

Physician Self Care

The BASICS: Part II — “A” is for Affect

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The following article is the second in a six-part series on the fundamental principles of physician self-care. The “BASICS” series offers practical suggestions for stress management, improved health and well-being, and building resilience.*

“A” is for Affect

“A” is for affect, which refers to our emotional states. However, it may be better considered as encompassing personal attitudes, thinking and self-awareness. These all interact in accordance with the experiences and stresses of life in ways that range from unconscious, passive reaction to deliberate self-management.

Consider this recent personal experience. Not long ago, I was offered an opportunity to present for 30 minutes during an annual scientific meeting of a particular specialty group. I believed the presentation went well, a perspective largely confirmed when the evaluation results were sent to me a few months later. The great majority of evaluations were very positive and reinforcing for me.

But there was one evaluation that wasn't good. In particular, it said that I didn't make sufficient use of humour. I was taken aback by the comment. It didn't seem to matter that the talk was about depression

and suicide in physicians — hardly material that lent itself to a humorous approach!

I admit that I was upset by the poor evaluation, and I remained upset all day, even when my attention shifted to other things.

By evening, I reflected that it hadn't been a good day. I felt glum, as though work had been unrewarding and less fun. For awhile, I didn't understand why that was so.

Then I remembered the evaluations that I had reviewed at the start of the day — and felt even worse! Thinking more about the whole thing, I realized my problem.

My thinking was the problem. I had given the many glowing evaluations and comments no weight. They barely registered with me. They were compliments thrust to the side so I could dwell on the single grumbling opinion.

In a cascade of linked and barely conscious thoughts, I concluded that I was:

1. A poor public speaker.

2. Bad at my job
3. A failure as a doctor.
4. A failure as a person!

No wonder I didn't have such a great day.

And I remember this happening many times over the years. If a patient didn't show for an appointment, I wondered what I had done wrong the last time I saw them. A request to transfer a patient's chart to another office could devastate me with self-doubt, even if I didn't really like that patient, and even though there were many more requests to join my family practice than I could accept.

Today, I know what this is about. I have a tendency to subscribe to the belief that my work performance should be perfect. This belief makes it difficult for me to accept compliments because perfect performance is the baseline expectation I set for myself. That makes a grievance about me an enormous affront that creates feelings of anger, self-doubt and irritation. Turns out I have some choice about that.

Personality, stress and suffering

There are a number of personality types and traits observed in medical trainees and doctors that are associated with a tendency to experience life as distressing. They include an introverted approach to life, pessimism, and passivity, to name a few.^{1,2}

Are these traits fixed, “hardwired” into the psyche, or learned? Are they ingrained into our way of being in the world, or can we modify their impact upon our thoughts, feelings and behaviour? I suspect the answer is some of both.

We will look at an example to learn how to become aware of the ways thinking influences feeling.

Perfectionism

Perfectionism is a common trait that we see expressed by many of the health professionals that call the Physician Health Program seeking help. Others who treat doctors observe the same thing.³ There is a strong association generally between perfectionism and increased risk for depression, anxiety, obsessive compulsive symptoms, and even suicide.⁴

At least one study has measured perfectionism in a population of health professional students (medical, dental, pharmacy and nursing) and notes it to be prevalent, and, not surprisingly, highly correlated with symptoms of psychological distress.⁵

Can perfectionism as an attitude and thinking style be recognized by someone who experiences it, and modified to reduce personal emotional tension and enhance resilience? Antony and Swinson think so, as described in their book, entitled *When Perfect Isn't Good Enough — Strategies for Coping with Perfectionism*.

There are three commonly described forms of perfectionism:⁶

- The first is self-oriented — placing impossible demands of perfection upon oneself, particularly in the area of work performance. An individual approaching life and work from this perspective reacts negatively to the fact, or the per-

ception, of making a mistake.

- Other-oriented perfectionism involves imposing the expectation of perfect performance upon others. Professionals experiencing this form of perfectionism understandably have difficulty delegating tasks to others, and judge them harshly when they fail to perform to expected levels.
- The third form, socially prescribed perfectionism, involves the perception that others expect a great deal of you and will criticize any kind of failure. This form of perfectionism is most highly associated with distress in medical students, and therefore might be the most malignant in doctors.⁵

It is likely that all three forms of perfectionism are present to some degree in many health professionals.

