Editorials

Burnt out or fired up?

Helping recovery in distressed patients can increase our own resilience

INTRODUCING RESILIENCE

Burnout has become a major concern in general practice in the UK, with high levels of exhaustion, depersonalisation, and low levels of personal effectiveness. A study in 2011 suggested that burnout was allied to pessimism.[1] With the major systemic problems in general practice in the NHS, such as shifts in funding, pay cuts, staff wastage, and contractual chaos, the need to be resilient, to foster better coping and creative solutions, has never been more pressing.

Resilience is a concept from materials science representing the ability to return to a previous state of resistance without deformation or loss of elasticity. Psychological resilience is similar, but additionally encompasses the concept of growth from stressful experiences, 'bouncing forwards', to become more resilient in the future.

EMPIRICAL EVIDENCE

In psychological research the effect of resilience on growth and optimism under stress has been shown to be strongly mediated by frequency of access to positive emotions.[2] There are a number of cognitive enhancements that are associated with the experience of positive emotions, including cognitive flexibility, creative and detailed problem solving, better working memory, and increased prosocial behaviours, such as compassion and generosity, increased social inclusion, and ability to focus effectively on negative information.[3] Relevant studies conducted with medical students and physicians showed that increasing positive emotions (receiving an unexpected reward such as a small gift or praise) increased diagnostic skills, problem solving, and a sense of vocation.[4]

The experience of positive emotions can become a self-sustaining positive feedback loop due to these cognitive enhancements, increasing positive social feedback through parasympathetic networks that signal approach(ability) to others, while building a sense of mastery. Memory of this sense of mastery builds a sense of personal effectiveness and positive self-esteem, which buffers the person from future stress.[5] Conversely negative emotions, perceived danger, failure, or social isolation increases activity in frontal regions related to sympathetic activity, and can cause a state of withdrawal, resulting in a narrowing of cognitive abilities.

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POSITIVE EMOTIONS AND RECOVERY

Depression is a condition characterised by low positive emotions and cognitive impairments that inversely reflect the cognitive enhancements from positive emotions, therefore increasing access to positive emotions is a promising way to reduce depression. Additionally, as the cognitive enhancement correlates of positive emotion have all been demonstrated in general populations, increasing positive emotions can not only aid recovery in those who are depressed, but also have a beneficial impact on the wider population, including stressed health professionals, building resilience, and reducing vulnerability to stress and depression.

Rewards that raise positive emotions can be praise, appreciation, love, gratitude, affiliative gentle touch, or humour. However, sometimes personal or working circumstances overwhelm our positive reserves. Individuals with depression definitively cannot access positive emotions. Promising new avenues of investigation have emerged in recent research, looking at the interaction of positive emotions, depression and recovery. The mode of processing your thoughts can be ruminative (thinking; 'why can't I do better?'), which is self critical, unconstructive, and correlated with depression vulnerability, or, alternatively, decentred, which can involve visualising how an event proceeded or focusing your attention on some internal process (breathing) or an external image and 'letting go' of your thoughts.[6] Accessing decentred processing facilitates re-interpretation of events in a non-judgemental way and boosts positive emotions in students with depressed mood (A Dobbin, unpublished data, 2014). Visualisation practice is helpful, as are other body/mind techniques such as breathing or relaxation training.

AN OPPORTUNITY FOR GPs

In 1985 one of the most comprehensive studies into depression was carried out, a multicentre study comparing four therapies: antidepressants, placebo, cognitive behavioural therapy, and interpersonal therapy. These were all delivered with clinical or psychological support for 16 weeks. The primary outcome was recovery at 16 weeks and 18 months. Surprisingly all groups experienced equal recovery, the most effective predictor of recovery was the patient's expectation, mediated by the relationship with the therapist. It has been established that non-specific treatment effects (placebo/expectancy) account for at least 75% of the effects of antidepressant medication, similarly in other conditions and possibly in all psychotherapy.[7] There is huge potential for upskilling GPs to use their position of trust and respect to maximise expectation and therapeutic alliance and help their patients with psychological therapies. This can be done through GP guided self-managed materials and can be cost effective.[8]

The understanding of the neurobiology of emotions, the biopsychosocial model of distress and the mind/body link is poorly covered in medical schools, despite its huge

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relevance to all fields.[9] Thus we end up with thousands of graduates who can (hopefully) recognise a medulloblastoma (obviously important but extremely rare) but have little idea about the origins and ramifications of distress, which, as GPs particularly, they will deal with every day. GPs are further marginalised by initiatives such as the Increasing Access to Psychological Therapies (IAPT) programme, where, rather than engaging with psychological treatment of patients with common mental health disorders, their sole purpose is seen as referral, which can also deter from clinical involvement in innovative treatment ideas. The recent figures for uptake and outcomes of this programme show the lack of patient engagement with a referral-based programme in primary care, and strengthens the case for devolvement to, and encouraging innovation in, the front line.[10] The most damaging outcome of this exclusion is that if you do not have the skills to help your patients, you do not, *ipso facto*, have the skills to help yourself. You must practice the alleviation of distress to understand it, the most important thing is to give your patient a credible model and explain how this will assist their recovery. The more you enable recovery in others the more you enable it in yourself. This is a concept I have called 'therapeutic mirroring'. The Buddha said '*you are the person most deserving of your compassion*'. Similarly, you are your most important patient; by understanding the neurobiology of distress, resilience, and recovery and integrating this into your clinical practice, you can learn to communicate this model and commence a process of increasing resilience thereby aiding recovery for your patients and yourself.

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