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Resilience and Mental Wellbeing: A Toolkit for Healthcare Professionals

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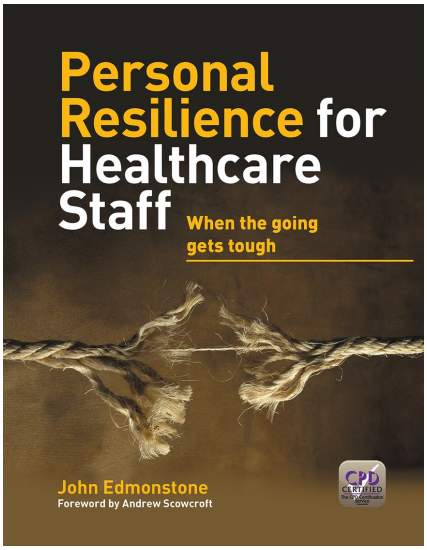

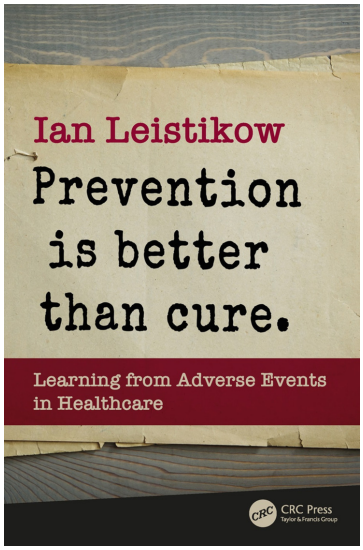

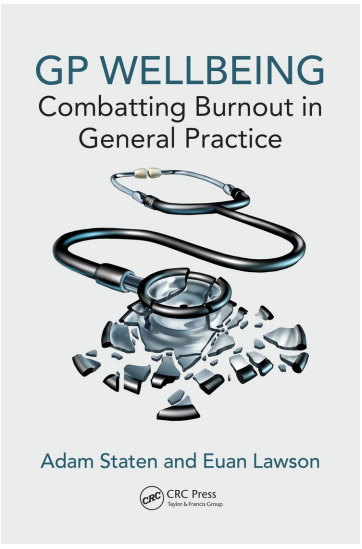

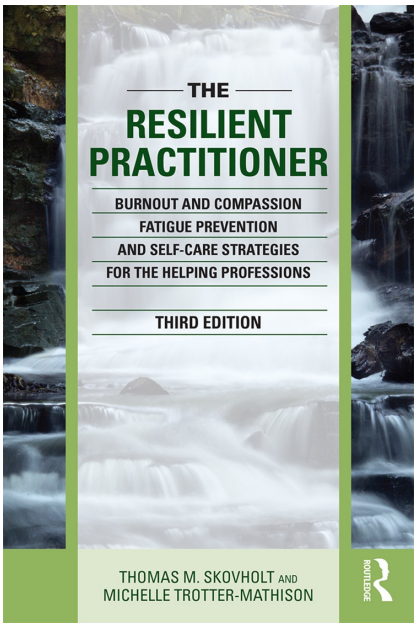

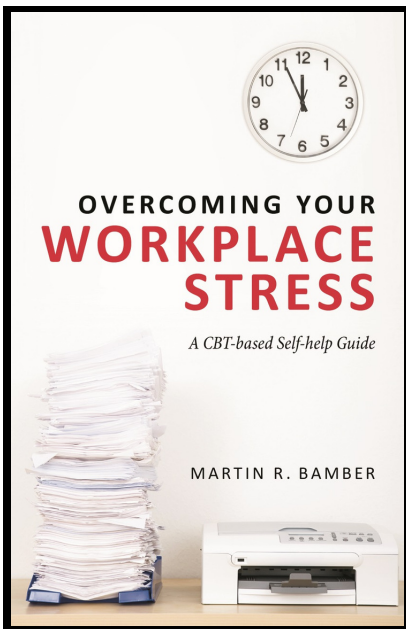

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Healthcare organisations: cradled in anxiety?

> 'If anyone feels secure, satisfied with what he thinks of as his established position in life, he is a fool. The forces that control our lives are as unpredictable as the behaviour of idiots. There is no such thing as certain happiness.' (Euripides, *The Trojan Women*)

This chapter considers whether healthcare organisations are a 'special case' where employees experience greater anxiety and stress than those in other sectors – particularly in industrial and commercial enterprises. The title is taken from the instigator of action learning, Reg Revans, who once described the hospital in particular as an 'institution cradled in anxiety'.[1] It is well recognised that a number of healthcare professions (most especially medicine and nursing) are subject to excessively high risks of stress.[2] In this respect, for example, the NHS in the UK has one of the worst sickness absence levels in any sector, claimed to be almost verging on epidemic levels.[3]

All healthcare systems around the world face inherent tensions and these are shown in Box 3.

Box 3: Tensions within healthcare systems

A focus on individual patient care	A focus on care for an entire population
Reactive health services	Preventative health services
Effective treatment of ill health	Promoting good health
Treating acute episodes of illness	Managing chronic ill health
Demand-led services	Needs-led services
Utility	Equity
Citizen perspectives and priorities	Professional perspectives and priorities
Generalist practice	Specialist practice
Appropriate standardisation	Appropriate diversity
National standards	Local sensitivity
Current service delivery	Developing the future workforce

The most seminal work addressing these issues was undertaken by Isobel Menzies Lyth in the late 1950s and early 1960s.[4] Noting that the purpose of a hospital was to care for ill people who cannot be cared for in their own homes, she identified that the major responsibility for such caring lay with the largest constituent part of the healthcare workforce – the nursing profession, who provided continuous patient care – what we would now describe as '24/7'. As a result, nursing bore the 'full, immediate and concentrated impact' of the distress, tragedy, death and dying which arose from patient care and which is not part of the typical working experience for most of the public.

The sources of such stress included close and regular contact with people undergoing suffering and death; the undertaking of 'distasteful, disgusting and frightening' tasks; coping with personal feelings of pity, compassion, love, guilt, anxiety, resentment and envy; and 'carrying' the depression, anxiety, fear and disgust of patients' relatives and friends.

Menzies Lyth claimed that, in order to deal with this anxiety, nurses unconsciously created and operated socially structured defence mechanisms. These included:

- an emphasis on task-focused, rather than patient-focused care
- depersonalisation and categorisation of patients. Nurses in training, for example, often show a preference for 'real' nursing – sticking needles and tubes into people – the physiological rather than the psychosocial (relational and emotional) skills
- the cultivation of professional detachment and self-control – a 'caring but distant' demeanour which suppressed and controlled emotions.[5] This has been described as 'emotional labour' – the induction or suppression of feeling in order to sustain an outward appearance that produces in others a sense of being cared for[6,7]
- ritualistic task performance to detailed and precise standardised procedures and instructions
- the checking and rechecking of decisions
- delegation upwards to seniors as a means of avoiding taking responsibility for decisions
- avoidance of change.

While the human state requires us to manage our anxiety to prevent it from overwhelming us and a certain level of emotional detachment is therefore healthy, in the longer term, the emotional dissonance arising from the constant suppression of such powerful emotions can lead to personal burn-out.[8] This powerful emotional cost to caring is rarely if ever discussed in the media, where coverage takes little or no account of such issues.

It should also be noted that nurses, doctors and other clinical professionals are, by training and socialisation, expert 'fixers' through clinical interventions. Patients with long-term and incurable conditions or who are dying can therefore potentially represent failure to them.

Menzies Lyth later reflected that she had over-emphasised the nature and effects of anxiety *within* the hospital without adequately reflecting the broader structural and management context.[9] Subsequently, Bain extended the focus from the single healthcare institution to what he termed the wider 'system domain fabric',[10] which included:

- the organisational structure, roles and relationships and authority and accountability systems
- policies and procedures and information systems
- professional education and training
- technology and technical systems
- organisational culture
- funding arrangements
- trade unions and professional associations.

So it seems that these unconscious defence mechanisms against anxiety operate at the level of the individual and the group, but also at the larger organisational level. They permeate healthcare organisations (especially hospitals) as 'emotional toxins',[11] evidenced in structures, roles and work processes, and thus have a major (but largely unrecognised) impact on the way they operate.

Healthcare organisations are, of course, professional organisations[12] where the frontline clinical professionals possess a high degree of control. Accordingly, the ability of managers in such organisations to *directly* influence clinical decision making is significantly more constrained and contingent than in other kinds of organisations[13] and because decision making within clinical professions is typically collegiate in nature, there is a premium on leaders with professional backgrounds leading change. Clinical professionals form what has been called the 'operating core' of healthcare organisations[14] – what they control is what Marxism would typify as the 'means of production'. Attention has also been drawn to what is termed the 'disconnected hierarchy' in healthcare – a disjunction between those who are responsible for frontline *management* and those who *deliver* frontline services.[15] This is, in effect, an inverted power structure in which people at the 'bottom' generally have greater influence over clinical decision making on a day-to-day basis than those who are nominally in control at the 'top'. As a result, the role of healthcare managers,

particularly at or close to the frontline, is often to lend support to clinicians in making changes, through the provision of finance, time and other resources, although the advent of general management may have convinced some healthcare managers that a simple command-and-control relationship exists *vis-à-vis* clinical professionals.[16]

In this respect, it has been claimed[17] that the advent of the 'new public management' (of which general management in healthcare is an expression) from the 1980s onwards has exacerbated those tensions between clinical professionals and healthcare managers by ignoring these emotional and psychological aspects of work. The suggestion is that prescriptive assessment and risk management procedures taken together with other bureaucratic elements of work may serve a defensive purpose in allowing clinical professionals to spend less time with patients or service users. Reassurance and relief from anxiety can be found through the performance of such ritual tasks – the completion of tick-box forms, checking and counter-checking and so on. In addition, prescriptive timescales and guidance, complicated recording systems, increased use of IT-based reporting, etc. all add to workload and generate anxiety about meeting deadlines and 'keeping on top' of paperwork.

All this serves to limit the degree of discretion which can be exercised by clinical professionals whose role it is to deliver 'frontline' care. The exercise of discretion rather than prescription of what is permissible was seen to be a key feature of the work of 'street-level bureaucrats'[18] – service providers across the public sector, such as doctors, nurses and therapists who worked face to face with their clients – partly because they operated in complex situations which could not easily be reduced to programmatic formats, partly because the situations they encountered might require compassionate treatment, and partly because the exercise of initiative in itself could inspire the trust of clients both in the individual professional and in the agency he or she represented. Latterly, however, it has been recognised that the advent of such managerial practices has increased levels of bureaucracy and deskilled professionals.[19]

While this emphasises the impact of healthcare management on the clinical professional, the way in which such healthcare leaders and managers tend to frame the problems which they experience also has a major impact. Grint[20] indicated that there were three such ways.

- **Critical:** this is a crisis situation where there is little or no time for discussion, disagreement or dissent about the problem or for worrying about procedures that get in the way of rapid resolution. It involves the use of coercion and authority 'for the public good'. The leader/manager acts as a *commander* and the message is *'Just do it – it doesn't matter what you think'.*

- **Tame:** in such situations, tried and tested procedures exist to resolve the problem because management has previously encountered this situation and has 'solved' it – just like a puzzle. There is clear agreement about the exact nature of the problem and the solution necessary. Facts can be clearly defined and analysed. The leader/manager acts as a *manager* and the message is *'I've seen this before and I know exactly what process will resolve it'.*
- **Wicked:** here there are no easy answers because the problem is a new, unknown situation that different people understand in different ways. It might be embedded in other problems so that actions taken may have unanticipated consequences. There is poor problem focus and little agreement about possible ways forward. The leader/manager therefore has to *lead*, asking appropriate questions and engaging collaboration. The message is *'I've never seen this problem before and we need to get a collective view on what to do'.*

Grint suggests that in healthcare, problems are typically seen or interpreted as either Critical *(Don't panic!)* or Tame *(Been there, done that, got the T-shirt!)*. In relation to the tendency to define Wicked problems as Tame ones, other authors[21] have commented:

> 'Our learnt instinct is to troubleshoot and fix things – in essence to break down the ambiguity, resolve any paradox, achieve more certainty and agreement and move into the simple system zone.'

So we can conclude that healthcare organisations operate in society as 'containers' of the emotions and anxiety of patients' relatives and families and that because of this, the experience of acting as a leader or manager of clinical professional staff in such a context is different from that of an industrial or commercial enterprise. Managerial initiatives from the 1980s to the present day have served to increase and bolster the potential defence mechanisms in play in order to deal with the inherent anxiety of working in healthcare. Increased bureaucratisation of professional work has also served to increase prescription and to decrease discretion. The labelling of Wicked health (and social) care problems as Critical or Tame (and therefore amenable to quick and repeatable solutions) has exacerbated this process, which is little understood by the rest of society and over-simplified (if addressed at all) by the media.

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HALT

THE CASE

Surgeon Patrick McCourt had had an exceptionally busy week. His theatre list was overbooked, his clinic overran on two consecutive days and the hospital had planned no fewer than three evening meetings, none of which was directly related to surgery. The longest meeting was on the electronic patient record that management wanted to implement. Patrick had been appointed spokesperson on behalf of the surgeons and this took up much more of his time, his spare-time to be exact, than he had anticipated. In training to become a surgeon, he never expected that as a surgeon he would spend so much of his time on non-surgical issues. All these things had kept him occupied that week, when on Friday evening he finally managed to be home on time for supper. His wife Kenzy had prepared a new dish, cauliflower and cumin fritters with lime yogurt, she had found in the vegetarian cookbook he had given her last Christmas. Niall and Todd, their 10- and 12-year-old sons, were already seated before the dinner was on the table, which seemed a first to him. Patrick skipped the glass of wine Kenzy offered him, because he was still on call. The patients on the ward had seemed reasonably stable, so he did not expect to be called, but you never know. As Patrick took a seat and smelled the dish, it hit him how hungry he was. Kenzy was serving out the plates when his mobile rang. Patrick sighed and stood up to find a piece of paper to take notes on. It was Doug calling, one of the A&E doctors.

