, and that’s not very healing... So, competence in practice is really staying on that tender, tough edge of not becoming the expert in somebody else’s life, remembering that you're not the expert, they are. And capitalizing, understanding, trying to understand the client’s expertise and what they know, and then you can go to work.

Lucy shared her opinion that an incompetent therapist approached the client as a “symptoms list” in order to come up with “what is wrong with the person and trying to fix that.” She stressed that this method was “a really big problem” because it placed the therapist’s “agenda on them” in that the therapist determined both what the problem and the solution would be. As a contrast, she stated that a competent therapist was one who maintained the stance of “not becoming the expert in somebody else’s life.” Given that stance, a competent therapist could then try to “understand the client’s expertise and what they know.”
While describing the core elements of developing relationships and connecting with the client’s expertise as ways in which a therapist knows he is providing competent practice, Peter noted that at times he could not be certain he was providing competent therapy. When asked the question how he knew he was providing competent therapy, he responded,

Well, I *don’t* know. I just have the sense that when it was appropriate, I would share my journey... I mean I understand the perspective of: “Holy shit, I better be able to therapize. I better be able to fix that. I better be able to cure it and then maybe I might be a good therapist.” I understand that logic and approach, but when I entered into this profession I still had bills to pay and kids to look after, so I was willing to enter into the journey fully aware of how vulnerable I was, but making sure that I got proper support and help and feedback.

Peter approached the concept of knowing he was a competent therapist tentatively. He stressed that he did not “know” fully but suggested that a key element in competent practice was an ability to sense when it was “appropriate” to use certain techniques in session such as self-disclosure to “share my journey” with clients. He also noted that competent therapy involved the willingness to remain “fully aware of how vulnerable I was” as well as the practical element of “making sure that I got proper support and help and feedback.”

For these participants, competent practice was evidenced through an ability to maintain a relationship to the self that could then extend to the client as well as an ability to see the client as an expert in his or her own life rather than simply as a “symptoms list.” A competent therapist was one who maintained a tentative sense of his or her own competence, knew how
to use specific techniques when appropriate, remained aware of his or her own vulnerabilities and continuously received “proper support and help and feedback.”

Recovery Defined

When discussing their experience with recovery from depression and ways in which they knew they were sufficiently recovered in terms of their ability to carry on client work, a few of the participants began by exploring what was meant by the term recovery. These participants made distinctions between recovery and “growth,” “evolution” and life “adjustments” as well as the belief that humans are “geared towards growth” as opposed to requiring “medicalized” recovery. For example, Jennifer viewed recovery in terms of “healing.” For her, healing implied that there was a “change,” “growth” or “evolution.” She shared,

I would define it more like a healing process. Recovery sounds a little more medical, black and white. Whereas healing implies that there is some kind of a change, some kind of growth in a positive way. Or the word evolution in terms of one’s character or your inner strength or how well you know yourself.

This “growth” or “evolution in terms of one’s character or inner strength or “how well you know yourself” was for Jennifer more than simply “recovery.” For Jennifer, recovery suggested something “medical,” something that was “black and white,” whereas her understanding related to the idea of “evolution” with deep implications for “one’s character” or self-knowledge.
This perspective was reflected by Lucy, who believed that recovery from depression suggested a “medicalized understanding” of depression. She reflected that,

I think there’s a continuum of human experiences from contented to not-so-contented with your life and we can pluck symptoms out of there and say “Okay, this collection of symptoms means this.” But I don’t know that works for me. So the word ‘recovery from depression’ is a medicalized understanding, it reflects a medicalized understanding of depression. So saying “I’ve recovered from it” is problematic.

For Lucy, the “continuum of human experiences” covers people from “contented to not-so-contended.” She understood depressive experiences not as a “collection of symptoms” but rather as an aspect of that “continuum.” And so the idea of recovery was “problematic” for her largely because,

I don’t think there’s anything to recover from for myself. There is an experience I’m having and I need to understand it and I need to understand how it’s impacting my life. Is that the way I want to live my life? So it just calls us to make adjustments. Recovery is not necessary - it’s the process. We’re like an organism that is geared towards growth if we can actually examine our own experience.

For Lucy, there was nothing from which to “recover” but rather an experience that “I need to understand how it’s impacting my life.” She suggested that people have difficulties in life, “adjustments” that need to be made, but that it was a “growth” process rather than a depressive experience from which to recover. Furthermore, she reflected that we are “geared
towards growth.” In line with the sense of growth, Peter discussed recovery as a “journey” that was “never over.” He noted,

I think for anybody, the journey is never over and we’re always growing and learning and it just sort of dips up and down with – I think there’s this myth about, you know, a therapist has to be 100% self-aware and perfectly healthy, not depressed or anxious or anything, but I think that’s kind of a myth.

Peter described how not only was the journey “never over” but that the idea of a “100% self-aware and perfectly healthy” therapist was “a myth” suggesting that recovery was never complete because we are “always growing and learning and it just sort of dips up and down.”

Jennifer, Lucy and Peter shared that recovery was a less accurate description or goal in relation to a depressive experience. They felt it referred to a “medical” or “black and white” understanding of depression. Rather, they viewed depression as an experience to “understand” that “calls us to make adjustments.” The result of these adjustments can be “change,” “growth” or “evolution in terms of one’s character or your inner strength or how well you know yourself.” The fact that we are “geared towards growth” will make this process easier if we are able to “examine our own experience” with awareness. The idea that someone can be “100% self-aware and perfectly healthy” was seen as a “myth” because we are “always growing and learning.”

Knowing Recovery

Each of the study participants spoke about a variety of ways in which they came to know they had sufficiently recovered from their depressive experience such that they were able to
provide competent therapy. Their responses revealed a blend of experience and understanding, meaningful descriptions that encompassed a broad range of areas. Three key themes emerged in understanding how participants came to know they were sufficiently recovered: through intrapersonal functioning; through interpersonal relationships; and through client work.

The first theme highlights the role of the participants’ intrapersonal functioning such as changes in emotional functioning and how they related to themselves as indicators of their recovery. The second theme focuses on participants’ reflections on how relationship dynamics and feedback provided indications of their recovery. And the third theme explores how the ability to provide more competent clinical work through changes in therapeutic skills such as empathy and the therapeutic use of self-disclosure indicated recovery. These are discussed below.

Through intrapersonal functioning

Each of the participants knew they were recovering from their depressive experience through changes they experienced in their own personal functioning. The participants’ discussions in this regard centered on five ways of knowing recovery, these included experiencing changes in: energy and motivation, such as Kohnka’s sense of “this is what I want”; how they related to and trusted the self, such as Peter’s developing a “loving sense of self”; how they related to depression, for example, Tallulah’s noting that depression “is not always bad”; sense of self-agency, for example in Heather’s sense of “control” over her emotions and her actions; as well as changes in daily activities such as Samuel’s change from
“attempting suicide” to focusing on school. The participants’ thoughts on each of these issues are included below.

**Energy and motivation.** One common means through which participants sensed that their own recovery was occurring was by reflecting upon changes in their motivation, energy and emotions. Participants noted either an increase in “energy,” a return to emotions such as “desire,” “hope,” or “peace,” or that they “wanted” to be happy as ways of knowing that they were recovering from their depressive state. Lucy, Peter and Kohnka shared their experiences with shifts in their energy and emotions in relation to knowing they were recovering.

Lucy stated that she knew she was recovering when she felt “lightness, energetic lightness. I had more energy and I think that would be the key, so I just started having more energy for the world.” Her description of “lightness” and “energy for the world” were key for her and indicated to her that she could begin to engage with the world again rather than holding what energy she had back for herself during her depressive experience.

Kohnka reflected that her emotional shift related more to “hope” and that she “wanted” to be happy. When asked how she knew she was recovering, Kohnka articulated,

You need to understand that I had really hit rock bottom. I went for therapy and there was, I think it was hope - the light at the end of the tunnel. I still didn’t know how to be happy. I still didn’t know really what does it mean, but I was in a company of like-minded people in a therapy group, even though the way they were speaking was a completely new language for me, it somewhere triggered a feeling of “this is what I
want,” or “this is what I always wanted.” And I’m sure I had dreams about these things. I began thinking how to be happy.

Kohnka described a process that went from wanting to get better to having “dreams about these things” to concretely “thinking how to be happy.” She noted that this was entwined in her therapy experience that resulted in an emotional sense of “this is what I want.” She understood desire and thinking about happiness to be ways in which she knew she was recovering. Kohnka also reflected upon how therapy aided this shift in emotion.

Like Kohnka, Peter also commented upon a return of his sense of “desire,” that he “still wanted to have all the things that now I did not have” as a way of knowing that he was recovering. He explained that,

My inner feminine had finally arrived up and now I was in a good space so that desire to want to share my life with another was alive and well. When I really felt really comfortable ... when I had become at peace with my own journey and [was] back to that place of: I still wanted to be a dad. I still wanted to be a family man. I still wanted to be a husband. I still wanted to have all the things that now I did not have.

In his reflection that his “inner feminine” had “finally arrived,” Peter was referring to an aspect of himself that desired relationship, an emotional compulsion that had until then been missing. This sense of a returned desire also involved feeling “really comfortable” and “at peace” with his recovery “journey”. His realization that he wanted to be a father and husband and family man led to a powerful emotional experience. He elaborated,
I realized that a year or so before my father had died and I had no emotion at the funeral and I knew there was something wrong with that. And then my own emotions started to come back and what a relief to be able to have a good old cry. One of my colleagues was killed in a car crash and so I was bawling my eyes out, but I knew I was crying for my father as well. My emotions had come back to me and I felt so much more at peace with myself.

This powerful description of realizing he had “no emotions” at his father’s funeral and knowing “there was something wrong with that” shifted when “my emotions started to come back.” At this point in his recovery, Peter felt relieved “to be able” to experience and express emotions through “a good old cry.” A death of a colleague provided a catalyst for Peter to express sorrow over his own father’s death, and he reacted by “bawling my eyes out.” He felt that his “emotions had come back” and he regarded this as a sign that he was recovering from his depressive experience.

Each of the participants reflected upon a number of energy, motivational and emotional shifts that indicated to them that they were recovering from their depressive experience. These included a sense of “hope” and a “desire” to be “happy” or to be a “family man,” a sense of “lightness” and “energy” as well as the feeling that their emotions had “returned” through “the inner feminine”. The participants were finally able to experience and express these emotions.

Relating to and trusting the self. A number of participants described a shift in how they related to themselves as well as the development of a sense of trust in the self as means of knowing they were recovering from their depressive experience. This was in relation to a sense
of increased “love” and “trust” of self, a bodily sense of “well-being,” and an increased interest in various elements of self and ways in which the participants “thought about” themselves. Mocha, Heather and Peter shared their experiences with these types of changes.

Mocha reflected succinctly that she noted a “change” in how she thought about herself as well as a sense of physical well-being as means of knowing she was recovering from her depressive experience. She noted, “I mean there is a definite general change in the quality of my thoughts and how I think about myself. And there is a sense of well-being in my body.”

This change in “how I think about myself” and the sense of “well-being in my body” refer to a shift in how Mocha related to herself in terms of self-perception and also how this relationship and perception impacted her physical sense of self. This alteration in how she thought about herself and how it manifested physically in a sense of well-being was similar to Peter’s “journey” of recovery. When asked how he knew he was recovering, Peter articulated,

The journey started back to getting more of a sense of a self in a solid way. I felt so much more at peace with myself. That’s what I was now bringing into the equation, a loving sense of self into whatever aspect that I was doing and the spiritual aspect of health and life and living and mental illness, then it was a really important aspect to have a handle on.

Peter shared that he related to himself in a number of different ways through his recovery “journey.” As well as relating to himself in a more “solid way,” he described being “more at peace” with himself, “loving” himself and gaining a “handle” on various aspects of
himself including the “spiritual” and “mental health” aspects of his life. He stressed that this was “a really important aspect to have a handle on.”

As well as noting a sense of “well-being” and “loving sense of self,” participants noted specifically that feeling that they could “trust” themselves was an indication that they were recovering. Heather commented upon how her view and thoughts of herself shifted as she recovered from her depressive experience through her sense of increased “trust” in herself. She recalled,

It was just getting that trust in myself back again. I felt better just when it was kind of like, not totally winging it, but you know just being a little bit more free and flexible and that I will know if this isn’t working and if I need to change something or do something differently.

She noted that this trust in herself allowed her to be “a little bit more free and flexible” with how she worked with clients. In trusting herself more, she also had a sense that she would “know if this isn’t working and I need to change something.” This trust in self increased both her flexibility and awareness. The idea of trust was also reflected in Peter’s comments, which seemed at first glance like circular reasoning. He knew he was recovered, in part, when he was able to develop a sense of “knowingness” and to “trust” in that knowingness. He explained,

There was a knowingness that just came from within inside of me that was – and I’d had that knowingness show up a few times before and – just learning to trust that
knowingness. I mean it wasn’t a sort of an intellectual knowingness. It was a knowingness that came from deep inside me.

Peter noted that this “knowingness” was not simply “intellectual” but rather that it came from “deep inside” himself. His ability to “trust” this sense helped him know that he was recovering. Peter further articulated that,

There was an intuitive sense of something inside of me that was sort of guiding me. The other thing I learned, was learning to trust that process. And this intuitive sense of guidance seemed to be much more present in the height of the struggle than when things seemed to be settling down. As time went by, I would keep what was meaningful to me and then eventually getting to a place of saying, “Okay, it’s time for me to get on with things.”

In these excerpts, Peter makes reference to using a sense of “knowingness” and to “trust that process.” He described it as “guidance” that allowed him to know when it was “time for me to get on with things” in that he was sufficiently recovered.

The participants found that their shifts in how they related to themselves provided a sense that they were recovering from their depressive experiences. These shifts included changes in “how I thought about myself,” a “sense” of bodily well-being, increased “trust” in self, feeling “more at peace,” “loving” and having a more “solid” sense of self, as well as a sense of “trust” and a “knowingness that came from deep inside me.”
Healthy relating to depression. This category explored the change in participants’ relationship to their depressive experience itself as a means of knowing they were recovering from that experience. Participants knew they were recovering from their depressive states when they were able to see the benefits of depression, feel more able to choose whether or not to “go there”, give a name to this place such as their “safe little place,” “my hole” or “this massive secret,” and were able to talk more openly about depression. Tallulah, Kohnka and Samuel reflected upon their evolving relationship with depression.

For example, Tallulah emphasized that she knew she was recovering when she was able to find benefit from her depressive experience. She shared that depression “is not always bad, it kept me isolated and that’s what I needed for a long time.” She also noted that,

There is something about being in your 20s and being very self-focused ... definitely getting older, less self-focused and it’s not that the depression doesn’t come up, but it’s an old story now, I’m like “Oh there’s my safe little place and I’m not going to go there because I know what happens then.”

Tallulah noted that her relationship to her depression changed in part when she was able to see benefits of the experience. She also noted that “getting older” allowed her to realize that when her depression does “come up” she is able to relate to it differently by seeing it as “an old story now,” one in which she feels that she can choose whether or not she is “going to go there” because she is aware of “what happens.” That she was able to more purposefully choose whether or not to fully engage with her depressive experience was an indicator that she was recovering.
In a similar fashion, Kohnka commented that her ability to “get out” of the “hole” of depression was a sign of her recovery:

I described it as being able to—you know, I would still fall into my hole, into my depression, but I could get much faster out of it, so that there was the next step. And now it’s much more like I fall into the hole but I get a little bit down, but I have so much awareness that I wake up and I say, “Okay, just a minute, it’s all about you and you need to take care of yourself.”

Kohnka noted that she can still fall “into my hole” but that she is more aware of depression and this awareness allows her to have a conversation with herself about whether she wants to engage with this behaviour. She described this as “the next step” in her recovery process. She referred to her stepping away from the depressive experience as a “wake up.”

Samuel also explained how an increased awareness and an ability to “talk about it” with his family and friends provided him a sense that he was recovering:

Once I didn’t have this massive secret. It was all out and my family could come and visit me and my friends could come and see me, there was a kind of relief that the secret was out. I started to sort of have a different idea of what was going on... day treatment is like six hours a day of getting an understanding of other people... I could talk about it with friends and family and my therapist and then I started to read more about it and then I started to say to myself “Oh, I didn’t even know I was depressed.”
Samuel spoke about not even initially being aware that he was “depressed.” This awareness through his suicide attempt and subsequent treatment, reading, discussion and sharing provided a structure from which he could relate to depression in a more adaptive way. By not keeping “this massive secret” to himself, he was able to shift how he related to depression, and through this he became more aware that he was recovering from the experience.

The participants commented on how the variety of changes in which they related to depression made them aware that they were recovering from their depressive experience. They knew that they were recovering from their depressive experiences when they could see the benefits of depression, label the depression in new ways, feel more choice over whether to engage or “get out” of the “old story” more easily, and speak openly rather than keep their depression as a “massive secret.”

**Self-agency.** Another way in which participants spoke about knowing they were recovering from a depressive experience was through their increased sense of self-agency. This included the sense of “awareness” that they “should” be making changes in their life, the feeling that they were in “control” and “responsible” for themselves as well as certainly that they were able to make these changes. Participants also reflected on the sense that they were returning to “normal,” that they were getting “bored” and wanted to reengage with life. For example, Jennifer shared that she knew she was recovering through “awareness about what was good for me.” She described having,

An awareness about what was good for me and what was not good for me and what I should be doing and what I should not be doing. You just eventually get to a place
where you just start to feel like “Yes, okay, I think I’m where I was before the episode of whatever caused me to be depressed in the first place.” It was more just my own feelings.

Jennifer’s self-agency manifested itself as “awareness” of what was “good” and “not good” for her as well as what she “should” and “should not” be doing. Her ability to act in ways that were “good” for her provided a sense of agency that indicated she was returning to how she felt prior to the depressive experience. She could also reflect that her feelings were “just my own feelings” instead of objective reality.

Kohnka also referred to the importance of “awareness” and “making choices” because she was “responsible” for herself. She recalled feeling,

Awareness of what I feel in my body and knowing that I have a choice that I want to be happy, so making choices. Taking care of myself on a physical level, so food and exercise. Awareness that it is all about me and I am responsible for myself. Nobody else can do that for me.

This awareness of her own personal responsibility and agency led her to “making choices.” She discussed how this manifested on a “physical level” through her choices to eat better and exercise. Her self-agency also manifested itself through awareness that “no one else” could make her happy or could take care of her, as she was “responsible for” herself.

The theme of awareness and choice was also shared by Heather. She took her sense of agency over her emotions as a sign she was recovering. She noted that prior to her recovery: “I
knew when I was out of control, I knew when I felt like I couldn’t really control it. I don’t know in the moment if I sort of would realize like, “Wow I’m really in control of my emotions here.” But I felt more confident that I could control them.”

Heather had a sense that she was “out of control” prior to her recovery. She experienced an increase in self-agency through feeling “more confident” that she was able to “control” her emotions and her actions. Heather then explored the importance of confidence in herself as a means of knowing recovery:

I felt reasonably confident that I could do it [recover] and I think because I did feel more normal ... in the sense like I could feel happy again sometimes, I could not think constantly about what had happened, I could sleep better, I could do normal daily activities without too much effort ... I was starting to get bored. I think that’s it too, that I mean I was feeling restless and I needed to be doing more and sort of engaging more in the world.

