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Work-related stress and the psychiatrist: a case study

This case study aims to draw attention to the impact of work-related stress on psychiatrists. The first author's account of his own experience is supplemented by accounts from his secretary and wife. The aims of this report are to assist others to recognise the effects of work-related stress in themselves, to point out the impact on others, and to propose that doctors in training should be made aware of the issues.

Background

The National Audit Office publication *A Safer Place to Work* recently stated that work-related stress 'has emerged as a serious issue' (National Audit Office, 2003 p. 3). However, literature on stress among psychiatrists is scarce. A recent questionnaire study in the West Midlands found that 22% of respondents admitted to past mental health problems (White *et al*, 2006). Hawton *et al* (2001) found significantly raised rates of suicide among female doctors and psychiatrists in the period 1979–1995. Of the 29 doctors for whom there was sufficient information, 25 had significant work-related problems and 14 had relationship difficulties (Hawton *et al*, 2004). Junior doctors also experience similar problems (Firth-Cozens, 1987; McManus *et al*, 2002, 2004). The case presented here focuses attention on how one psychiatrist was affected, and some issues arising from this.

Case study

T.H. is a consultant psychiatrist, in his late 50s, working with people with longer-term severe mental illness. The factors contributing to his disorder were complex, but the personality issues have been reported previously in an important paper entitled 'The role of compulsiveness in the normal physician' (Gabbard, 1985). Gabbard described a triad of doubt, guilt feelings and an exaggerated sense of responsibility which commonly affect doctors. These lead to maladaptive responses including: chronic feelings of not doing enough, difficulties in setting limits, and the confusion of selfishness with healthy self-interest. He also found that there were difficulties in allocating time to the family and an inability to relax or pursue pleasurable interests. Many of these were characteristic of T.H.'s approach to life. He volunteered on a number of

occasions to take on extra clinical commitments without properly assessing the impact on his abilities to cope. A second set of problems stemmed from long-standing inadequate medical support. Finally, the intractable nature of some of the assertive outreach work meant that endless attempts to achieve clinical improvements met with resistance and little evidence of success, which proved very wearing. The symptoms built up over 10 years.

> 'At no point until receiving therapy did I consider that there was a significant problem. The symptoms were typical but did not appear serious enough to warrant any attention. As each arose I ignored their interconnections. Waking at 3 o'clock in the morning, churning over patient-related anxieties demonstrated to me that I really didn't need sleep. This endless "revolving door" of pre-occupation was "normal".
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> At weekends the recurrent minor respiratory tract infections, with associated headaches, neck and shoulder pains, and excessive sweating, were seen as the inevitable consequence of having children at school. The diarrhoea I diagnosed as "irritable bowel syndrome" associated with a gluten allergy. The increasing self-centredness was just plain selfishness and part of an intractable insensitivity concerning the needs of others. The associated guilt increasingly prohibited discussion. My wife's consistent and patient attempts to point out that I was unwell I dismissed as overanxiety on her part. It was too trivial to bother the family doctor with. I entirely failed to recognise the distress that my condition caused in others.
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> The denouement came with two major infections, necessitating more time off sick in a year than during the previous 30. A quinsy was followed by pneumonia. I finally acknowledged the signs and negotiated "special" leave. As this approached I experienced episodes of frank anxiety with palpitations and mild panic. When I informed my therapist that I was possibly mildly stressed, he retorted that I was "boiling over"! It took weeks for this to sink in. Even now doubt lurks, despite the fact that treatment has eradicated most symptoms.'

One of the difficulties in recognising work-related stress is accepting the need for care. Many staff in the health service are terrified of caring for themselves. It is far easier to be a martyr. However, others were suffering. Their accounts now follow.

His secretary

> 'I have worked for T.H. for 11 years and didn't recognise that anything was wrong until he was off sick with pneumonia. Then the alarm bells started ringing. He did not tell me, or his

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colleagues, how he was feeling. Everyone is overstretched within the team and I thought it was pressure of work, as he was always taking on more or helping other teams out. Even when in hospital, he took his laptop computer with him and phoned me from the bed. He gave up extra work that he enjoyed, such as teaching, in order to concentrate on clinical work. I knew something was not right but did not know how to make sense of it. I have also had to cover administrative staff shortages in the team, adding to my own workload and stress. Neither of us found time to chat and reflect on what was going on.

It was becoming increasingly difficult to approach him, as he didn't seem to have time to talk or discuss things. He was not dealing with things; the post and messages mounted up and it was falling on me to sort things out, increasing my stress. We had no contact with each other first thing in the morning, and it got to the stage when he did not even greet me. He became niggly and preoccupied. At the end of one week when he had had to do a number of Mental Health Act assessments, he got particularly wound up when asked to do another and attempted to avoid it.

I have enjoyed working with T.H. over many years and I think he was trying to protect me from his difficulties. Consequently, at no point did I feel the need to discuss this with him or anybody else.'

His wife

'During the period described above my symptoms mirrored his. I felt anxious, unworthy and that there was nowhere to turn. Our social life dwindled, as did our sex life. My colleagues noticed my anxious state and became concerned for my physical condition. The children "just got on with it" and the fact that their father receded into the background was a constant nagging concern. Ours is a strong marriage – no wonder the partnerships of others are sacrificed where the relationship is not so secure. The feelings I have about the situation are still very raw and I still find it difficult to be objective, as painful feelings are revisited. I continue to watch him struggle to make an unchanged work situation bearable.'

Recognition

The first issue raised by this case study is the inability of the sufferer to identify the symptoms and then seek help. The reasons were a combination of denial, shame, fear of 'letting the side down' and the knowledge that others were similarly afflicted without 'caving in'. Family members were aware of the problems but were rendered powerless to intervene effectively. Team members found it difficult to approach a senior psychiatric colleague with their concerns.