A 50-year-old patient had been brought into the A&E Department by ambulance. She had fainted at home after she had pushed back her abdominal hernia. The patient had an extensive medical history. She had undergone gastric banding surgery for weight loss. A year later she had undergone abdominoplasty to remove loose skin and excess fat. Unfortunately this led to an abdominal hernia that they had decided not to repair for now. At certain intervals her hernia would protrude and she had learned how to push it back herself. She had done so this evening, but this time she had collapsed soon after.

Doug told Patrick that the patient seemed moderately sick. She could sit on the bed without support, but was uncomfortable and scored 8 on the pain scale. The hernia felt taut but was easily pushed back. The skin around the defect was red. The patient did not have guarding and Doug had heard peristalsis, be it slightly slower than normal. Percussion and palpation had been very painful in her lower abdomen. Doug had found no abnormalities in examining her lungs. Breathing was normal. The patient's blood pressure fluctuated between 95/50 and 130/75 with a heart rate around 110. Her blood showed a moderate leucocytosis and slightly elevated CRP and lactate. Arterial blood gas showed a slight acidosis. An abdominal X-ray and an erect chest X-ray showed no signs of bowl dilatation or free gas in the abdomen. The patient was not vomiting and did not complain of colicky pain, so Doug had dismissed ileus as the cause of the complaint but was not sure what else it could be.

Patrick listened to him. It was not an acute abdomen and the patient was not in a critical condition, so he did not have to come to the hospital, he concluded with relief. Most probably the patient had suffered a brief episode of bowel ischaemia after having pushed back her hernia. This would explain the pain and how sick she felt. They agreed that the patient would be admitted to the surgical ward for observation. If she remained stable, Patrick would visit her tomorrow morning. Patrick was glad it was Doug on the A&E tonight. How long had he been there already, 10 years, 15 years? He was already working A&E when Patrick joined the hospital. He was knowledgeable and reliable. And he didn't overload you with useless information like his colleague Ingrid would. Heavens, you could be on the phone for 10 minutes with her and still have no clue why she was calling. Patrick thanked Doug, hung up and returned to the dinner table. Finally something to eat.

That evening around 10 p.m. his phone rang again. Patrick had just dozed off. It was the surgical junior in charge of the ward. He was calling about the same patient. A nephew of the patient, a Dr Walker, had called the hospital and was very worried. He urged the surgical junior to do a CT scan. This nephew was a physician himself, a geriatrician working in the north of the country. When the surgical junior had explained to Dr Walker that he did not deem it necessary to order an emergency CT scan in the middle of the night because the patient was stable, Dr Walker pressed him to put him through to the senior surgeon himself. Could Patrick give him a call? Patrick agreed he would and asked how the patient was doing. Everything seemed stable. She had reacted well to morphine.

"You don't think I should come to the hospital to see her myself, do you?" Patrick asked.

"No, it's okay, I think I have it all under control here."

Patrick disconnected. He disabled phone number recognition on his mobile and called the nephew who picked up the phone immediately.

"I'm so glad you're calling. I don't mean to cause a fuss, but I'm just so worried. My Aunt Cora has a complex medical history, as I am sure you are aware. Troubled times behind her, one hospital admission after another. But the one thing she never does is complain about pain. So if she does, something is wrong. I don't feel comfortable about the way she has been treated since being admitted

to your hospital. I would appreciate it if you ordered extra diagnostics, an ultrasound or preferably a CT or MRI scan. Your junior told me he did not deem this necessary, but between you and me, what does a young lad really know? Nice to talk to you. I feel a bit put out, picturing my Aunt Cora just lying there in a ward in her current condition without the doctors knowing exactly what's causing her pain. More diagnostics must be done, don't you agree?"

Patrick stayed silent for a moment. He had to process this flood of words and felt annoyance building up inside of him. Doctors are the worst patients, they always think they know better.

"My Aunt Cora probably has a strangulated hernia, I've seen that before with patients of mine. Trust me, we need a CT scan to make sure the bowels have not been compromised."

"I understand your concern, Dr Walker, but your aunt is really not as sick as you think she is. Her vitals are stable and she is reacting well to the morphine we gave her. A CT scan has no added value whatsoever at this point in time. The hernia was pushed back without difficulty so if the pain originates from the hernia, the peritoneum is a much more probable cause of the pain than the bowels. Yes, that can hurt, as you know, but it's no reason for any surgical intervention."

The nephew repeated his previous plea. The extra arguments he made did not convince Patrick to reconsider his conclusion. It rather made him a little cranky. What gibberish. Let Dr Walker concern himself about his own patients and let the surgeons of this world determine whether somebody has an acute abdomen or not. Why should he listen to this second-rate doctor at all?, he thought, but immediately brushed this thought aside, realising it was unjustified.

"Don't worry, we take our responsibility for your aunt's wellbeing very seriously. She will be okay." Within minutes after disconnecting the phone, Patrick had fallen into a deep sleep.

The next morning Patrick found out that the patient had been transferred to the ICU late that night. They had not thought it necessary to inform him because the critical care physician was present and had taken over the responsibility for the patient. An emergency CT had shown a perforation in the small bowels. A colleague surgeon who was on call in the morning had tried to operate on her but the patient died on the operating table.

REFLECTION

Looking back we can often conclude that a patient's family was right in predicting a patient's impending deterioration. In this case the patient had a complex medical history but, according to her nephew, never complained about pain. That she did so this time was exceptional and that made the situation alarming for him. The nephew had spoken up to the A&E doctor and had even been so bold as to pursue a dialogue with the senior surgeon, despite the late hour. He was a doctor himself, so maybe it was not as big a deal for him to call the surgeon as it would be for other family members, but still... He was very concerned but the doctors who treated his aunt did not value his concern. On the other hand, it

happens much more often that the family is very concerned and the outcome for the patient turns out fine. The single factor of a concerned family does not always mean there will be an adverse outcome. It can be a warning signal, but just as often it can be noise or may even push doctors to actions that turn out to be detrimental to the patient. So the million dollar question is: how do you differentiate between signal and noise in the heat of the moment? The first step is always to take a concern seriously. Surgeon McCourt did no such thing. He tried to reassure the nephew, which clearly did not work. A detail that arose during the root cause analysis of the event was that the nephew was not aware that the surgeon was not at the hospital during the telephone conversation. Had he known this, he would have pushed harder. So how can it be that a highly trained, considerate doctor with no prior performance issues did not read the nephew's phone call as a signal to reassess the patient's situation?

A study published in 2004, in which almost 400 nurses were followed during 5300 shifts, showed that nurses who work 15.5 hours or longer have a threefold higher chance of making mistakes affecting patients[1]. The Joint Commission, a USA-based healthcare accreditation organisation, even issued a so called 'Sentinel Event Alert' in 2011, alerting healthcare organisations to the dangers of fatigue for patient safety[2]. In October 2010, when I was working at the Patient Safety Centre of the UMC Utrecht, we invited Chris Landrigan to contribute to our patient safety lecture series. Chris is a paediatrician affiliated with Harvard Medical School and Brigham and Women's Hospital in Boston, USA. He is a very enthusiastic and inspired doctor, who for a non-native speaker can sometimes be hard to follow because he talks so incredibly fast. Chris has done extensive research into the effects of sleep deprivation on the performance of doctors. Interns who regularly work 30-hour shifts turned out to make 36% more serious medical errors and five times as many serious diagnostic errors on an ICU than their colleagues who worked a maximum of 16 hours[3]. Also, completing a 24-hour shift doubled the chances of the doctor becoming involved in a traffic accident. In the USA, Chris Landrigan's work contributed to reducing the maximum amount of working hours for doctors in training. In many other countries, like my own, the number of hours a doctor in training works has luckily already been brought within normal limits. But medical specialists in private practice fall outside of this legislation and can work as many hours as they like. And a packed week, like the one Patrick McCourt was having, is rather the rule than the exception. Fatigue influences performance, in less extreme situations than a 30-hour shift. In commercial aviation this reality is acknowledged and pilots can indicate they are 'not fit to fly' if they are fatigued, for whatever reason. The Dutch College of Surgeons took a first step in this direction when they announced in 2014 that all surgical departments must mind the balance between workload and an individual surgeon's capacity and that they must all have a procedure in place for compensating strenuous on-call shifts[4]. To an outsider, this may seem a bit vague and unimpressive, but is a huge step from the macho culture prevalent less than 10 years ago, in which fatigue was simply denied.

A mnemonic I once learned is HALT[5]! If you are Hungry, Angry, Late or Tired: HALT; stop and realise that the chance you will make a mistake is increased. Use whatever means you have, coffee, a time-out, a consultation with a colleague, to decrease the effect of HALT. The main thing is to recognise the presence of HALT and acknowledge that this can negatively influence your decisions and performance. An example I discovered is that I make mistakes more often driving my car when I get annoyed by other road users. I had to miss my exit twice within 1 month before it hit me that it was my own annoyance that had distracted me from taking the exit on time. The same goes for hunger. Some say I get intolerable when I'm hungry. It cost me a couple of years and several unpleasant situations with my friends before I could admit this to myself. I have learned to recognise my own irritation or hunger and use them as warning signs that I have a bigger chance of making a mistake at that moment. When I was discussing HALT with Rob Bethune, a colorectal surgeon from England active in quality improvement for many years, he emphasised that the main difficulty with all of this is that HALT decreases your insight and knowledge of your own strengths. Simply put, you often don't know you're HALT and that's where the danger lies. You do, however, know when you are prone to HALT. Rob told me how when he was doing his surgical training and had young twin boys he would openly acknowledge during the preoperative brief that he had had a bad night's sleep and asked: "Can you people watch out for me?" He does the same thing now if he has been on-call the night before and is operating the next day. This is one way you can try to decrease the dangers of HALT for your patients.

An empty stomach during the conversation with Doug, the emergency physician, and irritation during the conversation with Dr Walker, the nephew, could have acted as warning signs for surgeon Patrick McCloud that he was vulnerable to making the wrong judgement call. If they had, Patrick could have taken a step back and reconsidered: "Am I certain that my mental image of this patient is correct? Have I thoroughly excluded the possibility that Doug is missing any important cues pointing towards an acute situation?" The first step would have been to go and see the patient himself and follow up on the concerns the family expressed. In another situation you could, for example, ask the nurse: "Do you have any concerns regarding the patient?"

Hunger, emotions, haste or fatigue can influence the decisions we make, and don't always lead us to the right choice. This is a human phenomenon. Just like darkness makes it impossible to see colours, hunger and fatigue make it difficult to think rationally. This is nothing to be ashamed of. However, it is something you can anticipate. If you recognise HALT in yourself or another, be open about it and realise that your chances of making a mistake are increased.

So it was not the conversation itself, but the condition surgeon McCloud was in during the conversation, that should have alerted him to read the nephew's concern as signal and not as noise.

HOW CAN THIS HELP ME TODAY?

- If you are Hungry, Angry, Late or Tired: HALT! Stop and realise that your chances of making a mistake are increased.
- If you see a colleague who is HALT, state your concern and ask how you can help.

HOW CAN I INVOLVE MY PATIENTS?

If you are Hungry, Angry, Late or Tired and this is influencing your interaction with a patient, be open about this and take a time-out. "I'm sorry, I feel I am not totally focussed because I am so hungry. Excuse me while I grab something to eat. I'll be back in a moment." Or, "I feel I am not at my best at the moment. Excuse me while I go and get a colleague to make sure we are giving you the care you need."

Resilience

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The first questions that anyone might ask about resilience are: 'What is it? How do I know whether I have resilience? And, how do I develop it? There are few easy answers to these questions, but there is an emerging consensus on some of the factors involved.

When the term 'resilience' is applied to materials, it refers to a quality that allows for it to be bent, stretched or compressed and still return to its original shape. It is easy to think of this as a metaphor for resilience in people. It is the ability to bounce back from adversity.

Lown et al. define resilience as follows, and this closely fits with a similar definition from the American Psychological Association: 'There are many definitions of resilience but it is best considered as the individual's ability to adapt to and manage stress and adversity: essential qualities for GPs'.[1]

Southwick and Charney have studied the quality of resilience in people who have been through trauma, both physical and psychological. Some had experienced trauma through being a soldier in a warzone, or through being the victim of a terrorist attack. Others had experienced trauma due to physical and sexual assaults, or perhaps through being involved in serious road traffic collisions. They noted that resilence is 'complex, multidimensional and dynamic in nature'.[2]

Resilience is not a fixed commodity. It can vary across the life course, it could vary from month to month even, and it can also vary depending on the exact nature of the stressor. There are various tests that can measure resilience, and these tests are generally self-reported using Likert scales. They are most useful for research and are less helpful for aiding the creation of day-to-day strategies for individuals.

NEUROBIOLOGY OF RESILIENCE

This is worth dwelling on. One might assume resilience is a rather wishy-washy new age term that is nebulous, related to aspects of personality or other inner qualities that are undefinable. Increasingly, neuroscience is mapping out the specific pathways where resilience is found, and this leads to credible strategies to address concerns when those pathways bend or break.

Acute stress response

This is how the mind and the body respond to persistent stress. We all know the hormones that rise in these circumstances: the fight-or-flight surge of adrenaline and catecholamines. There is a rise in cortisol levels and also in pro-inflammatory cytokines. These are primitive responses, enormously helpful in the course of evolution to preserve us from short-term hazards. In modern life, these responses do not necessarily ebb away, and this persistent stress activation can damage us with changes in the brain tissue and maladaption in the hypothalamic-pituitary-adrenal axis. This persistent stress is associated with chronic illnesses including cardiovascular disease.

