Compassionate Self-Care for the Compassionate Healthcare Professional: Challenges and Interventions

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Learning Objectives

1. to explore what it means to self-care
2. to integrate home-life and work-life and understand how one affects the other
3. to explore and provide own definition of what success is
4. to understand how lack of self-care is affecting our relationships at home and work
5. to acknowledge and validate gender differences and challenges in self-care

Introduction

Healthcare workers are routinely asked to satisfy the emotional, physical, and often spiritual, needs of others, both at work and at home. These often taxing demands and expectations make them particularly vulnerable to experiencing compassion fatigue, post-traumatic stress disorder (PTSD), depression, and anxiety, as well as personal relationship challenges such as a compromised quality of patient care [1].

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It is precisely because her/his life's work so intrinsically involves taking care of others, that the healthcare professional has an even greater responsibility to take care of oneself as well.

Throughout the past twenty years in our professional practice as a psychologist and a family physician, respectively, we have had the opportunity to interact and collaborate with a range of healthcare professionals on all levels of hierarchy. In the process, we have become acquainted with what we have come to understand as recurring presenting issues for those in the helping professions. In this paper, we share five case studies from our clinical practice to help underscore the critical role of self-care in enabling healthcare providers to achieve a high quality of life while extending compassion to others, in both professional and social contexts.

Case 1: Restrictive Emotionality

Luke is a sixty-year-old male surgeon who came to therapy presenting with symptoms consistent with depression and anxiety. He had decided to come to therapy after a long discussion with his wife and two adult children in their twenties, having come to the realization that he had, by and large, not participated in their upbringing and feeling alienated from them as a result. The client had begun to understand that he did not really know his children, who wanted to and needed to be known by their father. He also became mindful of the fact that his wife had come to resent him, as she experienced a sense of identity loss, having compromised her own personal and professional growth as the demands of her husband's work and career had always taken precedence over any of her wishes and needs. While he was saving lives, she had been changing diapers, providing homework assistance, doing school runs, arranging playdates and making doctors' appointments. This more traditional division of labor had come at a cost to the couple and to the family as a whole. She wanted him to be much more present at home, to listen better, and to do more of his part in raising their children. He also realized that he had lost his ability to communicate empathy and compassion to his wife, children, as well as patients and colleagues. He was suffering from covert depression, one that does not deprive the sufferer of functionality but instead manifests itself through anger, irritation, and extreme stress, usually directed toward those closest to him. He had become authoritarian in his family interactions, emotionally detached, controlling, and highly critical of others. He noticed that the behaviors of his wife and children towards him had become motivated not by a desire to make him happy but by a perceived need to prevent him from losing his temper/becoming angry at them. He had also begun to experience symptoms of compassion fatigue in his interactions with his patients, whose medical and emotional needs now elicited strong feelings of annoyance in him. In addition to that, he dealt with guilty feelings towards his family from being emotionally and physically absent.

Case 2: "I Need to Need"

Diana is a forty-two-year-old female physician who sought psychological support following a disproportionately strong emotional outburst toward her elementary school-aged elder child. Her symptoms were consistent with compassion fatigue and anxiety disorder. She routinely was in a bad mood and felt irritable, becoming aware that her listening skills, along with her ability to communicate empathy and compassion to her family, friends, and patients had overtime become significantly compromised. She also experienced deep resentment toward her husband for not being supportive and for blaming her for not spending enough time with her family. In an outpouring of emotion during a therapy session, she expressed her newly found understanding that the emotional demands placed on her, both at home from her family and at work from her patients and colleagues, had served to deplete her of her emotional, physical, and spiritual resources. She thus expressed her need for solitude: "I want to go away for some time to relax with no one in my head." Along with this newfound realization, guilt ensued. How could a mother, wife, and a successful professional abandon everyone to take care of herself at the expense of all others who had come to count on her? She had learned how not to need, realizing that she instead needed to also learn to—at least to a healthy degree—to be able to rely on others. In the course of her therapy, she became aware that she had constructed a life from which she needed to escape, living instead for the eventual vacation away from the demands of daily life, in the process neglecting her own psychological needs. Her life had become inconsistent with her true identity. As a result, she experienced what American psychologist and person-centered therapy developer described as incongruence. Rogers (2) posited that whenever one lives a life inconsistent with one's real identity, vulnerability to psychological disorders ensue, primarily depression and anxiety.

