James Gordon, MD: The Potential of Mind-Body Self Care to Free the World From the Effects of Trauma

Interview by Craig Gustafson

James S. Gordon, MD, *a Harvard-educated psychiatrist, is a world-renowned expert in using mind-body medicine to heal depression, anxiety, and psychological trauma. He is the founder and executive director of the Center for Mind-Body Medicine and clinical professor in the departments of psychiatry and family medicine at Georgetown Medical School in Washington, DC. Dr Gordon served as the first chairman of the program advisory council to the National Institutes of Health Office of Alternative Medicine and as chairman of the White House Commission on Complementary and Alternative Medicine Policy under Presidents Clinton and George W. Bush. He is author of* Manifesto for a New Medicine: Your Guide to Healing Partnerships and the Wise Use of Alternative Therapies, *and his most recent book is* Unstuck: Your Guide to the Seven-Stage Journey Out of Depression.

***Integrative Medicine: A Clinician's Journal* (*IMCJ*):** What originally drew you to focus attention on the issue of posttraumatic stress disorder, or PTSD, in your practice?

Dr Gordon: I was always interested in hearing people's stories, which is why I became a psychiatrist. I was particularly interested in the possibility that the act of telling me their stories and my being able to sit with them, listening and feeling what was going on with them, could be helpful. That was really very important to my becoming a doctor.

Early on, I also became interested in people who were going through very difficult times—whether it was old people on a surgical ward who were having terrible pain and were lonely in the middle of the night, or people who had lived a very hard life and were coming into the emergency room overwhelmed by their circumstances. I was always interested in seeing if I could be helpful to those people who seemed most troubled—most put upon by the world—most lost. That was one of the places that I thought I could be most useful: for those people whom others, for various reasons, did not want to pay much attention to. I was interested in what it was like to live in the midst of great difficulty or on the edge, and I was interested in how I, by reaching out to those people—by being with them—could help them find their own strength. I wanted to know how I could help them be the best and most skillful, satisfied, and fulfilled person that they could be, given those circumstances.

That is how I started. So in a sense, I have always been interested in psychological trauma. In the 1970s, I was a researcher at the National Institute of Mental Health, or NIMH, working with runaway and homeless kids who were certainly plenty traumatized. But in my private practice, people who had been tortured by various dictatorships began to come and see me. I began to work with those people who had survived torture, originally in Latin America and then in other places around the world. Word got out that I was somebody who was interested in working with survivors of torture and that people felt comfortable with me, and so more and more people began to come.

I started the Center for Mind-Body Medicine, or CMBM, in 1991, which is a nonprofit organization here in Washington, DC. I was interested in making self-awareness, self-care, and group support central to all health care, to the training of all health professionals, and to the education of our children. Initially, our work was with black and Hispanic kids here in Washington, DC, many of whom were very seriously traumatized by war in Central America or by poverty here in the United States. We were also interested in working with people with cancer, HIV, and other life-threatening illnesses; people dealing with trauma; and, finally, the other group we were working with was medical students. Their trauma is less severe and less obvious, but they, nevertheless, were dealing with stress.

The method that we developed at CMBM comprised teaching a variety of self-awareness and self-care techniques and creating small groups in which people could learn these techniques and find support. This worked extremely well with the populations here in Washington, DC. We then began to train health professionals all over the United States—people working in hospitals, clinics, and private practices. As that work unfolded and as it was successful, and as people were able to use what they had learned from us very well—first for themselves because the idea is that you cannot help other people learn self-care unless you have learned it and are

continuing to do it yourself, then for others—I became interested in whether or not the same approach we were using here in the United States might be useful in some of the more troubled parts of our planet. It was a question that came up, I suppose, partly out of my work with people who had been tortured in some of these places, partly out of my interest in seeing what I could learn from people who had lived in these extreme situations, and partly out of my sense that what we were doing—the approach of self-care and group support that we were developing—could be helpful to them in a way that conventional approaches were not.

In about 1996, I began to allow myself to be drawn to places where large numbers of people were suffering and had suffered severely. We can speculate about my psychology. Still, I do like going into situations where there is a good deal of trouble and pain and chaos and seeing if I can be helpful—seeing if I can create a situation of greater stability where people can help and heal themselves. It was a challenge, as well as an act of caring for me.