The problem with sustained stress is that it impairs decision making. Martin et al. highlight other impacts[3]:

- Interference with empathy and communication
- Narrowing of the field of vision (literally and metaphorically)
- Decrease in generosity
- Decrease in cooperativeness
- Increase in xenophobia
- Increased likelihood if interpreting ambiguous expressions as hostile
- Increased likelihood of displacing frustration and aggression onto those around us

As David Peters puts it, 'it makes us more dull-witted and less friendly'.[4] As these responses kick in, it has been shown that compassion and empathy diminish. Clearly, this is not ideal for anybody, and it is particularly worrying in the medical profession. However, this is a feature of medical training in general. There tends to be a decline in empathy over the course of training with an increase in 'professional numbing'.

PHYSICIAN PERSONALITY AND RESILIENCE

Physician personality has been found to be associated with wellness. One Norwegian study found that neuroticism and conscientiousness traits predict stress in medical students.[5] Workaholism and perfectionism have been traits associated with suicide in physicians.[6] Lemaire and Wallace explored personality and doctors' perceptions with a cross-sectional study that surveyed more than

1000 Canadian physicians.[7] They had previously noted that physicians tended to identify strongly (%) with three different personality types (Figure 7.1):

- Workaholic personality – 53%
- Type A personality – 62%
- Control freak personality – 36%

They also compared the physicians who identified with these personalities with those who did not. Specifically, they wanted to see how they differed in how they perceived the impact of personality on professional performance and how they experienced wellness.

They found that most of the physicians did identify with at least one of these personalities. The workaholic personality was associated with one potentially harmful and three positive wellbeing outcomes. The control freak personality was associated with five potentially harmful outcomes.

There are several factors in play with physician personalities. There is an issue with selection, but there is also a culture within medicine that can exacerbate existing traits in physicians. Personalities themselves may not be malleable, but awareness amongst physicians of their own potential vulnerabilities, their inherent resilience and their ability to withstand burnout is crucial to manage clinician wellness.

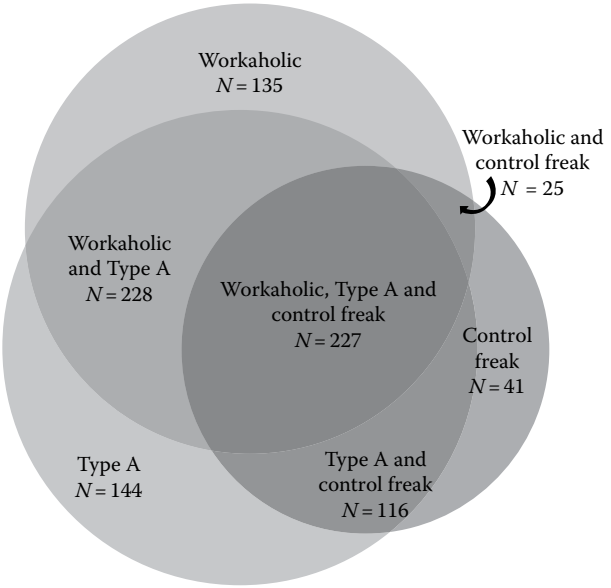

Figure 7.1 Proportions of 916 Respondents Who Identified with One, Two or All Three of the Predetermined Personalities. (From Lemaire, J.B., and Wallace, J.E., *BMC Health Serv Res.*, 14, 616, 2014.)

OTHER FEATURES ASSOCIATED WITH RESILIENCE

Charney and Southwick found 10 factors associated with resilience.[2]

Psychological and social factors associated with resilience

- Facing fear: an adaptive response
- Having a moral compass
- Religion and spirituality
- Social support
- Having good role models
- Being physically fit
- Brain fitness: making sure your brain is challenged
- Having 'cognitive and emotional flexibility'
- Having 'meaning, purpose and growth' in life
- 'Realistic' optimism

These are more encouraging because they are not all necessarily fixed traits. They can, potentially, be addressed.

'Realistic' optimism

What do we mean by optimism? Southwick and Charney regard this as a 'future orientated attitude.' Optimists tend to believe that the future will be bright and that good things will happen to people who work hard. Psychologists have developed tests to measure optimism. Some of the most resilient people that have been studied have been the most optimistic. Psychologists have investigated why optimists seem to be particularly resilient. It has been suggested that this leads us back to the fight-or-flight reaction that has already been described. It has been shown that when we have positive emotions it tends to reduce physiological arousal, so there is a direct mechanism to ensure that people get various benefits from their optimism. These are things such as improved attention and ability to actively problem solve as well as our greater interest in socialising.

Facing fear: An adaptive response

This factor associated with resilience is also linked to the fight-or-flight response. Pavlov's dogs and the phenomenon of classical conditioning are familiar to most people. We experience a response such as fear when exposed to a stimulus which would not otherwise cause distress but has been previously associated with some kind of traumatic event. This resilience-associated factor is particularly important to people who have had a very traumatic experience in the past.

Ethics and altruism: Having a moral compass

The reason that Southwick and Charney included this ethics and altruism was because when they interviewed people who had been through trauma,

they found that many of the individuals who seem to be particularly resilient had a sense of right and wrong that was particularly valuable to them during periods of extreme stress. They also found that altruism, a concern for the welfare of others, was often part of that value system. Some trauma survivors, particularly those who had been involved in torture, had been forced to face some deeply difficult moral choices. To some extent, this may be less relevant to the medical profession where there is often already a strong code of moral and ethical behaviour. However, there could certainly be value in deepening the links and engagement with that moral compass – working with colleagues who reinforce those ethical positions and sense of altruism could be of particular benefit to health care professionals.

Religion and spirituality

Many people find that their religious beliefs offer them resilience. Southwick and Charney felt this to be as applicable to people who are atheists as to those with strongly held beliefs in any of the world's major religions. The important thing about this factor is that that does not necessarily denote having to believe in a particular God. It is more about people who are comfortable with their place in the universe. That said, many of the most highly resilient individuals were found by Southwick and Charney to have had particularly strong benefits from their spirituality or religion.

Social support

Humans are basically social creatures. Having a social support network has been clearly associated with resilience. It has been shown that social support can promote physical and mental health. And the relationship seems to work both ways – it may even be the case that giving social support is more beneficial for physical health than receiving it. There is an underlying biology of relationships and specific neurobiological changes that occur in the context of relationships have been noted by neuroscientists. In particular, the hormone oxytocin seems to play a strong role in social communication and the formation of a sense of affiliation, as well as in other interactions such as sexual behaviour.

General practice may seem like a highly social activity, but it is entirely possible for general practitioners (GPs) to become very isolated. The work of seeing patients does, by necessity, happen in isolation and behind closed doors. Those interactions with people are not necessarily social in the sense that is beneficial to the GP. GPs may go prolonged periods without the opportunity to socialise with colleagues in a way that promotes their own health.

Wallace and Lemaire studied positive and negative factors associated with physician wellbeing and noted the importance of co-worker support. Interestingly, this study also highlighted the role of patients in wellbeing. While being a source of stress, patients were also an important source of satisfaction and therefore wellbeing for doctors.[8]

Having good role models

In some of the first studies to look at resilience it was shown that the most resilient children usually had at least one person who gave them genuine support and served as a role model. Southwick and Charney found similar findings in their own research. Their research established that everybody needs appropriate, resilient role models. Mentors form the critical role in inspiring and motivating their charges and fostering resilience. How does it work? This seems to be down to imitation – an innate ability and one that we have from the earliest infancy but that persists throughout our lives. Role modelling has been well established in medical education and for trainees at all levels but, perhaps, there could be further development of this area for more senior clinicians.

Being physically fit

The obvious benefits of physical exercise to our physical health seem also to extend to benefits to mental health including improvements to mood and cognition. Most importantly, there seems to be benefit in terms of resilience. There are clear neurobiological mechanisms that explain how this could function. The chemicals that improve mood such as endorphins, serotonin and dopamine are all increased after exercise. In addition the pathways that release cortisol are dampened by exercise. There are other potential mechanisms including neurogenesis which involve the making of new brain cells when specific genes are switched on.

One of the key points to remember about exercise and resilience is that we only get stronger and more physically fit by ensuring we have appropriate rest periods. This is often neglected. Physical exercise itself is the stressor but the adaptation only comes afterward. This means diet and sleep are key factors in developing resilience due to physical activity.

Brain fitness: Making sure your brain is challenged

Southwick and Charney found that people who are lifelong learners tend to have higher levels of resilience. They found that it is possible to do various different activities that can promote both cognitive and emotional improvements in brain function – mental training. There is still some scepticism around 'brain training', but there is certainly good evidence that there is an enormous amount of plasticity inherent in the brain and that this neuroplasticity can be developed in some form. It is also known that the use of techniques such as mindfulness can help us learn how to develop calm and an improved awareness of our emotions and perceptions. Even if people remain sceptical about interventions such as mindfulness, there is clear evidence for cognitive behavioural therapy, an obvious form of mental and emotional training.

Having cognitive and emotional flexibility

Cognitive flexibility is an important factor in resilience. We need to have the ability to accept the reality of the situations that we are in. It is obvious that avoidance and denial are not helpful in coping with changing circumstances. This concept of 'acceptance' has been identified by psychologists as an important ingredient in people being able to tolerate highly stressful circumstances. It has also been shown to be associated with better psychological and physical health.

This is been described by Southwick and Charney as cognitive reappraisal. This cognitive reappraisal can come in many different forms. One potential area is in the shape of gratitude. Resilient people that have been through particularly traumatic events often then appreciate the things they still have. They also suggest that humour is a form of cognitive reappraisal. It is a mechanism to help people reframe events and to face their fears. There is the possibility that it can be used as an avoidance tactic, but for many people the ability to see humour, even in the most tragic of circumstances, is an important factor in resilience.

Having 'meaning, purpose and growth' in life

The 10th factor described by Southwick and Charney is about having a purpose. Those people who have a clear sense of mission often have a very deep resilience and ability to withstand enormous stresses and strains. In many ways, in the United Kingdom, the National Health Service (NHS) has provided many clinicians with that sense of purpose in their clinical practice. As Nigel Lawson, a Conservative politician said, the NHS is 'the closest thing the English have to a religion'. It gives many workers in the NHS a meaning that goes beyond the monthly pay packet. This requirement for meaning and purpose has been shown repeatedly in studies with soldiers who have embarked on missions. However, it has also been of importance in civilian workers who have been able to cope with work-related stress. This factor also highlights a potential unintended consequence of re-organisations and stress within the NHS system; it will, indirectly, erode the resilience of the workers within it.

THE PARADOX

One of the biggest challenges facing the medical profession is the fundamental paradox at the heart of managing burnout. There is an expectation that doctors will be cool, calm, and collected. Confident and yet still caring and empathetic.

These may not be obviously mutually exclusive: the neurobiology of the human brain rather suggests that, to some extent, they are exactly that. Doctors are faced with people going through tremendously intense emotional experiences while unwell. Yet, clinicians need to suppress the parts of the brain – limbic and reptilian – that regard these experiences as highlighting a threat. Patients push our limbic brain buttons, even if it is happening subconsciously.

CLINICAL SUPERVISION

Dr. Rebecca Farrington

GPwSI in Refugee Health, Clinical Lecturer, University of Manchester

Dr. Jude Boyles

Psychological Therapist, Manager of Freedom from Torture North West Centre in Manchester

As part of my role as a GP for asylum seekers, I sought clinical supervision from Freedom from Torture, a credible and reputable organisation working with a similar group of patients. This has proven essential for me in avoiding vicarious trauma and keeping my work life sustainable. My experiences have helped me realise that clinical supervision is also valuable for GPs in mainstream practice. We are all exposed to extremes of emotion and the difficult lives of our patients on a regular basis. Maintaining our humanity and retaining our compassion are important.

The role of supervision is to provide a reflective space to explore our work with patients: the treatments offered or the relationships and dynamics in the consultation. Sometimes, we find ourselves being confused about our emotional responses to a patient or feel ill equipped to manage a particular presentation. It is not therapy but supervision that gives us a non-judgemental opportunity to examine new or different ways of practicing or communicating. It is a chance to think about the impact of the work and ensure we continue to practice safely, healthily and ethically.

The supervisor should not in any way be personally connected to the supervisee so that they can be as objective as possible. The supervision is confidential, but the supervisor has similar duties to other health care staff in that if the supervisor considers that the practitioner is unsafe to practice or has not acted appropriately around safeguarding, the supervisor is expected to act upon these concerns.

I have found it useful to have a non-GP clinician as my supervisor on a one-to-one basis. Others may find that sharing experiences collectively, such as in Balint groups or Schwarz rounds, suits them better.

Resilience is our ability to soak up that neurobiological stress and not develop the adverse consequences of persistent stress and arousal. The need to develop resilience in trainees has been recognised. In one study GP trainees on a scheme in the south of England were found to have significant levels of burnout in their first year of training.[9] It was also noted that less than half of the trainees were under-estimating their levels of burnout.

If the innate resilience of doctors is being stretched as this early stage in their careers, it suggests that we need to start building on that innate resilience at medical school, during training, and on through our careers, to future proof ourselves against the increasing stresses of our working lives.

GP WELLBEING: LESSONS LEARNED FROM A TRAINEE-LED INITIATIVE

DR. DUNCAN SHREWSBURY
GP Registrar, Chair RCGP AiT Committee

It is unfortunately the case that those training and working within the medical profession are at significantly greater risk of mental illness and suicide than the general public.[10] At a time when junior doctor morale in the United Kingdom was believed to be at a nadir, several cases where junior doctors had turned to suicide were reported in the UK mainstream media.[11] This highlighted the issue of morale, but also wellbeing. Anecdotally, trainees experienced a lack of understanding, empathy or even basic kindness when approaching colleagues and seniors for support with issues relating to distress caused by their own mental illness, or that of peers.

GP trainees on the Royal College of General Practitioners (RCGP) Associates in Training committee wanted to take action to address this issue. We collectively felt saddened, disappointed and incensed that a colleague or friend would find himself or herself in a situation where the only option that they felt able to take was to end their own life. Even more, we felt that the rhetoric around such tragedies, and the response that trainees received to similar problems, denied the sympathy and humanity that we would wish to afford our own patients in times of great distress.