Heather spoke about feeling “confident” and “normal” as markers of her recovery. This was also similar to Jennifer’s comment about feeling as she had prior to “whatever caused me to be depressed in the first place.” For Heather, her self-agency was evidenced through her ability to “not think constantly about what had happened,” that she could now “do normal daily activities without too much effort” and that she was “bored” and “restless” because she wanted to engage more “in the world.”
The participants referred to an increased sense of self-agency as a sign that they were recovering from their depressive experience. This self-agency was expressed through the participants’ awareness of what they “should” be doing, a sense that they were “responsible” and in “control” of their emotions and actions, that “nobody else” could do this for them and that they had the ability to make changes and engage “in the world” as they chose.

**Changes in daily activities.** This category focused on behavioural capabilities and concrete steps that participants commented upon in relation to knowing they were moving past their depression. These behaviours suggested to them that indeed they were recovering from those depressive experiences. These behavioural shifts included no longer using recreational or prescription drugs, eating better, attending yoga, being able to “pull” out of the depressive state and take concrete steps towards life and away from suicide. Participants also reflected upon the sense of enjoying both these changes and life itself.

Tallulah shared that a change in her recreational drug use was a means of knowing she was recovering. She shared that “I stopped smoking pot every day, you know which reinforces depression. It was no longer interesting to me to be like all fogged out, I wanted to be more clear.”

This behavioural change began with her being “no longer interested” in being “fogged out” and that she “wanted to be more clear.” Tallulah felt that her change in desire, which was reflected in her change in behaviour was an indicator that she had begun to recover from her depressive experience. It was a simple, though difficult behavioural step towards taking care of herself in a more adaptive way. Jennifer likewise described how her own ability to care for
herself as well as her ability to note whether that was happening were indicators of her recovery. She articulated,

For me it’d be more like how do I function all day up to now over the past week or two weeks. Am I eating or am I still going to yoga? Those kinds of things. How is the day to day functioning going? And once that starts to get back on track then you can look at your ability to help other people.

Jennifer tracked her behavioural shifts in terms of “day to day functioning.” Part of her behavioural change was to assess how she functioned “over the past week or two weeks.” This was done in part simply through checking in with her eating and attending yoga. She used these simple behavioral markers to assess her own recovery; she knew that once those behaviours started “to get back on track” then she would be to look at her “ability to help other people.”

Jennifer then proceeded to reflect further upon some simple behavioural changes and other “little tangible things” as markers for recovery. She elaborated that,

I know that I’m better because I got up out of bed and ate or I went to yoga and I didn’t cry that day or whatever it is. There are all these, yes, there are lots of little tangible things. Sometimes you just have to pull yourself out of it and be on your way... you can learn from that in terms of your own humanity.

Jennifer knew that she was “better” because she was able to engage with a number of behaviours; that she “got up” out of bed, “ate,” “went to yoga” and “didn’t cry that day.” She described these as “little tangible things.” She also reflected that her ability to “pull” herself
“out of it” and “be on” her way was a behavioral indication that she was recovered sufficiently from her depression, as someone in the midst of a depressive experience would be less able to “pull” themselves out of the experience.

June discussed how “reducing” her use of anti-depressant and observing how she felt “after coming off it” provided a sense of her state of recovery. She explained,

At different times I’ve had a solid period of two years on a medication. And then I’d test it out and go off, by reducing. If you’ve been on medication, if you reduce your dose and you do it with supervision, then you want to see how you feel after coming off of it. By the time it’s out of your system you can tell whether you’re feeling a noticeable difference or it’s done what it needs to do, because I know what my symptoms would be otherwise: Whether that’s feeling like I can’t get up to face the day, starting to cry a lot more, irritability. I might feel like a certain client is too much for me, like I can’t do this work.

June stressed the importance of going off medication “with supervision” and so provided an additional sense of recovery in that her doctor would not recommend this activity if they did not think she was recovering. She further described what while “reducing” her medication, she would check in to see whether her symptoms like “irritability” and “starting to cry” a lot more were returning and whether this was having an impact on her clients, or in other words, whether she was truly recovered or not.
Whereas June focused on a specific behaviour in her use of medication as her marker for recovery, Samuel reflected upon larger life goals, such as school and career. He noted that his ability to focus on these issues rather than obsessing over his planned suicide attempt, was a behavioural indication of his recovery. In his reflections, Samuel gave a dramatic before and after picture of the behaviours to which both depression and recovery led him. When asked how he knew he was recovering, he shared that:

Some of the reason I think that it happened is first of all I had decided I’m going to commit suicide and this was the right thing to do. However, once I woke up in the hospital I was quite lucky because the clinical director let me go back to school. As soon as I was not dead I changed – I was like, “Oh, I might lose my year. I don’t want to lose my year.” So right away I shifted back into goal-directed behaviour... I redirected my energies to finishing with school and so on and so forth.

Samuel commented that his depression led him to decide to commit suicide. However, once he had attempted it and “woke up in the hospital,” he quickly “redirected” his energies and changed his “goal-directed behaviour” back into “school and so on and so forth.” He felt that his recovery happened because of his decision to “do something” about his depression, even though that decision was to kill himself. He was able to sense his recovery from his depression in that he had subsequently become focused on going “back to school” and not losing a year.

Each participant described a change in his or her behaviours as a marker that he or she was recovering. For Tallulah and June, it was as the desire and ability to stop their recreational and prescription drug use. For Jennifer, it was a series of behaviours such as getting out of bed,
going to yoga, eating and being able to “pull” herself out of her depressive state. She noted that these self-helping steps were prerequisites to helping others. For Samuel, his behaviours went from suicide oriented to growth and learning oriented.

In sum, the participants reflected upon a number of ways in which they knew they were recovering from their depressive experiences through changes in their intrapersonal functioning. Some shared their sense of a change in energy and a “return” of motivation and emotions they described as hope, lightness, peace and desire for happiness and family as well as the arrival of the “inner feminine.” Participants reflected on feeling more personally grounded, self-compassionate, comfortable with themselves and less raw. They described being able to attend to various parts of themselves and that they had a more solid sense of self and were able to trust themselves and their sense of recovery knowingness. Other participants noted their ability to relate differently to their depressive experience through seeing benefits in their experience, reading about the topic, discussing depression with others, attending treatment, giving a label to depression and feeling more able to control how they interacted with it. Participants reflected that they had a sense that they “should” be acting differently, and that they knew they were responsible, in control, and able to make changes. Their self-agency was also reflected in the awareness that no one else was able to make these changes for them. Participants noted a number of behavioural shifts as indicators of recovery. They reflected upon simple daily behaviours like eating, exercising and pulling oneself out of one’s depressive mood, the cessation of recreational and prescription drug use and the shift from behaviours that were potentially self-destructive to growth and learning oriented behaviours.
With each of these aspects of intrapersonal functioning, the participants were able to elaborate upon a number of metrics that indicated recovery. However, these aspects related largely to personal functioning rather than to relational functioning and feedback. As such, this theme provided a starting point for further elaborations on specifically how participants came to know they were sufficiently recovered in terms of being able to work competently with clients. The next section examines the changes in a variety of relational dynamics between the participants and others that indicated to the participants that they were recovered from their depressive experience and able to work competently with their clients.

**Through interpersonal relationships**

Every participant reflected upon the importance of changes in their relationships in helping them know whether they were sufficiently recovered to work competently with clients. The participants spoke about a variety of relationships and how the specific feedback from them as well as changes in relational dynamics indicated to them their state of recovery. Specifically, four relational themes emerged from the participant discussions: changes in relationships with friends and family, for example with Peter noting that a particular friendship felt “normal” rather than “heroic”; the feedback of the participants’ own therapist and health professionals, for example Graham being told by his therapist that “you’re not ready right now and now you are ready” to work with clients; changes in the interactions with supervisors and colleagues, for example when Tallulah’s supervisor “refers clients” to her and invites her to “collegial” events; and changes in the client relationship, for example whether the client was
“coming back” to session as noted by Heather and whether Lucy could be “open” to the client without “taking on” their experiences. These are each explored below.

**Friends and family.** Several of the participants discussed how they knew they were recovering through changes in interactions with friends and family members. Whereas during their depression, they would relate through “isolation” or be unable to “cope” with family difficulties, their recovery was noted in part as a return their old selves and “having people around” whom they “care about.” For example, Peter reflected that the quality and the tone of his interactions with others shifted when he was recovering. He shared an example of how one friendship became “normal” instead of something “heroic”:

I don’t think we would ever sit and kind of go through some checklist, but as more about “Well, where are you now and what’s going on?” It’s more about catching up with my family and his family and just enjoying that sort of normal connection that I have with him as opposed to “We’re doing some heroic therapy.” It was more of the desire just to connect at an interpersonal level... that was a good marker for, “Okay, I seem to be coming through this.”

Peter stressed the informal nature of the relationship, that they did not “go through some checklist” but rather had a “catching up” about their families. This “normal connection” with his friend was a way he knew that he was recovering. The fact that he had “the desire” to connect was itself an indication to Peter that he was recovering, that “I seem to be coming through this.”

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This was similar to Tallulah, who shared that her increased “interest” in her family was a sign of her recovery. She noted,

The real sign was that I had interest in relationships again. So throughout my depression I couldn’t care less about friends or colleagues and spent a lot of time in isolation, self-protecting. And when I was done with that whole scene I really got interested in building a network, building community and that reinforces wellness for me, having people around and people who care about me and people I care about.

For Tallulah, she knew she was recovering not only in that she was simply “more interested” in relationships, but how she wanted these relationships structured. She spoke of a large contrast between “self isolation” and “self-protecting” and “building a network” that “reinforces wellness in me.” She did this by “having people around” who “care about me” and also whom she cared about. She took this change in focus and desire as a sign that she was recovering.

June had a sense she was recovering when she was better able to handle the stressors of family relationships:

Being able to cope with whatever my son was going through, being able to be emotionally available for my kids without being irritable or being impatient given their particular traits. That for me is an indicator. If I’m having difficulties in my home life, then that’s an issue because what am I going to be bringing to my client?

June found that “particular traits” in her children would make her upset when she was not sufficiently recovered. Conversely, she described “being able to cope” with her son’s issues
and being “emotionally available” to her children without being “irritable” or “impatient” were “indicator[s]” that she was recovering. She then reflected upon why this was important in relation to client work because if she was “having difficulties in my home life” then she was concerned as to what was she “going to be bringing” to her client.

Each of these participants shared that having an interest in relationships, specifically ones that “build community” and “reinforces wellness,” being able to “cope” and be “emotionally available” to family and to just be able to catch up with friends and not have to have “heroic” types of friendships were ways in which they knew they were recovering.

**Therapists and health professionals.** Feedback from the participants’ own therapists and health professionals was important for knowing recovery. Participants spoke about how they used the opinion of these relationships as a way to help them know they were recovered and able to provide competent practice. Specifically, the therapist provided a before and after sense, from “you’re not ready right now” to “now you are ready,” for Graham; or the therapist advised the participant she was not recovered because she did not have the “capacity to worry,” in the case of June. Health professionals helped provide knowledge of recovery directly through feedback as well as indirectly by giving a timeline and strategy for recovery.

When elaborating upon how his therapist helped give Graham a sense of his own recovery, he stressed:

> I took time off work to do my psychotherapy, for about six months. This was over 20 years ago. Going back to work after that... an opening up process happened during that time. I took that time before people around me said “Yeah, you’re ready to start up
again.” Specifically, my therapist saying “You’re not ready right now and now you are ready. We’ll give it a try and see how you do.” I think he was looking to see that there was a level of self-awareness that hadn’t been there before... And I think he could see there had been a transition that happened where I’d become aware that I might be one to please people rather than do what was appropriate.

Graham stated that he “took time off work” to undergo his own “psychotherapy” because of his depressive state. He underwent an “opening up process” while working with his therapist. His sense of knowing his recovery in relation to when he was able to return to work relied in part on “people around me” saying that he was “ready to start up again.” Specifically, Graham emphasized that his therapist’s opinion was critical in providing a clear distinction between “you’re not ready right now” to “you are ready” though even when returning to practice, his therapist still wanted to “see how” Graham was with the clients through continuing therapy. Graham believed that the indicator his therapist was looking for was a “level of self-awareness” that Graham had not previously possessed and that his therapist had seen “a transition” from wanting to “please people” to doing “what was appropriate.”

In a contrasting example, June stated that her group therapist let her know she was not sufficiently recovered when she was initially in her therapist training program. She commented that

My group therapist was the one who had to tell me that I was not going to move on to the next stage of the program. And he said something to me that I thank him for to this day. He later became my therapist. He said, “You don’t have enough meat on your
bones. You’re mothered out.” Initially, I was upset. I’d done my work. I’d done everything I have to do. “But you’re mothered out. You don’t have any meat on your bones to be worrying about a client and you need to have the capacity to worry, but you’ve got too much on your plate.” If you’re depleted, you really don’t have much to give.

June recalled being initially “upset” because she thought, “I’ve done everything I have to do” and she thought she was ready to start seeing clients. Her group therapist told her she “was not going to move on” because she was “mothered out” and had “too much” on her plate. This was his way of telling June that she did not have the “capacity to worry” and work with clients at that point because she was “depleted.” This feedback is something she continues to “thank him for to this day.”

In a similar manner as the feedback provided by therapists, a few participants said that they received feedback from other health professionals as to their state of recovery and ability to work with clients. For example, June sought her psychiatrist’s opinion of her state of recovery regarding client work:

I would talk to my psychiatrist about – you know, she knows I’m seeing clients. I’d have to say to her, “This is how I’m feeling. Do you think I can help somebody if I’m like this?” And she would say, “Well, yes, because you know what it feels like. You can empathize with what they’re feeling.”
June’s psychiatrist opined that June was sufficiently recovered and in fact saw a benefit in June’s depression in that June was able to “empathize with what they’re feeling.” This relationship was therefore one way through which June knew she was recovered and able to work competently with clients. Jennifer also spoke about meeting with her family doctor and the time she would need to recover. She trusted that once this time frame had ended, she would be sufficiently recovered in terms of day to day personal functioning. She explained that,

I had adrenal fatigue and I wasn’t sleeping and I was just basically exhausted. And so I needed the time to rest. And so three weeks was the doctor’s recommendation so that’s what I did... I just listened to his rationale because I have a good relationship with my doctor.

Jennifer relied on her doctor’s opinion that she would be recovered from her “adrenal fatigue” in three weeks’ time and would be able to return to working with clients. The plan they put in place provided her with a sense that after the three weeks off from work, she would be sufficiently recovered and ready to return to work. She “listened to his rationale” and trusted that after this time period, she would be sufficiently recovered and able to return to work.

Feedback from the participants’ own therapists was one way in which they knew they were recovered. This feedback helped clarify whether the participants were “ready” for practice through noting a “transition” in the participants’ ability “to do what was appropriate” with the client, or if the participants were not yet “able to move on” because they were “mothered out” and unable to properly “worry” and work with a client. Health professionals
helped provide knowledge of recovery through direct feedback as well as indirect feedback such as giving a timeline and strategy for recovery.

**Supervisors and colleagues.** A number of participants shared that changes in the dynamics of supervisor and collegial relationships were ways in which they knew they were recovering and able to work competently with clients. At times, this could involve the referral of clients and being invited to “collegial” events by the supervisor. In relation to colleagues, participants spoke of direct “feedback” on how the participants were relating to their clients as well as indirect feedback in how “open” and “clear the relationship feels.” Colleagues would also provide advice and perspective if “steps” were ever needed for recovery.

Tallulah elaborated upon how her supervisor knew she was recovering by reflecting on a few key indicators from this relationship, including the fact that he would refer clients to her, give “feedback around my strengths” and invite her to “more collegial things.” She clarified:

> It’s hard to pinpoint individual feedback. It’s been this long process and it’s still ongoing. But he refers clients to me now and I’m always like “Oh my god he doesn’t think I’m crazy.” Even though I come to him like a mess sometimes, I get a call from him a couple days later, “I have a couple, do you see couples?” so that kind of validation. [Also] a sense of feedback around my strengths … being invited to more collegial things with a supervisor, that’s always been a good sign.

Tallulah recalled that her supervisor did not provide direct “individual feedback” as to whether she was sufficiently recovered. Rather, the way in which he interacted with her indicated that he felt she was recovered. She trusted that her supervisor would not refer clients or invite her
to “collegial” events if she was still in the midst of a depressive state. These interactions provided “validation” for her and a “good sign” that she was recovering.

June also relied on her supervisor to help her to know she was recovering. Her supervisor helped her note, for example, whose “depression is whose” between her and her clients. She emphasized,

I am always checking in with my supervisor... to give me some feedback as to okay, if I’m working – first of all am I ready now to work with clients. There was always this ongoing feedback as to what my clients’ issues were – if there was depression involved. I’d be talking about my client’s depression, but my supervisor knows me so well that they could give me feedback about what’s mine and what might be the client’s, what’s being triggered in me, what I’m resonating with. That close contact with my supervisor helped me figure out whose depression is whose.

She pointed out the “feedback” that her supervisor provided, especially when discussing clients who were depressed, as that was something with which June struggled, as well as wondering whether she was “ready now to work with clients.” If she was still being “triggered” or “resonating with” an issue the client was dealing with, this “close contact” with her supervisor allowed for an awareness of “whose depression is whose” and to know whether she was sufficiently recovered.

In a similar manner to their relationships with their supervisors, participants spoke about how their collegial relationships provided a means of knowing their recovery and ability
to provide competent practice. For example, Mocha distinguished between “feedback” and simply “how clear the relationship feels” in reflecting upon her use of her therapy partner relationship on her state of recovery. She articulated:

For me it's not so much the feedback from my therapy partner, it's more how clear the relationship feels. If the connection is good, if we are having a really clear loving open kind of connection, it’s important because that's the way I'm relating to clients too...

And likewise with other colleagues, it's not so much their feedback, their saying “you're looking kind of down today.” Not like that. It's more if there's an open connected feeling between us then that's my feedback to know that I should be working with clients or I shouldn't be working with clients. And if not, I better do something to, or to shift something.

This “connection” was an important marker for Mocha. She did not need direct “feedback” from her partner or other colleagues as to her level of recovery, but rather could detect her state of recovery through whether the connection was “good” and whether she and her therapy partner had “a really clear loving open kind of connection.” This “open” and “loving” connection was also important to Mocha in her ability to provide competent therapy because “that's the way I’m relating to clients too.” So if she was not able to connect with her therapy partner, she would not be able to connect with her clients, which would indicate she was not sufficiently recovered. If she did not feel that “open connected feeling” with other colleagues, she may take this as an indication that she was not sufficiently recovered and therefore that she “shouldn’t be working with clients.”
Graham indicated that his therapy partner helped him know his own recovery because she “would sit in” on his sessions when he was returning to work after taking time off because of his own depressive experience. He reflected upon the change in interactions she had witnessed over the course of “the time I was off work” and how her feedback helped him know he was recovered. He explained:

Well, I’d met my therapy partner during the time I was off work doing psychotherapy. She was just learning psychotherapy and would sit in on my sessions and we’d give each other feedback... compared to my practice before I took time off, I think over this time she would see that there’d be less driven-ness to please. That I was being compassionate, being understanding, but not unconsciously trying to draw something from the client, which had been what I’d been doing before. That there was wanting to have my ego stroked in some way by being the white knight helping people. So that would be a critical part of it.