Case 3: Self-Doubt

Jane is a forty-four-year-old nurse at a large hospital who came for couple's therapy with her husband Rob following an intense argument during which they were verbally abusive to each other in front of their young children. They acknowledged the deterioration of their fifteen-year-old relationship, which they perceived as having reached "rock-bottom." Jane had also been on medication to deal with symptoms of depression and anxiety. Draining shift work and numerous other demanding aspects of her profession had placed additional stress on her relationship with her husband. She had also found herself being constantly irritated with almost all others, both at home and at work. In talking with some of her colleagues, she observed that they were experiencing very similar symptoms. Jane felt emotionally empty and found herself feeling resentful of anyone who had any needs or placed any demands on

her. Believing she was failing to meet their expectations of her roles as wife and mother, her husband and in-laws were highly critical of her. Jane soon realized she felt lonely and trapped—and as a result depressed—in both her marital and professional relationships. In exploring her own needs, she gained insight into how ingrained self-doubt had become in her thinking, in the process losing herself. Rob, a very dynamic man in his own right and one who had developed a highly successful career in the corporate world, would amplify Jane's confusion about herself in a self-assured and subtly authoritarian manner. These dynamics caused Jane significant distress in the form of anxiety. In observing herself in these experiences, she realized that was responding in similar ways to those at work with similar personality types, in particular supervisors and doctors. She became conditioned to have instinctual, involuntary, emotional, and physiological responses triggered by other people's behaviors such as tone of voice, or even just a look that she would either rightly or wrongly interpret as invalidating. She had to work on reclaiming her identity and not becoming symptoms of other people's issues.

Case 4: Emotional and Verbal Self-Oppression

John is a thirty-seven-year-old cardiologist who had been referred by his wife to seek psychological help following a number of angry outbursts toward her over the previous 3 years. She had given him an ultimatum to seek therapy or else she would leave the relationship. The sustained stress from his work at the hospital took a toll on his mental and physical health, experiencing panic attacks on a regular basis. Thinking he was about to die, John would self-administer an electrocardiogram 2–3 times a week. As the results revealed a healthy heart, he would find temporary relief from his anxiety, later repeating the same step in the cycle. Having "let [himself] go," John took comfort in food, gaining enough weight to be classified as morbidly obese. His free time dwindled as he could not turn away new patients who needed him and whom he knew he could help. Plans he and his wife shared to have a family, and the considered expenses he realized this would entail, also weighed on his decision to take on a heavier workload as he was the one with significantly higher income earning power. As his main focus became his work, there was little time left for anything else or anyone else. John became easily irritated with anyone who had any need for him or placed any demand on him for his time. His wife reported that he had morphed from a kind, compassionate, fun-loving man to an angry, keep-away-from-me aggressive one. John acknowledged the transformation, one completely inconsistent with how he saw himself. This incongruence caused him anxiety and left him feeling lonely and isolated, his relationships becoming superficial and routine, including that with his own wife. Feeling lonely and frustrated in her marriage, she had begun to reassess the relationship and question whether she wanted to stay in it. In the course of therapy, John came to understand that his wife was a solid base in his life and that in the midst of his preoccupation with work and family responsibilities he had come to nonetheless take her for granted. Early on in his

psychotherapy process, he had set as his initial goal to invest more in his relationship with her. In order to accomplish this goal, he began to spend time with her, establishing mutually agreed couple routines and new traditions and, crucially, sharing his feelings, thoughts, fears, and hopes with his spouse about various aspects of his life. He became aware that he had been suffering from “emotional constipation” that was toxic to his relationships and his wellbeing more broadly. His panic attacks had been his body’s way of telegraphing its need to take care of it. A key intervention proved to be to allow his wife the opportunity to serve as a good listener to him as someone who cared for and understood him. He described the process as relaxing. John’s case emphasizes the importance of having a good listener/social support in our life and utilizing him/her.

Case 5: Injecting Life into Living

Leia is a thirty-two-year-old medical student who sought psychological services to cope with the overwhelming demands of medical school. She complained of not having enough hours in the day to carry out her responsibilities as a student, wife, and mother of a young child. Leia felt constantly tired and had problems with storing and retrieving information. As her sleep hygiene was compromised, she found herself being struck by headaches, stomach pains, and recurring cold sores on her lips. She reported finding herself comparing herself to other medical students and also becoming hyper-aware of the feedback of her supervisors, who often lacked sensitivity and empathy. Becoming a doctor represented the culmination of a lifelong dream of hers and had entailed a major career change. The medical school experience, however, had extracted life from living. In attempts to alleviate her symptoms, she had resorted to conventional medication, only to realize her interventions had been only temporarily effective as they did not address the root cause of her somatic condition. Leia had also been experiencing great guilt for neglecting her husband as an emotionally and financially supportive partner. Paradoxically, she resented being dependent on him to pick up the deficit in her own contributions to the parental relationship and to the running of the household. Guilt ensued when she engaged in any self-care activity such as exercising or having coffee with a friend. She perceived these as taking time away from her studies and family life. She also questioned her ability to assimilate the material and to perform well in the practical component of her coursework. Nonetheless, she rationalized her stressful experience by echoing the old refrain heard from a number of her medical student peers, “This is medical school.” Leia also wondered what life would be like for her after she graduated from medical school. How much time would she have to spend with her family? How mentally present would she be able to show up for others? How involved would she be in the raising of her child? Would she be able to cope with the stresses and anxieties of having another child, something that both she and her husband wanted? She questioned if that was the life she truly wanted to have. She became aware that an essential factor for a meaningful life with a shot for happiness