At a February meeting of the whole committee, we discussed and developed an idea to address the situation. We wanted to support a vision of happy, healthy colleagues who were able to invest in and maintain their wellbeing. We wanted to change the conversation around needing, seeking and providing help for doctors experiencing difficulty. However, we acknowledged the challenge of stigma around such issues and were wary of adding to negativity. The simple idea of trying to achieve change positively prompted us to look wider. We drew on ideas from positive psychology (literally, the study of how positive outcomes are achieved,[12] rather than the study of pathological psychology), and took inspiration from work done in the teaching profession.[13]

A group of teachers had started a campaign called #Teacher5aDay. It was largely facilitated through social media (hence the hashtag) but involved coordinated activities taking place in schools across the United Kingdom. It was so popular, in fact, that a national conference grew out of the initiative after less than 2 years. Their campaign centred on the five themes that emerged from a systematic review published in 2008, which looked at wellbeing across society, and how it can be improved.[14] The five themes were connect, be active, take notice, keep learning, and give. We re-deployed this as #GP5aDay (with the blessing from the #Teacher5aDay team). The key messages being that by building activities in your daily life that facilitated your social connections, kept you physically healthy, allowed you to pause and reflect on the good in your life, and enabled you to engage in acts of altruism, there was a good chance you would be better and happier for it and be more resilient to some of the factors that are believed to be contributing to the burnout of those working in general practice.[15]

Crucial to this story (although, ironically, not the campaign) is that the teachers had given out 'wellbeing bags' to their colleagues. These bags contained little messages about the campaign, and treats that were aligned to the messages, such as tea bags (to *connect* with someone over a cup or tea). Instead of leaflets further highlighting the negativity around working in health care at present, we felt the wellbeing bags offered an alternative form of campaign collateral that would help signpost key messages and resources as well as catalyse conversations when taken by trainees and shared with their peers and colleagues.

Our proposal gained support from leadership within the College. Members of staff were excited by the potential to work on something immediately tangible that could help make a difference. The campaign collateral was refined, re-designed and then piloted with trainees and early-career general practitioners, and then showcased at a meeting of college council. The feedback had been largely positive. The 'well-being bags' had morphed into boxes. The tea bags were still present, but they were now joined by a mindfulness colouring book and gratitude journal (both of which have a growing body of evidence suggesting their utility in mental health[16–18]).

Separated from the aims and messages of the campaign, an image of the mindfulness colouring book made its way into social media and trade-press. Subsequently, general practitioners across the country became enraged at the idea that they may be posted a colouring book to solve the issues that they face due to over-stretched and under-resourced workforce issues. Our objective, and morals, were questioned. The idea of the campaign was challenged. Plans to embark on a wider trial were slowed.

Amidst the negativity, however, came requests for sharing of work and ideas from other professions (law, veterinary medicine, policing) and requests from colleagues for the 'wellbeing boxes'.

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BURNOUT PREVENTION AND SELF-CARE STRATEGIES OF EXPERT PRACTITIONERS*

Mary Mullenbach and Thomas M. Skovholt

We are excited to present the results of this study in this chapter. To the best of our understanding, this is the first and only resiliency study that has investigated validly chosen expert/master therapists. Peer nomination methodology, a method that has good validity and reliability data, was used to find these experts. This method is excellent in finding those described by Kottler and Carlson (2014, p. 218): "The most creative practitioners work in relative obscurity, uninterested in notoriety and too busy to broadcast their ideas to a larger audience." These experts often do not actively advocate a new approach or speak charismatically to an audience of novice practitioners – those most in need of the certainty of method/tips/procedures while experiencing the uncertainty of professional work. Rather, expert practitioners often just keep working in direct client care and clinical supervision, satisfied by being able to directly respond to human need and suffering.

This method of peer nomination to find experts or master therapists, followed by qualitative interviews, has been used in more studies in recent years. These studies did not directly focus on resiliency patterns for these practitioners, but they did study characteristics, defined broadly. Studies of master therapists outside of the U.S. include those in Canada (Smith, 2008), Japan (Hirai, 2010), Korea (Kwon & Kim, 2007), Portugal (Carvalho & Matos, 2011a, 2011b), and Singapore (Jennings et al., 2008).

The focus of the current chapter is on the methods used by one group of practitioners in the helping professions in order to maintain professional vitality. The ideas presented here can be of use to a wide variety of practitioners across the rainbow of the many helping professions, caring professions, and relationship-intense professions. This is a big group of helpers, healers, teachers, clergy, human resource professionals, and attorneys in areas such as family law and immigration.

Practitioners encounter stressors that originate from both internal and external sources (Baker, 2003; Freudenberger, 1990; Norcross & Guy, 2007). Both have a direct effect on the practitioner. Burnout is especially prevalent in helping professionals. Practitioners are expected to engage in an ongoing series of professional attachments and separations, as discussed in Chapter 3. The stress of attachment and separation is often intensified by a lack of client success, nonreciprocated giving within the counseling relationship, overwork, difficult client behaviors, discouragement as a result of the slow and uneven pace of the helping process, the practitioner's existing personal issues that emerge in response to involvement in the counseling process, isolation, and administrative demands from agency and managed care organizations (Dupree & Day, 1995; Farber, 1990; Figley, 2002; Kassam-Adams, 1995). Burnout occurs when the practitioner is continuously depleted from this intense process of engagement.

The debilitating effects of the helping role on the practitioner have long been recognized as an occupational hazard with far-reaching effects (Freudenberger & Robbins, 1979; Smith & Moss, 2009). Based on his research, Farber (1983) concluded that counseling work can have a substantial negative impact on practitioners' self-identity, behavior, and attitudes, both within and outside of the work setting. Historically, studies in this area have primarily focused on identifying work-related stressors.

As mentioned in the beginning of this chapter, this is the first, and to the best of our knowledge, only study of the resiliency patterns of validly chosen expert practitioners. In 1996, a research program was started with 10 peer-nominated mental health practitioners. The purpose of the initial study was to identify the components of mastery among this group of expert practitioners. Since that time, the research program has been expanded. The current study identified components relevant to wellness and professional resiliency in this group of practitioners. In this study, a qualitative design was utilized as a means of drawing a store of rich information from the sample group. Data were collected through the use of a semi-structured interview format, with questions cultivated from existing research focused on stressors among mental health practitioners. The questions were designed to identify stressors and to access information pertaining to the emotional wellness and professional resiliency of these practitioners. The data analysis relied on an inductive approach that allowed for an in-depth exploration. Two interviews were completed with each of the participants. An analysis of a second data source obtained from a previous study with this same group of participants was used to supplement the findings. The total amount of research time, most clocked by Mary Mullenbach (2000), was in the hundreds of hours. Quality qualitative research often takes a lot of time! The selected findings presented in this chapter focus on high-level stressors and self-care strategies identified within this group of practitioners. The quotations from the participants are often very meaningful for readers of this research. We hope this is true for you too!

This chapter presents 20 themes within five categories that originated from the data analysis. The five categories are (1) professional stressors, (2) emergence of the expert practitioner, (3) creating a positive work structure, (4) protective factors, and (5) nurturing self through solitude and relationships. A summary of the information is in the list below.

CATEGORY A: PROFESSIONAL STRESSORS

Category A contains four themes that identify stressor areas that are confronted by the participants in their work.

Category A: Professional Stressors

Participants are stressed by issues that challenge their competency.
A frozen therapy process is highly stressful for participants.
Breaches in peer relationships are stressful.
Intrapersonal crises negatively impact the professional role.

Category B: Emergence of the Expert Practitioner

Participants learned role limits and boundaries.
Over time, participants experienced less performance anxiety.
With experience, participants moved from theory to use of self.
Participants view attachment and separation as a natural process.
Participants understand human suffering at a profound level.

Category C: Creating a Positive Work Structure

Mentor and peer support was critical at the novice phase.
Participants have ongoing and enriching peer relationships.
Multiple roles are a protective factor.
Participants create health-promoting work environments.

Category D: Protective Factors

Participants directly engage highly stressful professional dilemmas.
Participants confront and resolve personal issues.
Highly engaged learning is a powerful source of renewal.

Category E: Nurturing Self Through Solitude and Relationships

Participants foster professional stability by nurturing a personal life.
Participants invest in a broad array of restorative activities.
Participants construct fortifying personal relationships.
Participants value an internal focus.

Theme 1: Participants are stressed by issues that challenge their competency

Participants reported an array of issues and events that challenge their sense of wellness. Sometimes, as in the case of a suicidal client, these experiences

represented unpredicted critical incidents for the practitioners. Other, less intense events and issues were chronic in nature and occurred on an ongoing basis. Regardless of the specific experience, a commonality that ran through was the participants' experience of feeling "tapped out" in regard to their level of competency or comfort. One participant discussed the emotional impact of a client who committed suicide during a hospitalization.**

> I know that she ended up in the hospital; I arranged it. . . . So I took care of her safety, I felt. And I don't know what the heck they did; she was suicidal, and they weren't watching her, and she hung herself. And it was really hard; I just felt heartbroken, and I was so pissed at the psychiatrist.

One participant discussed the ongoing stressors that are related to working with chronically ill clients who don't progress:

> . . . depression that doesn't lift. All kinds of interventions; I mean, some people have had therapy for years before they get to me. Some of them have had shock treatment, some of them have had medication, and nothing seems to be helpful. You know, people who have been searching for a long while, and maybe you can help them make some inroads, but there are some people for whom it just feels like we don't have what's needed yet.

Other participants discussed their sense of feeling lost or depleted when working with specific client behaviors:

> And I'm realizing that, for example, I don't work well with addictives, people who are addictive. I find I get sucked into their dynamics, and I can't keep track that these people are also con people because they need to be.
>
> I've had a few men who have been very abusive . . . they're coming to me, and the allegation of physical or sexual abuse may be in the air, but they haven't dealt with it at all, or maybe it hasn't been in the air at all. But I find myself angry at the end of those sessions. Those are the people that I find myself, I feel used up rather than giving 100%; I feel like I've been stolen from; I feel like I've been taken from. It's totally unrewarding, like they don't give anything back.

Sometimes this sense of being tapped out resulted from the level of distress expressed by the client:

> I think it has more to do with when there's been a lot. So, for example, there are some weeks where it feels like you always thought you heard the worst that you could possibly hear and then someone comes in with something worse about what people are able to do to people that causes pain and distress. . . . And sometimes it's just in waves.

Theme 2: A frozen therapy process is highly stressful for participants

Participants reported that they experienced a sense of boredom related to clients who were unmotivated or resistant to treatment. This experience of feeling bored within the therapeutic relationship was reported as a significant stressor. Participants stated:

> For me the issues would be probably somebody is just really without any willingness whatsoever to reflect. It is always something outside of themselves, continuously so . . . mostly I think I lose interest.
>
> I think what's challenging, frankly, are the boring clients, you know, where it's time after time and very little is happening.

In reflecting on his work with clients who were resistant, one participant spoke about the need to deal with his own defensive response:

> Well, I find I don't mind their resistance; it's when I start getting resistant in the face of their resistance. I mean, they have the right; I expect them to get resistant. But then when they do their resistance in a way that engenders my resistance, then I don't like that.

Theme 3: Breaches in peer relationships are stressful

Participants consistently reported that they derived a beneficial sense of support from their peer relationships, both within the work environment and in the broader professional community. Not surprisingly, breaches in these relationships are especially stressful. One participant stated:

> Some of the most stressful times have been when I've accidentally ended up working with colleagues that I didn't feel compatible with, to come to work every morning and greet a face that you're not happy to see. Someone you don't trust or respect who doesn't seem to trust or respect me, that's very hard, but it's not my situation now.

Another participant discussed his struggle to stay engaged with peers in the broader professional community when discussing issues relevant to professional practice and integrity:

> [Stressful for me are] my own relationships and associations with colleagues where we hit points of important divergence. And my willingness to stay present to those, to stay in a relationship with those colleagues and to stay present to the divergence without favoring a tendency to want to split off or isolate or withdraw.

In a similar way, a participant spoke about her negative response to conflicts between separate divisions in the psychological community:

> They're both really good groups, and I think it's good for our practices and the community and everything else, but there are elements of competition and resentment and politics, I guess is what you'd call it, but I really dislike it, and when I'm caught in the middle of one of those frays, I'm very unhappy.

Theme 4: Intrapersonal crises have a negative impact on the professional role

Participants reported that personal life crises and related problems presented challenging situations in their professional role. Although the participants had developed proactive methods for coping with these issues, they reported a strong sense of discomfort when initially faced with this type of challenge. One participant described the unease that he felt when personal issues created a sense of incongruence in his perception of self:

> When I was experiencing a lot of tearing in relation to my own family, which I did some years ago, a long time ago. That was pretty difficult, and I think the difficulty was having to redo my conception of myself while I was continuing to practice. And you really can't take yourself off line and decide to redo your conception of yourself and come back because that's always so closely integrated to whatever you're doing every place else.

Another participant described the hardship that she encounters when she is in the process of resolving her own crises:

> So then I feel very split in terms of what I need to attend to with clients, and yet knowing this other thing is playing in my own life that is not going to resolve today in a phone call and is not going to resolve in a week, and it's going to be with me for whatever period of time. And so those, frankly, are torture chambers for me. . . . When I'm sitting with clients and they're talking about anything that remotely is similar or identifies with or touches on, the anxiety just shoots up. . . . How do I manage that level of anxiety and at the same time try to be here for my clients?

CATEGORY B: EMERGENCE OF THE EXPERT PRACTITIONER

Category B contains five themes that highlight aspects of the participants' approaches to professional practice. These themes reflect attitudes and techniques that promote wellness and preserve professional vitality.