***IMCJ*:** You mentioned that you have a fairly developed program that you are teaching people and working with. Where did it start from and how did it evolve?

Dr Gordon: I began to become interested in self-awareness, self-care, and group support for myself. That started 50 years ago, when I was still in medical school. I was interested in exploring, "How do I deal with a situation that's stressful in certain ways?" I was in therapy when I was in medical school, psychotherapy, which was very helpful to me. I also wondered what else there was. This was the 1960s, and I was looking at what other aspects of consciousness I could explore and how they could help me to move beyond the horizons that I was seeing, and even the depths that I was exploring in psychotherapy. So I started getting interested in meditation, and I started getting interested in consciousness-expanding plants.

By the end of the 1960s, I began to get interested in Chinese medicine and yoga and, in the early 1970s, in t'ai chi. I was interested in food and nutrition. All these things were initially for myself and then, over time, as I began to integrate these approaches into my own life, I began to want to integrate them into the lives of the people I was working with: the kids whom I was working with in runaway houses and the people I was seeing in my private practice.

I also wanted to find out what was known about all these approaches, so in 1974 or 1975 as part of my job at the National Institute of Mental Health, I began to look into these approaches and to bring together the people who were using them—both the self-care approaches and other approaches that required a professional, like herbalism and acupuncture and the manipulation that chiropractors and osteopaths do. By the time I left NIMH in 1982, I had begun to develop a way of working with myself, which included a number of these different approaches: meditation, guided imagery, yoga, t'ai chi and qigong, and self-expression in words and movement, and nutrition and herbalism. They were a part of my life and I was using them with other people and teaching them in workshops.

When I created the CMBM, I brought together a group of people and we developed a curriculum of mind-body medicine—much of which was based on approaches that I had learned about and that were important to me, but other people in this group of volunteers also brought other approaches. Mary Lee Esty, PhD, for example, a psychologist who has now become one of the country's leading experts in neurofeedback, brought in biofeedback and a more refined approach to the use of music.

We began to use our curriculum to train groups of people who were working with seriously psychologically troubled people. We used it for a program we put together for war-traumatized kids from El Salvador and Georgetown medical students. We taught these groups, together, the techniques of mind-body medicine and created a mentorship program for the high school kids with the Georgetown medical students.

Then we developed what became a national training program that included all these approaches: meditation; guided imagery; biofeedback; autogenic training; genograms; family trees; small-group support; self-expression in words, drawings, and movement; and mindful eating.

By 1993, we had a curriculum very much in place and we began training people in the Washington, DC, area. After that first training, which exceeded our hopes, we decided to go national. We developed an advanced training program, and then we developed a program of supervision for the people we trained. Now we have probably the most comprehensive program of training in mind-body medicine anywhere on the planet. About 5000 people have come through our initial training course.

As I said, by 1996, I was wondering if we could start using this in places where the need was enormous—the pain and suffering were so great. Susan Lord, MD, who is a family physician and a colleague, was very much my partner in this work. We began to go overseas, initially to Mozambique and South Africa. We also went to Bosnia shortly after the Dayton Accords had been signed, ending the war there.

The question we went with—the question we always have when we go anywhere—was: "Do you think this could be useful?" We give workshops. We tell people about what we are doing. We give them the experience of what we are doing. Then we ask them, "Can this be useful to you, to your colleagues, to the tens or hundreds of thousands of people you serve in your region or your country?"

The answer kept coming back, "Yes." It came back that way in Mozambique, but we actually decided to do our first large-scale international program in Bosnia because 250 000 people had been killed in the war there. It just

seemed like such an obvious place for us to go. The work was very well received by many people. We began to train both people in the Christian community, Catholic Croats, and also people in the Islamic community. We could not work with the Serbian community there. Things were, as they still are, very much split between Croat and Muslim on one hand and the Serbs on the other.

The work was going well, but it became clear that the trauma had become entrenched in people. A year and a half after the Dayton Accords were signed, all the physiological patterns, the psychological patterns, and the behavioral patterns had become very fixed in the people. There had been 4 years of war. The whole population was deeply traumatized. So, although we could be helpful, it was clear to us that the best time to begin to work with trauma is right when it was happening.

When the war in Kosovo began in 1998, Susan and I went there. We wanted to be there to begin work right at the beginning—right in the middle of a war. We also spent time in Serbia during the war, and we worked in Kosovo in 1998 and 1999. When the NATO bombings of Kosovo started, we began to work in Macedonia with the refugees who went there.