His partner aided in his sense of recovery because she was able to see a number of changes in how he interacted with clients. This included “less driven-ness to please,” “being compassionate,” “being understanding,” not trying to “draw something from” the client for his own benefit, and not “wanting to have my ego stroked” by being “the white knight helping people.” He noted that this was a “critical part” of what she noticed and how he knew he was recovered.

In a similar fashion, June noted that her group therapy colleagues helped her “know my depression and my recovery.” She spoke about:
The work that I studied in depth, it really helped inform me as to what I needed to do or whether I could be with clients. As part of our program, we were all required to participate in therapy for ourselves in a group. This group training helped me know my depression and my recovery because when I’m talking about my depression in group, I’m really talking about my depression and it’s helping me to talk about it. And I’m working through all kinds of family of origin issues, present issues in my relationships, and what I’m encountering in group as well.

June clarified that her “group” helped her know her level of recovery. She shared that through this group therapy and discussions with her colleagues, she worked “through all kinds of family of origin issues” and other difficulties that could interfere with her recovery. The awareness of her level of recovery and ability to work with her “depression” competently was provided through her work with this group.

Each of the participants described ways in which their supervisors and colleagues provided knowledge of their recovery. Referring clients, providing feedback on strengths, being invited to collegial events and providing a sense of whose depression was whose were all means that the participants drew upon to know their own recovery. Like their supervisors, the participants also discussed the importance of feedback and relational input from their colleagues as indicators of their own recovery. This included a sense of an open connection with therapy partners that would indicate whether or not the individual “should be working with clients,” as well as any substantial changes that their partner would notice. The manner in
which they interacted with their colleagues related to the way they also related to their clients, and these were all indications of their level of recovery.

**Clients.** The relationship most commonly commented upon as a means of knowing recovery by the study participants was the client relationship. More specifically, the participants described how changes in three client relationship dynamics indicated to the participants that they were recovering and able to provide competent practice. Based on the interviews, these three sub-themes were that: the clients were “sticking around longer” in therapy with Tallulah and that they would “refer” other clients to Mocha; that participants like Graham could see improvements and “changes taking place” in their clients; and that participants like June were better able to handle “ruptures” and other client relationship difficulties in a therapeutic manner. Each of these changes in client relationships and interactions indicated to the participants that they were recovering. Each is described below.

*When clients were returning and referring.* A few participants shared that they knew they were recovering sufficiently when their clients returned to therapy and referred others to therapy. Tallulah, Heather and Mocha offered their perspectives on what it meant when their clients were “sticking around,” “coming back” and referring new clients to the practice. This dynamic indicated recovery to these participants because when not recovered, clients were neither returning nor referring clients to these participants.

Tallulah reflected that she had a sense she was sufficiently recovered from her depressive experience because clients were coming back and not terminating therapy. Regarding this element of knowing recovery, she shared simply that “the only thing I can say
about that is that my clients are sticking around longer which is a good sign that you’re doing good work.”

Heather shared a similar insight. When asked how she knew she was recovering and able to provide competent practice she responded “the fact that... clients were coming back. If I stopped having a lot of people come back that would be some indication” of her lack of recovery. Both of these participants understood that their clients “sticking around” and “coming back” was an indication from a client dynamics perspective that they were sufficiently recovered from their depressive experience in terms of being able to provide competent practice. If they were not sufficiently recovered, the participants reasoned, these clients would not be returning.

On a related point, Mocha noted that she sensed her own recovery through the number of referrals she and her therapy partner received. She noted that “our work has come word of mouth, so becoming busier and busier I see that we're more and more effective because people won’t refer to us otherwise.” Mocha believed that the fact that clients and others referred people to their practice suggested that she was sufficiently recovered from her depressive experience “because people won’t refer to us otherwise.”

These excerpts provided to the participants a sense of their own recovery. That their clients were “sticking around longer” and “coming back” as well as that their clients would “refer” other clients to the practice were ways that the participants used to sense that they were recovered in terms of being able to provide competent therapy.
When clients were improving. As well as having clients continuing to attend sessions and referring other clients to the practice, a number of participants reflected upon how seeing improvements in their clients’ lives helped them know that they were sufficiently recovered from their depressive experience and providing competent practice. This included seeing changes in their clients’ lives, that the clients were bringing a “loving presence” into their lives and that the clients were “integrating information.” Changes were detected through “body language” and “energy” shifts as well as the clients’ belief that they could make changes. Feeling connected to and engaged with the client was an important way to detect these improvements. Participants noted that when they were less sufficiently recovered, clients were not showing these kinds of improvements.

Graham recalled how he knew he was sufficiently recovered in relation to working with clients when he could “see the results” in their lives. When asked what were the means by which he knew he was sufficiently recovered to provide competent practice, he articulated,

The one that comes up for me is where you just see the results in their lives and their families, and the changes taking place in their world. You see them actually processing and integrating information. What you want to see is them to bring a loving presence into their lives through their own internal self talk. And when you hear that happening then you know things are happening.

Here, Graham provides several ways in which he noted improvements in his clients’ lives. He talked about seeing “changes taking place in their world,” seeing them “processing and integrating information,” bringing “a loving presence into their lives,” and noting changes
in their “self talk.” That these things were happening in his clients’ lives were indications to Graham that he was recovering from his depressive state.

In a reverse manner, Heather noted that “if people really seemed to not be doing well,” that would be a sign that she was not recovered and providing competent therapy. She clarified:

If people really seemed to not be doing well that would be some indication. I have a lot of clients who are still not doing well even though they’ve been seeing me for a while just by virtue of their issue, but I have some who seem to be doing better. But if it felt like that wasn’t happening or if it felt like we weren’t connecting, that there just wasn’t an easy dynamic happening or that they seemed hesitant or angry or resentful or if I felt like I couldn’t remember what we had talked about or what was this or if I was feeling disconnected or bored, those kind of things would suggest I wasn’t there yet.

Heather noted that she needed to see some changes and improvement to get “some indication” that she was providing competent therapy and therefore that she was recovered sufficiently. As a means of being able to detect and be a part of these changes, she also reflected upon the importance of feeling connected to the client. She described how the client relationship would feel when she was not sufficiently recovered, that she “wasn’t there yet,” including a sense that “we weren’t connecting” or a lack of “an easy dynamic happening” or that the client seemed “hesitant” or if she were unable to “remember what we had talked about” or she felt “disconnected or bored.” Heather believed that these were all indications
that she and the client were not properly connected and that she was not sufficiently recovered and providing competent therapy.

For Heather, the improvement of the client could be seen through the “easy dynamic” and the fact that they were “connecting.” Similar to both Heather and Graham, June emphasized that the client’s improvement was an indicator of her own recovery. June spoke about both the verbal and behavioural feedback she receives from clients when asked how she knew she was recovered sufficiently to provide competent practice:

It might be something as subtle as “Boy, when I came in here I just felt awful and I just feel like my energy shifted” or, “I can take that one step.” It might be body language. A person comes in slumped over. By the time they leave you could see they’re sitting up. You can also get feedback … you have to hear from your own client, do they look – do they feel more depressed to you when they leave the room or is there a little spark there where they felt maybe more enlivened after the session. At the end of the session the depressed client feels uplifted because of my work with them… but you have to be sitting there waiting, totally present for when they do look at you and you have to be filled with life yourself.

For June, recovery involved being “filled with life yourself” and therefore able to be “sitting there waiting, totally present” for the client “when they do look at you.” When in that state of recovery, she felt more able to facilitate and note clients’ improvement through their “energy” shift, the clients’ ability to “take that one step” as well as their “body language.” These markers of client improvement indicated to her that she was providing competent therapy and
therefore was sufficiently recovered. She also stressed this improvement in terms of getting “feedback” from the client.

Each of the participants articulated a sense of knowing their own recovery through noting whether or not their clients were improving. This involved noting adaptive changes in their clients’ “families” and in their “world,” bringing “a loving presence into their lives,” noting an “easy dynamic” and getting feedback from the clients that they felt “uplifted” and “enlivened” because of the therapists’ work with them. Feeling connected with the client was an important element in being able to detect whether these improvements were present in the client’s life.

*When clients’ problems and criticisms were therapeutically handled.* One way in which a number of participants knew that they were sufficiently recovered and providing competent therapy was when they were able to deal with their clients’ issues and criticisms therapeutically. Participants revealed that client dynamics could often be difficult, for example with clients “yelling at” and being “furious” with them, as noted by Tallulah and June, respectively. This sense of handling issues therapeutically included a sense of standing up for themselves in session, “being open” but not “taking on” their experiences, and dealing with “ruptures” appropriately. For example, Lucy knew she was recovered when she was able to meet the client “halfway” without feeling the sole responsibility to fix them. When asked how she knew she was recovered in terms of being able to provide competent therapy, she explained that,
When I was in it, when I was actually working with somebody, I felt in a very healthy way open to their experience without taking it on. I could meet them halfway so to speak, and I wasn’t trying to [fix them] because I knew I’m in a process and this isn’t a deadly process, this is a natural process.

Lucy distinguishes between being “open to their experience without taking it on.” This distinction between the client’s life and her own created a healthy boundary from which she realized that “this isn’t a deadly process, this is a natural process.” Her realization of this ability indicated to Lucy that she was sufficiently recovered and able to provide competent practice.

This ability to be “open” without “taking” on the client’s issues was also reflected in Tallulah’s comments. She stated,

Therapy is about the client and it’s for them but you’re also in the room so don’t leave yourself out. If you’re ignoring your own needs you’re not doing good work. For example, I had a client a few months ago go off the handle with me. He started yelling at me and he was super masochistic and for the first time ever I said “You need to leave my office right now, it’s not acceptable for you to talk to people that way.” He needed to see his impact on the other. So I think even the clients that we turn away it can be therapeutic... Now I’m more experienced. But if I was still depressed I would have definitely thought that I was the worst therapist ever and seen it as my mistake.

Tallulah stressed the importance of not “ignoring your own needs” because ultimately that affects your ability to do “good work.” She understood that asking the verbally abusive client to
“leave my office right now” was “therapeutic” because “he needed to see his impact on the other.” She noted that she would have thought she was the “worst therapist” and viewed the incident as her “mistake” if she were not “more experienced” and not sufficiently recovered from her depressive state. Because she was recovered, Tallulah was able to work with the client in this manner.

June shared a similar anecdote to Tallulah that demonstrated that her ability to handle a “rupture” indicated she was sufficiently recovered practice competently. She suggested,

You can tell through mistakes. I had a huge rupture with a client recently. She was furious with me and I had to sit there and endure her outrage at me and do the work of acknowledging it and repairing it. Not in the room, but outside of the room with my supervisor as to why I’d had this very strong reaction and how it affected my client. She felt judged as a parent because I had a strong reaction to something that happened with her child. On this particular day, I was the child’s therapist, not my client’s therapist and that caused a rupture and then I had to work on repairing it.

June explained that she could sense her recovery through how she dealt with “mistakes” she had made. This “rupture with a client” and June’s ability to “endure her outrage,” “do the work of acknowledging it and repairing it” indicated to her that she was providing competent therapy and therefore recovered. Her supervisor helped June understand why she “had this very strong reaction and how it affected” her client.
The participants all recalled that the ability to stand up for oneself in a therapeutic fashion, deal with ruptures appropriately, be “open” to the client’s experience without “taking it on” and not try to “fix” the client by keeping in mind the “natural process” of depression helped them know they were providing competent therapy and were therefore sufficiently recovered in terms of client work. These were not ways in which they worked with clients when less sufficiently recovered.

Within each of these sub-themes, the participants saw changes in client dynamics as a means of knowing recovery for the participants. Whether the client was returning and referring others, or the participant sensed in various ways that the client was improving, or that the participant withstood and worked with the client’s problems and criticisms therapeutically, this method of knowing was important for the participants’ awareness of their own recovery and ability to work competently with their clients.

In sum, participants relied on both relational feedback and changes in the dynamics of a variety of relationships to know that they were sufficiently recovered and able to provide competent therapy. Changes in how the participants related to their friends and family indicated to them their recovery, such as whether the participants tended to isolate themselves from family or were able to “cope” with or “care about” them and have “normal” friendships instead of “heroic” ones. Feedback from the participants’ therapists was invaluable in knowing their level of recovery. Their therapists would note if a “transition” occurred in the participant which would allow them to be “ready” for practice. Health professionals provided a timeline for recovery and a return to work if necessary. Likewise, supervisors provided a sense of the
participants’ level of recovery, not always through direct feedback but rather interacting collegially with them, referring clients to them, and helping them distinguish “whose depression was whose.” Colleagues also provided knowledge through a felt sense of the participants’ ability to feel a “connection” with the other as well as through direct feedback as to how they were interacting with their shared clients. On the level of client interactions, participants noted that more clients were returning, “sticking around” longer and referring other clients, that clients’ lives were changing and “improving,” that the participant was “open” to the client without “taking on” their issues and able to stand up for themselves therapeutically with clients. The final major area through which participants gained knowledge of their recovery and ability to work with clients is explored in the next section.

**Through client work**

The participants spoke at length about how they knew they were recovering and able to provide competent therapy through changes in the quantity and quality of that therapy they were able to offer clients relative to how they operated while in the midst of their depressive experience. This present section explores the shift in the use of a variety of therapeutic skills through which the study participants knew they were recovering to the point that they were therapeutically competent. Six themes emerged from these explorations that indicated recovery: being able to return to and increase client work, as Jennifer described “testing the waters”; an ability to focus and empathize, Lucy’s notion of being “zoned” in; building “connection and comfort” with clients through the therapeutic use of humour as noted by Heather; the therapeutic use of self-disclosure “for the benefit of the patient” as reflected by Graham; therapeutic self-awareness as demonstrated in Jennifer’s ability to “check in” with
herself; and therapeutic autonomy, Tallulah’s ability to “feel the impact but not engage with it as something that has to do with me.” The participants’ perspectives on each of these themes is explored below.

**Returning to and increasing client work.** Several participants described their ability to return to work and to increase their client work load as a way of knowing they were recovering and able to provide competent therapy, since while they were in the midst of a depressive experience they were not able to see as many clients, or indeed any clients at all. For example, Lucy knew she was recovered when “I could kind of increase my schedule, my workload, again.” She articulated,

The fear I had, the fearful feelings and the worry and the nervousness about practicing was when I was going to work. Once I was there it was gone ... certainly as that fear of going in to work lifted, or that worry and nervousness about it, “Can I do this?” Then I knew I could pick up the schedule again. I could kind of increase my schedule, my workload, again.

After having taken some time off, she recalled some “fearful feelings” about returning to work in therapy but that “once I was there it was gone.” Lucy spoke about a sense of knowing by doing, that she knew she was recovered because she was able to “do this.” She was unsure initially whether she was ready but she trusted herself and was able to slowly begin to “increase” her workload. Reflecting upon the work she was doing with this increased workload allowed her to get a sense that was sufficiently recovered and conducting competent practice.
This was similar to Jennifer, who stated that she knew she was recovered by actually returning to therapy work,

Just trying to see how I could do it. It’s like a process, you just know, you just start by testing the waters really... you can try it, like have one or two clients and see how you do. And just base your decision on that... You don’t until you try right... I could lie around in my pyjamas in bed for three weeks and wonder “Am I ready?” I have no idea. You don’t know these things until you try.

In this excerpt, Jennifer stated that as she was able to “have one or two clients” and review how she did with them; this process allowed her to step back into more full time work as she came to know she was recovered through this increase in workload and reflection upon how she was doing. Similar to Lucy, Jennifer stressed that “you don’t know until you try.”

This sentiment that one does not truly know until one is in the room was also shared by June when she stated,

The way I know that I can do it is that I show up. I’m able to get up and able to do what I have to do. But I might notice that I need a lot more time to recover. For example, the client might trigger me and I might feel that low mood for longer than I would if I wasn’t feeling more, you know – had more strength, more energy.

For June, she knew she was sufficiently recovered and able to provide competent therapy when she felt able to “show up,” when she was “able to get up and able to do what I have to do.” She recognized the permeable nature of recovery when she noted that when she first returned to
work, “the client might trigger me and I might feel that low mood for longer,” moreso than when she was even further along in her recovery process with “more strength, more energy.”

Each of these participants noted that one way in which they knew they were recovered sufficiently to provide competent practice was by returning to and increasing their work load. They would reflect upon how they were doing in this process of “testing the waters,” that “you don’t know these things until you try” and that the way to “know that I can do it is that I show up.”

**Ability to focus and empathize.** The ability to focus and empathize as a means of knowing they were sufficiently recovered in terms of working competently with clients was a common theme among the study participants. Participants pointed out their ability to connect with, stay focused on and feel compassion for their clients. Jennifer, Lucy and Graham shared their thoughts on how element of knowing recovery.

Jennifer stated quite plainly that if “I can stay focused on the client and then the session is over and I haven’t even thought about my own problems for a whole hour, to me that’s progress.” She reflected elsewhere that “you know you’re better if you can go for an hour and not be affected by or have any intrusive thoughts or think about your own problem.”

This ability to “stay focused on the client” was a measure for Jennifer in knowing whether she was recovering or not. Her ability to concentrate also meant that she would “not be affected by or have any intrusive thoughts” over the course of the therapy session. She further elaborated,
For me being able to focus on somebody else’s problems for an hour and not think about myself, not having sort of any thoughts that I didn’t even want to have interrupt my ability to focus on someone else, I think having had those experiences has made me realize “Okay well like even though I’ve got this crap going on in my life that’s upsetting me it doesn’t mean that I’m not fit to help someone else.

For Jennifer, a significant indicator of her recovery was her ability to empathize with the client and their issues rather than getting distracted and losing her focus. She clarified that there was still “crap” going on in her life, but not to the extent that she was “not fit to help someone else.”

This sense of focus and connection was shared by Lucy, who described it as being “zoned and focused.” She emphasized that:

Once I’m actually with somebody I get pretty zoned and focused. When I’m with one person and ... I’m really trying to connect their experience, all of my energy and focus goes there, so it’s a very mindful experience... If people talk about mindfulness, this would speak to that. So it’s a more focused experience, there is not a whole lot of space for anything else.

Lucy referred to her being “zoned” and “focused” and related this to having a “mindful experience,” which is very much related to awareness and focus. During these moments, “there is not a whole lot of space for anything else” and so she is focused, which indicates she is recovering.
Graham felt that his “sense of connection” with his clients as well as his ability to shift out of his mood in order to focus on his client were indicators that he was recovering:

Even when I’d have these periodic bouts, either situational or just coming up for no obvious reason, I would find that when I – so the appointment time came five to ten. I would start preparing myself for the client and I could switch out of a dark place quite easily and be really there for someone else. You come with a certain degree of compassion for the client and it’s also a felt sense of connection with the person.

Graham noted that he comes into the session “with a certain degree of compassion for the client” even prior to seeing the person. His ability to “switch out of a dark place” quite easily in order to connect and “be really there for someone else” was a way through which he knew he was recovering and able to provide competent therapy.

Jennifer, Lucy and Graham found that having “compassion for” and a “felt sense of connection” with the client as well as being “mindful,” “zoned” in and “able to focus” on their issues were ways in which they knew they were recovering in terms of being able to work with clients. This contrasted to times when the participants were distracted by their own personal difficulties and “crap” when they were less recovered.