Theme 1: Participants learned role limits and boundaries

Over time, participants learned the value of establishing clear boundaries and limits in areas that included their role as a helper, the level of responsibility that they assumed, the structure of their practice, the makeup of their caseloads, and their relationships with clients. The establishment of these boundaries and limits enabled the practitioners to maintain a sense of wellness and vitality, to cope more effectively with difficult client behaviors, and to manage their own continuous exposure to suffering. In discussing her evolving role, one participant stated:

> I'm far more wise about all the things that I don't need to know about and don't need to fix, and I think when I started out, like most of us when we start out, feeling a need to have all the answers. My job was to fix this, be helpful. I think with experience and time in the field, you learn that our job is really to relax more and sit back and listen and hear better what it is that the person is trying to sort through.

One participant discussed the establishment of limits and boundaries as a necessary ingredient in both practicing with integrity and fostering a sense of wellness and vitality:

> It is up to me to do everything I can to maintain my own emotional health so that I can actually be available to my patients without needing them. I think one of the ways therapy goes awry is that the therapist starts to use the patient for their own emotional sustenance, regulation of the therapist's self-esteem, all those sorts of things. I think that to be a good therapist, you must be well fed and well loved. Basically, have a life out there that is working.

Participants noted that limits and boundaries played a key role in structuring their actual workday. In discussing the framework of her schedule, one participant stated:

> It's important for me to keep track of the hours I'm putting in because it's very easy to start going over a 40-hour week. And I start to know that something's wrong when I wake up in the morning and I'm not rested or when I'm dreading the day, or I'll find myself sleepy or bored, and this is not boring work, and I start to make mistakes, double schedule people, or there are just certain signs I recognize as that I'm working too hard.

Regarding his ability to implement limits on client behaviors, one participant stated:

> I'm more sure of myself. . . . I can set limits with, you know, the authority of a Dutch uncle, and it can have the subtleties of both nurturance and a stop sign.

Another participant noted the importance of understanding her limitations as a practitioner:

> Part of it has been to really advocate for clients where it feels like it's really important; part of it has been to make alternatives available, like sliding fees for people; some of it is just coming to grips with that there are certain agencies that can provide certain things, and that we can't provide everything for everybody. So part of it is accepting limitations.

Theme 2: Over time, participants experienced less performance anxiety

With time, participants became more comfortable in their professional role. With this change, they experienced a decrease in stress and an increase in confidence and ability to handle a variety of difficult therapeutic issues and client behaviors. This shift allowed them to be more open and genuine in their role as a helper. Three practitioners commented:

> There's less of a need to prove yourself, and so you can be more open because you don't feel as much that you need to defend anything or protect anything. I think when you first start out sometimes, it feels like you're on the line, you know; no one knows who you are, how you're doing, and so I think there's much more a sense of protection around yourself; seems like as you grow older and more experienced, there's more of a sense of "We all don't know, and we're all learning," so you can be pretty open about hearing feedback, getting information.
>
> I laugh a lot more, a lot more. I am old. That is one thing that helps. And . . . I am not forever wondering if I am good enough.
>
> Comfort with coming to work each day and assuming that it would be okay. You know, I'd do all right somehow, or I'd be able to deal with whatever happened that day; I'm just guessing, but I'm thinking maybe 10 years into my practice, I started to have that kind of sense of equilibrium about it.

Theme 3: With experience, participants moved from theory to use of self

Participants noted that, as they accumulated experience, they moved from a reliance on specific techniques and approaches to being more open and genuine. This change occurred as they became increasingly aware of the therapeutic process and how to best use their own self within the relationship. For these participants, the shift from a reliance on specific approaches to the use of self required an element of risk and openness. Once achieved, it felt more like a comfortable professional "fit" that was conducive in creating intimate and intense interactions with clients that enhanced their work. When focusing on

the intense and intimate nature of the therapeutic relationship with clients, participants stated:

> In a sense it's a joy. . . . It's the fact of working with people and watching them grow and feeling that you have a part in that growth. It's fun.
>
> Well, I get off on it. I mean, honest to God, contact is very exciting. I mean, when two boundaries meet, that's where the energy is.
>
> Well, I think the one thing that has prevented me from burning out . . . is the fact that no two people look alike to me. The people who burn out begin to see everybody as alike; they see people as problems, and they see problems as the things they are working with.

Theme 4: Participants view attachment and separation as a natural process

Participants discussed their belief that attachments and separations in the therapeutic relationship followed a natural course, similar to those experienced in other relationships. This belief appears to fortify the participants through years of fostering attachments and facilitating separations with a multitude of clients. They are committed to engaging in that process, even through times of difficulty, and hold the belief that it is a mutually beneficial process. One participant discussed her belief that the therapeutic process of attachment and separation mimics life:

> But it seems to me that all of life is about attachment and separation. You know, even with marriage, there are times when attachment is really important, but there's also times when separation is really important. Where you're individuals and you have different needs and different abilities to be present. So I think that's how I help myself with it, is that it feels part and parcel with just what's true in life . . . I think it's totally important that people are able to attach in order to work through some of what might not have happened for them. But I also think it's important to be able to separate and let go.

Participants also discussed their experience that relationships continue beyond the separation. This continuation may exist on an internal level or, in other cases, actually involve the client returning to therapy. In some cases, work that began with a client eventually extended to the client's children. This belief regarding the ongoing nature of relationships appeared to insulate the participants from the potential distress of repeated attachments and separations:

> And then a number of people come back over the years, so I have more and more confidence, sort of like an object constancy, in me at least, that these people remain alive in my psyche. They're out there in the world, and I feel connected to them and believe that they'd return if the situation arose.

I think in a core way, attachment is an internal phenomena rather than external. You can see people for years every day and probably not have that much attachment. So if you stop seeing people, there is some loss, but it doesn't mean that, therefore, something got yanked out.

I feel like I really do give people something, part of myself, and when they leave, I really have an investment. But these days, I almost never say a permanent goodbye to anybody. I'm always having old clients come back; I'm even having the children who were playing on the floor coming in with their spouses at this point.

Theme 5: Participants understand human suffering at a profound level

Through their work, participants developed a profound understanding of suffering. This includes an awareness of the painful elements and the potential for growth. The participants' comments reflected a profound awareness of suffering and the healing process that is part of their role as a helper. Their hopeful outlook toward how suffering can be transformed also seemed to enhance their own lives. One participant talked about how his perspective has been altered through continual exposure to suffering:

> I think all in all, it leaves me with a certain kind of enthusiasm because I see people go through extraordinary pain and come out the other side. And so it makes me patient.

Another participant differentiated between the short-term stressors and the long-term benefits continually confronting client suffering:

> In visiting the intensity of the private world of several people who are your clients, empathizing with the misery, and it can feel like, at the end of the day, lonely to have been so intensely in all of those places, and nobody had been in all of those places with me. And I couldn't tell anybody where I'd been. . . . The loneliness of that is a big part of the burden, I think. But that's more like the immediate at the end of the day kind of thing. What I think I'm left with is more a sense of the humanity. . . . And I think I'm a lot more comfortable with the topics of grief and sex and life crises. I just think that I just have that settled sense of the humanity of it.

CATEGORY C: CREATING A POSITIVE WORK STRUCTURE

Category C contains four themes that focus on how, over time, the participants created important support that enhanced their sense of wellness in the work environment.

Theme 1: Mentor and peer support was critical at the novice phase

Participants reported that positive mentor and peer relationships had a great impact on the novice phase of their careers. These relationships often developed during long-term first placements that were frequently described as challenging but not overwhelming. The novice setting provided enriching work environments full of learning opportunities and encouragement for responsible autonomy and risk taking. While at these sites, a foundation was built for the participants' future practices. In reflecting on his first placement, one participant stated:

> I remember those as good years. I'm sure they were stressful because a lot was new, but I felt very supported. I had resources about me, and I was valued and also I had a tremendous amount of independence.

Another participant stated:

> [It was] a time of working intensely with colleagues in relation to having lots of feedback, lots of inspection of one's practice. All of that, by and large, was very good. I certainly wouldn't trade those years.

While discussing a supervisor at her first placement following graduate training, one participant stated:

> At my first job, I was fortunate enough to have a really fine supervisor who literally I credit with the major amount of training and experience that I have. And that was totally geared to emotional self-awareness and use of self in ways in which I grew a hell of a lot, but I also learned never to ignore that part. . . . It opened all the doors for me, and it also made what I was doing very vital and real, and I feel real grateful for that.

Another participant discussed her decision to join a group of seasoned clinicians who then became important mentors and teachers:

> I think that I had either the good fortune or the good judgment to join a group of senior clinicians, all people 20 years older than I, very experienced, and I brought them something they needed which was the M.D. I could prescribe medications for their patients, and I could hospitalize their patients, which was fine. But they gave me the depth and breadth of clinical experience and an understanding of how the practice works, and it was very important to me.

Although the need for strong mentor relationships gradually diminished over time for many of the participants, the salience of these early relationships was highlighted in the reflections of one participant:

> It's more in retrospect than I was aware at the time, that there were people along the way who believed in me and kind of engaged with me because

> they believed in me. And I really thrived on that, more than I knew, in the moment. I got so much from that in a way that if I hadn't gotten that, my life . . . would have taken a different path.

Theme 2: Participants have ongoing and enriching peer relationships

Participants reported that they initiated and sustained relationships with a variety of peers and coworkers beyond the novice phase. These relationships served a critical role in supporting the participants. One participant described the value of combining ongoing experience with peer relationships in this way:

> I don't think years of experience by itself does it, because . . . I might have the same year of experience 20 times, and so I need to put that together with good consultation and a good collegial system around you; that is a part of the therapist's well-being.

When discussing peer relationships specific to the work environment, one participant stated:

> I think that it is actually kind of a unique and rare environment that offers a therapist that kind of support for continuing growth. One that says even if you've been in this business for a number of years, you are still allowed to not know, you're still allowed to be afraid of what's happening, you're still allowed to feel like a failure, or whatever the issue is.

Both formal and informal interactions were emphasized as being important components of peer relationships in the work environment. One participant described how she and her coworkers had strategically created a work environment that provided a variety of interactions:

> We've made a coffee room so that we run into each other on purpose, and we meet once a week for lunch, and that's very helpful both for relaxation and socializing and for consulting. There's always somebody I can say, "Listen to this situation, tell me what you think," and without naming names, I can describe the problem and get feedback from somebody that I respect.

In reflecting on his peer relationships, one participant highlighted the value of friendship and of sharing life events along with professional concerns:

> We sit down for our staff meeting, and before we do anything else, we just sit at the table, take a few minutes, and talk about our lives. It's sort of this is what's happening with my kids; this is what I did last weekend; by the

way, I saw a great movie; and just that personal level, before we get into talking about [clients].

Oftentimes, the intimate quality of peer and coworker relationships was an enriching factor in the participants' ability to deepen their level of self-awareness and, in turn, to invest more intensely in the therapeutic process with clients. Two participants described the importance of sustained, close relationships in the actual work environment:

> Here, for example, we have a group of six, and some of us have been together for about 14 years, so you really have a chance to deepen the experience with one another and, therefore, I think also be able to deepen your work with clients, because you're better able to know about yourself in relationship to the work, and other people know you well enough to say, "Hey, look at this."
>
> . . . we've been present here in this practice for going on 18 years, and we've always done weekly consultations and the kind that really gets at what might be stopping us, what might be blocking us, what we might be struggling with.

Diverse peer relationships in the broader professional community were also highlighted as vital sources of support. Participants tended to be actively involved in numerous professional activities, organizations, and community groups. One participant discussed the value of serving on a committee with a cross-section of helping professionals:

> To have all these people giving time and energy to thinking about what will make our work improve. It's just inspiring, and for me it's invigorating and energizing. Just helpful in that way.

Similarly, another participant stated:

> I have a group of colleagues that are very important to me, have been for 10 years now, and we meet in the West Coast every year; we spend a week together; we rent a room together for a week. They're all existentialists, and they're my closest colleagues in terms of tradition, and I see them maybe two, three times a year in groups or individually . . . . And that has been very, very helpful over the years.

Theme 3: Multiple roles are a protective factor

Participants reported that they structured their practices to include multiple tasks and professional involvements. They also exhibit a measure of freedom in choosing the type of clients they work with and how they do their billing. The

ability to control the nature of their practice provided the participants with a stimulating balance of professional responsibilities while limiting the stressors that they encounter. In discussing her need for task diversity versus doing only clinical work, one participant stated:

> If I did only this work, I would be bored out of my mind. . . . It has nothing to do with the people I see; it's about having to empty yourself out so constantly and regularly to do that work. And that wouldn't be healthy; it just wouldn't be healthy.

Another participant discussed how involvement in diverse activities improved her professional and clinical work:

> I think there is something really enriching about supervising and teaching. It keeps me interested in my work and feeling alive and motivated to read and to think from some point of view other than just inside my head.

Participants reported that freedom to design one's caseload and control the billing also contributed positively to the professional experience. On client-related stressors, one participant stated:

> I don't think of my clients as impacting me in ways that I would consider stressors; . . . there's been stuff obviously over the years . . . we'll be dealing with suicide or we'll be dealing with this or that. . . . I haven't had much of that for a long time, and it's partly this practice; I mean, it's set up in a way in which I'm not dealing with crisis. I mean I'm dealing with . . . wellness perspectives. So I'm also not in situations at this point that would push that.

One participant discussed the way that she structured her caseload and completed billing:

> I've been very fortunate in two ways. One is that I'm an old-timer, so I've developed my own reputation and my own referral. Most of my patients come referred by other patients. And many pay out of pocket, and I'm willing to make some adjustments; I'd rather give them the money than the insurance company actually in terms of discount.

Theme 4: Participants create health-promoting work environments

Participants said that their work environments were suited to meet specific needs of space, aesthetics, and personal comfort. Equally important, these

environments were conducive to facilitating successful therapeutic relationships. One participant outlined the benefits of her work area:

> I really like it here. I like my space. I like being here. I love being here when it's raining or snowing, and it's kind of a cocoon kind of feel to it. I think about the holding environment that helps therapy to work. That is part of what's here, and I like it, and I've heard clients talk about that it's nice to be here.