Ultimately, we brought a team back into Kosovo when the NATO forces returned to Kosovo and we trained 600 people, including everyone who worked in the community mental-health system. Our model of mind-body medicine became a central part of the mental-health system in Kosovo. So far as I know, it is the only country in the world where mind-body medicine is an official part of the health care system and it continues to be part of the health care system to this day. Kosovo really became our pilot project for working with population-wide psychological trauma.

***IMCJ*:** These results require populations to put mind-body self-care into daily practice. Would you discuss how you go about making such a foundational change in the way people live their everyday lives?

Dr Gordon: I think the issue is true here in the United States as well as overseas. In some ways, it is harder here in the United States because we have been so dependent on medical care and on the medical model, believing that physicians or somebody in authority has the answer to our problems.

It is a process of waking up to the fact that for most chronic problems, that dependency simply does not work. In a place like Kosovo or Gaza or Haiti, it is easier because the desperation is so great. When we come in, nobody is really paying attention to the great suffering and the population, itself, is very mistrustful of the methods that are available—the drugs that can be given out, which have really been the major response to trauma in those places. On one hand, people do not have access to much in the way of psychological care. On the other hand, they are leery of the care that they do have. When we begin teaching this approach and people can see benefits right away, it does not take much convincing.

We begin by training those people who are open to what we have to offer and are in a position to help others. Wherever we go, I—and sometimes others who come with me—will meet with the ministry of health, will meet with the hospitals, will meet with the Red Cross or the Red Crescent, and will meet with nongovernment organizations and the heads of the school system. People from those systems who are interested will come to the training that we set up. They see very quickly that what we are teaching can make a difference. After simply breathing slowly and deeply and relaxing, people say, "Oh, my God. I feel different. In 10 minutes, I feel more relaxed. My shoulders are more relaxed. My mind is a little bit clearer." And at night, perhaps they sleep a little bit better.

It is not a question of convincing people. They get it. They experience it. In the course of a 5-day training, they have many such experiences of being able to feel more free from all the pressure that has been building up, being a little less anxious, and being a little less angry. They experience using our drawings or guided imagery to mobilize their imaginations, so they can imagine solutions to problems that looked intractable. The people we train, right from the get go, have an experience that not only helps them, but gives them hope that life can be different.

As we teach them to use this approach with other people, they learn to communicate that to other people. When they go out, they are people who are known in the community. Let's say a school counselor has come through our training. She goes back to her school and she says to the teachers and to the kids, "Listen, I learned these things. I feel so much better now. I am not smacking my kids around. I can sleep at night. I am more relaxed. Would you like to learn these things?" It is an invitation that comes from her whole being, so people get it and they respond that way because they know her.

That is the way our work disseminates. People want something that will be helpful. They are in these desperate situations and often, nothing is offered to them. In places like Haiti, there are half-a-dozen psychiatrists and maybe a dozen PhD psychologists for 9 million people, so they are not going to get individual therapy. They are not going to line up at a clinic. The clinics do not exist. But when somebody in the community—a doctor, nurse, teacher, priest, nun, or a voodoo healer—says, "Here's something I have to offer," and they know this person, then they respond.

That is how things happen. It is harder, actually, in a society that has many more choices because there is this sense that there are all kinds of vested interests in providing these other approaches. What we say in any place we go within the United States, or a place like Israel where there are many other therapies available—we're not saying it's either/or. What we are saying is: "This is primary health care, primary mental health care. This is

for everybody. If you want to use other approaches, fine. But everybody on our planet needs to know how to take care of herself or himself."

***IMCJ*:** There is a piece you wrote for the *Atlantic* a while back that talked specifically about the United States military and veterans and dealing with some of the issues related to their service.[1] You also discussed, as you were saying here, that this is primary care that everybody needs to know—that these types of therapies and this approach can be very positive and very impactful for veterans—but there are all kinds of hurdles that need to be dismantled in order for this to be accepted. Could you discuss how that can be achieved?

Dr Gordon: I think there are, as you say, several major hurdles that need to be surmounted or, even better, taken away. One of the first ones is confidentiality. People who come for help need to know—and this does not have much to do with our approach, but any approach—they need to know that the consultation is not going on their record because otherwise, they are just not going to come, so that's number 1.