**Use of humour.** Several participants shared that their ability to use humour in their therapy practice was a way in which they knew they were recovering in terms of working competently with clients. The participants found they could use humour when they had “resolved fixed patterns,” could shift their perspectives “with fluidity,” and could build
“connection” with the client. It allowed them to “feel normal,” while a lack of ability to “laugh at” oneself was an indication that “you’re in trouble.”

For example, Tallulah recalled that, “for me when humour arises it is because I have resolved fixed patterns and am able to shift my perspective with fluidity and without investment. Humour is only possible when you have created emotional space from your own fixed perspective.”

For Tallulah, humour is the result of resolution and recovery. Humour “arises” when she is able to “shift” her “perspective with fluidity and without investment.” There is an ease to which she is interacting with the client. Using humour was an indication that she had “created emotional space” from her own “fixed perspective” and that she was therefore recovering.

Like Tallulah, June also viewed the “capacity for humour” as a sign of recovery. She reflected:

If you’re in your own personal therapy and you can’t laugh at anything about yourself you’re in trouble. If a therapist is depressed and doesn’t have the capacity for humour, that is going to be a really dry, dull, dead therapy. Your client won’t have the capacity for humour because they’re depressed. You have to wait for the moment. So you have to be awake and alive all the time.

June commented that the inability to use humour was an indication that “you’re in trouble” and not recovered. She also noted that this inability to use humour will directly impact therapy,
causing it to become “dry, dull, dead therapy.” For her, the ability to use humour was also an indication of presence and ability to stay with the client.

For Heather, her use of humour “was a sign of how I knew that I hadn’t lost myself completely and reassurance that I wouldn’t be sad forever.” This was similar to Tallulah’s comment about moving from a “fixed position” as noted above. Heather shared that:

I do try to use some gentle humour to build connection and comfort with clients... I would say that humour was personally important to me ... as a way of providing some relief from pain but also feeling that my "old self" still existed and... to try and feel a little bit normal. And I would say it became easier to smile and laugh and feel lighter as I slowly healed... After I lost my child I didn't laugh much for quite a while beyond that "laugh so you don't cry" kind of thing and so being able to use humour again did feel like a sign of getting better to be able to be free in that way again.

Heather spoke about how the ability to use humour suggested recovery in several ways. She noted that the use of humour indicated that she was able to “build connection and comfort” with clients, indicating that her “old self” still existed, helping her feel “normal,” providing “reassurance” that she “wouldn't be sad forever” and overall as “a sign of getting better.” That laughter and humour became “easier” with time as she “slowly healed” was a marker of her recovery.

In each of these excerpts, the participants described the importance of being able to use humour therapeutically as an indication of recovery in terms of client work. Humour was
described variously as a sign of “fluidity” without investment, a resolution of “fixed perspective,” of “being awake and alive,” that the “old self” still existed and overall as “a sign of getting better.” The ability to use humour provided “reassurance that I wouldn't be sad forever.”

**Use of self-disclosure.** The use of self-disclosure as a means of knowing recovery was discussed by a number of participants. This referred to the participants knowing they were recovering sufficiently in terms of competent client work when they were able to disclose personal information and thoughts to the client in a manner that was therapeutic and beneficial to the process. Participants recalled that they “over-shared” for their “own need” when less recovered but that their disclosures provided “benefit” and “help” when more sufficiently recovered. “Clear” boundaries aided this process. Graham, Kohnka and June stated their thoughts in relation to self-disclosure.

Graham distinguished between the way he self-disclosed prior to undergoing his own therapy and the way he currently disclosed as a measure of his own sense of recovery. He emphasized that “the disclosure that I did before I did my own therapy was often – not always but often was of my own need. After doing my own therapy, disclosure became primarily for the benefit of the patient.”

Graham described that in his early practice “before I did my own therapy” he would self-disclose often for his “own need.” After he had been involved in therapy, this disclosure “became primarily for the benefit of the patient.” This sense of whether the disclosure was for
his benefit or that of the client provided him with a simple measure of his own recovery as he
had shared more for his “own need” before therapy and his own recovery.

In a similar fashion, Kohnka noted that she feels she is recovering when she is able to
“share with my clients” appropriately. She reflected that:

I share with my clients a fair amount and they love it because they feel that I relate to
them, especially if it is with traumatized people. At the beginning I’m sure I over-shared
and part of it was that “I want to share this but I don’t want the person to take care of
me.” Having a clear boundary around it is important and not to bring in anything which
is right now acute.

Kohnka used her clients’ response to her self-disclosures as a measure of her own recovery.
She stressed that in “the beginning” she “over-shared” which would lead some clients to
potentially “take care of” her rather than have her be the therapist. She clarified that currently,
she knows she is sharing appropriately because her clients “love it because they feel that I
relate to them.” She pointed out the importance of having “a clear boundary” as part of
knowing when to use self-disclosure therapeutically. One of her boundaries was not to discuss
anything in her life that was “acute.”

June noted that she knew she was recovering when she felt able to “self-disclose.” She
discussed how she will “self disclose at times that I’ve had depression myself. I might do that if
the timing is right. If I think it will benefit.” However, she clarified that:
If it’s just self-disclosure for myself, there’s no purpose to it. I have to be clear on when that self-disclosure might actually give the person hope. That “Oh, maybe I can be like her because, you know, she has lived with depression through her whole life.” But you just don’t tell that to everybody.

June reflected that therapeutic self-disclosure was an indicator of recovery when she was able to sense whether its use was appropriate or not in a given circumstance. For her, disclosure was appropriate when “the timing is right,” “I think it will benefit,” when it “might actually give the person hope” and when the person might be able to use her as a model of someone who had successfully overcome depression. June felt self-disclosure was not appropriate when “it’s just self-disclosure for myself, there’s no purpose to it.” June was also aware that “you don’t just tell” everyone that “I’ve had depression myself.”

Each of the participants talked about the importance of therapeutic use of self-disclosure as a means of knowing their recovery. This included an ability to sense whether the self-disclosure was for their “own needs” or for that of the client, whether the “timing was right,” if they thought “it would benefit” by giving the client “hope” as well as providing a model for the client to follow. Participants were aware that they “over-shared” when they were less recovered, potentially causing clients to try to “take care” of them. This oversharing was a sign of their lack of recovery.

**Feeling open and self-aware.** Participants commented upon an increase their own self-awareness and how this self-awareness impacted their client work in a therapeutic fashion. Part
of self-awareness included feeling more “grounded” in their life, feeling “open” to their own limitations, and having an “increased ability” to be able to check in with oneself.

Lucy stated that she felt she was recovering when she began feeling “more grounded” in her life and when she was able to “recognize” her “ego” when it began to appear and dominate a session. She sensed her recovery,

*When I started to feel more grounded in my life again, and I regained a perspective.*

*When I was less symptomatic. Recognizing when your ego just walked into the room or when your agenda’s just walked into the room, and I struggle all the time, because it’s much easier to think checklist, which is something I struggle with all the time. But I also know my limits, and I had to learn them the hard way.*

Lucy articulated a number of ways of knowing recovery in terms of therapeutic self-awareness. This included feeling “more grounded” in her own life, feeling “less symptomatic,” being aware when her “ego” was interfering with therapy and knowing her “limits.” She suggested that self-awareness was learned through experience “the hard way.”

In a similar fashion, Tallulah expressed the importance of being aware and “open” as a means of knowing she was recovering. Tallulah noted that markers of recovery included feeling

*More open to difference, more open to making mistakes, open to my own limitations.*

*More open to new points of view about how I am in the world. We all have limitations and it comes out as a therapist, clients I can’t work with, clients I don’t work well with, there’s a trigger.*

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Tallulah pointed to a number of markers that she used to know her recovery. She felt that her openness to “difference,” “making mistakes,” her “own limitations” and to “new points of view” suggested that she was recovering in that she was able to work effectively with clients. Knowing which clients she was unable to work with was also a “trigger” or an aspect of self-awareness.

While Tallulah described the importance of being “open,” June had a sense that she was recovering related to her ability to check in with herself. For June, self-awareness meant she had a self with which she could check in:

“It’s this checking in of myself. Subjectively, depression for me is a state of my body language, my energy, my capacity for presence. And I could check in with these. Eventually, certainly, I would be more able to do this. I can tell my energy level and check in with myself because I did things like mindful meditation.”

June’s self-awareness gave her a sense that her depression manifests in her “body language,” “energy” and “capacity for presence”. As she was able to “check in” through techniques like “mindful meditation,” June was able to detect her own “energy level” and recovery and therefore her readiness and ability to conduct therapy. She noted that this self-awareness “eventually” increased over time through her recovery and that as a result she “would be more able to” be self-aware.

Each of the participants described the importance of being self-aware as a measure of their own recovery. This included their ability to be more “open” and “check in” with
themselves and to feel “more grounded” and “recognize” when their ego was helping or hindering therapy. They also felt the ability to effectively use awareness techniques like “mindful meditation” and the sense that this ability to “check in” increased as the participants recovered.

**Separating self from client.** In reflecting upon ways in which they knew they were recovering from their depressive experience in order to work competently with clients, several participants spoke about their increasing sense of a healthy distinction between themselves and their clients. This included an ability to interact with clients in an adaptive way, not “taking home” the “heaviness of people’s stories” and being better able to distinguish the client’s needs from their own needs. For example, Heather noted a shift towards recovery when she became “better at separating other people’s experiences from my own”:

I’m probably getting better at separating other people’s experiences from my own or kind of not taking home as much of the you know heaviness of people’s stories, and that was something that I was worried about because when I was really freshly grieving I felt so shaky and like so overwhelmed with things, like I can’t take any more stress or you know bad -- like I was really afraid, like what if something else happens. I needed to make sure I could do that because you hear sad stories all the time from people in counselling or they’re talking about their own lives and I wanted to be able to show empathy but not get lost in my own feelings and experience.

Heather emphasized that this ability to separate “other people’s experiences” from her own meant that she was still able to care for her clients, but that the “heaviness” of their “stories”
did not become her own and that the autonomy of their two lives was maintained in a therapeutic manner. While less recovered, Heather was “worried” that she might be unable to maintain this separation, that she would be “overwhelmed with things.” Feeling more recovered involved a decrease in this worry and fear as her ability to maintain autonomy increased. For Heather, to “not get lost” in her own feelings during therapy suggested therapeutic self-autonomy and therefore recovery.

Heather’s reflection on the therapeutic separation between herself and the client was mirrored in Tallulah’s description of “emotional distancing.” Tallulah explained that she knew she was developing healthy self-autonomy when she stopped feeling burdened by client “issues” or “outcome”:

Client stories and issues didn’t feel like burdens, where before I would be like, “Oh my god the world is so horrible.” I’m not as attached to outcome... Able to hear something truly horrific and feel the impact but not engage with it as something that has to do with me. So there was a little bit of emotional distancing that had to happen.

Tallulah’s awareness of self-autonomy meant that she no longer felt the “burdens” of the “client stories and issues” nor was she “attached to outcome.” She was still able to hear “truly horrific” stories and “feel the impact but not engage with it as something that has to do with me.” Her “emotional distancing” allowed her to maintain her therapeutic effectiveness.

While Tallulah described a shift in her attachment to the client and “to outcome” as a sign of self-autonomy, Graham also stated that when less recovered, he relied too much on his
clients, “wanting” things from them because he “wasn’t getting it anywhere else” in his life. He reflected,

You can be aware of how much of that you’re putting out and how much you’re relying on … that you’re wanting, for example, praise from a client. It’s always nice when it comes but for me, before I had started therapy there was such an unconscious hunger for that because I wasn’t getting it anywhere else in my life, versus afterwards that was not a driver.

Graham spoke about “before” he “started therapy” and still in a depressive state, he felt “an unconscious hunger” and “wanting, for example, praise from a client.” For him, this represented a lack of self-autonomy and recovery. He noted that “afterwards” therapy aided this autonomy because at that point this need “was not a driver” any longer. He used this sense of “before” and “afterwards” to know he was recovering and able to provide competent practice.

Each of these participants talked about a stronger awareness of autonomy as a means of knowing they were recovering in relation to client work. They shared being “better able to separate” their own lives and stories from those of their clients, choosing to “engage” with stories and issues as appropriate through the use of “emotional distancing.” They discussed the importance of listening but not getting “lost” in the client’s experience and marking the fact that “client stories and issues didn’t feel like burdens” as a sense they were recovering. When recovered, they also relied less on the client for their own wants and needs.
In sum, the participants shared a variety of ways in which changes in the quality and quantity of their client work indicated that they were recovering from their depressive experience in terms of their ability to work competently with clients. These ways of knowing recovery related directly to therapy practice. Participants spoke about being better able to have a “mindful experience,” a “felt sense of connection,” and of being “zoned” in and “able to focus” on the client. Participants shared their view that the use of humour with clients reflected recovery, specifically because humour was a sign of “fluidity” without “investment,” a resolution of “fixed perspective” and of “being awake and alive” and overall as “a sign of getting better.” A number of participants reflected upon their increased awareness of which self-disclosures were helpful to the client and which were primarily being used to fulfill the participants “own needs.” They also felt better able to define what constituted therapeutic self-disclosure in relation to the client. Participants spoke of an increased ability to be “open” and “check in” with themselves, to feel “more grounded” and to “recognize” when their ego was helping or hindering therapy. Participants discussed being “better able to separate” their own lives and stories from those of their clients, listening but not getting “lost” in the client’s experience in an autonomous way and sensing that “client stories and issues” no longer felt “like burdens” through the adaptive use of “emotional distancing.”

Through the increased awareness and adaptive use of each of these interpersonal therapeutic skills, the participants knew they were recovering from their depressive experience and they were able to work competently with their clients. These interpersonal measures were a complement to the set of intrapersonal and interpersonal ways of knowing explored in the previous sections.
Summary: Recovery awareness

Reflecting on ways in which participants knew they were sufficiently recovering in order to work competently with clients, a number of themes emerged. While most began with an exploration of intrapersonal, interpersonal and client work related discussions, a few participants began with an exploration of what was meant by recovery. These participants viewed recovery from depression along the lines of “growth” and “adjustments” rather than as a “medical” issue that requires intervention.

In terms of intrapersonal functioning, participants shared that a change in energy and a return of emotions like “hope” and “desire” indicated recovery. Feeling more grounded, self-compassionate, being able to attend to various parts of themselves, viewing their depressive experience in a different light, feeling more capable and responsible to behave adaptively as well as engaging in simple daily behaviours like eating, exercise and being able to pull oneself out of their depressive mood were ways in which participants knew they were sufficiently recovering.

Relational feedback and changes in relational dynamics were other ways through which participants knew they were recovering in terms of being able to provide competent practice. With client relationships, this included noting that clients were returning and referring, that they were improving and that their issues were withstood therapeutically. Feedback from the participants’ therapists, colleagues and therapy partners provided an awareness of how the participant was interacting with clients and whether they were ready to work. Supervisors who were more collegial and referred clients, and other health professionals provided feedback on participants’ recovery. And finally, the participants’ interactions with their friends and family
helped the participants know they were sufficiently recovering and able to provide competent practice.

Turning to the use of clinical skills as a way of knowing recovery in terms of being able to provide competent practice, participants reflected that being better able to have a “mindful experience” and being “zoned” on the client were indicators. Other ways of knowing they were able to practice competently included the use of humour with clients, an increased ability to be “open” and “check in” with themselves and “recognize” when their ego was helping or hindering therapy, being “better able to separate” their own lives and stories from those of their clients, and listening and sensing that “client stories and issues” no longer felt “like burdens” through the adaptive use of “emotional distancing.”

These results provided a sense of how participants knew they were sufficiently recovered from their depressive experience in order to work completely with their clients. This understanding will help as we turn to the next chapter and explore how the participants’ recovery process impacted their work with clients.
Discussion

The present study investigated the ways in which psychologists and other mental health therapists came to know they had sufficiently recovered from their depressive experience such that they were now able to provide competent therapy. The results chapter described the experiences of ten mental health therapists with a history of depressive experiences from which they felt they had sufficiently recovered. The data was gathered from semi-structured interviews with these individuals and were organized into three themes. These three themes are explored in this discussion chapter.

The participants’ accounts documented through these in-depth interviews demonstrated the fluid nature of depression and recovery as well as the numerous avenues participants used in order to know they were sufficiently recovered. The data revealed three distinct themes related to the participants’ awareness of recovery; these themes focused on knowing through their personal and professional functioning and knowing through their relationships. These three themes were: through intrapersonal functioning, through interpersonal relationships, and through client work.

There appears to be very little or no research that explicitly answers the question of how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they were able to provide competent therapy. Research has covered related topics, such as the process of recovering from depression (Romakkaniemi & Kilpeläinen, 2015), how to know if one is no longer depressed (Lloyd, King, & Moore, 2010), returning to work following a depressive experience (de Vries et al., 2012), using depressive
experiences and other wounds adaptively in clinical work (Jackson, 2001), understanding therapist competence (Fairburn & Cooper, 2011), and distinguishing impaired professionals from wounded healers (Conchar & Repper, 2014). As stated earlier, previous studies that align closest to the current study are ones that examined narrative case studies or theoretical frameworks of how an individual becomes a wounded healer (Esping, 2014; Miller et al., 1998; Wolglen & Coady, 1997). These studies provided an understanding of the general process of becoming a wounded healer through an adaptation of one’s wounds, but did not directly answer the current research question of how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are able to provide competent therapy.

The three themes (through intrapersonal functioning, through interpersonal relationships, and through client work) are discussed within the broader context of other scholarly writing. Their relationship to the awareness of recovery and to specific points of the mid-level theory will also be explored. While each theme describes a way of knowing one is sufficiently recovered, ultimately it was the client relationship and the dynamics within the client work itself that provided the most direct indicator that their depressive experience was sufficiently recovered such that the experience aided rather than detracted from the therapist’s clinical work. The discussion chapter will therefore focus especially on the role of interpersonal relationships and changes in professional functioning in self-knowledge of recovery.

Through Intrapersonal Functioning

Results from the data suggested that one crucial way the therapists became aware of their recovery was through noting shifts in functioning on an intrapersonal level. While this
indicator provided the least direct awareness of recovery in terms of providing competent practice, it was understood as important to that end. The findings demonstrated two distinct means through which shifts in intrapersonal functioning provided an awareness of recovery: the first was through an abatement of depressive symptoms and the second was through a more holistic sense of psychological recovery and increased efficacy. In terms of the justification of beliefs (Bengson & Moffett, 2011), the two forms of justification demonstrated within this theme were empiricism and deductive reasoning (Gertler, 2011).

One way participants knew they were recovering was by noticing a dissipation of their clinical depressive symptoms. This was the most elemental shift in their intrapersonal functioning. Detecting mental illness through symptom presentation and recovery through symptom abatement is well established in the literature (Conradi, Ormel & de Jonge, 2012; Gonzales, Lewinsohn & Clarke, 1985; Strauss, Mergl, Sander, Schönknecht & Hegerl, 2015; Whitley, Palmer, & Gunn, 2015). For example, Conradi, Ormel and de Jonge (2012) stated that “symptoms are the building blocks of remission, recovery, relapse and recurrence” (p. 639), with recovery indicated by a fairly stable remission of depression symptoms. The foundation of mental disorder diagnosis within the DSM 5 is based on detecting constellations of symptoms combined with functional impairment (American Psychiatric Association, 2013). While not specifically defined as recovery, the DSM 5 states that a person is considered inter-episode when their symptoms have abated such that they have not met criteria for a major depressive episode for a period of two months (Ibid, 2013). While the data from the current study did not distinguish between inter-episode symptom absence and sustained recovery, the findings
suggested a self-diagnosis of recovery in terms of no longer meeting DSM 5 symptom criteria for a depressive diagnosis.