Other participants also discussed the need to create a comfortable, therapeutic work area:

> Space that allows for both enough distance to accommodate mine but also the other person's personal space requirements. And with clients, that varies actually. So I think sometimes I move forward or backward, depending on what I'm sensing, but also not so big that it feels like you're talking into a room rather than connecting to people. I think something that feels, that gives the sense of privacy and safety. I think it has the sense of being protected but not trapped.
>
> You know, I'm really into friendly textures and colors, and the light is important; the quiet is important. We went to great lengths to soundproof all these offices. The building would think that it was adequately soundproof, but I could still hear what was going on next door. We just kept putting insulation in the walls until it was soundproof. I guess I have to feel generally safe. I know people who work in clinics and kind of dangerous parts of town, and I think that's not conducive to the comfort of therapist or patient.

CATEGORY D: PROTECTIVE FACTORS

Category D contains three themes identifying proactive strategies that participants employ to master stressors.

Theme 1: Participants directly engage highly stressful professional dilemmas

Participants are skilled in their ability to handle ongoing difficult situations and to manage crises in a proactive manner that serves to prevent future incidents. Their strategies reflect an ability to adapt to change, and to bounce about unexpected or shifting events and issues. Participants tended to identify and frame challenges and issues in a hopeful light and to access appropriate resources. In confronting challenges and issues, participants discussed their

need to remain receptive to possibilities and approaches on both internal and external levels:

> And then I have to engage [the stressful issue] in myself because there's always the possibility that there's some piece of me working here that would rather not see this, would rather not own the power that I have; I'd rather see that I wasn't that important, diminish my own responsibility in that way, or minimize my responsibility to be a better attender to somebody else's experience.
>
> One of my most profound learning experiences was stimulated by, first of all, working with a couple of therapists who turned out to be highly unethical and abusing their patients, and I had a dear friend of mine exploited by a therapist, and I'm thinking, "I've got to understand this; something really went wrong here." I find myself somewhat of an expert on boundaries and boundary violations because it really challenged my whole self-concept as a therapist or challenged the whole idea of therapy as a healing process. So I wanted to go after that problem.

An appropriate reliance on peer consultation was a critical resource that participants used in their process of exploring important issues and incidents:

> I get lots of consultation, so I'm not by myself with the really hard cases. That's primary for me. If there's anything that feels really important, it's not to be by myself in really hard situations, that I have colleagues with me. So that I feel that kind of a sense that I'm not all alone in this. It's really important to me that I'm seeing things clearly, and I think it's hard sometimes when you're all by yourself. And to have other eyes and ears looking at something with you. So that's one major way [to protect myself].

A key characteristic of the participants' reports was their willingness to remain open and to adapt. In discussing these traits, one participant stated:

> I think sometimes it's caused me not to feel like I know what I know at times, but on the other hand, it also keeps me kind of fresh and open. I'm willing to entertain almost anything, and I'm willing to look at where I could be off base about almost anything.

Another participant described her daily clinical work and provided an example of her ability to adapt from one client to another:

> I think I'm emotionally resilient in the sense of I can be with someone in their pain . . . but then I can in the next session be laughing with somebody about something or celebratory with somebody. So it feels like that's a way that I can move.

Theme 2: Participants confront and resolve personal issues

Participants reported that their own personal life crises and problems were a challenging area for them. They also believed that direct acknowledgment and resolution of these issues allowed for congruence between the personal self and the professional self. One participant explained how her experience in dealing with the unexpected death of a family member challenged her at a profoundly personal level yet allowed her to be more attuned to clients:

> Well, I think the suicide [in the family] made the work very challenging. And yet at the same time, I was fortunate in that I had a very fine therapist. And because I had that therapist, while the work was difficult, I constantly felt like I was being so tended to emotionally . . . I found myself taking from that experience and just automatically moving it into what I was doing with clients. So it's like as the therapist was willing to go with me where I needed to go and that opened up areas or that developed areas inside of me that I didn't even know were there. Then, automatically, I would hear those areas in clients. I would ask the questions because they were coming from where I'd been taken to.

Theme 3: Highly engaged learning is a powerful source of renewal

Participants reported that they had histories of being open to new experiences, seeking out diverse avenues of learning, and synthesizing information from multiple sources. Their lives were marked by an insatiable curiosity, a deep comfort with ambiguity, and constant consumption of knowledge. This ongoing learning process helped them to maintain an energy level necessary to continually engage in the helper role. In discussing a draw toward learning and its effect on her, one participant stated:

> Well, it provides constant energy for one thing, and I think what happens in our field is that we can get tired and exhausted, but I think that's one of the things that keeps me feeling high energy and a lot of interest and love for what we do, and it's exciting.

Some participants described why a tolerance for ambiguity and an openness for learning were critical ingredients in their work:

> I mean, we don't throw away what we know in favor of mystery, but to favor mystery is to prefer it above what we know.
>
> If nothing else, you want to work with these people from all walks of life with various occupations and various interests, and if you don't sustain at least some awareness or at least openness to learn from your patients about their work, then how can you be of any use to them if you stay on the outside? So one has to have the interest and curiosity and some

> fondness, I think, for the client. If you're not interested in joining them, then why would they trust you to come and open themselves up.
>
> If you can't work with the unknown and the uncertain, you can't last in this business.

Another participant discussed her efforts to bring new information into her work:

> When I read, I always know what I define as active learning, which is trying to take the new information and see how I can incorporate it into what's already there, which means that I'm always modifying existing information too. And adapting it to my needs and integrating what I already know. It can be a negative thing if you go with the approach that everything has to fit to some rigid fixed scheme set already in existence. But I don't think I do that. I think I really constantly modify my schemes by incorporating the new stuff, but it's probably the integration and incorporation that are really important.

One participant discussed how she utilized peers to facilitate her own learning process:

> I think being in a group practice has helped because it keeps you kind of interested and hungry for what's available and keeps you open, I think. I've done groups with co-therapists for years upon years. I've done co-therapy, marriage therapy. I think that also helps to stay open because you're constantly getting new information, getting new ways of thinking when working with someone. Getting input about your ways of working, so I think that also helps.

CATEGORY E: NURTURING SELF THROUGH SOLITUDE AND RELATIONSHIPS

Participants clearly identified their need to maintain a strong sense of self. Category E contains four themes that focus on components important to the participants for this need. The themes reflect multiple approaches and a network of internal and external involvements that enable the participants to maintain a personal and professional congruency.

Theme 1: Participants foster professional stability by nurturing a personal life

Participants were aware of the importance of maintaining a balance between their personal and professional lives. They believe that their role as a helper is

facilitated by a lifestyle that includes multiple involvements and connections apart from their professional life. One participant verbalized this sentiment when he stated:

> What helps me do it well is to give a damn about what I'm doing, but . . . I've got to have a life out of here. This can't be everything. I can't be over-invested in it. There's an appropriate kind of investment in which I care very much about what happens here, and I'm willing to invest myself as fully as I can, and part of what helps me do that is the fact that I've got a very real existence in a lot of ways, not just this.

Another participant succinctly stated:

> There's [need for] some kind of larger balance. I don't think anybody could do this work justice and not tip over in some way. The tendency to get off center is too great.

Theme 2: Participants invest in a broad array of restorative activities

Participants cultivate a collection of activities and leisure pursuits. Although the actual involvements are varied, a shared theme that runs through them is their function of providing a diversion from work-related stressors and an avenue for reconnecting with self and others. The function of these activities and pursuits was reflected in one participant's statement:

> [Helpful is] doing things personally like physical kinds of things. When we talked about secondary post-trauma, there are some days when I just feel like I need to go out and kick something and just kind of biking real hard or walking real fast; doing things like that can be really helpful I think. I do a lot of going to plays, going to movies, getting together with friends, and just talking about plays we've seen, books we've read.

A similar draw toward multiple involvements was reflected when this participant stated:

> I love mystery stories and historical biography; that's where I learn my history, from historical novels. I like movies; I love sports; I'm an avid football fan; I knit; I do a lot of knitting and crocheting.

Other participants discussed the pull that they feel to nature and other creative activities:

> I think something happens for me spiritually when I'm doing stuff with flowers and plants. I've got plants all over the place in my home, and it's

kind of a ritualistic peace about tending those. I have gardens here and at a cabin up north, and there's, again, sort of a ritualistic peace with tending those. I think that takes me to a place that is real deeply nourishing, and I can get lost in it in a whole different way. I love the creative so the book that I wrote and stuff that I do for school and the papers, I really try to approach those as creative endeavors.

I find that music is a way for me to ground myself in the larger experience of my life and life itself. I suppose that's true for a lot of people . . . but that's certainly true for me, and always has been. And one of the ways, when I find myself feeling deprived of being able to cry, it'll come through that way.

One participant discussed the critical function of travel:

It's very helpful for perspective purposes. Very helpful. The trick is to be gone long enough . . . so you recognize fully your entire replaceability. That you are absolutely replaceable. And there, you talked about freedom and relief; there is real freedom and relief in that.

Theme 3: Participants construct fortifying personal relationships

Participants are highly skilled relationship builders. They establish nurturing and challenging connections with family, friends, and other social groups that are intimate and rich. Among other things, their relationships with others provide consistent, ongoing support and enable a realistic perspective of self. Although these relationships are important on a day-to-day basis, they are especially critical in times of crisis. Some of the participants discussed how a network of supportive relationships fortified their lives and acted as an emotional safety net:

If you have good friends in your life, if you have a good support system, folks will let you know that you're feeling worn out or depleted or whatever and then will support you getting some help.

A lot of close friends and my children are best friends. And they keep me very well balanced and keep my perspective, don't let me get a big head. They're very good, a very supportive bunch.

Having your own family connection solid is, at least for me, pretty important. I think I have a lot of reliance on other people in my life or friends or my wife, catching me in areas where I don't catch myself.

Some participants spoke about the encouragement and comfort they derived from a relationship with a spouse or life partner:

I married the right lady; my wife has a master's level degree in child development. And so we can talk, and she understood what I did. She never

> worked after we got married because she started having kids right away. But we could communicate and understand each other. And she was always a nice balance when my head started getting too big. She would pop it. . . . And so that was very supportive, still is.
>
> We met actually as classmates. And I'm sure that's probably the most important relationship personally, but also I think probably professionally in some ways. We do talk psychology with each other, have all these years. So I'm sure that's been very important.

One participant highlighted the essential function of children and family:

> We do a lot with family celebrations. Socializing, having people over for dinner. My children, now they are out of the home, but when they were younger, I think we did some things that were really helpful. Taking time just to play some games together. Just do something completely separate from work.

Another participant also commented on the very significant role that her friends play:

> What I would say is that there are a few close friends, and when I'm in trouble, when they're in trouble, the rules are we get access to each other whenever and however long we need it. And when the trouble's over, we go back to our lives. And those people are very in place, and I think I am for them too.

Participants also fostered an essential relationship with the world at large, and they usually spoke about this in terms of a spiritual awareness or seeking a greater sense of connection with others:

> I have a sense of spirit. I have a sense of reverence. I have a sense of place in the universe even though I know it's just a speck; it's a place to participate. I believe that there's benevolence in all that. I believe that warm, gentle breezes blow my way besides the cold, bitter winds.

Theme 4: Participants value an internal focus

Participants reported that they are aware of the significant role that their internal processes play in sustaining their own sense of wellness and in their ability to function effectively as practitioners. They are open to, and willingly engage in, their own personal therapy as a means of enhancing this process of introspection and self-examination. This commitment to understanding self represents an important self-care method that has a positive impact on their

sense of resiliency and wellness in the helping role. Statements by the participants reflected the value of being continually self-aware. One said that it was important to attend to:

> what's coming up in my world that needs me to understand what's going on or feel like I get it in terms of whatever's happening internally so that when I'm doing my work, I'm sort of cleared out, and it isn't that the stuff isn't in there, but I'm not obsessing about it; it's not taking me some other place than where I need to be in the room.

Another stated:

> To learn something about vulnerability yourself, I don't know that anybody can really do therapy well until they know vulnerability, unless they are aware of their woundedness. . . . And be able to work from there.

One participant shared her belief that staying attuned to internal processes was, in part, an ethical responsibility:

> I think that's where we need to build this self-monitoring and be self-aware. If I become psychotic, then probably those around me would notice it, but outside of those extremes, if my work fluctuates on life events or whatever like physical health . . . I think to what extent one is ethical in their conduct [relates to] the kind of posture of self-reflection and self-monitoring and judgment.

Other participants discussed their belief that personal therapy was an important vehicle in their quest for self-awareness. One participant stated:

> The other thing I would say is it's important for every therapist to know when it's time to go back for some therapy of your own; personal anxieties or problems are either getting stirred up by the work or are intruding from the outside world.

CONCLUSION

Several pertinent areas were highlighted in this chapter. Participants identified stressors connected to various therapeutic issues and client behaviors, breaches in peer relationships, and the impact of their own personal crises and life changes. The areas of stressors that were reflected in the participants' comments underscore the demanding nature of the helping role and reinforce the value of protective approaches and self-care strategies as a means of ensuring practitioner wellness and professional vitality.

The participants identified important protective factors. These factors ranged from internal coping strategies to variables within the external environment. A commonality that existed among this group of participants was their commitment to self-care and their high-level skill in accessing valuable resources.

This group of practitioners has acute awareness of the internal landscape and maintains a watchful focus on their emotional selves. Their strong commitment to self-observation was frequently combined with a proactive style in directly confronting stressors that emerged both from their work and in their personal lives. When combined, these approaches allowed the participants to maintain a sense of personal congruence and an energy level that are critical components in professional wellness and burnout prevention.

This group of participants was nurtured through multiple avenues and relationships. The role that peers played in providing the participants with a realistic perspective and ongoing professional support was emphasized. While peer support was vital throughout the participants' careers, it played an especially key role during the participants' novice phase of development and also during times of unexpected crisis. In a similar way, participants also noted the importance of immersing themselves in enriching relationships and activities apart from their work environments. It appears that these diverse involvements were essential components to self-care plans that maintained a healthy sense of balance.