Number 2 is that we need to be able to reach all of the military. Military people get this. They get this approach. Being in the military means you learn skills. That is what basic training is about. That is what continuing training is about. People in the military like to learn skills. I would add that most of us like to learn skills if they are interesting and fun. They appreciate that somebody is acknowledging their strengths and their ability. It is a matter of making this therapy available to them because they will often come to people who are leading our mind-body skills groups, preferentially to going to the doctor who is handing out pills. So it is a question of how we make it available in the system to everybody. That is another hurdle because once it is in the system and it is known that it is confidential, people will flock to it. They do.

Another piece is that it is important that we not focus only on those people with diagnosed PTSD, because, again, if you say you have PTSD and that diagnosis is confirmed, yes, you can get out of the military and you will be able to get disability, but you also cannot stay in the military. And many people want to stay. They do not want to have the diagnosis and they also do not want to be treated as patients. They would much rather be treated as members of the military, as people learning how to help themselves, as students, really. It is this question of shifting out of that diagnostic box and making the approach available to everyone. So except for research purposes, all of our groups within the military are open to anyone who comes. You do not have to say, "I've got PTSD," or, "I've got traumatic brain injury," to come. All you need to say is, "You know, I'd like to learn how to help myself better." Beautiful! It takes away the stigma that goes with mental-health treatment. I know the military is trying to do away with the stigma, but it has not happened yet, for sure.

Many people in the military also prefer groups. That is the way the military is organized: in small groups. They do not feel very comfortable with individual therapy, even if the therapist is good. A lot of people have said to me, "I felt like a bug under a microscope." That is not a good way to feel. Some people love individual therapy. That is fine, but what I am saying is that we need to make group therapy available to everyone. We need to make these skills and these techniques available to everyone. This needs to be central to everyone's care and we need to make the other therapies—medication, which may be necessary in some cases—not be considered the primary care. It is a question of shifting, turning the medical model inside out and making self-care, which is usually regarded as peripheral, central to all care. That needs to be done in the military as well.

We have also found, again and again, when training clinicians who work with the military and in the VA, is that those folks are totally stressed out themselves. It is not easy work helping so many people who have been so deeply traumatized. There needs to be a program to help the clinicians help themselves—to create a supportive community among the clinicians, where the clinicians can share what they have learned with the people they are working with. That changes the dynamic completely.

One of our psychologists who we have trained in Louisiana says it so beautifully. She said, "You know, when I do other therapies or even when I do other groups, I'm really saying: 'There's something wrong with you and we have a treatment for you.' When I lead CMBM mind-body skills groups, what I am saying is, 'Look, these techniques, this kind of group, changed my life. I use these techniques every day. I use them with my family. Would you like to learn them?'" It's changing from an order to an invitation. It is so beautiful and the guys, and the women as well, respond to this invitation. It is completely different from being told there is something wrong with you.

My hope is, and what I have been working for, especially these last 7 or 8 years, is to make our approach available throughout the military and the VA system. Then it will be there as a primary vocabulary and grammar that everybody should learn to help and understand themselves. The small groups will be there so that people can share with one another and help each other. Importantly, we are also training peer counselors in the military. You do not have to be a physician or a mental-health professional to lead these groups. Smart people who are committed to working on themselves, helping others, and getting supervision can do it.

***IMCJ*:** Both the military and conventional medical practice are very algorithm oriented. There are regulations and a way to do things. Integrative medicine is becoming more and more centered on personalization, so how do you bridge that chasm from working through an algorithm to opening a toolbox to determine what works best for that individual?

Dr Gordon: See, each person is the bridge that you are talking about. The approach is there. All the different tools are there. We are saying to people, "Here are all the tools. Let's see which ones work best for you." It is not up to me as the leader of the group or the therapist and a psychiatrist in my practice to say, "This is the one you have to do." My job is to help you see which ones are most helpful to you and to help you to use them in a way that gives you the most benefit—to individualize it within this model.