To the extent that perfectionism arises out of temperament, an ingrained personality structure, that can't be helped. But perfectionism is also learned.⁶

Exemplary behaviour throughout life can be reinforced through reward: praise, awards, and so on.

On the other hand, and perhaps more pernicious, punishment experienced for less-than-perfect behaviour might be an even greater reinforcer of perfectionism. Certainly, in medical practice, the ultimate punishment for what could be seen as less-than-perfect performance would be the death of a patient. Modeling of perfectionism in teachers and mentors can also contribute to the adopting of a perfectionistic approach to work.

It can be argued that medical professionalization draws upon all of these elements, beginning with selection to medical school and continuing onwards, thereby encouraging perfectionism in its trainees and practitioners.

Perfectionists might well excel in the areas of life where they apply themselves. That is their mission, after all. So what happens if they aren't able to excel? The tendency is to become upset and drop that ac-

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tivity, or never undertake it at all.

Perfectionists don't dabble. They don't have much fun either, because they don't tend to try new things, and they give up the other things in their lives, often recreational, they can't master.

Test this idea yourself. How many new things have you undertaken in the past year or two? Have you avoided trying new things because you're not immediately good at them? Do you still enjoy playing golf or piano? Have you given up any activities because they were not fun when you couldn't rise to the level of performance you demanded of yourself? Maybe you think it's a matter of time pressure that has forced you to abandon your hobbies, but does honest reflection reveal some other reason?

There isn't much resilience in a life primarily devoted only to those things one does really well.

Cognitive distortions

There are a number of thought patterns and styles associated with perfectionism that I suspect will be familiar to many.⁶ While common, they aren't always helpful or realistic, so they are also known as cognitive distortions. Some of them include:

- *All or nothing*: All-or-nothing thinkers approach life in a very black and white manner. They clearly see only two ways about anything: their way or the wrong way. All-or-nothing thinkers will, of necessity, face frustration trying to navigate a world of uncertainty and shades of gray.
- *Filtering*: Perfectionists tend to select certain details they will focus upon — usually negative ones. Expecting perfection, they tend to discount the impact of positive feedback. The result can be an obsessive and upsetting preoccupation with criticism that is not balanced by the appreciation of compliments or a job well done.
- *Mind reading*: The perfectionist, especially one who is socially

prescribed, will think he or she knows what others are thinking of them. And all too often they will believe that others are judging them harshly.

- *Catastrophizing*: This involves the magnification of negative outcomes coupled with the sense that they can't be prevented or managed.
- *Over-responsibility*: This one is common in many health professionals seen by the Physician Health Program, and involves the sense that they are in greater control of situations than they realistically are. So, when outcomes don't match expectations, the tendency is to blame oneself. Anger, frustration and guilt are common feelings that result.

There are other hazardous assumptions doctors are prone to make that contribute to unnecessary stress.⁷ These can be associated with perfectionism and include:

- Assuming that the doctor's role is

to stamp out disease, suffering and death.

- Assuming that one is indispensable to patients and profession.
- Assuming that no patient could ever be angry with you, or leave your practice.
- Assuming that professional esteem and self-esteem are the same.

There is a paradox to perfection: attitudes and behaviours designed to exert control over circumstances, and others intending perfect outcomes, can often have the opposite result and cause distress in the perfectionist and others.

The challenge is to differentiate appropriate standards (of excellence, let's say, acknowledging the psyche of most medical professionals) from perfect (and therefore unattainable) ones.

Changing thinking, changing feeling

Antony and Swinson offer a variety of simple, practical, everyday strategies that are well worth learning.⁶ They

can be applied to modify the thought distortions and unwanted feelings associated with perfectionism.

The first step is to become aware of the influence of perfectionism when it's happening. We need to ask ourselves: is the adherence to standards of perfection helping or hurting? What is the impact upon our family and professional relationships? Most importantly, what feelings are associated with a perfection-based approach to life situations?