Self-deception would have led T.H. to give a negative response to the postal survey of White et al (2006). The General Health Questionnaire would fail to identify caseness because of the chronicity (Goldberg & Williams, 1988).

Management

Once the problem was identified there were difficulties in taking appropriate action. T.H. found it difficult to relinquish control and so took a course that prioritised the corporate needs of the trust (identifying a locum and

timing his actions to suit this person). However, he failed to ensure adequate leave time, clarification of payment arrangements and appropriate therapy. The latter was only instituted at the insistence of his wife. No one else who was consulted was involved in making these decisions.

Return to work

Uncertainty over how to manage a sick psychiatrist continued on his return to work. It was clear that his particular job was contributing significantly to the stress but it appeared to be impossible to modify this. His own plans, probably justifiably, were seen as unaffordable in a time of financial restraint. No one mentioned therapy, except when he did. Indeed there was evident relief that he seemed to be managing these issues himself.

Consequences

It would be inappropriate to allocate blame for this situation. It is better to recognise that it is not unusual and will occur in others. As a consequence of their leadership role and seniority, it is inevitable that consultants will experience high stress levels related to their work. This also means that they must take greater responsibility for their self-management. To do this they need to be prepared. Their training should include an understanding of how work-related stress arises, overcoming resistance to accepting its relevance, self-management techniques, recognition of symptoms, seeking appropriate treatment and planning appropriate work changes. There are perhaps some jobs that can only be managed for a limited number of years by most individuals (e.g. assertive outreach). All of this requires greater openness and active efforts to overcome the personal and system-wide denial that such disorders tend to engender. If psychiatrists are failing to manage their stress, the service is wasting valuable assets and is also compromising the work of others.

Declaration of interest

None.

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Diary from Sri Lanka's east coast: departure

The day I leave Ampara on Sri Lanka's east coast, a wild elephant kills a woman and severely injures two others on the road near my house. This is the second fatal attack in town this year and, as before, the animal is rounded up and bundled back to the jungle in a truck. The incident seems to encapsulate something important about the nature of Sri Lanka: dark forces coiled beneath an appearance of calm. In the past month, for example, three security guards have been gunned down at hospitals in Ampara, Batticaloa and Sammanthurai. Yet the world of crisp nursing bonnets and clinical order remains intact throughout. No one knows who the killers were or how they chose their victims, but in this smoke and mirror conflict, rumours are fuelled of a final push by one side or the other. Then nothing happens, just more of the same, daily isolated encounters, as if it were in no one's interest to go for all-out war. Meanwhile the world's attention moves on to Lebanon.

I sit in the departure lounge at Bandaranaike International Airport wondering whether to buy another T-shirt with an elephant on it. In fact it's hard to find elephant-free souvenirs. I try to work out what good I've been to Sri Lanka during my 3-month stint of training doctors on the east coast. Could I have even done harm?

The plan, in keeping with current foreign aid theory (Degnbol-Martinussen & Engberg-Pedersen, 2003), had been to work collaboratively with the existing health system to increase its capacity to detect and treat people with severe mental illness. At face value things had been fine. Doctors at half a dozen new regular clinics had been intensively supervised in both assessing and treating patients, and in training their community staff to identify and bring in new patients; 30 further doctors had been given clinical and teaching skills-based workshop training; around 400 community staff were given training so that they could recognise and support those with severe mental illness; and nearly 150 people were engaged in supervised psychiatric treatment they would otherwise not have received.

But, could the aid have caused unintended harm? Or damage from friendly fire as Amartya Sen puts it (Sen, 2005)? Was there anything that should have been done differently?

Although I avoided the hit and run model of teaching characterised by context-free training, minimal skills development and lack of follow through, I only had 3 months before handing over to another trainer. Three months of fortnightly clinics with busy doctors who had many other duties wasn't enough to really consolidate their psychiatric skills or bed down the new primary care mental health system. Effective supervision relies on fostering good relationships and providing continuity and containment over a significant period. Something that was tricky to deliver in 3 months across a network of distant clinics, particularly since it takes a few weeks to get orientated and a few more to disengage when you leave. Not to mention the dodgy roads, super-cool bus drivers with a death wish and menacing road blocks (where you go real slow, turn off the music, remove the shades, switch on the interior light if it's dark and make sure everyone's hands are visible). Moreover, a third of clinics were cancelled or unsupervised, mainly because of security concerns. So, a trainer staying for a full 6 months would have been better, ideally with top-up visits during a 1- or 2-year follow-up period to support the programme's sustainability, which is something non-governmental organisations (NGOs) have been accused of sidelining (Degnbol-Martinussen & Engberg-Pedersen, 2003).

The other possible source of damage I worried about was the way free aid might let local services off the hook by sorting out problems for them, a pattern that could be taken for granted. Relying on NGOs for building projects, vehicles and training acts as a disincentive for government to sort these things out. Yet the dilemma is that since government resources are so stretched, these things may only happen if NGOs get involved. However, the trick that local health leaders appear to have learnt was impressive. They were certainly dependent on aid for the building of new hospitals and clinics, and the provision of many training programmes (to the point that some health staff felt burnt out by so much foreign aid training), but in adapting to this 'window of opportunity' aid-rich environment, they had become pretty effective at getting NGOs to do what they wanted. So, in practice, a balance had been struck between the inevitably Westernised agenda of donors and NGOs and the strategic concerns of local health service leaders. Maybe that's as good as it can get: a potentially creative, although sometimes tense interface between outside agencies and local leaders producing what happens on the ground. All lubricated by the