Two commonly accepted definitions for recovery from depression in terms of symptom abatement are found in the Research Diagnostic Criteria (RDC) (Spitzer, Endicott & Robins, 1978) and in the results of the MacArthur Foundation task force (Frank et al., 1991). Briefly, the RDC defines recovery as a period of at least eight weeks with either no symptoms of depression or only one or two symptoms at a mild severity level. Frank et al. (1991) offered definitions of both remission and recovery. According to Boland and Keller (2009), remission is “defined by a period of time in which an individual no longer meets criteria for the disorder” (p. 23), while recovery is “defined as a full remission that lasts for a defined period. Conceptually, it implies the end of an episode of the illness, not the end of the illness itself” (p. 24). This distinction between the end of an episode as opposed to the end of the illness is shared by Zerubavel and Wright (2012), who noted that “recovery is not necessarily linear or, when achieved, permanent” (p. 485). Data from the current study confirmed that the diminishment of depressive symptoms was one indicator of recovery while also noting that recovery was ongoing and never entirely complete.

Based on the definitions provided by Frank et al. (1991), the descriptions of the participants’ depression-related states presented in the research data could realistically fit either remission or recovery through the focus on symptom abatement. Indeed, as discussed in Friedman, Anderson, Arone, and Denko (2014), the Frank et al. (1991) “model has been helpful conceptually and in treatment trail design, but in practice it is not possible to know when
remission becomes recovery” (p. 100). This distinction was largely unimportant in relation to the present study. On a conceptual level, the term “recovery” used during participant interviews did not distinguish whether the participants defined themselves as recovered or in remission. Rather, what was important was how they knew they were able to use their depressive experiences adaptively in their client work. One facet of knowing was gained through an abatement of their clinical depressive symptoms.

Both the RDC and Frank et al. (1991) definitions of recovery (as well as the DSM 5 understanding of what constitutes being between episodes of depression) include a timeframe of minimal symptom presentation as a critical component of recovery and inter-episode depression, respectively: the RDC requires eight weeks, the DSM 5 lists two months, and Frank et al. suggest between four to six months. The current study found significant differences in the length of time that participants cut back or left their practice entirely due to their depressive experience; participants described taking a few weeks, a few months, or longer during this recovery period. Perhaps paralleling the inconsistencies of these various definitions of recovery, the findings also varied in the amount of time needed to recover and therefore to become aware of recovery. Despite the time range, the key was that some amount of time was described as being needed; indeed, the data suggested that recovery was never experienced immediately. This makes sense given the interaction of awareness and adjustments in recovery noted in the current study. Awareness takes time to arise and adjustments take time to implement; therefore, depending on the individual and the circumstances, more or less time for both will be required.
Beyond simply becoming aware of recovery through a decrease in depressive symptoms, the participants suggested a second means through which shifts in intrapersonal functioning provided a sense of recovery. They noted a number of adaptive shifts in the intrapersonal realm, including increased energy, agency, trust in self and altered relationship to depression. Overall, these changes can be described as noting the shift in experiencing life with efficacy rather than with passivity.

The idea that recovery can be understood through adaptive, efficacious shifts in intrapersonal functioning and not simply as the abatement of depressive symptoms broadly parallels Andresen et al.’s (2003) concept of psychological recovery, which they defined as “the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination” (p. 588). While focusing on schizophrenia and “other serious mental illness” (p. 586) and not specifically depression, Andresen et al. identified a number of recovery processes, including finding and maintaining hope, reestablishing a positive identity, finding meaning in life and taking responsibility for one’s life. Their study further identified recovery from the psychological consequences of the illness rather than as the absence of symptoms. As such, it provides a contrast to the DSM 5 notions of pathology and recovery. The current findings support Andresen et al.’s (2003) concept of psychological recovery applied to depression in that recovery was found in part to be the abatement of clinical depressive symptoms but also related to increased energy and ability to trust the self, feeling more self-agentic, and participating in more fulfilling and personally meaningful activities.
In particular, the current study’s finding that a changing relationship with depression indicated recovery supports Andresen et al.’s perspective that psychological recovery means, in part, recovery from the psychological consequences of the illness rather than as the absence of symptoms (2003). This change focused not on the diminishment of depressive symptoms, but rather in the participants seeing benefits of their depression, having more control in how they interacted with the experience and feeling more open and less stigmatized to talk about it. While not specific to recovery, Andrews and Thomson (2009), Raison and Miller (2013) have discussed alternative orientations to depression, theorizing that depression is not always maladaptive. Both Andrews and Thomson (2009) and Raison and Miller (2013) suggested that rather than being an illness from which to recover, depression can be functional in that it allows the person to focus and learn from his or her mistakes and that depressive-behavioural responses such as withdrawal tendencies, energy conservation, hypervigilance and anorexia are not maladaptive but rather are helpful for survival, historically, in order to avoid illness. For the participants in the current study, feeling less stigmatized about their depression, seeing the benefits of depression, and relating to depression in a more open way appeared to reduce its controlling influence. In that sense, the participants were recovered from the psychological consequences of the illness (Andresen et al., 2003). The symptoms might still be present, but the participants’ increased ability to interact with these symptoms in a less pathologizing manner was one way in which they sensed their own recovery.

The results of the current study suggest that the participants’ intrapersonal functioning also made them aware of their recovery through their increased ability to trust the self. Trusting the self appears to relate conceptually to self-efficacy or the strength of one’s belief in
one’s abilities that one can achieve stated goals (Bandura, 1977). Depression, which commonly includes a lack of confidence, feelings of worthlessness and diminished activities (American Psychiatric Association, 2013) contrasts sharply with self-efficacy and its focus on “confidence in one’s ability to perform a behaviour” (Wagner, Holloway, Ghosh-Dastidar, Kityo & Mugyenyi, 2011, p. 411). Trusting the self, or an increased self-efficacy, indicated recovery among the participants in the current study because depression and self-efficacy were theorized in the study to be largely opposing phenomena, while self-efficacy and recovery were theorized to be highly related. Indeed, Muris (2002) found that low levels of self-efficacy were generally accompanied by high levels of depressive symptoms, while Blackburn and Owens (2015) noted that strengthening self-efficacy may help lower levels of depressive symptomatology and promote recovery. Results from the current study suggested that an increased sense of trust in self and self-efficacy was one means of becoming aware of recovery from one’s depressive experience.

In this study, participants’ recovery was conceptualized, in part, to include the idea of personal growth, with the results suggesting that humans are both geared towards growth even though this recovery or growth is also never complete. This notion that humans are geared towards growth is perhaps best understood in terms of Rogers’ “actualizing tendency” (Rogers, 1959; Bazzano, 2012), which Rogers saw as a motivational construct involving “development toward the differentiation of organs and functions, expansion and enhancement through reproduction” (Rogers, 2008, p. 18). Participants noting this actualizing tendency occurring in their own lives indicated to them they were recovering. The second point, that growth or recovery is never complete, has been noted by authors such as Zerubavel and Wright
(2012), who suggest that “recovery is not necessarily linear or, when achieved, permanent” (p. 485). As for not being permanent or complete, participants stated that the idea of a 100% functioning and recovered therapist was a myth. Participants discussed how accepting the incompleteness of recovery was itself an indication of their recovery, noting that while the memories of depression never fully disappeared, the control over and shifting relationship with the affect related to these memories indicated an increase in self-efficacy and psychological recovery.

Dunning, Heath and Suls (2004), in reviewing a broad range of psychological literature and relating the findings to the fields of health, education and the workplace, found that, “in general, people’s self-views hold only a tenuous to modest relationship with their actual behaviour and performance” (p. 69). This was unrelated to whether or not the individual was in a depressive state. Given this finding, and that “the correlation between self-ratings of skill and actual performance in many domains is moderate to meagre – indeed, at times, other people’s predictions of a person’s outcome proves more accurate than that person’s self-predictions” (p. 69, italics added), relationships seemed to be important in terms of providing accurate assessments of the participants’ functioning and emotional states especially in relation to knowing recovery. We turn to this discussion next.

To summarize the first theme, changes in the participants’ intrapersonal functioning provided them an awareness of recovery. Two related processes arose from these data. In the first process, participants noted the diminishment of depressive symptoms, which paralleled the DSM 5’s (American Psychiatric Association, 2013), the RDC’s (Spitzer et al., 1978) and Frank
et al.’s (1991) definitions of depression and recovery. In the second process, participants gained a sense of psychological recovery, or “the establishment of a fulfilling, meaningful life and a positive sense of identity founded on hopefulness and self-determination” (Andresen et al., 2003, p. 588). Recovery in this sense was more than simply the abatement of depressive symptoms, but rather involved relating to these symptoms in a less pathologizing manner, having an increased trust in the self and experiencing recovery as actualizing growth. As stated earlier, while these means provided the least direct sense of whether the participants were recovered such that they would be able to provide competent practice, they were nonetheless considered important because of the impact of intrapersonal functioning on therapy competence (Probst, 2015). The role of intrapersonal relationships in awareness of recovery is discussed next.

**Through Interpersonal Relationships**

While the previous theme discussed how shifts in intrapersonal functioning provided awareness of recovery, this theme examined the role that relationships played in this awareness. Four relational categories are discussed, each contributing uniquely to this awareness of recovery: friends and family, therapists and health professionals, supervisors and colleagues, and clients. These relationships provided participants with an awareness of recovery both directly through feedback and indirectly through noted changes in relational dynamics. In terms of the justification of beliefs (Bengson & Moffett, 2011), the primary form of justification demonstrated within this theme was authoritative testimony (Gertler, 2011).

The results of the current study indicated that the changes in the participants’ relational dynamics with family and friends helped them become aware of their recovery, rather than
through direct feedback. For example, the data showed that the participants’ desire and capacity to care for friends and family indicated to them that they were recovery. The participants’ newfound ability to enjoy these connections, where previously they had been unable to cope or be interested in connecting, was an indication of recovery. This connects with previous research noting various relational changes catalyzed by depression and recovery states, specifically that depression leads to social isolation, while recovery leads to social interest and desire for community (Cruwys, Haslam, Dingle, Haslam & Jetten, 2014; Wade & Kendler, 2000). This also related to Adler’s (1982) notion of social interest as being a key indicator or mental health. The influence of depression on relationships aligns well with the work by Karp (1996), which noted that many of his research participants who had all experienced a depressive episode(s) viewed depression as, at its core, a “disease of isolation” (p. 20). Karp noted that what people with depression wanted was to connect with others, but that their depression was fundamentally separating. It makes sense, then that the current participants understood recovery as a movement away from social isolation and towards social connection and that a desire for connection suggested recovery. Noting the rise in this desire and ability to connect was itself an indication of recovery.

Speaking to the role that family had in improving therapeutic competence, Wolgien and Coady (1997) interviewed eight “effective” therapists and found that their process of becoming a healer (though not necessarily a wounded healer) involved support and learning from partners and children. They noted that having the safety of a partner allowed the therapists to intimately connect with clients without feeling overwhelmed, and that the ability to connect and renegotiate their relationships with their children over their lives contributed to their
ability to help others. Wolgien and Coady further spoke of the “protective factors” (1997, p. 29) of partners and children. Extrapolating from this research, the current study theorized that therapists’ partners and children also helped them know their emotional state and professional capacity more accurately because of their intimate, sustained connections and as such were a source of recovery awareness. This also speaks to the central role of feedback and relationship with significant others in terms of self-knowledge and behaviour regulation.

In relation to knowing recovery through the returned interest and ability to connect with friends and family as revealed by the current study, Solomon et al. (2008) examined psychosocial functioning as a predictor of recovery from an episode of unipolar major depression. They concluded that assessment of psychosocial impairment might help identify the likelihood of recovery from an episode of major depression. As Solomon et al.’s (2008) notion of psychosocial impairment involved impairment in interpersonal relationships, the present study connects to their findings in that both suggest that an improvement in interpersonal relationships is an indication of recovery.

Continuing with the theme of psychosocial functioning as an indicator of recovery, Fowler, Wareham-Fowler, and Barnes (2013) found that “higher levels of positive social interaction, and a stronger sense of community belongingness predicted less severity and shorter duration” of a depressive experience (p. E85). Fowler et al. found that, similar to Wolgien and Coady (1997), social interaction and belongingness provided a protective factor against depression because they helped mitigate the isolative aspects of depression (Karp, 1996). Maheux and Price (2016) found that social support and social interaction helps one
recover from trauma and depression through the internalization of others’ compassion into the individual’s self-compassion. So it seems that Fowler, Wareham-Fowler, and Barnes (2013), and Maheux and Price (2016) all theorized that family and friendships helped facilitate recovery through supportive interactions and the internalization of self-compassion. Results from the current data suggest that family and friends provided knowledge of recovery indirectly as the participants noted adaptive changes in their interactions, specifically as the participants were able to accept the support and experience the self-compassion fostered through their various relationships.

Moving away from the friends and family category, results from the interview data revealed that therapists and health professionals also provided awareness of recovery, primarily through direct feedback. People often come to therapy wanting help with a troubling element of their lives or else because of a general sense that something is not quite right (Duncan & Miller, 2000; Teyber, 2006). As therapy progresses, people often seek feedback on how the therapy process is going or on how the therapist or health professional thinks the person is doing. The present study found that a similar process occurred in participants’ efforts to get a sense of their state of recovery. Participants actively sought feedback from their therapists and health professionals as to whether or not they were sufficiently recovered to return to (or increase) their practice. The centrality of feedback differs among therapy modalities as does the type of feedback. Indeed, Kreuter, Strecher and Glassman (1999) have provided a taxonomy of feedback from generic communication to interpersonal communication, defining the latter as based on an assessment of the individual and involving
highly individualized content. This study refers to this latter form of communication when
describing feedback.

While there appears to be little to no research on the role of therapist feedback on
recovery awareness, Schmidt et al. (2006) discussed the role of the therapist’s direct feedback
on recovery itself. They examined whether personalized feedback improved outcomes of
cognitive behavioural guided self-care in bulimia nervosa. Feedback included personalized
letters after assessment, specially designed feedback forms during treatment and computerized
feedback about bulimia and other symptoms. They found that this feedback did improve
outcomes. As well as aiding in the recovery process itself, the current study proposes that the
feedback forms provided during Schmidt et al.’s (2006) treatment also provided an indicator to
their participants on their state of recovery or functioning related to bulimia nervosa. While
this type of formalized feedback was not discussed in the data, verbal feedback on the
participants’ state of recovery was discussed as a source of recovery awareness.

The data from the current study showed that as well as helping directly in the recovery
process, therapists and health professionals were often asked to provide feedback specifically
on whether the participant was sufficiently recovered such that a return to practice was
possible. The role of health professionals in the return to work process was described by
Wisenthal and Krupa (2013), who examined the relationship between depression, cognitive
work hardening, recovery and returning to work. They noted that “people recovering from
depression are often not ready to return to the actual workplace even with improvement in
symptoms following standard medical treatment” (p. 426). These authors discussed how
reduced stamina, cognitive functioning, lack of routine, lack of self-confidence and the stigma of having a mental illness interfere with a successful return to work. Related to feedback, Wisenthal and Krupa noted that “markers of work performance are inherent in the process, providing clients ongoing evaluation and feedback which serve as a barometer of their functioning and readiness for work” (p. 425). The overall process of work hardening and specifically the “ongoing evaluation and feedback” by the occupational therapist overseeing this cognitive work hardening acting as a “barometer” for their readiness to return to work was mirrored in the present study through therapists and health professionals helping the participants recover from their depressive experience while simultaneously providing their opinion as to whether or not my participants were sufficiently recovered such that they would be able to return to work.

One particular element that participants sought feedback on was whether they were sufficiently competent to return to their clinical work. In this manner, recovery and competence were theorized to be highly related given the clinical difficulties that often arise with the presence of therapist depression (Charlemagne-Odle, Harmon, & Maltby, 2014; Gilroy, Carroll, & Murra, 2001). While not specifically addressing awareness of competence in therapists, the competence gained through therapy was described by Probst’s (2015) research on what clinical social workers gained from their own recovery in therapy as they moved from the client chair to the therapist chair. Probst found that “by fostering better mental health, therapy is presumed to contribute to the enhancement of personal qualities in a therapist often cited as conducive to therapeutic effectiveness such as self-awareness, empathy, warmth and genuineness” (p. 52). Probst suggested that if the individual gains these qualities through his or her own therapy,
he or she will be more competent with his or her own clients. The current study therefore theorized that if the participant/client gains these qualities through the process of recovering in therapy, then the therapist relationship has also provided awareness of recovery (indirectly at least) as these competent qualities are manifested in the therapist/client’s own clinical work.

Moving on to the next category, data from the current study indicated that supervisors and colleagues provided both direct and indirect feedback to the participants about whether they were sufficiently recovered from their depressive experience such that the experience aided rather than detracted from client work.

One direct way in which supervisors provided an awareness of recovery was in helping the participants distinguish their own issues from those of their clients. Stated another way, unexplored countertransference was viewed as an indication of lack of sufficient recovery and so a discussion and amelioration of that countertransference provided knowledge of the participants’ level of recovery in relation to competent therapy. Cummings, Ballantyne and Scallion (2015) have noted that the primary role of supervision is to train as well as to spot and provide feedback on any potential technical or personal blind spots of the supervised. More specifically, evaluating a supervisee’s personal reactivity or countertransference is seen as a critical component in supervision (Pakdaman, Shafranske & Falender, 2015; Ponton & Sauerheber, 2014). Providing feedback on that countertransference was understood to be an important process in mitigating the potentially maladaptive effects of countertransference and therefore promoting and knowing recovery. Indeed, the current study found that this
countertransference feedback improved participants’ therapeutic competence and was one way in which they could gauge their own state of recovery.

As well as direct feedback on issues such as countertransference, the data from the current research indicated that the participants’ relationships with supervisors and colleagues indirectly helped clients know they were recovering. The participants understood they were recovering when they perceived a clear, open connection between themselves and their supervisors, and when they perceived that the supervisor regarded the participant as a professional equal. In terms of sensing an open connection, recovery was equated with an ability to connect with colleagues, and more importantly, that this represented an ability to connect with clients. The ability to connect is a key feature of competent therapy (Fairburn & Cooper, 2011) and, as stated earlier, the desire to connect is a key feature in psychological recovery (Andresen et al., 2003). Participants used this sense of an open connection as a means of knowing they were recovered in terms of being able to provide competent therapy. In terms of being a professional equal, the supervisor demonstrated this opinion through such activities as referring clients and inviting the participant to professional, collegial events. The present study theorized that the supervisor would not engage in these types of activities if he or she did not believe that the participant were sufficiently recovered, and therefore this behaviour provided an awareness of recovery.

