



More Than the Blues: Clinical Depression, Invisible Disabilities and Academe

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Introduction

[1] In my brief remarks, I will consider the impact of the “invisible disability” clinical depression within the context of the institutions in which we work and study. In doing so, I will draw upon my own experiences, both as a reflection on the dismal state of awareness in post-secondary institutions and as an encouragement to others that you are not alone in your struggles with the disorder and with your university about the disorder. Perhaps the awareness that someone else in our field has had experiences like yours can serve to empower or at least enhearten you.

[2] An invisible disability (ID) is defined as “one that is hidden so as not to be immediately noticed by an observer except under unusual circumstances or by disclosure” (Mathews and Harrington 2000, 405). In 2006, 15% of the American population, or 41 million people, reported having a disability, with 6% indicating a “mental disability.”⁽¹⁾ If most ID’s are subsumed within the category of “mental disability” and the university community reflects tendencies in the general populace, about one out of sixteen faculty colleagues suffers from some type of invisible disability, with clinical depression leading the way.

[3] As explained by Gotlib and Rottenberg in the *International Encyclopedia of the Social and Behavioral Sciences*, clinical depression “is a syndrome, or constellation of co-occurring psychiatric symptoms, that affects about 20 percent of the population. Major Depressive Disorder, the psychiatric label for clinically significant depression, is characterized by at least a two-week period of persistent sad mood or a loss of interest or pleasure in daily activities, and four or more additional symptoms, such as marked changes in weight or appetite, sleep disturbance, psychomotor agitation or retardation, fatigue, feelings of guilt or worthlessness, and concentration difficulties. People diagnosed with Major Depressive Disorder show marked impairment in their social and occupational functioning; they also have an elevated risk of death from a number of causes” (Gotlib and Rottenberg 2001, 3511). These authors identify genetic factors as being decisive in a person’s proclivity toward depression, but the actual trigger mechanisms reside in negative expectations or “schemas” from childhood, which “serve as filters through which stimuli and events in [the individual’s] environment are perceived, evaluated, attended to, and remembered. The negative schemas remain inactive until the person encounters a relevant stressful event or experience. The stressful experience serves to activate the negative schema, which leads the individual to process information in a negative manner, in turn leading to ineffective coping, culminating in a depressive episode.”⁽²⁾ Within the academic career, significant stress inducers include tenure decisions, major administrative work, grant competitions, publication submissions, and even the twenty-first century classroom. The standard indicators of clinically significant depression for the professoriate are the same

as those indicated above for the general populace, only academics may be more adept at hiding the symptoms. Nevertheless, a state of Major Depressive Disorder is especially debilitating for university faculty, since it first and foremost affects the mind: we are unable to concentrate, lose the ability to make decisions, and become pathologically fearful of speaking in public. In other words, seriously depressed academics are impaired in undertaking our basic responsibilities as researchers, administrators, and instructors. A worst case scenario would involve an inability to cope with even the simplest demands of our jobs, a state of catatonia in which the sufferer retreats from active life. The loss of pleasure in music is a particular blow for clinically depressed musicians, since performance and/or listening ironically represent what we normally consider to be “therapeutic” activities.

[4] The traditional method of treatment involves a combination of medication and therapy.⁽³⁾ Once treatment has begun, recovery can take anywhere from several months to several years, depending on how the individual responds to the treatment. Academics may need to take sick leave or, for more severe cases, a leave of absence (as a disability benefit). During this period, most depressives take gradual steps to rejoin society, which may well involve resumption of less stressful activities in academe such as research and/or teaching. Granted the personal nature of any invisible disability, I would not be surprised to discover colleagues who have been or are in treatment for depression and yet whose disorder is unknown to departmental colleagues and administrators. I am more concerned about fellow academics who suffer in silence without assistance or treatment because they are either unaware or ashamed of having a Major Depressive Disorder. It is those individuals to whom I dedicate the following narrative of my experiences with depression.

One Musicologist's Journey

[5] I certainly had the right genetic code for an eventual diagnosis of clinical depression. My two older sisters struggled with it for over twenty years. My mother suffered from depression all her years, but received her diagnosis only in the last year of life at the nursing home. In her day, depression was not regarded as anything other than one's own weakness, a personal inability to “buck up” about which no one spoke. Treatment was not an option, not even a consideration.

[6] A series of personal tragedies and setbacks in late 1999 triggered my ongoing battle with depression, which has put me under treatment at various points during the last ten years. At the time of the first and most serious episode, which lasted over three months, I was director of an interdisciplinary arts school at a major Canadian university. The university had no protocol for dealing with mental health crises (unlike its established policies for medical emergencies) and, in the absence of any clear path of responsibility, I contacted the Dean of the Faculty who was not unsympathetic. During this entire first bout with depression, I only informed two other individuals at the university about my mental health crisis: my administrative coordinator who had to know yet exhibited little understanding of the problem, and a trusted colleague who was quite supportive. I was literally deathly afraid of the potential responses from my other colleagues, so I did not inform or involve them. As a result, I was left to my own resources to work through the crisis, which was exacerbated by the holiday season, not only because of my inability to enter into the Christmas spirit but also due to the unavailability of treatment possibilities for the first two weeks. It was touch and go for those early days, during which I hardly ventured forth from the security of bed and did not communicate with anyone beyond my immediate family. Music, normally a vehicle for healing, brought no consolation. I write this not to arouse sympathy, but rather to make you aware of how the system and society in general, fails us who suffer from “invisible disabilities.” As Osterholm, Nash and Kritsonis report in a study from 2007, “society may view invisible disabilities as illegitimate excuses for failure to conform to achievement standards and other expectations” (Osterholm, Nash, and Kritsonis 2007, 2).