Then we can look at the outcome. We can study the outcome. So far, we have published 3 papers on the use of this small group model with war-traumatized children and adolescents, including the first-ever randomized, controlled trial of any intervention with war-traumatized kids.[2-4] We are getting ready to publish 5 more. What the results show is that there is an 80% to 90% decrease in posttraumatic stress disorder in those people who participate in our groups after 10 or 12 weeks of once-weekly sessions. Those gains largely hold at follow-up. We and others have also published 5 papers on the effectiveness of the model with medical students. Our program lowers their level of stress; improves mood, sleep, and academic performance; makes them more hopeful about becoming physicians; and, perhaps best of all, more compassionate to each other.[5]

The evidence is there. I think it's a new way of individualizing. It is not my algorithm. It is us working out what is best for you and it is going to be different for everyone. Somebody comes into one of our groups and I always ask, at the end, "What technique did you like best?" I'm blown away by the different answers.

One little girl in Gaza, who was about 9 years old said, "The most important technique for me was mindful eating." I said, "Really? How come?" She said, "It made such a difference in how much I enjoy my food and I really love my food now. Before, I never paid much attention." She said, "I taught it to my whole family and our dinners, where everybody used to argue all the time, are now much calmer and everybody is much nicer to each other." I said, "Fantastic!"

A little boy in Haiti, who was 8 years old, looked at me with a big grin, and then he showed me this incredibly fast, deep breathing that we teach: breathing in and out through the nose, using the arms like a bellows to make the breathing faster and deeper. It is not an easy technique; we do it to break up the fixed patterns in the body that come after trauma. It energizes people who are depleted and who are frozen because of trauma.

I asked him, "How come you like that so much?" This is a little boy who is living in a tent camp and learning from a priest we had trained. He said, "During the earthquake, I saw my mother die and she was buried under the rubble. At night, I was afraid to go to sleep because I would have terrible dreams about her. After Father Freddy taught us that fast, deep breathing, I decided that I was going to use that before I went to sleep. After a while, I was able to calm down and go to sleep and I didn't have those terrible dreams. And so now I do it every night."

I could not have predicted that response in a million years. We generally tell people not to do that technique before going to sleep because it is going to keep you up. It is very energizing. But this little boy knew. Maybe we can take a little bit of credit for helping him to trust his intuition so that he would know to use this. That's the way it works. It works for each person by taking what is most useful and using it. We encourage people to do that and then tell us what worked or what did not work. I would encourage readers to take a look at the published studies, which show that this works. Doing outcome studies is a beautiful way to get results and certainly is a respected methodology.

***IMCJ*:** You mentioned that you are drawn to places where you feel you can help. When you went into this, did you think more in terms of helping people on a personal level and, if so, then did it surprise you to start seeing that there may be some more societal-level changes that stem from your work?

Dr Gordon: First, all of us who go into the healing professions want to help people. I am not unique. It is just the reason why I do this work, otherwise, I would have done something else. What gives me fulfillment is being useful to other people. I could have been a plumber, I suppose, and that would have been useful, too. But I like being useful in a very personal way. I like helping people when they are really in trouble. I think most of us do. That is why we do this work.

The people who come to our trainings in the United States—and I really invite all your readers to come to our trainings—are looking for different ways to help people. What we are offering is a way to help people that is a complement to, and can be easily integrated into, anybody's practice. This work grows out of who I am as a physician. Initially, the work was with individuals, but I have to say right from the beginning, I was interested in how to work with groups of people.

I suppose that is part of my training as a psychiatrist where, on a psychiatric ward, you work with a whole ward of people. It is also part of being alive as a human being in the 1960s and being part of the civil rights movement and the antiwar movement and wanting and feeling the power of those movements to change people and to help change the world. I think right from the beginning, I had a sense that I wanted, somehow—although I didn't know exactly how—to work on a larger scale. I was always interested in the intersection between individual lives and larger social change.

One of my teachers was my therapist in medical school, a man named Robert Coles, MD, who worked with kids who were integrating the schools in New Orleans in the 1950s and 1960s. Another great teacher was Erik

Erikson, who wrote so brilliantly about how individual issues and challenges reflect larger social challenges and how individual lives can affect the larger society. This is who I am and it's a part of me.

I think that it is part of who we are as human beings to have the inclination from time to time to reach out to others—to reach out beyond our offices. A lot of people we train are working in medical and other professional schools and teach this to work in our communities. Many of the trainees said, "Maybe I can do some of this work in a homeless shelter," or, "Maybe I could work in my church or synagogue or mosque or some place in my community." I think it's part of the contribution that we feel that we can make to other people. For me, it has been very natural. As I say, it is very much a part of who I am and I think part of my function is to raise that possibility for other people.