The final relational category discussed in this chapter, and the one most commonly commented upon as a means of knowing recovery in the current study, was the client relationship. This refers to the therapeutic relationship that a therapist has with his or her
client during session. The client relationship made the participant aware of his or her recovery in several ways. One such way was the client’s continued attendance in therapy as well as the client’s referral of others to the practice. The data suggested that recovery led to a more authentic and competent therapist who was better able to connect with and assist the client; therefore the clients’ continuation of their therapy implied recovery. Moreover, some clients referred others to the participant, suggesting that they valued the participant’s authenticity and competence. This also contributed to the participants’ knowledge that they were sufficiently recovered. The idea of authenticity as an indicator of depression recovery was discussed by Ridge and Ziebland (2006). In qualitative interviews with 38 men and women who had previously been depressed, the authors noted that “a repeated narrative about recovery was the quest for more authentic living and self” (p. 1047). They stated that authenticity was more than simply a narrative turn but that living authentically was commonly commended for its ability to reinvigorate the lives of those interviewed. Sensing this authenticity through interactions with clients was an indicator of recovery awareness in the present study.

Another means was through noting improvements in the clients’ lives. This suggested a parallel process (Mendelsohn, 2012) in which the participants’ ability to detect recovery in their clients’ lives indicated that they themselves were recovering. The data suggested that an impaired therapist would be less able to guide a client to mental health; hence, when the participants saw their clients recovering, they reasoned that they themselves must also be recovering. The idea that people who are more sufficiently recovered can lead those who are less sufficiently recovered is a key feature in associations like Alcoholics Anonymous (Jackson, 2001). The mentors in Alcoholics Anonymous cannot work with mentees until they themselves
have demonstrated their own sustained recovery, as it is believed that the mentees will not improve if their mentor has not already demonstrated personal improvement and growth. Similarly, in the present study, the participants became aware of their recovery in part by seeing improvements in their clients’ lives, which suggested to them that they themselves must be sufficiently recovered to have helped facilitate this improvement.

The ability to effectively handle clients’ problems and criticisms suggested a more extreme version of the first client indicator in that the therapists’ recovery and authenticity were tested through these ruptures. If the participants were truly recovered and genuinely authentic, they would pass this test and remain connected to their clients rather than letting their own wounds interfere and lead to further and perhaps clinically fatal ruptures. Ruptures potentially indicate the emergence of the client’s core conflictual themes, and as such their presence suggests that the therapy is deepening in a competent manner (Sommerfeld, Orbach, Zim, & Mikulincer, 2008). Haskayne, Larkin and Hirschfeld (2014) offered an important caveat that the emergence of core conflictual themes through rupture is only therapeutic if resolved and that unresolved ruptures were linked to poor therapeutic outcomes.

The interpersonal relationships covered in this theme each helped to make the participants aware of their recovery. Friends and family did so indirectly as the participants noted changes in relational dynamics such as an increased interest and ability to connect. Therapists and other health professionals provided direct feedback on participants’ competence and whether they were ready to return to practice. Supervisors and colleagues provided both direct feedback on countertransference issues and indirect feedback through
changes in how they and the participants related to one another. By staying in therapy, referring others and improving in their own lives, clients provided awareness of recovery in that the participants felt these elements would not be occurring were they not recovered. This also applied to their ability to handle ruptures competently. The final way in which the data suggested that awareness of recovery was acquired was through the client work itself. This will be discussed next.

**Through Client Work**

While the previous themes discussed the awareness of recovery on an intrapersonal level and in relation to interpersonal relationships, the current theme extended that discussion to examine knowing recovery in terms of the client work itself. In other words, this theme builds upon the previous themes in order to continue addressing the focus of this research: to understand how mental health therapists became aware they were sufficiently recovered from their depressive experience such that the experience would aid rather than detract from therapy. Two primary means of knowing recovery in relation to client work emerged from the data. The first was the sense of being able to connect with clients and the second was the sense of becoming a wounded healer. Both are discussed below. In terms of the justification of beliefs (Bengson & Moffett, 2011), the primary forms of justification demonstrated within this theme were empiricism and deductive reasoning (Gertler, 2011).

Results from the interviews indicated that participants knew they were sufficiently recovered to practice competently when they sensed an increased ability to connect with the client within an appropriate holding environment (Winnicot, 1965). Participants described how
they often struggled to maintain connection with clients while in the midst of their depressive experience and that this shift in ability indicated to them they were recovering. This ability to connect relates strongly to the concept of the therapeutic working alliance (Bordin, 1979; Hentschel, 2005). Gelso and Hayes (1998) described the working alliance as the joining of the therapist’s working or analyzing side with the client’s reasonable side. Three specific aspects of client interactions wove together to provide the means for this alliance or connection within the holding environment (Winnicot, 1965): an ability to focus on the client (Schneider, 2015), the appropriate use of humour (Sultanoff, 2013) and the appropriate use of self-disclosure (Panagiotidou & Zervas, 2014).

The first category, the ability to connect through a sustained focus on the client, contrasted against a relative inability to do so while participants were in the midst of their depressive experience for those who had continued to work during that experience. This category speaks to two elements of awareness of recovery as it relates to competent therapy: a decrease in rumination on personal difficulties (Ietsugu et al., 2015), which led to an increased ability to be present during session (Schneider; 2015).

Rumination, the first element of the ability to sustain focus on the client, has been defined as a response style characterized by attentional focus on symptoms and their causes and consequences (Nolen-Hoeksema, 1991) and has been positively correlated with the onset, severity and duration of depressive symptoms (Crane, Barnhofer, Visser, Nightingale, & Williams, 2007). Related to recovery, efforts to diminish depression relapse have focused on changing the trajectories of rumination and anxious worry (Ietsugu et al., 2015). The current
study noted that diminished rumination suggested recovery because of the decrease in depressive focus. Furthermore, the subsequent increase in mental and emotional space available for the client and their issues due to the decrease in rumination suggested the potential for competent therapy. The ability to note this decrease in rumination was itself described by the participants in the current study as an indicator of recovery.

Along with a decrease in rumination, the data revealed that an increased focus on and presence with the client suggested recovery in terms of competent therapy. Schneider (2015) suggested that presence is “the core contextual factor of therapeutic effectiveness” (p. 304). While his definition incorporates more active components such as concerted engagement and expressiveness, the core feature of presence was reflected in the present study in terms of knowing recovery. From a related perspective, Møller (2014) linked the lack of presence to non-competent analysis and explained why psychoanalysts at times have difficulty embarking on analysis. She specifically centered on analytic presence and noted that anxiety and a “fragile psychoanalytic identity” (p. 485) are often central to their failure to be analytically present. This fragile psychoanalytic identity was understood in the current study to relate to the depressive state in that both speak of insecurity and a less competent stance in therapy. Awareness of recovery was reflected in the ability to be present with clients as the participants confronted and worked on these “inner impediments” (Møller, 2014, p. 485).

Along with an ability to focus on the client, the current study suggested that the participants’ appropriate use of humour was another means of connecting with clients. Humour also indicated recovery related to competent therapy in that participants did not use
humour while they were in the midst of their depressive experience, and so its subsequent use was an indication of recovery. Related to the relationship between humour and competent practice, Sultanoff (2013) discussed the “core conditions” (p. 395; Rogers, 1957) of the therapist necessary to use humour effectively in therapy. These were empathy, genuineness and positive regard. Each of these conditions is regarded in the literature as elements of competent therapy (Ridley, Mollen, & Kelly, 2011; Rogers, 1957; Sharpless & Barber, 2009). The present study theorized that the use of humour in session indicated the presence of these core conditions, and therefore a central component of competent therapy. Panichelli (2013) extended this conversation by discussing the relationship between humour, competence and working alliance. He argued that humour resolved the paradox that therapists are expected to help reframe the client’s perspective while also joining them in their original perspective, through “humor’s ability to produce verbal communication and contradictory nonverbal signals simultaneously” (p. 438). Panichelli noted that humor, if used effectively, strengthens the working alliance. The present study theorized that an ability to use humour in therapy indicated the presence of empathy, genuineness, and positive regard and that the paradox of joining and reframing was resolved. The ability to use humor in session demonstrated to the participants their recovery in relation to competent therapy and allowed them to better connect with clients.

The third aspect that indicated an increased ability to connect with clients was the appropriate use of self-disclosure. Unlike humour, participants used self-disclosure in both the depressive and recovered states, with the distinction that self-disclosing for the benefit of the client was viewed as an indicator of recovery while self-disclosing for the benefit of the
participant was viewed otherwise. As an indicator of non-recovery, the impact of improper self-disclosure on therapy has been described as role-reversal (Lazarus & Zur, 2002) and boundary violation (Cole, 2006). Participants in the present study described making improper disclosures when they were in the midst of their depressive experience, which indicated to them both non-recovery and non-competence in client work. On the other hand, disclosures that helped normalize and provide a model for new perspectives and behaviors implied recovery (Panagiotidou & Zervas, 2014). Relating self-disclosures to competence, Henretty, Currier, Berman and Levitt (2014) found that appropriate and competent disclosures were those that revealed similarity between client and counselor, expressed negative or uncomfortable thoughts or feelings (rather than positive thoughts or feelings, which could be perceived as somewhat artificial) for the client or therapy, and expressed socially undesirable (rather than socially desirable) personal information of the therapist. As suggested by Panagiotidou and Zervas (2014), these types of disclosures were valued because they helped normalize the client and their experiences and also served to build rapport and empathy with the client. The participants in the present study noted that these types of appropriate self-disclosures increased the sense of connection with their clients and indicated their own recovery in terms of being able to provide competent therapy to those clients.

The three means of connection with the clients described above occurred within a therapeutic holding environment. Winnicot’s (1965) term “holding environment” described his perception of the process of therapy analogous to the mother-infant relationship. From this perspective, the mother is a caring, reliable and competent provider to the child, just as a competent therapist maintains the frame of therapy for the client in a safe, caring way. The
term serves to organize as well as explain a multitude of concepts related to the therapeutic or developmental process itself (Babits, 2001). While the holding environment typically refers to the client’s issues being safely held within the therapy session, the data from the current study suggested that participants knew they were recovered in terms of being able to provide competent therapy when they felt able to join together with the client in therapy but then to truly decouple until the next session. In other words, the therapy environment adaptively held their issues as much as the client’s.

As well as noting an improved ability to connect with clients, the data suggested that a second significant means of becoming aware of recovery through client work was through the participants becoming what is best described as a wounded healer rather than an impaired professional. In discussing the wounded healer concept, Jung (1963) stated that “only the wounded physician heals” (p. 134) and that “it is his own hurt that gives the measure of his power to heal. This, and nothing else, is the meaning of the Greek myth of the wounded physician” (Jung, 1953, p. 116). According to Foreman, the wounded healer is an individual who is transcending or has transcended the trauma and injury of personal wounding by integrating his or her issues (2005). By contrast, impaired professionals “are broadly defined as psychologists whose work is impaired or adversely affected by physical, emotional, legal or job related problems” (Nathan, Thoreson & Killburg, 1983 as cited in Wood, Klein, Cross, Lammers & Elliott, 1985, p. 843). The present study found that participants knew they were sufficiently recovered when they experienced more of the wounded healer identity and less of the impaired professional identity indicated recovery. Specifically, the participants’ integration and competent use of their depressive experience and vulnerabilities in session (Miller & Baldwin,
2000), their awareness of the need for support (Cummings, Ballantyne, & Scallion, 2015), and their healthy separation of self from client (Mahoney & Morris, 2012) indicated to them a sufficient level of recovery in relation to the ability to provide competent therapy. These elements were not present during the depressive experience; therefore, their appearance indicated recovery.

In relation to the wounded healer paradigm, the present study suggested that Foreman’s (2005) notion of “transcending” strongly parallels the present study’s notion of recovery in that both relate to moving beyond the injury/depressive experience through an adaptive integration of the experience into their lives and work. Furthermore, Nouwen’s (1972) suggestion that healing power itself emerges from the healer’s own woundedness aligns with the present study’s findings that part of the implication of becoming a wounded healer was an improved ability to practice therapy competently. Making the further connection between competent practice and the wounded healer paradigm, the study found that competent therapy was understood in terms of viewing oneself not as the expert but rather as being aware of one’s own vulnerabilities while tapping into the strength and expertise of the client. This aligns with Kirmayer’s (2003) position that it is the activation of the wounded-healer duality for both the therapist and patient that constructively informs the healing process. Healing occurs when the therapist views himself or herself and can help the client view himself or herself as both wounded and as a healer. The present study suggested that participants understood they had sufficiently recovered when they saw vulnerability as a potential strength rather than simply a liability.
How does this vulnerability lead to competent practice? Related to the present study’s finding that an awareness of the value of vulnerability suggested both recovery and an alignment with the wounded healer paradigm (Jackson, 2001; Nouwen, 1972), Miller and Baldwin (2000) posited that vulnerability can be cultivated as a strength through “conscious inner attention” (p. 250). Data from the interviews suggested that the cultivation of this “conscious inner attention” led, in part, to the awareness of the need for professional support and guidance and that this was potentially one process whereby an individual moves from being an impaired professional to a wounded healer. The current study theorized that awareness of the need for supervision is a distinguishing feature between wounded healers and impaired professionals (Kern, 2014; Wheeler, 2007). Furthermore, supervision and therapy are widely recommended for professionals working within mental health (Cummings, Ballantyne, & Scallion, 2015; Orlinsky, Schofield, Schroder, & Kazantzis, 2011; Probst, 2015; Steven, Goodyear, & Robertson, 1998). The findings from the present study noted that participants’ awareness of the need for support paralleled their awareness of being recovered in terms of competent practice. Part of the wounded healer paradigm therefore was the relationship between competent practice and seeking out support and feedback. The results confirmed that feedback and supervision were considered central to competence and were also sources of knowledge of recovery.

Despite a common perspective that therapists with personal experiences relatable to that of the client provide better therapy (Jackson, 2001; Costin & Johnson, 2002), part of what distinguishes the wounded healer from the impaired professional is not relating too strongly or over-identifying with the client and their difficulties (Mahoney & Morris, 2012; Swearingen,
1990), or in other words, maintaining a healthy separation. The data from this study found that the participants’ ability to maintain a healthy separation from the client was an indication of both identification with the wounded healer paradigm as well as recovery in terms of being able to provide competent practice (Hayes, 2002; Zerubavel & Wright, 2012). This included both not needing anything from the client as well as not taking anything from the client in terms of bringing client issues “home.” Stated more technically, the data suggested that knowing recovery involved the participants’ ability to manage problematic countertransference through the use of adaptive professional boundaries. Importantly, these were both elements found within the wounded healer paradigm (Jackson, 2001).

Countertransference has been defined as the “therapist’s transference to the client’s material, both the transference and the nontransference communications presented to the client” (Gelso & Carter, 1994, p. 297). Traditionally, these reactions are understood to be evoked by the client but are based on the therapist’s unresolved issues (Markin, McCarthy, & Barber, 2013). A number of authors have distinguished between harmful and helpful countertransference (Ivey & Partington, 2014; Pakdaman, Shafranske, & Falender, 2015; Sedgwick, 1994). For example, Sedgwick (1994) described the helpful variety when linking the therapist’s capacity to be wounded with countertransference, coining the term neurotic-countertransference. Sedgwick stated that “the more personalised the counter-transference can become, the greater the potential utility and healing. Or in Jungian terms: for wounded healer work to be healing, the analyst has to be really wounded by the patient, the deeper the better” (p. 108). Harmful countertransference was succinctly described by Nouwen (1972) who said that “open wounds stink and do not heal” (p. 88). Data from the present study suggested
that awareness of recovery occurred as the participants became aware of unresolved issues in their depressive experiences and were then able to minimize unhelpful countertransference while still connecting with their clients.

Related to countertransference is the concept of boundaries, “the safe foundation for the therapeutic relationship” (Speight, 2012, p. 133). Wallin (2007) noted that the therapist who is able to maintain the “frame” of the treatment – that is, the boundaries – creates a kind of transitional space in which a therapeutic relationship can develop that is pretend as well as real. Wallin noted that the pretend aspect of therapy along with the secure base of the therapeutic relationship allows for a degree of safety and freedom for the client to imagine, think and feel. Wounded healers are able to provide this safe foundation and frame, whereas impaired professionals are typically seen as unable to do so (Jackson, 2001; Ivey & Partington, 2014). Data from the present study revealed that successful maintenance of boundaries in terms of appropriate emotional distance was an indication both of recovery and of becoming a wounded healer because there was no longer an unhealthy overidentification with the client and his or her issues.

The aspects of client work covered in this theme each helped the participants become aware of their recovery. The participants sensed that they were able to connect with the clients through the decrease in personal rumination, the increase in presence, the use of humour and adaptive self disclosure within a therapeutic holding environment. These forms of connection indicated to the participants they were sufficiently recovered such that they were providing competent practice. Importantly, their ability to see that they were transiting from an impaired
professional to a wounded healer indicated that their depressive experience aided rather than detracted from therapy. This identification with the wounded healer paradigm included integration and competent use of their own depressive experience and vulnerabilities in session, the awareness of the need for support, the healthy separation of self from client through managing countertransference, and the appropriate use of boundaries and self-awareness.

In sum, by connecting the three themes identified in the results chapter with the appropriate literature, this discussion chapter explored how these three themes indicated to the participants that they were sufficiently recovered in terms of their ability to provide competent therapy. From an intrapersonal perspective, the participants sensed they were recovering as their depressive symptoms abated and as they felt more psychologically recovered (Andresen et al., 2003). Their state of recovery was verified through a number of relationships. Family and friends provided this sense indirectly through the returned ability and desire to connect. Therapists and health professionals provided direct feedback both on participants’ recovery state and on their professional competence, supervisors gave direct feedback on issues like countertransference, and colleagues provided feedback indirectly through how they interacted with the participants (i.e., openly and with equality). Clients provided indirect feedback in three major ways: on whether participants were authentic through the patient’s continuing in therapy and referring others, through a type of parallel process wherein the clients would not be recovering if the participants themselves were not sufficiently recovered, and through a type of limit testing wherein core conflictual themes were unearthed. Whether participants’ depressive experience was recovered to the point that it
aided rather than detracted from client work was most directly understood by examining the client work itself. Participants noted that the ability to connect with clients through a decrease in personal rumination, increased presence, adaptive use of humour and self-disclosure indicated recovery. They also noted that their identification with the wounded healer paradigm, namely by seeing vulnerability as a strength, understanding the value of supervision and therapy and not overly connecting with the client, indicated to them they were sufficiently recovered to provide competent therapy. The client relationship and the client work especially provided a strong sense to the participants whether they were recovered from the depressive experience such that it aided rather than detracted from client work.

The following section will discuss the mid-level theory of knowing recovery developed through the present study.

**Mid-Level Theory of Knowing Recovery**

A number of theoretical orientations helped shape the foundation of this research generally and the mid-level theory specifically. As will be argued below, a critical component of recovery awareness involved relational components, both intrapersonal and interpersonal. Therefore the research offers the following broad statement: the participants became aware of their recovery through the changed relationship they experienced with themselves as well as with important others in their lives. This relational focus aligns well with research in interpersonal theory (Hilliard, Henry, & Strupp, 2000; Sullivan, 1953), object relations (Blum, 2010; Klein, 1960), attachment theory (Bowlby, 1988; Burke, Danquah, & Berry, 2015), and intersubjective psychoanalysis (Stolorow, Brandchaft, & Atwood, 1987; Orange, 2010). To varying degrees, each of these theoretical orientations posits that knowledge, including self-
knowledge and awareness arises out of a relational context, both internally and externally. It is out of this relational orientation that the rationale for this mid-level theory is argued.