This isn't easy. Once and seemingly forever immersed in a particular value system and approach to life, it's hard to see it in action, let alone change it.

Think of a situation in your life, perhaps an experience similar to the ones described at the beginning of this article, and see if you can identify distortions of perfectionism at play. Which ones? Were they "self-oriented," "other-oriented," or "socially prescribed?" What was the impact upon you, co-workers, and others?

Sometimes it can be helpful to ask others close to you to help with this exercise. Check with a spouse, partner, co-worker or friend for their perspective. It's necessary to promote unconscious attitudes and thoughts to conscious awareness in order to change the feelings that follow.

Here are a number of good questions doctors can ask themselves to penetrate their unhelpful assertions:⁸

- Am I thinking in "all-or-nothing" terms? Look for words that suggest absolutes, like "always" or "never."
- Am I confusing a rare occurrence with a probability? This is a reality check.
- Am I assuming the worst possible outcome? This is not the same as a rational consideration of a worst-case scenario when charting a course of action.
- Am I blaming myself for something that was beyond my control? The benefit of accurate hindsight is helpful here.
- What would have happened if I

had handled the situation differently? Especially consider alternatives less shaped by perfectionism.

- What difference will this make in a week, a year, or 10 years? Will anyone really judge me harshly in the future?

The next step is to consider alternatives to the perfection-based approach. Can standards of perfection for oneself or others be "downgraded" to just plain excellent? Or good? How would someone else think about this situation? Return to your own example. Challenge your value system. Open your mind and list alternatives. Then choose a new, more helpful way of thinking about the situation.

Perhaps it's acceptable to be unable to please everyone, every time. Maybe if nine people out of 10 rate a presentation highly, that's good enough. A reminder that even the best of doctors will occasionally make a mistake is a good reality check. Be deliberate. Be realistic. Be daring!

Finally, consider the feelings that accompany these thought alternatives. Some anxiety? Perhaps at first. Thoughts that challenge deeply held values, if not pre-emptively dismissed, might be provocative. But, if there are any feelings of relief, then those new, more reality-based thoughts are "keepers." Practise these thought-re-shaping procedures often, applying them to as many situations as possible — and feel better.

Conclusion

These are the links between "head and heart," thoughts and feelings. Naturally, they blend like paint on a canvas, colouring everything in our lives. Resilient physicians have learned to recognize and manage them.

They have also learned to share their thoughts and feelings with others in ways of mutual benefit.

Stress-resistant doctors accept that they and others are imperfect. They understand that the goal is progress, not perfection.

References

1. Vaillant GE, Sobowale NC, McArthur C. Some Psychological Vulnerabilities of Physicians; *New England Journal of Medicine* 1972, 287(8), p. 372-375.
2. McCranie EW, Brandsma JM. Personality antecedents of burnout among middle-aged physicians, *Behavioral Medicine* 1988, 14(1), p. 30-36.
3. Gautam M. *Irondoc — Practical Stress Management Tools for Physicians*, Book Coach Press, Ottawa, 2004, p. 46.
4. Blatt S. The destructiveness of perfectionism: implications for the treatment of depression, *American Psychologist* 50, 1995, p. 1003-20.
5. Henning K, Ey S, Shaw D. Perfectionism, the imposter phenomenon and psychological adjustment in medical, dental, nursing and pharmacy students, *Medical Education* 1998, 32, p. 456-464.
6. Antony MM, Swinson RP. *When Perfect Isn't Good Enough — Strategies for Coping With Perfectionism*; New Harbinger Publications, 1998, Oakland, USA.
7. Vincent MO. Physician well-being and impairment: an overview, *Annals RCPSC*, Vol. 18(4), 1985, p. 339-343.
8. Sotile WM, Sotile MO. *The Resilient Physician*, American Medical Association Press 2002, p. 79-80.

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* Part I of this series, "B is for Body," appeared in the October 2006 issue of the Ontario Medical Review and is posted on the OMA website (<http://www.oma.org/pcomm/OMR/oct/06maintoc.htm>).

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