was time. Time for her, time for her husband, time to play with her child, and time to just be. The main point of this case is to redefine what success means. And this is a very individual process.

Case 6: A Preventable Death

David, a sixty-year-old married with 3 children interventional cardiologist and head of department, was running a very busy clinic working numerous hours per week. During that time, he engaged in numerous professional activities that included management tasks, conferences, professional development, and national medical committee participation. He was obese, suffering from hyperlipidemia, generalized anxiety disorder, and sleep apnea. Making no time for exercise, family activities, or hobbies, he ate late at night with friends after leaving his clinic. He rarely contacted his family doctor for medical reasons as he was basically self-diagnosed, self-treated, and self-medicated. In the process, he had been postponing lifestyle interventions due to his work-related activities, David died from sudden death due to acute myocardial infarction.

Self-Care: Challenges

A common theme that emerges from all the above cases is a general inability and lack of motivation to self-care, and to be kind to oneself. The loss of self in the demands of the profession is core to the issues addressed in psychological therapy. A frequent homework that we give clients in the healthcare industry is to explore ways of being kind to themselves by developing an awareness of what they need. This typically comes after the difficulty in answering the question, "How do you take care of yourself?" Many times the initial response to this question is a pensive smile or faint laughter.

One of the most difficult challenges for medical professionals is to embrace the healthy shift from being a care provider to the recipient of psychological or medical care services. Making time for such an adjustment is in and of itself stressful because it requires time and space—as well as an acceptance of their own vulnerability and needs. Time is a valuable commodity. Increasingly, many psychological sessions take place online or on the phone, inserted between patient appointments or on clients' drive home to or from work. The length of the phone session typically reflects the time it takes to drive from work to home, or vice-versa. The decision to seek psychological support will often follow a long period of being comfortable in the familiarity of one's own discomfort. Many of us may not feel well but may get used to this less-than-optimal state of existing. Finally reaching "rock-bottom" is a very difficult place to find oneself in, but not necessarily a bad one, as that is the place where people become aware and mindful of the need to see a mental health professional. This self-awareness is one of the areas of Emotional Intelligence, particularly important for healthcare workers. Fessel and Coleman (2020) emphasize the

importance of physicians and healthcare workers to take care of their emotional and physical health in order to prevent burnout, compassion fatigue and somatic illnesses. Needless to state, healthcare professionals must avoid self-diagnosis, self-medication or treating members of their own family [2]. Positive outcomes include greater doctor–patient trust, higher levels of patient satisfaction, less physician burnout, better results, improved productivity, and higher job satisfaction.

Self-Care: Interventions into Practice

Before outlining some basic self-care techniques, it would be imperative for each healthcare professional to explore the strategies that work best for him/her. This is a very individual exploration that needs to be delved into without any outside distractions or influence. The healthcare professional must assume responsibility for his/her own wellbeing. Crucially, the chosen methods of self-care must be consistent with one's identity. They have to feel "right."

1. Prioritize and invest in meaningful, healthy relationships, especially those with your family members [1]. Good relationships can help physicians prevent burnout [3]. A way to assess the quality of our life is to be mindful of our feelings when entertaining the idea of joining someone or engaging in a given event, whether going home to a spouse and children on the way from work, going on vacation with someone, returning to one's daily life from vacation, meeting someone from dinner or going to another social event. Finding oneself experiencing discomfort, whether a general unease or plain dread at a given thought begs for further exploration on one's part. Two of our most important destinations for joy must ideally be home and work. And what typically determines joy is the quality of relationships that we engage in. It is therefore imperative, to both one's psychological and physical health, to establish meaningful connections in both areas of one's life.
2. Be mindful of how you connect with but also how you might alienate others, and practice *kenosis*, the Greek word connoting creation of a physical, psychological, professional, and spiritual space where two or more people are invited to enrich one's existential experience.
3. Acknowledge your capacity to be narcissistic and work on your ability to empathize [4]. Mindfulness techniques such as meditation focusing on kindness can decrease anxiety and are associated with better overall wellbeing as well as a greater capacity to communicate empathy and compassion [5].
4. Have a good listener in your life. In the case of John, what proved to be therapeutic was opening up to his wife about his thoughts and feelings, allowing her to respond to him with compassion and empathy. In relationships in which partners extend empathy to each other, there is more emotional intimacy and relaxation.
5. Acknowledge and express needs. In the case of Diana, she became almost completely focused on others such as her family members, her patients, and her colleagues at her expense. Ultimately, she worked on expressing her needs with

no guilt. Also, as a woman, she was particularly vulnerable to compassion fatigue, and lower professional fulfillment [6].