One of the things that people experience with our method is that they are with a group of people in a way that they really get to know each other. They have a sense of connection to each other. There is a depth of experience that they have with each other that all of us crave as human beings. Again, that is part of who we are. Our species evolved in intimate groups, so we want that and we are nourished by that.

I also think another piece of it is that if we're going to have an effect on the larger systems in which we work, whether we are MDs, naturopaths, psychologists, acupuncturists, social workers, or nurses—whatever we are—we need to learn how to work with a group of people. We are doing a program with Eskenazi Health Systems in Indiana where we are working with the whole hospital—4000 employees. We are training 200 of them in mind-body medicine and nutrition and they are working with the rest of the employees. They are building community and people really like it. People like being part of a community. Not everyone is going to want to do it, but a surprising number of people get really interested in doing it once they experience the self-care techniques, the small groups, and being part of a community that is devoted to healing.

***IMCJ*:** A basic tenet of your method is the concept of self-care and that the trainers have to be using it first. Why is the concept of needing to be right, yourself, in order to care for someone else so important?

Dr Gordon: Trauma is universal. This is really important: All of us are traumatized in one way or another by serious illness, by abuse or neglect, by somebody else in the family being ill, maltreatment, being fired from a job, or, if nothing else, by facing the fact of our own mortality and everyone else's mortality. Trauma is universal.

So, we are all in this together; we all have our issues. Many of us got into integrative medicine because we wanted to heal ourselves. Of course, we are all dealing with trauma. We are all dealing with stress. We are dealing with being human. So the way we can help other people and use our technical expertise best is by understanding that we are not so different from them—that we have to create a foundation of self-awareness and self-care. And that, then, is what we can build on.

Once we have that, then everything else we do falls into place and we can help people in all the different ways that we have learned. If we understand that we're in this together, then it is not even a question of these slightly clumsy phrases like *patient-centered care* or *relationship-centered care*.

The techniques that I use, if people want to see how they work with people who are traumatized here in the United States—ordinary people, the very kinds of people who appear in everybody's practice—they can take a look at my book *Unstuck*.[6] I want to say to everybody who is reading this, "You are working with trauma. You, too, have been or will be traumatized. This is my invitation for you to take a look at these approaches and techniques and this kind of work for yourself and in your practice and in your life."

The next round of training starts in Portland, Oregon, in October. Every year, we do at least 1 full "open" training in the United States, where anyone who wants to come and learn what we have to teach is welcome.

***IMCJ*:** You have to wonder why more people aren't doing it.

Dr Gordon: I think people do not know that it is possible. Part of the problem for medicine, and certainly for MDs, is that they are intimidated. There is so much fear in the system. People feel they have to do things in a particular way. This is the way you make a living: You do *this*. So expanding beyond that, becoming engaged in integrative medicine, is a big step to begin with. Then making another step or making it part of your practice to actually get outside the office, to go into the world, is another step beyond what we think we can do or we are supposed to do. Perhaps we feel vulnerable being out of our customary role—out of our comfort zone.

I think enormous growth is possible there. Rudolf Virchow, MD, the great pathologist of the 19th century, said that medicine is a social science and doctors are the natural attorneys of the poor. That is not conveyed to us. We are in a model of working with individuals in an office, so we really need to open up to the possibility that we can do it and we need to have examples. That is one of the reasons why I am very grateful that you are doing this interview—so people can see, "Oh, yeah. This guy is doing it." We have a faculty of 160 people around the world who are teaching other people to do this work, a faculty that is very much like the readers of your journal, many of them—particularly here in the United States.

Several thousand people have come through our training and they are interested in opening up. We have got to create the opportunities for this to happen. Then

people will see it is possible. On an organizational, institutional, and collective level, that is what needs to happen. People need to listen to that still, small voice that says, "You know, I'd like to try that. I'd like to see what that's like." They need to have the experience of self-care and of community for themselves. Once you start having the experience and once you start looking at how that work can be helpful to others, then everything becomes possible. We have people who never dreamed they would be doing this kind of work who are doing it. Many of them are travelling all over the world and are doing it in places that they never imagined they would ever go to. It is possible, but you have to start by taking it step by step.

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