There are many practical applications of this chapter. One active practitioner in psychology working in a school setting, and in a private practice too, says she uses these insights *every day* as she works with great vitality to be helpful to those in need. Now that is an example of useful research!

SELF-REFLECTION EXERCISES

1. What impresses you most about the methods used by experts to maintain professional vitality?

2. What can the experts teach you for your own resiliency development and self-care?

NOTES

* This chapter is based on the work of Mullenbach, M. A. (2000). *Expert therapists: A study of professional resiliency and emotional wellness* (Unpublished doctoral dissertation). University of Minnesota, Minneapolis. Thomas Skovholt was the dissertation advisor. This study also appeared in Skovholt, T. M., & Jennings, L. (Eds.) (2004). *Master therapists: Exploring expertise in therapy and counseling.* Boston, MA: Allyn & Bacon.

** Quotations have been edited with small changes that increase the clarity of the writing.

Developing relaxation skills

Introduction

The physical and mental symptoms of stress were outlined in Chapter 1. The result is that the individual remains in a state of 'high alert', being in a constantly overaroused state and unable to switch off either physically or mentally. This is where learning relaxation skills can be helpful. Mentally they can help the individual develop a calmer response towards negative, distracting or worrying thoughts and images. Physically they can help to reduce and ultimately eliminate the bodily symptoms of stress. Being relaxed means being in a 'distress free' state, so any intervention that contributes towards bringing about such a state can be said to have relaxation properties. The relationship between stress and relaxation can be conceptualized as being on a continuum. The aim of relaxation training is thus to create a state of inner wellbeing and peacefulness and bring the individual towards the relaxed end of the continuum, as shown in Figure 8.1.

There are a few possible reasons why people find it difficult to relax. The first of these is that they have been under stress for so long they have simply forgotten how to relax. The second one is that they may never have learned the skills of relaxation. Relaxation training equips them with the tools and techniques to enable them to move from the 'stressed' end towards the more 'relaxed' end of the continuum. However, being too relaxed in a work situation can also lead to problems of its own. For example, the individual may be seen as unmotivated, not working fast enough or not taking their job seriously. So it is important to reach a

Figure 8.1 The stress–relaxation continuum

healthy balance. This chapter aims to teach you a range of informal, semi-formal and formal relaxation strategies to help you manage your stress more effectively.

Informal relaxation techniques

It is not advisable to be too prescriptive about what informal relaxation techniques to use, since everyone has their own unique way of relaxing. For example, one individual may enjoy reading a book, or listening to music, whereas another person may enjoy having a hot bath and a warm milky drink and then putting their feet up. Some people enjoy going to the cinema or theatre or to the local pub, or staying in to watching a good film on television. However, relaxation techniques are not only about being physically inactive. A good workout at the gym, swimming, jogging or a game of squash may be just what they need to help them relax. While physical activity may not be relaxing at the time, it is a good stress buster and usually results in a very relaxed state after the physical exertion is over. Broadly speaking, people tend to choose activities which compensate for the stressful work environment in which they work. For example, a person who works largely in isolation from others is more likely to want to engage in social activities outside of work than someone who has extensive contact with people at work. A person who has a physically very demanding job is more likely to want to engage in restful activities outside of work than someone who has a very inactive and sedentary job. A person who has a mentally very demanding job is less likely to want to engage in mentally demanding activities and hobbies outside of work than a person who has a mentally undemanding job. Because of the hectic pace of modern working life, it is more common for people to choose informal relaxation strategies that involve slowing down rather than speeding up. Ultimately, however, the method of relaxation chosen will also depend on the specific interests and hobbies of the individual concerned and these can vary enormously. For example, one individual will find spending hours going through their stamp collection a relaxing pastime, whereas another individual might find such an activity incredibly boring or even stressful. Therefore, the important thing when choosing an informal relaxation strategy is to decide the right one for you personally.

Semi-formal relaxation techniques

The introduction of informal relaxation techniques may be sufficient to help many people manage their stress more effectively. However, for

some they are not and where this is the case, slightly more structured relaxation techniques may be required to help them become more relaxed. These are known as semi-formal relaxation techniques and there are numerous kinds of such techniques. Some of the most popular ones include massage, yoga and Tai Chi.

Massage

Receiving a full body massage is an excellent way of getting the muscles in your body into a state of deep relaxation. As your body relaxes, so does your mind, so a massage can have beneficial effects both mentally and physically. Two of the most common types are Swedish massage and Shiatsu massage. The techniques they use are different: Swedish massage is a soothing one but Shiatsu massage manipulates the body's pressure points. Although such forms of massage can be beneficial, the downside is that you generally have to pay for them. However, there are other inexpensive and enjoyable techniques you can use. For example, if you have a partner you can take turns in massaging each other. There are also a range of self-massage techniques that you can use and some examples of these are described below.

Releasing your shoulder tension

The shoulders can get particularly tense as a result of stress. One way of reducing tension in the shoulders is to reach one arm across the front of your body to your opposite shoulder and using a circular motion press firmly on the muscle above your shoulder blade. You need to press quite firmly but not so hard that it hurts you. Continue massaging in a circular motion for a couple of minutes and then move to the other shoulder and repeat the exercise on that one.

Soothing your scalp

Place your thumbs behind your ears and spread your fingers over the top of your head. Then move your scalp back and forth gently while making circular movements with your fingertips for 30 seconds or so.

Relaxing your eyes

Close your eyes and place your ring fingers directly under your eyebrows near the bridge of your nose. Then slowly increase the pressure for 10 seconds and then release. Repeat this exercise three or four times.

Yoga

Yoga involves learning a range of moving and stationary poses and combining these with deep breathing exercises. Perhaps one of the most enjoyable and sociable ways to learn and develop your yoga skills is to join a yoga class. Basic yoga for beginners involves learning slow, gentle movements, stretching exercises and relaxed breathing. It is important that you do not attempt some of the more strenuous forms of yoga until you have developed the right level of fitness, since you could do yourself physical damage if you are not fit enough. If you are unsure about what is best for you, check this out with a yoga instructor to ensure that you are starting at the right level for you. If you have a medical condition you may also need to check with your doctor that it is all right to do yoga exercises. It is safest to learn yoga by attending a group with a professional instructor to ensure that you get the basics right. Make sure that you learn at your own pace and do not feel tempted to try exercises that you do not feel ready to do because others are pressurizing you to do so. You should stop doing any exercise if it is painful. Once you have learned the basics, you can then practise alone or with others without necessarily having to go to the expense of attending yoga classes.

Tai Chi

Tai Chi is usually practised in groups and consists of learning a series of slow, self-paced, non-competitive and flowing body movements. These exercises require concentration, relaxed breathing and focusing attention on the here and now. Tai Chi is a safe and low impact option for people of all ages and levels of fitness. Once you have learned it, it can be practised anywhere, either on your own or with others. As with yoga it is best to learn the basic techniques from a professional instructor. If you have any health or mobility concerns, check with your doctor and instructor.

Formal relaxation techniques

Where an individual is experiencing severe and chronic stress related tension, informal and semi-formal relaxation techniques may be insufficient to break the habit and more formal relaxation techniques may be required. These may consist of physical or mental exercises, or a combination of both. Some common examples of formal relaxation techniques which have been demonstrated to be effective include deep breathing exercises, progressive muscular relaxation, meditation, mindfulness, imagery and visualization exercises. Learning the basics of these exercises is not

difficult, but it takes regular practice to master the skills involved and gain maximum benefit from them. They need to be practised at least daily until the individual is able to use them effectively. It is no good trying to fit them in to a spare few minutes in your schedule. You need to set aside time to practise them once or twice daily and not to rush them. Also they are not intended simply as exercises to help you get to sleep at night. It is important to learn how to become relaxed in the fully waking state since you will get the most out of them in this way. There is no one technique that has been proven to be best for everyone, so it is important that you choose the one that suits you, your preferences and lifestyle best. Some of the most common techniques used are described below.

Deep breathing exercises

When people are stressed their breathing is affected. The muscular floor across the abdomen (the diaphragm) and the muscles between the ribs (intercostal muscles) become rigid and do not allow the lungs to expand freely within the rib cage, so the chest feels tight. Breathing thus becomes shallower and more rapid in order to get sufficient oxygen into the body. It is analogous to trying to inflate a balloon within the confined space of a small cage. Relaxed breathing involves learning to breathe more deeply and slowly from the abdomen rather than shallow fast breaths from the upper chest. This is known as 'diaphragmatic' breathing and is the starting point for many other forms of relaxation such as yoga and Tai Chi mentioned earlier, as well as the meditation techniques described later in this chapter. It can also be combined with other elements such as aromatherapy and relaxing music. An example of a deep breathing exercise which you can practise to help you relax is outlined below.

A deep breathing exercise

1. Sit comfortably with your back straight. Check your breathing by placing one hand on your upper chest and the other on the top of your stomach. If your breathing is correct, when you breathe in, your stomach and lower ribs should move out before your chest, which should move very little. If this is not the case, you need to learn how to breathe correctly.
2. Breathe out through your mouth, pushing out as much air as possible while at the same time contracting your abdominal muscles. Try to do this in a slow and controlled way rather than a sudden exhale. One way of doing this is to imagine that you have a lighted candle

6 inches away from your mouth, that you do not want to blow out. This will ensure that you release the air from your lungs slowly.

3 Breathe in through your nose slowly counting to 3 or 4 seconds as you breathe in, taking the air right down into your lungs. Notice the hand on your abdomen moving out as your lungs expand fully. Hold the air in for 3 or 4 seconds.

4 Continue to breathe in slowly through your nose, holding the air in and then exhaling slowly through your mouth. Notice the lower abdomen rising and falling as you do this. If you are breathing correctly, the hand on your chest will move very little.

5 If you find it difficult to breathe from your abdomen while sitting up, try doing the exercises while lying on the floor.

Progressive muscular relaxation

Progressive muscular relaxation training teaches the individual to develop advanced muscular skills which allow them to recognize and release even small amounts of tension. With regular practice the individual develops an intimate familiarity with what tension as well as complete relaxation feel like in different parts of the body and how to achieve deep levels of muscular relaxation. Also there is thought to be a powerful feedback loop between the muscles in the body and mental activity in the brain. It has been found that when a person's muscles are relaxed they are also more likely to report feeling calmer mentally. There are different types of muscular relaxation techniques but the one which is most commonly used is the 'contrast' technique. This involves learning a series of step-by-step muscle tensing and releasing exercises in different muscles groups in the body. The aim of these exercises is to teach the individual the difference between the feeling of tension and relaxation in each group of muscles around the body. So, ultimately, with lots of practice the individual learns to be able to spot and counteract the first signs of muscular tension that accompany stress and can relax these muscles at will.

Most progressive relaxation practitioners start at the feet and work their way up to the head and follow a sequence of muscle groups as they progress through the body. Learning this skill takes practice and in order to learn relaxation techniques properly you will need to set aside about 20 minutes a day to go through the exercises. If you do not make this level of commitment on a daily basis, you are unlikely to gain benefit from the training. There is a range of CDs on the market that can help you learn the techniques which are outlined below. It is important that you do the training only when there is no immediate time pressure.

For example, it is no good trying to fit it in 15 minutes before you rush off to work. This is likely to lead to skipping steps in the process or having your mind on other things rather than relaxation and ultimately experiencing the training as ineffective.

Once you have decided on the best time of day to do the relaxation training, prepare yourself by creating the right environment. Start by finding a room which is quiet and where you are unlikely to be disturbed. If necessary, inform others in the house that you are doing the exercises and do not wish to be disturbed. You do not want the distraction of someone walking into the room to get something or telling you there is a telephone call for you halfway through the exercises. Also, make sure that the room is not too hot or too cold and the lighting is dimmed if possible. You may need to close the curtains if it is too bright. Make yourself comfortable by either lying on a bed or sitting in a comfortable armchair. Loosen any tight clothing such as a belt, tie or the top button of a shirt. Take off your shoes and get yourself comfortable. Take a few minutes to concentrate on your breathing using the breathing exercises described earlier. Once you are breathing in and out in slow deep breaths, you are ready to start the progressive muscular relaxation routine outlined below.

A progressive muscular relaxation exercise

1. Focus your attention to your right foot, squeezing it as tightly as possible to the count of ten.
2. Relax your right foot. Notice the difference between tension and relaxation in the muscles of your right foot. Enjoy the feeling of your foot loosening up and the feeling of warmth as the blood returns to the muscles in the foot. Wiggle your toes around gently and notice the cooler air circulating around them.
3. Stay in this relaxed state for a moment, breathing deeply and slowly.
4. Shift your attention to the left foot and repeat the exercise.
5. Stay in this relaxed state for a moment, breathing deeply and slowly.
6. Move slowly up through your body contracting and relaxing the muscle groups as you go – right calf, left calf, right thigh, left thigh, hips and buttocks, stomach, chest, back, right arm and hand, left arm and hand, neck, shoulders, face, eyes and head.
7. Periodically return to your breathing to ensure that you are breathing slow, deep breaths.
8. Once you have gone through the full routine, spend a few minutes simply enjoying the relaxed state that you are in before returning to your everyday tasks.

9 Repeat this exercise daily until you feel that you have fully mastered the techniques involved.
10 If you notice that the tension is worse in particular muscle groups in the body, tailor the exercise routine to spend extra time on these muscle groups and less on those where it is not such a problem.
11 Once you have learned and are comfortable with the relaxation exercises, you can then begin to use them to combat stress in real life situations, for example when you are stuck in your car in a traffic jam or during your coffee break at work.

A brief relaxation exercise for the neck and shoulders

For many people who are stressed, muscular tension is most severe in the neck and shoulder muscles. Below is a relaxation exercise which takes very little time to do and specifically focuses on the neck and shoulders. It consists of exercises aimed at adopting the correct posture, relaxing the shoulders and relaxing the neck muscles.