The mid-level theory presented in Figure 1 (see below) offers a visual explanation for how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are now able to provide competent therapy. The theory suggests that, following a depressive experience, the therapist comes to a sufficient level of recovery that relates to both his or her personal and professional life. Awareness of this recovery occurs in tandem as the therapist notes a number of personal (Spitzer et al., 1978) and professional changes (Schneider, 2015) that are also verified through significant others in the therapist’s life (Cruwys et al., 2014; Cummings, Ballantyne, & Scallion, 2015).
From left to right, the diagram of the mid-level theory argues that each indicator provides an increasingly direct, accurate and cumulative sense of awareness that the therapist is sufficiently recovered such that he or she is able to provide competent therapy. For example, while a reduction of depressive symptoms (Frank et al., 1991) and an increased sense of psychological recovery (Andresen et al., 2003) are indicators of sufficient recovery, they are not as central and direct as the sense of being able to connect with clients (Gelso & Hayes, 1998; Hentschel, 2005) and identify with the wounded healer paradigm (Jung, 1963; Nouwen, 1972). The circular arrows intersecting the six indicators reflects the dynamic nature of recovery and
therefore knowing that recovery. Despite the weighted nature of these indicators, each is considered necessary for recovery awareness, though none is considered sufficient in itself. It is only through the relative agreement of each of the individual indicators that necessity and sufficiency are met. This mid-level theory suggests that the accurate awareness of recovery facilitated by this agreement relies principally on two elements: comparison and consensus.

Comparison. The mid-level theory states that each of the indicators relies on some form of comparison in order to assess recovery. From the intrapersonal perspective, the therapist compares his or her own current symptom presentation and functioning against what is generally understood to indicate either the presence or absence of a depressive state (Frank et al., 1991). The therapist also compares his or her current functioning against what is generally considered to indicate psychological recovery (Andresen et al., 2003). Psychological recovery includes relating to the depressive symptoms in a less pathologizing manner (Ibid, 2003), increased self-efficacy (Bandura, 1977) and experiencing recovery as actualizing growth (Rogers, 1959). If these comparisons lead the therapist to conclude that both his or her current symptom presentation and functioning aligns more strongly with the general absence of depressive symptoms and the presence of psychological recovery, the therapist is recovering (Blackburn & Owens, 2015; Boland & Keller, 2009). While these two indicators do not in and of themselves indicate sufficiently to the therapist whether he or she is recovered in terms of being able to provide competent practice, this personal state of recovery is considered a fundamental element due to the impact of intrapersonal functioning on therapy competence (Probst, 2015).
As well as comparing his or her own functioning in relation to concepts like depressive symptomatology and psychological recovery, the mid-level theory suggests the therapist also uses a number of important relationships in order to sense his or her recovery. Like the intrapersonal examination, the interpersonal examination relies strongly on comparison, with each relationship being used somewhat differently for the therapist to sense his or her recovery. Beginning with friends and family, the therapist compares his or her current ability and desire to connect relative to the lack of ability and desire while in the previous depressive state (Fowler, Wareham-Fowler, & Barnes, 2013; Solomon et al., 2008). In relation to collegial relationships, the therapist senses indirectly whether his or her colleagues think he or she is recovered by how openly and equally they treat the therapist currently compared to how they treated the therapist when he or she was in the depressive state (Cummings, Ballantyne, & Scallion, 2015; Fairburn & Cooper, 2011). The therapist’s therapist, health provider and supervisor compare the therapist’s current presentation against his or her own professional understanding of what constitutes a recovered therapist and competent mental health worker in order to opine whether the therapist is sufficiently recovered (Probst, 2015; Wisenthal & Krupa, 2013). The therapist also compares how the clients interact with him or her relative to previously as an indirect means of knowing his or her own state of recovery (Ridge & Ziebland, 2006; Sommerfeld, Orbach, Zim, & Mikulincer, 2008). As with the intrapersonal indicators stated above, each of these four categories of interpersonal indicators provide an increasingly direct, accurate and cumulative awareness of recovery in terms of competent practice, though none are considered sufficient to this end.
As the final major element in the process of self-examination via comparisons, the mid-level theory states that the therapist also compares his or her professional functioning in session to previous levels of functioning. Comparing his or her current ability to connect with clients relative to his or her inability to do so while depressed indicates recovery (Møller, 2014; Schneider, 2015). The therapist also compares his or her own functioning and presentation with what is generally accepted to be definitive features of a wounded healer (Foreman, 2005; Jung, 1963) relative to previous functioning that aligned more closely to that of an impaired professional (Mahoney & Morris, 2012; Wood, Klein, Cross, Lammers, & Elliott, 1985). Noting the abilities to connect appropriately with clients and align more closely to aspects of the wounded healer paradigm are key indicators that the therapist is sufficiently recovered in terms of being able to provide competent therapy.

**Consensus.** The mid-level theory states that a therapist becomes aware that he or she is sufficiently recovered from his or her depressive experience such that the experience now generally aids rather than detracted from client work when the above mentioned comparisons draw the same conclusion—in other words, when a consensus of recovery is met. This consensus includes both the therapist’s personal opinion on his or her state of personal functioning and professional competence as well as the validating direct and indirect feedback from important others in his or her life. Importantly, this consensus helps the therapist attribute the changes in his or her personal life and professional functioning to recovery rather than some coincidence or fluke (Hewstone, 1983). In terms of the justification of beliefs, this mid-level theory argues that the necessary and sufficient knowledge gained through the consensus of these various comparisons meet the threshold of a justified true belief (Bengson &
Moffett, 2011) and therefore the therapist attains a relative degree of certainty that he or she is indeed sufficiently recovered in terms of being able to provide competent therapy.

The outcome from the mid-level theory is that consensus gained through the variety of comparisons provides a strong overall indication to the therapist that he or she is recovered from the depressive experience such that the experience now generally aids rather than detracts from client work. Each indicator is considered necessary but none is sufficient in and of itself. The model also suggested that the continued ability to maintain competent therapy is not assumed and is rather conditional upon continued sufficient recovery and growth in relation to present or potential future depressive experiences or other forms of wounding.
Conclusion

The present study, with its focus on how mental health therapists come to know they have sufficiently recovered from their depressive experience such that they are able to provide competent therapy was explored through a socially constructed, grounded theory methodology by in-depth interviews with ten mental health therapists. The results chapter suggested that these therapists come to know they were recovered through noting changes in their intrapersonal functioning and in their professional practice and that these changes were verified by a number of important others in their lives. These three subthemes were then explored in the discussion chapter in relation to the relevant literature.

Social constructivism assumes that meaning is constructed by humans as they engage with the world they are interpreting, that this engagement is based on both their historical and social perspectives and that the basic generation of meaning always arises out of interaction with the broader community (Crotty, 1998). This tendency towards constructing meaning through interaction and interpretation was evident throughout the interviews, as each participant described his or her subjective world as accurately as he or she could. As the interview data have already been discussed, the focus now turns to an exploration of the strengths, weakness and implications of the findings as well as areas for future research. Each of these is explored below.

Strengths and Contributions

This study offered a number of strengths in research design, participant demographics, interview focus and outcomes as well as contributions to the literature.
The socially constructed, qualitative nature of the research allowed for a nuanced discussion of depression, recovery and competent therapy taking into account the individual’s experience and unique expertise while presuming as little as possible about neither the pathological nature of depression nor the formalized process of recovery. To date, much of the research in the areas of depression and recovery and competent therapy has been more quantitatively focused, with goals such as defining constructs, designing measurement tools and refining treatment protocols (Cooper et al., 2015; Frank et al., 1991; McHugh & Barlow, 2010; Ridley, Mollen, & Kelly, 2011; Spitzer, Endicott, & Robins, 1978; Summers & Barber, 2003). Depression is often viewed in the literature as a mental illness and recovery as primarily related to symptom diminishment (see Andrews & Thomson, 2009; Raison & Miller, 2013). However, the open-ended nature of the interviews allowed for a more nuanced discussion of the phenomena in that several of the participants viewed depression as difficult, though not necessarily harmful, and recovery as related more to growth and evolution than mere symptom reduction. The experiential voices heard in this research are not often found in the published literature, and so the participant discussions helped augment the understanding of these phenomena.

Another strength of this study was the multilayered and cumulative effect that the three subthemes had on the process of knowing recovery: through intrapersonal functioning, through interpersonal relationships, and through client work. Taken separately, each of these subthemes is insufficient as a source of recovery knowledge. However, when combined, participants expressed reasonable confidence that they knew they were sufficiently recovered such that they were able to provide competent therapy to their clients. Related to these subthemes, an
additional strength of the research rested in the sustained focus of the research, where a conscious attempt was made to keep the discussion centered on knowing recovery as much as possible while still maintaining an open stance toward the participants’ narratives. This is contrasted with other research that attempts to cover broader topics while sacrificing depth and understanding in the process.

The participants themselves were a source of strength for the research. A wide range of mental health workers, from psychologists to psychotherapists to a social worker and physicians practicing psychotherapy, participated in this research. The range of experience from 6 to 40 years and the fact that 30% of the participants were male was felt to be a fairly accurate cross-sample of therapists in Canada in terms of age, gender and years of experience. The depressive experiences that the participants brought to the discussions were also wide ranging, providing a good representation of etiology, length of experiences, severity, diagnosis/non-diagnosis, treatment experiences and time since recovery. Furthermore, adequacy of the data sample size and level of discussion was presumed based on the “saturation” level reached during interviews (Morse, 2015).

One unique contribution was the heretofore apparent non-existence of research specifically examining how interpersonal relationships provided knowledge to mental health therapists (or indeed to other professionals such as nurses, social workers, and teachers) as to whether or not they were sufficiently recovered from a depressive experience such that their experience would aid rather than detract from their clinical work. Most of the extant literature on knowing the self and knowing recovery centered either on assessment measures (Frank et
al., 1991; Luszczakoski, Olmos-Gallo, Milnor, & McKinney, 2014; Spitzer et al., 1978) or an intrapersonal sense of knowing and change (de Vries et al., 2012; Lloyd, King, & Moore, 2010; Solomon et al., 2008). This was especially true in relation to mental health therapists. Despite the lack of existing research focused on the interpersonal element of recovery awareness, the sheer number of references in the participant interviews and the centrality it held in the discussion suggested that relationships were a critical component in knowing and therefore worthy of exploration.

A second contribution related to the important role that awareness of and identification with the wounded healer paradigm played in the participants’ conceptualization of what constituted the culmination between recovery and competent practice. Miller and Baldwin’s (2000) warning that a lack of integration of the healer’s wounds could negatively influence therapy appeared well understood by the participants. This understanding spoke to the fact that these critically reflective therapists could use both their depressive and recovery experiences in the service of their clients, and aligned well with numerous studies on the potential for healing contained within the wounded healer (Aponte & Winter, 1987; Groesbeck, 1975; Guggenbuhl-Craig, 1971; Jackson, 2001; Jung, 1963; Kirmayer, 2003; Nouwen, 1972). It is argued that the current study helped to provide additional confirmation of the centrality of the wounded healer paradigm for knowing one is recovered in relation to being able to provide competent therapy to a client population.

Limitations

The study has a number of limitations. One significant limitation was the relative lack of ethnic and cultural diversity among my participant pool. Although three of my participants were
born outside Canada (two from Great Britain and one from central Europe), the participants were all white. Given more diversity, the interviews and analysis might have yielded additional themes or perspectives. As with all voluntary samples, it was impossible to say what those who did not volunteer might have said. Related to the participant pool, the snowball sampling used to collect participants may well have resulted in a more homogenous data set than if weaker connections existed between participants.

As stated previously, while saturation was apparently met, it is possible that an even larger sample size would have resulted in a greater diversity of themes and points of discussion. A larger data set would certainly have led to more raw data from which to draw analysis, and this could have had a significant bearing on the remainder of the research including the implications of this study. In a similar fashion, the single interview session format employed for this study was a potential limitation. Meeting with participants over multiple interviews could have yielded additional data. Certainly, a period for reflection between sessions could have generated meaningful discussions.

Any research, and in particular qualitative research, is potentially hampered by uneven power dynamics between researcher and participant. This can be especially true when participants are discussing vulnerable and potentially stigmatizing topics such as their personal experiences with depression. Incidentally, this was one reason the interview format initially focused on participants’ recovery experiences rather than their depressive history and experiences. However, the feedback from participants was they needed to speak about their depressive experience as it related to recovery. Trusting that they were intelligent, insightful
people who provided the information they felt needed in order to better understand the phenomena, the interviews proceeded with the inclusion of more of their depressive history, as they felt comfortable sharing.

One particular practice often recommended by qualitative research protocols is seeking direct feedback from participants once emergent themes start to arise (Berg, 2007, Creswell, 2009). This is done to ensure that the essence of the participant’s story and perspective remains central to the end product. Feedback in the form of a second interview was not sought for this study and as such could be seen as a potential limitation. The researcher was aware of this potential limitation beforehand, however, and reasoned that this limitation could be sufficiently offset through the additional verification tools provided by the grounded theory process. Namely, the selective sampling arising from forced coding as well as the use of constant comparison helped assure that the themes and subthemes arising from the data were true to the participants’ voices. The later participant interviews provided a type of surrogate feedback and confirmation of the earlier interviews as well as their own unique sources of data. The fact that saturation was met also helped verify that the concepts being researched were sufficiently understood in their complexity and entirety. And finally, the relevant literature appeared to support the conclusions of this research. However, despite these verification tools, the fact remained that confirmation as well as potentially a deepening analysis of the data could have been garnered through the use of a second feedback interview.

Also inherent in qualitative research is the potential for subjective researcher bias. This researcher certainly has his own views on depression, recovery, competent practice as well as
the process of knowing in relation to these phenomena. These views are informed not only by his reading, training and work as a therapist but also as an individual who has experienced his own set of personal challenges and difficulties in life. Indeed, each of these sources of knowledge helped guide the orientation of this research. Because of that, this researcher attempted to be as aware as possible of his own potential bias at each stage of the research process. This was accomplished by frequent journal writing, discussions with his dissertation supervisor, committee and colleagues as well as continuing to read up on relevant literature. Despite this, there remains, of course, a possibility of undue bias in the final product.

Implications for Clinical and Counselling Psychology

As stated earlier in this dissertation, psychologists and other mental health therapists play a critical role in their work with the public. Miller and Baldwin (2000) have pointed to the risks therapists run in not being sufficiently recovered from their wounds and the damage these unrecovered wounds can cause to themselves and their clients. It was from a desire to minimize that risk through increased self-knowledge and awareness that this research originated. To that end, this research was intended for mental health therapists, not particularly the lay public. On one level, this research attempted to provide a framework for knowing recovery via the mid-level theory for either a mental health professional recovering from a depressive experience, or a supervisor or therapist working with a mental health professional recovering from such an experience. The intent was to assist this person in knowing, by reflecting upon this theory, that the person was sufficiently recovered and able to work competently because their depressive experience would now aid rather than detract from their client work (see Probst, 2015). However, in moving through the interview data, it became
apparent that while a mid-level theory could be developed to help that process of knowing, ultimately *recovery* could not be known with certainty apart from actually stepping into the therapy session and doing the work. In other words, the findings presented a paradox of sorts: that one cannot know one is ready to return to practice until one has returned to practice. The larger implication of this finding is twofold: that a comprehensive theory would be difficult if not impossible to produce as a foolproof quality control measure and that careful supervision, personal reflection and self-care are critical at this juncture as the individual continues to feel out where he or she is at in terms of recovery and his or her ability to provide competent therapy (Fairburn & Cooper, 2011; Pakdaman, Shafranske, & Falender, 2015).

In relation to the idea of a quality control measure, one implication of this study is that, while not comprehensive, a partial checklist could be generated based on the three subthemes and their categories discussed by the participants. Broadly speaking, sensing an adaptive shift in a therapist’s own intrapersonal functioning and client work and having these shifts verified by a number of relations in his or her life could go a long way in helping the therapist know whether or not he or she was ready to return to practice, and when returning to practice, in determining whether or not the therapist was providing competent therapy. Depending on the relative position along the depression/recovery continuum that the individual therapist finds him or herself, he or she might have more or less insight into their own state. This is true at the best of times, given the literature on potential biases in self-awareness (Abela & D’Allessandro, 2002; Dunning, Heath & Suls, 2004). Making this explicit in training programs could be invaluable, especially given that from a number of therapeutic perspectives, including those with a psychoanalytic (Smith, 2000) or interpersonal (Teyber, 2006) orientation, the therapist is
the instrument used in sessions: if we are not finely tuned, we run the risk of giving out poor readouts and providing poor service to clients (Gilroy, Carroll, & Murra, 2002). However, despite the usefulness of these indicators, the central role of supervision and other relationships in knowing recovery cannot be stressed strongly enough.

On a content level, it was also hoped that the results from the participant interviews presented depression and recovery in a more holistic light than as simply defined through symptom exacerbation and symptom diminishment, respectively. In terms of the wounded healer paradigm (Jackson, 2001; Jung, 1963), depression and other wounds are not merely something to move past but rather offer a type of strength in woundedness and vulnerability (Miller & Baldwin, 2000). This aligns with Nouwen’s (1972) suggestion that from the healer’s own woundedness emerges healing power as well as Kirmayer’s (2003) position that the activation of the wounded-healer duality for both the therapist and patient constructively informs the healing process. As the fields of clinical and counselling psychology continue to better understand these perspectives, issues like shame, stigma and gatekeeping responsibilities can be discussed and understood in a more nuanced light with an eye toward normalizing as opposed to simply pathologizing.

On a supervisory level, it is hoped that this research can help explicate the process of recovery, in particular how the awareness of recovery comes about. This could have implications for gatekeeping and the ethics around protection of the public. Supervisors and therapists have an important public role, and the more information they have to aid in the process of supervision, the better served are the public and the individual therapist.
Recommendations for Future Research

This research examined how participants came to know they were sufficiently recovered from a depressive experience such that they could provide competent therapy. Future research could extend this to examine not simply the knowing element of recovery but the process of recovery itself and explore how this process influenced client work (Zerubavel & Wright, 2012). This is not simply in reference to the end result of being recovered and what participants would no doubt describe as positive benefits to their work, but rather the process of recovery. In other words, future research could examine mental health therapists at multiple time points along their depression/recovery continuum and understand more clearly how they operated with clients at each point along their recovery journey (assuming they continued to see clients while in the midst of their depressive experience). An assumption in the literature seems to be that therapists should not see clients while in the midst of their own current, personal depressive experience (see Conchar & Repper, 2014). Knowing how they operated with clients at various time points along this progression could help answer how much of their current state of recovery would be reflected in their client work and what might be the implications for clinical competence.

In all probability, the process of being depressed/wounded and then recovering/healing and returning to client work with this experience now embedded and adapted to the client work broadly follows the process of becoming a wounded healer. As stated prior, there are a few studies that examine the process of becoming a wounded healer (Esping, 2014; Miller et al., 1998; Wolgien & Coady, 1997), but these are largely linear accounts and do not include the possibility of having wounds simultaneously that are healing while others are not. To find and
talk to people willing to talk while in this raw unhealed position would aid in understanding this area greatly, especially in relation to therapists and providing service to clients. The outcome could be a greater understanding of the process of becoming a wounded healer as well as potentially some predictive markers as to who will become a wounded healer as opposed to an impaired professional.