[7] My return to mental health was painfully slow—I had to mask the true nature of the crisis. Fortunately, the semester came to an end (others covered for me) and the summer brought adequate time for resuming research and a lighter administrative load. Those of us in the process of recovery have to face further stigmatization that can delay healing. As Bill Wilkerson, CEO of the Global Business and Economic Roundtable on Addiction and Mental Health, so powerfully articulates in a special report about depression in Toronto's *Globe and Mail* from June of 2008: “There's this attitude out there that if you come back from cancer, you're a hero, but if you come back from depression, you're damaged goods.”⁽⁴⁾ In a classic manifestation of “don't ask, don't tell,” no one at the university (other than my close colleague) ever asked me about this malady after my return to normal functioning, even though rumors had been in circulation.

[8] The lack of institutional understanding for mental health problems like depression caused me to hide my disability during subsequent briefer episodes. To the external observer, its manifestation looked like a case of moodiness, although I knew the malady for what it was. Fortunately, strong support networks outside of the university enabled me to compensate for its own failure to accommodate or assist with the treatment of my “invisible disability.” Still, it is a cruel and ironic twist that those

very institutions committed to hearing and studying the voices of the “Other” should so miserably fail those in their very midst who can only silently cry out for help and understanding. This may not be the experience at every university, but reports from such diverse institutions as the University of Washington, the Ohio State University, and Denison University help to illustrate a general climate of misunderstanding in institutions of higher learning.⁽⁵⁾

[9] My current university has an active center for students with disabilities—over 1000 students are registered with the center for a variety of physical, emotional and learning disabilities. However, when I inquired into assistance and accommodation for my own condition, I discovered that there was no one place for non-students to turn, no office that coordinated services for faculty and staff with disabilities. I was referred to an amalgam of individual services and individuals: an off-campus counseling service,⁽⁶⁾ the on-campus Equity Officer, and my union steward, none of whom have contact with each other. In other words, I have ended up relying upon the same type of non-university support networks that I did in my previous position.

[10] If there is a silver lining to this cloud, it is a greater sensitivity to colleagues and especially students who might similarly struggle with depression. It is no coincidence that, during winter term of 2008, I was individually approached by three students who were suffering from clinical depression. I was able to show understanding for their crises and work out an accommodation schedule for their late submission of work.

[11] Where do we go from here? We could engage in activism for greater awareness, although that could put us in a double bind. On the one hand, those of us in the midst of depression are in no position to take decisive action on anything. On the other, we may justifiably fear the repercussions of making our condition public, even (or especially) at a university. The problem of advocacy for invisible disabilities is the absence of specific measures for accommodation, of a detailed agenda for agitation, since the disorders vary so widely among themselves and often involve intangible remediations (e.g. leave for an unspecified time or “stress-free” activities, in the case of depressives). In terms of activism, I have become a member of the Equity Issues Steering Committee for the Canadian Federation for Humanities and Social Sciences, which is the Canadian equivalent of the ACLS, in order to agitate for awareness at a higher, inter-institutional level. I have also attempted to work with my current university to facilitate the dissemination of information about disability services and accommodations to new faculty. With regard to “coming out,” I have discovered that one of the advantages of tenure is the ability to take an activist position without fearing the loss of employment or other sanctions. Yet many of us who suffer from depression do not enjoy that security, nor do we necessarily have the energy to make our own cases.

[12] In the final analysis, those of us who suffer from invisible disabilities like depression, bipolar disorder and autoimmune diseases must look beyond ourselves for advocacy. As just mentioned, we are often emotionally incapable of aggressively promoting our own causes, immobilized by the disorders from which we suffer. Thus I would ask each reader to consider how you might agitate for support services for faculty and staff with invisible disabilities on your campuses. I also encourage you to be watchful for colleagues and students who might be victims of these disorders. A kind word or gesture toward someone visibly struggling with an invisible “foe” probably will not turn the tide, nor even necessarily meet with a friendly response, but be assured that we do appreciate any and all signs of understanding!

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Footnotes

1. Brault 2008. This report prepared for the U.S. Census Bureau is available at: <http://www.census.gov/hhes/www/disability/GQdisability.pdf>. The term "mental disability" is problematic as an alternative to "invisible disability," since the latter designation covers a broader range of disorders, including chronic pain and arthritis.

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2. Gotlib and Rottenberg 2001, 3512. This cognitive theory of depression dates back to the findings of Aaron Beck in his classical text *Cognitive Therapy and the Emotional Disorders* (Beck 1976).

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3. In acute cases, electroshock therapy is commonly used by psychiatrists as a further method of treatment.

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4. Cited in André Picard, *The Globe and Mail*, June 22, 2008.

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5. See the following websites:

<http://dailyuw.com/2008/2/25/invisible-disabilities-student-disabilities-commis/>

http://ada.osu.edu/resources/fastfacts/Invisible_Disabilities.htm

<http://www.denison.edu/academics/support/grievance.html>

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6. The fact that these "confidential" counseling services are off-campus is a two-edged sword, for while it protects the privacy of the sufferer, it also disassociates the disorder from the university, whereby a tacit policy of silence is enforced.

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