1 *Find the correct sitting position*: stand up straight with your arms at your sides about six inches in front of a chair. Move the left leg back so that the back of the knee touches the chair. In one swift movement stick your bottom out and sit back in the chair. Allow yourself to slide into position in the chair with both feet flat on the ground and your back straight.
2 *Neck rotation*: sitting in an upright position looking straight ahead of you, slowly rotate your head to the left until your chin is parallel to your left shoulder. Hold your head there to the count of ten before slowly returning your head to look straight ahead of you. Repeat the exercise, moving your head to the right. Go through the full routine a few times.
3 *Neck elongation*: imagine that you are a puppet with a string attached to the top of your head and someone is pulling the string upwards. You will experience an 'elongation' feeling in the vertebrae (bones) of the spine in your neck. Do not resist this but simply allow it to happen for a count of ten. Then relax and notice a 'sinking' feeling as you relax. Repeat the exercise again after a 30 second gap. When repeated, the action should feel like there is a 'spring' in your neck.
4 *Shoulder exercises*: slowly and gently hunch your shoulders up tightly and move them upwards as if you are trying to touch your ears with them. Hold the position for the count of ten and then relax your shoulders. Repeat the exercise a couple of times.

Note: do not do the neck and shoulder exercises more than three times in one session but do them regularly, especially when you are feeling tension in your neck.

Mental relaxation techniques

So far in this chapter the relaxation exercises described have focused on physical relaxation. However, there are a range of mental relaxation exercises that have also been demonstrated to be effective in reducing stress. Generally speaking they work by reducing the 'mental chatter' that people who are stressed are bombarded with on a daily basis and inducing an inner sense of calm and peacefulness. Some of the best-known techniques include meditation, mindfulness, mental refocusing and visual imagery and these are outlined below.

Meditation

Meditation is often equated with Eastern mysticism and something that The Beatles did in the 1960s while on drugs. However, there is nothing intrinsically mysterious about meditation. It is simply a set of techniques aimed at helping the individual relax mentally. There is a wide range of meditative techniques but generally they involve sitting in a quiet comfortable environment, doing some preliminary muscle relaxation and breathing exercises to ensure a physically relaxed state and then practising a mental exercise which induces a passive attitude to the internal mental activity and external distractions that are being experienced. Meditation uses a 'neutral' focal device to engage the attention of the individual, such as a mental image (picture) or a 'mantra' (a chant or repeating a word or number over and over again). Focusing one's attention on to the neutral focal device allows all other information to drift in and out of the individual's consciousness without paying much attention to it at all. One example of a focal device is to imagine a translucent blue pyramid shape floating in three-dimensional space. Another is to imagine the word 'RELAX' in large bold three-dimensional letters revolving slowly in three-dimensional space. In some ways these examples are comparable to a screen saver on a computer, in that the image moves or rotates slowly on the screen while all other programs are shut down. An example of a mantra would be to the sound 'Oommh' over and over again. The result of paying attention to a neutral focusing device is to induce an inner sense or peacefulness and calm.

Mindfulness

Mindfulness is a particular kind of mediation derived from the Buddhist philosophy. It is based on the observation that when we are in a tense or distressed state, our mind is usually somewhere other than the present moment in time. For example, anxious people tend to live in the future. They spend much of their time worrying about what might happen tomorrow, next week or some time in the future. They predict that disaster and catastrophe are just round the corner. Depressed people on the other hand spend much of their time focusing on the past, missed opportunities and losses. Mindfulness meditation techniques, however, involve teaching the individual how to be fully engaged in the present moment without excessively analysing or over-thinking the experience. So rather than worrying about the future, or dwelling on the past, mindfulness meditation switches the focus of attention to what is happening in the here and now. There is a range of techniques that can bring about a state of mindfulness and some examples of these are outlined below. Give them a try and see what it feels like.

MINDFUL EATING

How often do you sit there at work eating your lunch while your mind is elsewhere? You may be worrying about the meeting that you have to go to later that afternoon, or you may be focusing on the memory of some event that has happened in the past. Because your attention is elsewhere it is likely that you have not even noticed the taste, touch or texture of the food that you are placing in your mouth. You may even be gulping the food down because you are in a hurry. Mindful eating involves paying full attention to the meal that you are eating. Try to eat slowly, taking time to fully enjoy the tastes, smells, colour and textures of the foods you are eating. Notice what it feels like when you chew and swallow each bite of your food.

BODY SCAN

In some respects body scanning is similar to progressive muscular relaxation in that you focus your attention on various parts of your body, starting with your feet and then working your way up the body. However, it is different from progressive muscular relaxation in that in mindfulness you are simply noticing ‘what is’ rather than tensing and relaxing your muscles, or labelling sensations as good and bad. It is about observing all

the sensations you are experiencing in your body without trying to change anything. For example, you may observe that the muscles in your neck are particularly tense but instead of trying to change the sensation, mindfulness is about accepting that this is the way your neck is feeling at the present moment in the here and now.

MINDFUL WALKING

As for eating, how often do we simply rush from one place to another with our mind somewhere else? Mindful walking involves focusing your attention on the physical experience of every step that you take. Notice the sensation of pressure on your feet and in your shoes as your feet touch the ground. Experience the changes when you walk on different kinds of surface. Observe your body movements and sensations in your muscles. Notice the rhythm of your breathing and the feeling of the wind, rain or sunshine against your face. Soak up the sounds, sights and smells impinging on your senses as you progress on your journey.

Mental refocusing

Research has shown that humans have quite a limited attention span. It amounts on average to approximately seven 'bits' of information. So, for example, if we are asked to remember a series of digits in a telephone number, the average person can usually remember seven. Some people can remember one or two more than this and others fewer, but on average it is seven. This is important since although we are constantly being bombarded by hundreds of bits of information from all sensory modalities (sight, sound, taste, touch and smell), we can selectively and consciously pay attention to only a small number of them. The ones that we select are those which we perceive to be most important or relevant to us and the rest are processed unconsciously and go by unnoticed. To illustrate an example of selective attention, imagine that you are at a party and deep in conversation with someone. You are so engrossed that you do not notice what else is going on around you. However, you suddenly hear your name mentioned in a conversation nearby and immediately you switch your attention to that conversation. Why and how can this happen? It happens because your brain is geared up to selectively pay attention to those bits of information that are most relevant and important to you. However, your brain must have been unconsciously processing lots of other incoming information in order to be able to switch attention in this way.

When people are under stress they are hypervigilant to incoming information that signals threat or danger and get into the habit of focusing

most (if not all) their conscious attention span to such stimuli. Mental refocusing techniques can be used to train the individual to shift their focus of attention away from the distressing stimuli to neutral or positive ones. One example of mental refocusing is the attention shift exercise. For example, some people experiencing stress may show an attention bias towards internal bodily sensations and symptoms rather than stimuli in their external environment. The purpose of attention training in this context would thus be to shift attention away from focusing on the self towards external, more neutral environmental cues. This change of focus can ultimately result in a reduction in stress in that individual. Exercises can also focus on shifting attention between the five sensory modalities (i.e., sight, sound, smell, taste and touch), or between tasks within a particular sensory modality. To illustrate this you can try the little experiment below for yourself.

A MENTAL REFOCUSING EXERCISE

Begin by focusing your attention on the ticking of the clock in your room. Before being instructed to do this, you may not have even noticed that the clock was ticking. It does not have to be a clock since any sound source will suffice for this experiment. You will notice that once you pay attention to the sound, it seems to get louder. Do this for a couple of minutes before switching your attention to another sound in the room such as the hum of the refrigerator, the fluorescent light or the boiler. While you are paying attention to the second sound source, you will no longer be able to listen to the first one (i.e., the clock). Do this for a couple of minutes. Now notice the sounds coming from outside of the room such as people talking, cars passing by or perhaps the sound of an ambulance siren in the distance? And pay attention to one of these. If you practise these attention training exercises regularly over a period of time, you will become more skilled at shifting your attention. Research has found that attention training can be effective in reducing stress if practised at least twice a day over a period of six months.

Visual imagery

Visual imagery (sometimes called visualization or guided imagery) is a variation on traditional mediation that can have powerful relaxation properties. It involves imagining a scene which makes you feel at peace. You can choose whatever scene you wish. This might be a favourite place from your childhood, an image from a relaxing holiday that you once had, or even a picture by your favourite artist. The main point of the

exercise is to find an image, scene or setting which is the most calming to you. You can do the imagery exercise with a therapist, on your own, or with the use of an audio recording. There are lots of CDs on the market which can be used for this purpose. For example, the 'rose garden' takes you in your imagination through a beautiful garden of roses and asks you to savour the experience through all your sensory modalities. Another one is called the 'enchanted forest', which takes you on a magical journey through a very beautiful and peaceful forest. Others create the sounds that you might hear while lying on a beach, for example including the gentle lapping of the waves on the shore or the sound of seagulls flying above you, and ask you to relax in the presence of these sounds.

The important thing about doing imagery successfully is that you imagine a setting that is most relaxing for you personally. To gain maximum benefit from an imagery exercise, you need first of all to do it somewhere comfortable and when you are not in any hurry and unlikely to be disturbed. Start by closing your eyes and clearing your mind of any mental chatter. Focus on deep breathing for a few minutes before commencing the imagery exercise that you have chosen. Picture the images as vividly as you possibly can in all the sensory modalities. Imagine in great detail the sights, sounds, smells, tastes and touch of the setting you have placed yourself in. You could try the following exercise.

A VISUAL IMAGERY EXERCISE

Imagine you have chosen the setting of a Christmas Eve long ago in your childhood at a time when you felt happy, safe and secure. Try to imagine the room you are in, the lighting of the room, the patterns on the wallpaper, the pictures on the wall, the colour schemes, who is there with you, where you are in the room, the way in which the Christmas tree has been decorated, the smell of cooking from the kitchen, the smell of the freshly cut pine tree, the sounds of excited children and Christmas carols coming from the radio, the feeling of warmth on your face from the roaring log fire, the texture of your brand new dressing gown, the taste and sensation of eating a warm mince pie, the reflections from the fire light on the wall and the sight of snow flakes gently fluttering past the window.

This example may of course be a very romantic version of your actual childhood experiences of Christmas Eve. However, it does not really matter if the scene that you imagine is a real memory of a time in the past when you have felt particularly happy and safe, or a product of your imagination. The main thing is that it is a restful image and creates a sense of peace and mental wellbeing in you.

Summary and main learning points

- Stress and relaxation can be conceptualized as being at opposite ends of a continuum.
- Individuals who are experiencing stress either have forgotten how to relax or may have never learned the art of relaxation in the first place.
- There is a range of practical tools and techniques that can help the individual move from the stressed to the relaxed end of the continuum.
- The interventions described in this chapter are at three levels, namely informal, semi-formal and formal relaxation skills.
- For many people informal relaxation strategies are all that are needed to help them manage their stress effectively.
- It is not possible to be too prescriptive with respect to which informal relaxation techniques are best for you personally, since everyone has their own different way of relaxing informally.
- Examples of some of the most popular informal relaxation strategies include reading, listening to music, having a hot bath, going to the cinema, theatre or pub, or watching television. Alternatively, some people prefer to use a physical activity such as swimming, jogging, squash or a vigorous workout at the gym.
- The important thing when choosing an informal relaxation strategy is to decide which one is the right one for you.
- Where informal relaxation strategies are insufficient to help an individual cope with their stress, then semi-formal relaxation techniques may be required.
- Semi-formal interventions consist of slightly more structured relaxation techniques than informal relaxation strategies.
- There are numerous kinds of semi-formal relaxation techniques and some of the most popular ones include massage, yoga and Tai Chi.
- Where an individual is experiencing more chronic stress related tension, informal and semi-formal relaxation techniques are insufficient to break the habit and more formal relaxation techniques may be required.
- Formal relaxation may consist of physical or mental exercises, or a combination of both.
- Some common examples of formal physical relaxation techniques which have been demonstrated to have beneficial effects include deep breathing and progressive muscular relaxation exercises.
- Some common examples of formal mental relaxation techniques which have been demonstrated to have beneficial effects include meditation, mindfulness and visual imagery exercises.

- Deep breathing is of key importance in terms of relaxing and is the starting point for many forms of physical and mental relaxation including progressive muscular relaxation, yoga, Tai Chi and meditation.
- Learning the basics of these more formal physical and mental exercises is not difficult but it takes regular practice to master the skills involved and gain maximum benefit from them.
- Relaxation exercises need to be practised at least daily and preferably more frequently than this until the individual is able to use them effectively.

In conclusion, there is no one technique or level of intervention that has been proven to be best for everyone, so it is important that you choose the technique and level that most appropriately meets your needs, preferences and lifestyle. Once you have decided on the intervention which is best for you, you need to practise it at least daily. Practice is essential when learning a new skill and without it, it is unlikely that you will gain maximum benefit. If in doubt about what is the best level to start, it is preferable to begin with informal interventions, since often these are sufficient to produce the desired effect. It is only if you find the informal techniques to be ineffective that you will need to progress on to the more formal level of interventions as outlined earlier in this chapter. If you are unsure about what interventions to start with, try experimenting with some informal interventions that you think might work for you. If they have the desired effect, that is great. However, you may not get it right first time and it is important that you do not give up at the first hurdle. Treat it as an experiment in which you may try a number of interventions before you find the right one for you. Once you have started putting the relaxation techniques you have learned into practice, you should experience a reduction in your stress levels and a corresponding increase in the feeling of relaxation over time as you move to the more relaxed end of the continuum. You can monitor your progress in this respect by readministering the stress checklist found in Chapter 1 on a regular basis and notice how your scores on the symptoms of stress reduce over time. The range of tools and techniques found in this chapter may not be sufficient to overcome more severe, clinical levels of stress. Where this is the case, the interventions for overcoming stress syndromes outlined in Chapter 10 are likely to be more beneficial.