A few participants did speak about recovering from depression primarily in terms of symptom reduction rather than on growth or evolution. These participants focused more on clinical presentation: how each particular symptom (i.e., rumination) impacted client work and therefore how the amelioration of each symptom improved client work, rather than describing recovery in more holistic or growth terms (see psychological recovery [Andresen et al., 2003]). It could be beneficial to interview mental health professionals with a depressive history to compare their understanding of recovery with their understanding of client work. In other words, did those who saw their own recovery as largely symptom reduction transpose that idea of recovery into their work with their own clients, and what implications would that have on competent therapy?

Given the central role that relationships had on aiding participant self knowledge in relation to their state of recovery in the current research, the continuation of inquiry along this theme is recommended. As stated earlier, this researcher had difficulty finding articles on the role that others play on self knowledge – and not simply on knowing recovery, but also in a broader sense of general self knowledge. Perhaps for those who work from a developmental or object relations perspective, the idea is simply stitched into the fabric such that they assume
and do not research the topic, but I viewed this as a real gap in knowledge. As one possibility along these lines, future research could examine the impact of interpersonal working models on self-perception in relation to recovery. For example, given that our working models of attachment relationships are composed of “representations of interactions that have been generalized” (Stern, 1985, p. 97) rather than on the person him or herself, understanding the impact of this sort of projective representation on the feedback that others gave the research participant could be valuable, especially given their differing placement along the depression/recovery continuum. Do different people place differing levels of trust in the opinion of others, and how much of this has to do with either their state of recovery or on how they relate to others?

Another recommendation for future research would be to continue the trend by those authors who have taken a more nuanced and even adaptive view of depression and other mental health realities (e.g. Andrews & Thomson, 2009; Raison & Miller, 2013). For example, Andrews and Thomson (2009) view the ruminative aspect of depression as adaptive in that it allows for complex problem solving to identify the difficulty underlying the depressive experience so as to avoid repetition in the future. To apply the somewhat crude analogy of cancer to depression, it appears that some mental health researchers are focused on eradicating the symptoms of cancer without addressing the underlying cause. Much of the literature appears focused on the maladaptive impacts of depression and presumes that the eradication of depressive symptoms should be a primary goal of therapy and mental health treatment. This is not to say that a depressive state is desirable; rather this researcher is suggesting that to focus on the symptoms rather than on what the symptoms are indicating is
perhaps missing the point. And so research to this end could be invaluable to the fields of clinical and counselling psychology.

Finally, the value of knowing, of being aware and conscious of one’s recovery and healing in relation to a depressive experience and furthermore the implications of this awareness on clinical practice cannot be overstated. The ancient Greek aphorism to know thyself continues to be as relevant today as it was in days long since past. A psychologist or other mental health therapist who is aware of his or her own level of recovery will be able to engage with his or her clients on a much more relational and helpful level. As stated previously, the focus is not on being 100% healed, indeed this appears largely a myth, but rather to accurately assess whether one is able to competently work with clients. Creating space for this sort of self-knowledge through education, training and supervision could lead to awareness without the need to invoke shame or stigma. The benefits extend beyond the avoidance of burnout and compassion fatigue into the lives of the clients as well. It is hoped that the ideas generated by this study as well as other similar studies that have utilized critical perspectives in therapist practice will inform and help shape theory building, practice and research for future development of the fields of clinical and counselling psychology.

A Personal Reflection on Conducting this Research

While I was excited when first exploring this research topic (both on a professional and on a personal level), I was also somewhat nervous that no one else (especially research participants) would share this excitement and interest. I thought that perhaps no one would be willing or able to come forward to talk about their depressive experiences, even if they were currently recovered rather than depressed, for fear of being perceived as a less competent or
flawed therapist. This fear was quickly dispelled, however, as the early responses from participants suggested a genuine interest, for that very reason. A number of participants, when asked why they were interested in participating, noted that the value of this research was in helping counter the myth that therapists are supposed to be perfectly recovered and completely mentally healthy. Several participants reflected upon the fact that this was of course not true, but that the more this therapist-as-perfect myth was allowed to survive, the more stigma and maladaptive gatekeeping behaviours increased, which would unfortunately result in silence and deter individuals from seeking help. Participants noted that this negative feedback loop ultimately hurt both therapists and clients alike.

Throughout the interviews I was constantly struck with how each participant demonstrated a willingness to open up and share not only his or her recovery experience and ways of knowing, but also his or her honest accounts of the difficult experiences leading up to and culminating in the variety of depressive experiences. At the same time, an understanding that this was part of the human experience permeated the interviews. The participants I interviewed seemed to define the spirit of the wounded healer, and embraced the vulnerability and the healing power that arose from their various experiences.

In order to make sure their knowledge was disseminated as accurately as possible, I sought frequent feedback from my supervisor, colleagues and the literature. My journal writing during this time was crisscrossed with my own personal hopes that I was “getting it right.” However, the later interviews and the strength of the themes that eventually emerged provided strong indications that noting shifts in their intrapersonal and professional functioning
as well as the direct and indirect feedback from important others was indeed how at least these ten participants came to know they were sufficiently recovered in order to be able to provide competent therapy to their clients. These participants could not “know” this without the knowledge and perspective provided by relationships (with themselves and with others). And of course, somewhat paradoxically, the participants could not have known they were able to provide competent therapy until they were in the therapy room itself.

In closing, I was honoured to hear the participants’ experiences. I trust that this research will be of benefit to those wanting to better understand the relationship between depression, recovery, competent practice, the wounded healer paradigm and more specifically, how one can know he or she has sufficiently recovered in terms of being able to provide competent therapy. These topics entwine in numerous ways and it is my hope that I have described at least some of these relationships with accuracy and fidelity.
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Appendix A: Email script for Initial Contact of Potential Participant

Dear (name of potential therapist participant),

My name is Kevin Corney and I am a PhD student in Counselling and Clinical Psychology at the Ontario Institute for Studies in Education, University of Toronto.

For my doctoral dissertation, I am conducting a qualitative study with therapists and other mental health practitioners who have a personal experience of depression from which they have recovered sufficiently in order to work competently with their clients.

I am specifically interested in how the therapist participants came to know they had recovered sufficiently from their depressive experience such that they were now able to provide competent therapy.

I hope that your participation will have the following benefits:

1. Benefit to the profession. Sharing your unique experience of how you have come to know you have recovered sufficiently in order to practice competently will provide important information to the field of counselling psychology.
2. Benefit to the professional. Sharing your unique experience will hopefully provide you with some additional insights into your own life and personal processes.

If you or a therapist/mental health practitioner that you know fit the criteria and would be interested in participating or at least speaking to me further about this project, I would be happy to do so.

Thank you for considering my request. If you have any questions about the study, please feel free to contact me: Kevin Corney by phone (416) 668-3309 or email kevin.corney@utoronto.ca. My supervisor, Dr. Roy Moodley can also be contacted either by phone (416) 978-0721 or email roy.moodley@utoronto.ca.
Appendix B: Information and Consent Form

My name is Kevin Corney and I am a PhD student in Counselling and Clinical Psychology at the Ontario Institute for Studies in Education, University of Toronto. For my doctoral dissertation, I am conducting qualitative interviews with mental health therapists who have had personal experience with depression and who are able to discuss how they came to know they had sufficiently recovered from that depression in order to work competently with their clients. I would like to invite you to participate in this research study. This study is under the supervision of Professor Roy Moodley. This study will help fulfill requirements for my doctoral degree.

WHAT IS THIS STUDY ABOUT?

I am conducting a study to examine how mental health therapists with a personal experience of depression come to know they have sufficiently recovered from their depression in order to work competently with their clients.

Since I am a mental health therapist with my own historical experience of emotional wounding, I have a personal interest in this area. I believe that mental health therapists provide an important supportive role. However, little is known in the academic literature about this process of knowing one has recovered. My study seeks to address this gap in present knowledge. In this study, I will conduct in-depth interviews with 10 to 15 mental health therapists, who, like you, have a personal experience of depression and are able to speak about their own process of self-knowledge.

For the interview, I am looking for individuals who:

1. Work as a mental health therapist and who have some certification toward this end: a master’s degree in psychology, equivalent diploma or other certification that entitles them to work with the general public in the role of therapist.

2. Self-identify as having a personal history of depression which they are able to speak candidly as to how they came to know they had recovered sufficiently in order to work competently.

3. Are not currently in a state of clinical depression, nor are actively suicidal or self-harming.

WHAT WILL I BE ASKED TO DO?

You will be asked to participate in one interview that will last for 60 to 90 minutes. During the interview, I will ask you to talk about how you came to know you had recovered sufficiently in order to practice competently with your clients. I will not ask you to specifically
speak about your own depressive experience unless you feel that would be important to the
conversation. I will also not ask you to discuss details about individual clients as I realize that
information is confidential. Instead, I will ask you to reflect on your own process of recovery,
specifically with how you came to know you had sufficiently recovered from your depression in
order to work competently with your clients. During the interview, I will ask you a small number
of open-ended questions, and you can choose how much detail to include. My hope is that we
can simply have an informal conversation about your experiences.

You may contact me at any point after the interview should you require clarification
about anything we discussed during the interview. When my research is complete, you will
have the option of receiving a copy should you wish. You may withdraw your data from the
research project at any point until two weeks prior to the final analyses. This deadline reflects
the practical matter that your data will eventually be aggregated, analyzed and used towards
the completion of my doctoral degree. I will contact you prior to this deadline, in order to
remind you of this point.

DO I HAVE TO PARTICIPATE?

Of course your participation in this research is completely voluntary. You may refuse to
participate at any time, decline to answer any questions, and even withdraw during the course
of the interview without any negative consequences. No one other than me will know that you
have participated in this study.

ARE THERE ANY RISKS AND/OR BENEFITS TO PARTICIPATING?

Talking about your own recovery process may bring up memories of your own
depressive history and related memories. Should you become distressed at any time, we can
pause or stop the interview. At the end of the interview, in addition to having my supervisor
and my own contact information, you will be given a list of resources that you can access
should you continue to experience emotional distress following your participation in the study.

I hope that your participation will have the following benefits:

1. Benefit to the profession. Sharing your unique experience of how you have come to know
you have recovered sufficiently in order to practice competently will provide important
information to the field of counselling psychology.

2. Benefit to the professional. Sharing your unique experience will hopefully provide you with
some additional insights into your own life and personal processes.

WHAT WILL HAPPEN TO THE INFORMATION AFTER MY PARTICIPATION?
All personal information collected as a result of your participation in this study will remain strictly confidential. The data collected over the course of the project may be used for publication in journals or books, and/or for public presentations, but your anonymity will be maintained. The audio file will be deleted after two months. The transcribed data, information sheets and consent forms will be retained for a period of seven years from date of collection point by Dr. Roy Moodley, and it will be kept in a secure location, a locked filing cabinet in OISE, room 9-164. The data will be accessible only to the principal investigator (Kevin Corney) and my supervisor (Dr. Roy Moodley). Kevin Corney will transcribe all the interviews, and the audio recordings will be erased one month after the sessions are transcribed.

If you would like a copy of the results of this research when it becomes available, we would be happy to offer it to you. If you have any questions about the study please contact either myself or my supervisor, Dr. Roy Moodley. I can be contacted either by phone (416) 668-3309 or email kevin.corney@utoronto.ca. Dr. Moodley can be contacted either by phone (416) 978-0721 or email roy.moodley@utoronto.ca. You may also contact my Graduate Program: Counselling and Clinical Psychology, OISE, University of Toronto; 252 Bloor Street West, Toronto, ON, M5S-1V6; phone number: (416) 978-0682. Also, if you have any questions about your rights as a research participant, feel free to contact the University of Toronto’s Office of Research Ethics by phone (416) 946-3273 or email ethics.review@utoronto.ca.

LEGAL RIGHTS AND SIGNATURES

I (__________________), consent to participate in this research study conducted by Kevin Corney. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent and I realize that I may withdraw my consent at any time.

CONTACT INFORMATION AND REQUEST FOR COMPLETED STUDY

☐ I wish to receive a copy of the completed study.

Please send me the above item(s) by:

☐ Email

☐ Canada Post

Address: ________________________________________________________________

City and Province: __________________________ Postal Code: ______________________

Email address: ____________________________________________________________
SIGNATURES:

_________________________________________  ___________________________
Participant                                     Date

_________________________________________  ___________________________
Principal Investigator                        Date
Appendix C: Interview Guide

**Opening question** (stated in an open ended fashion to allow the participant room to take the interview where they feel it is most germane to their experience):

You have been through an experience of depression from which you’ve recovered and you’re working with clients, some of whom are depressed themselves. How has this whole process been like for you?

* How did you know you had sufficiently recovered from depression in order to practice competently with your clients?

  For instance, what means have you used, whether personally, interpersonally, subjectively or otherwise to help you decide you were recovered enough to provide competent service to your clients?

**Final Thoughts**

As a way of ending, what made you interested in participating in this research?

Are there any other issues that you would like to comment on?

Are there any questions you feel I should have asked as part of this interview and did not?
Appendix D: Participant Information Form

Confidentiality and your anonymity are critical to the success of this project. This participant information form is included simply to provide some context to your experience with the information discussed in the interview. If you feel that answering any (or all) of these questions would compromise confidentiality or your anonymity, please feel free not to answer.

As stated earlier, the only people with access to this completed information form will be myself (Kevin Corney) and my supervisor (Dr. Roy Moodley).

1. Participant’s name:

2. Pseudonym:

3. Participant’s age range: Early 20s to late 20s
   Early 30s to late 30s
   Early 40s to late 40s
   Early 50s to late 50s
   Early 60s to late 60s
   Early 70s to late 70s
   80 +

4. Gender:

5. Ethnicity:

6. Number of years working as a mental health therapist:

7. Extent of current work in the field: Part-time
   Full-time
## Appendix E: Participant details

<table>
<thead>
<tr>
<th>Name (pseudonym)</th>
<th>Age Range</th>
<th>Title</th>
<th>Gender</th>
<th>Number of years working as a therapist</th>
<th>Full-time or part-time</th>
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<tbody>
<tr>
<td>Graham</td>
<td>60s</td>
<td>Psychotherapist</td>
<td>Male</td>
<td>40</td>
<td>Full-time</td>
</tr>
<tr>
<td>Mocha</td>
<td>60s</td>
<td>Psychotherapist</td>
<td>Female</td>
<td>24</td>
<td>Full-time</td>
</tr>
<tr>
<td>Tallulah</td>
<td>30s</td>
<td>Social worker</td>
<td>Female</td>
<td>8</td>
<td>Full-time</td>
</tr>
<tr>
<td>Heather</td>
<td>30s</td>
<td>Psychologist</td>
<td>Female</td>
<td>6</td>
<td>Full-time</td>
</tr>
<tr>
<td>Lucy</td>
<td>40s</td>
<td>Psychologist</td>
<td>Female</td>
<td>14</td>
<td>Full-time</td>
</tr>
<tr>
<td>Jennifer</td>
<td>40s</td>
<td>Psychologist</td>
<td>Female</td>
<td>8</td>
<td>Full-time</td>
</tr>
<tr>
<td>Peter</td>
<td>60s</td>
<td>Physician practicing psychotherapy</td>
<td>Male</td>
<td>20</td>
<td>Full-time</td>
</tr>
<tr>
<td>June</td>
<td>50s</td>
<td>Psychotherapist</td>
<td>Female</td>
<td>14</td>
<td>Part-time</td>
</tr>
<tr>
<td>Kohnka</td>
<td>60s</td>
<td>Physician practicing psychotherapy</td>
<td>Female</td>
<td>14</td>
<td>Full-time</td>
</tr>
<tr>
<td>Samuel</td>
<td>50s</td>
<td>Physician practicing psychotherapy</td>
<td>Male</td>
<td>27</td>
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</tbody>
</table>
APPENDIX F: RECRUITMENT FLYER

PARTICIPANTS WANTED FOR RESEARCH STUDY

MENTAL HEALTH THERAPISTS, IF YOU HAVE PERSONAL EXPERIENCE WITH DEPRESSION, WE WOULD LIKE TO HEAR FROM YOU ABOUT HOW YOU CAME TO KNOW YOU HAD RECOVERED FROM THAT IN ORDER TO WORK EFFECTIVELY WITH YOUR CLIENTS

Ontario Institute for Studies in Education, University of Toronto

Principal investigator: Kevin Corney (Applied Psychology and Human Development Dept.)

Findings will contribute to the investigator’s understanding of the subject matter chosen for his doctoral dissertation in the field of counselling/clinical psychology.

Eligibility for this study: (1) You are a practicing mental health therapist (2) You have had a personal experience with depression about which you are willing and able to speak about (3) You are not currently in a state of clinical depression, nor are actively suicidal or in a state of self-harming.

Procedures: If you are interested in participating, please contact me as soon as convenient. We’ll have a brief discussion to confirm your eligibility for the study. Once confirmed, we will set up a meeting date/time. Interviews will last from 60 to 90 minutes and we can meet at a location suitable for us both.

Possible risks: While unlikely, some questions may be perceived as a source of emotional/psychological discomfort. A list of resources will be provided to you prior to the interview if you need to follow up with a professional due to some discomfort arising for you.

Possible benefits: Findings will help inform the field of psychology about the process of knowing one has recovered sufficiently in order to practice competently with clients. Personal benefits may be realized as well as you get the opportunity to revisit this important aspect of your experiences.

Confidentiality: Your anonymity will be secured. Original names will NOT BE used.

Compensation: There is no compensation associated with this study.

Participation and withdrawal: Your participation is ENTIRELY voluntary. Withdrawal from the study at any time will not result in any penalty or negative consequences.

Additional information: Please contact, Kevin Corney via phone: 416-668-3309 via email: kevin.corney@utoronto.ca
Appendix G: Counselling Resource Sheet

1. **Gerstein Crisis Centre**  
   100 Charles Street East; Toronto, ON  
   1045 Bloor Street West; Toronto, ON  
   416-929-5200  
   Website: gersteincentre.org

2. **Toronto Distress Centre**  
   10 Trinity Square; Toronto, ON  
   700 Lawrence Ave West; Toronto, ON  
   416-408-4357 (408-HELP)

3. **Centre for Addiction and Mental Health Services**  
   1001 Queen Street East, Toronto, ON  
   416-535-8501/1-800-463-6273  
   Website: http://www.camh.ca/en/hospital/Pages/home.aspx

4. **The Counselling and Psychoeducational Clinic at OISE**  
   Suite 7-296  
   252 Bloor St. West, Toronto, ON  
   416-978-0620  
   Website: http://www.oise.utoronto.ca/psychservices/

5. **Counselling and Psychological Services at the University of Toronto**  
   Room 111  
   Koffler Student Services Centre  
   214 College Street, Toronto, ON  
   416-978-8070  
   Website: http://caps.utoronto.ca/main.htm

6. **Family Service Toronto**  
   355 Church Street, Toronto, ON  
   416-595-9618  
   Website: http://www.familyservicetoronto.org

7. **George Hull Centre for Children and Families**  
   3rd Floor  
   81 The East Mall, Toronto, ON  
   416-622-8833  
   Website: http://www.georgehullcentre.on.ca
8. **Jewish Family and Child Services**  
   6th Floor  
   4600 Bathurst Street, Toronto, ON  
   416-638-7800  
   Website: http://www.jfandcs.com

9. **Native Child and Family Services**  
   30 College Street, Toronto, ON  
   416-969-8510  
   Website: http://www.nativechild.org