6. Exercise. Physical activity in the form of exercise has been shown to be effective in reducing symptoms of depression and anxiety [1]. Even though exercise will not in and of itself solve any problems, it typically places an individual in a better emotional and physical position to address life issues.
7. Remove from your schedule unnecessary sources of stress. In all the cases presented in the beginning of this chapter, a major issue was not having enough time to do daily activities. Explore what can be removed from daily/weekly schedule to have more time for self-care. Research suggests that valuing time over money is associated with greater happiness and overall wellbeing as well as better decision-making [7, 8].
8. Take care of your physical health. Many medical students and physicians alike believe that they must always adjust to the demands/needs of their patients and colleagues and that asking for help due to excessive stress/pressure will be perceived as a sign of weakness. They are therefore less likely to discuss any health concerns with others [9]. David's case illustrates the need for healthcare professionals to engage in lifestyle interventions and avoid falling into the trap of self-medicating and self-diagnosing.
9. Seek psychological support when you need it. One of the first signs of mental health is the awareness and acknowledgement of personal challenges for which one needs support from a mental health practitioner. The option to see a psychologist should be encouraged rather than resorting to self-medicating [10].
10. Introduce mindfulness about self-care in medical school training. This must be infused into all aspects of medical school training and explicitly emphasized by instructors.
11. Be aware of relapse. Most of the times people seek psychological help when they reach "rock-bottom." This is a very difficult place to be at but it can be an instructive one as that it is the point at which people decide that they cannot continue their life as it is and that they therefore need to do something about it. Through their work with a psychologist, they initially make the necessary changes in their life and have their symptoms alleviated. This could be a period of vulnerability and susceptibility to relapse because this may be when people gradually revert to their old lifestyle. This is where some maintenance work should be done with a mental health practitioner to monitor progress and to become mindful of symptoms of relapse.
12. Spiritual care can help healthcare professionals recognize and respond to the needs to the human spirit, including the need for meaning, purpose, and connection [11, 12] Spirituality has been shown to be a protective factor among an array of healthcare providers mitigating cognitive, emotional, and physical symptoms of burnout [13]. Additionally, spirituality is related to lower levels of exhaustion and greater patient empathy [14]. (See **Chapter 10**. Compassionate Spiritual care).

Redefining Success

Even though what it means to be successful is a very personal topic for exploration, the following questions frequently emerge during the course of psychological therapy among healthcare workers:

"Am I happy with my life?"
"Did I get into the right field?"
"Am I cut out for this?"
"What is it like for my spouse to have me as a husband/wife?"
"What is it like for my children to have me as a father/mother?"
"What is the experience of my patients of having me as their physician?"
"What would my colleagues say about me? How do I affect them?"
"Do I have a pressing need to escape from my life?"
"Is there any unfinished business in my life?"

These questions can be used as guides to help explore and uncover what may matter most to oneself and will most contribute to a one's sense of psychological wellbeing and sense of purpose—along with the motivation to proactively look after one's physical health. Instructively, a quote popularized by late US senator Paul Tsongas shortly after he was diagnosed with cancer, that "No one on his deathbed ever said, 'I should have spent more time at the office'" finds resonance with the work of Bronnie Ward [15], a palliative care volunteer in Australia who documented her dying patients' epiphanies in the last three to twelve weeks of their lives. In that process, five top regrets emerged: (1). "I wish I'd had the courage to live a life true to myself, not the life others expected of me"; (2). "I wish I hadn't worked so hard"; (3). "I wish I'd had the courage to express my feelings"; (4). "I wish I had stayed in touch with my friends"; and (5). "I wish I had let myself be happier."

The emerging issues discussed in this chapter strongly point to a need for healthcare workers to reflect on their needs and to extend to themselves (and often their loved ones) the kind of compassion and self-care they routinely extend to others. The decision to adopt healthier self-care practices must be understood as such as a process of the implementation of practices, however gradual, rather than as single-time interventions. The maintenance work required for self-care is, in a very real sense, akin to the professional development practices healthcare professionals exercise and fully expect of themselves. Effectively extending care to others, particularly over the long haul, necessarily involves doing so from a position of physical, psychological, and emotional strength.

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